Overview

Project Title: To develop a community based health navigation service to assist patients to access healthcare services efficiently.

Actively Engaged Definition: the number of participating patients assisted by community navigators (in-person, telephonic, or web-based) (*to warrant being "assisted", there is no minimum number of connections per patient)*.

- Project goal: 26,500 by the end of Demonstration Year 3 Quarter Four (March 31, 2018). This is our Project's Speed and Scale.

Counting Criteria: A count of Medicaid patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients across the PPS are not allowed. The count is not additive across DSRIP years. A DSRIP Year commences April 1 and ends March 31, starting in 2015.

To count a patient engagement for Speed and Scale and contracting purposes, Partner Organizations will need to capture the following:

1. Name of staff providing the service,
2. Documentation of competency of staff to provide navigation services
    a. Follow training guidelines outlined in this document
    b. Proof of training placed in personnel file
3. Three patient identifiers (PHI will be HIPAA protected by all provider agencies)
    a. First and last name
    b. DOB
    c. Zip code
    d. Medicaid #
4. Time & date of call
5. Reason for call.
    a. Responsibilities/functions as outlined on page 3 will be used to qualify the encounter as meeting the definition of assistance and documented in the Electronic Health Record (EHR) system.

Data Source : EHRs or other IT Platforms (i.e. patient registries)

Requirements of the Project:

1. Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently. (Develop roles and training)
2. Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social services providers.
    a. **Responsibility: Community Health Advocates will contribute to development and maintenance of a community resource guide in conjunction with the oversight committee.**
3. Recruit for Community Health Advocates, ideally spearheaded by residents in the targeted area to ensure community familiarity.
4. Resource appropriately for the Community Health Advocates, evaluating placement and service type.
5. Provide Community Health Advocates with access to non-clinical resources, such as transportation and housing services.
6. Establish caseloads and discharge processes to ensure efficiency in the system for Community Health Advocates who are following patients longitudinally.
7. Market the availability of community-based Community Health Advocate services.
8. Use E H R's and other technical platforms to track all patients engaged in the project.

Important Clarifying point:

Medicaid is not providing a definition of what a Community Health Advocate is or how they function. It is expected that this will be created by the project team.

Responsibilities/Functions

Community Health Advocates guide patients through the healthcare system by eliminating barriers to timely access to healthcare services. Barriers to accessing care include financial, logistical, clinical and cultural. Guidance can be through phone calls, in person, or web-based. Responsibilities differ between Service Type One Community Health Advocates and Service Type Two Community Health Advocates as outlined below. All encounters are documented and Community Health Advocates will have the skills needed to capture criteria outlined as necessary for counting the encounters and justifying assistance.

SERVICE TYPE ONE COMMUNITY HEALTH ADVOCATES

NON-CLINICAL/MEDICAL			CLINICAL/MEDICAL
Financial Assistance	**Logistical Assistance**	**Cultural Assistance**	**Clinical Assistance**
Seek financial assistance for basic needs (food, shelter, utilities, and transportation) or health care expenses, when facing financial distress potentially impacting healthcare decisions.	Utilize Community resource Guide and provide information to patients		Refer patients to other community providers such as home care, palliative care, hospice, transitions of care or other medical programs as appropriate.
Make appointments with health insurance Community Health Advocate to obtain renewal of Medicaid coverage thru NYS Marketplace	Refer to Community organization such as housing, nutrition, childcare		Refer to medical services offered at no cost or on sliding scale
Obtain charity care & prescription assistance	Advise patients about community resource guide and 211 services.		
	Find transportation to medical appointments		

SERVICE TYPE TWO COMMUNITY HEALTH ADVOCATES

NON-CLINICAL/MEDICAL			CLINICAL/MEDICAL
Financial Assistance	**Logistical Assistance**	**Cultural Assistance**	**Clinical Assistance**
Understand Medical bills and working out payment plans with providers in order to ensure care.	Assist with obtaining cell phone so that patient can be contacted or have means of assisting self	Assist in awareness and understanding	Screen for Health Home eligibility and make referrals to Health Homes for those who meet eligibility criteria
Obtain coverage or additional coverage outside of the NYS Health Insurance Marketplace		Provide emotional assistance	Help empower individuals to access their health coverage and be their own advocates
Obtain an exemption or exclusion from Medicaid Managed Care		Assist with language/ethnic preferences	Provide coaching to patients
Understand patient rights and responsibilities under the ACA			Find a primary care provider, specialist
Understand COBRA in order to assist patients appropriately			Make apts. with providers

Resolve plan issues like claims denial or billing			
Understand and assist with appeal rights for denials of coverage or care			
Obtain prior authorization for care			
Discharge of patients occurs when barriers to care are eliminated or resolved for both Service Type One and Service Type Two Community Health Advocates.			

Competencies & Training Criteria

In order to reach the diversity and number of patients in the community that are needed for this project , the best approach is for each provider agency to develop their own screening, orientation & training for staff that will be providing Community Health Advocate assistance. The common element is that each provider agency will have the criteria written and formalized and included in the contract process with CCN. Completion of screening, orientation and training will be recorded in each Community Health Advocate personnel record. This is a grass roots approach which will meet the needs of patients in the communities where they are served and allow for diversity in approach to maximize effectiveness. Each provider knows their own community best. Best practices may emerge as reports and results are analyzed going forward.

Competencies of All Community Health Advocates

Provider agencies will ensure that Community Health Advocates will be knowledgeable of the community in which they serve.

Training of All Community Health Advocates

The Workforce Development Team and Cultural Competency Team will develop a training regarding standards of the PPS. This training will ensure understanding of DSRIP, all projects and ensure understanding of the Community Resource Guide. All Community Health Advocates will receive - and contracting provider organizations will certify - completion of training.

Additional Community Health Advocate Training by Service Type	
Service Type One Community Health Advocates	**Service Type Two Community Health Advocates**

• **Each provider organization develops and documents their own orientation program to meet the needs of their community and patients served.** • **Standards & Quality Measures include:** o **Service Delivery** ▪ **Assessment & Referral provision** ▪ **Information Provision** ▪ **Methods to Access to Community Resource Information** ▪ **Inquirer Advocacy** ▪ **Crisis Intervention** ▪ **Follow-up** o **Resource Guide** o **Cooperative Relationships** ▪ **with service providers**	• **Each provider organization develops and documents their own orientation program to meet the needs of their community and patients served.** • **Standards & Quality Measures include:** o **What is Managed Care** o **Charity Care & financial Assistance** o **Prescription Assistance** o **Prior Authorization /Appeals** o **Fair Hearing Process & Rights** o **Grievance Procedures** o **Utilization Review Process** o **External Review Appeals** o **Eligibility requirements to meet Health Home Criteria.**