Project Option 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB navigation program

Unique Project ID: 999999999.2.5
Performing Provider Name/TPI: Urban Health System / 999999999

Project Description:

Urban Health proposes to provide navigation services to targeted obstetrics patients who are at high risk of disconnect from institutionalized health care.

The project would improve access to pre- and post-natal care throughout a woman's pregnancy through comprehensive, effective patient navigation through the Urban Health System. The OB Navigation Program will provide for a collaborative team of Navigators, including Community Health Workers (CHWs), Case Managers (CMs), Social Workers (SWs), and Licensed Nurses (OB Navigator RNs), who will be responsible for navigating high-risk mothers through the healthcare system throughout their pregnancy and postpartum period. The care team will cover all 11 facilities providing obstetrics care in the Urban Health System.

The care team has the potential to recruit an additional 300 women per month into prenatal care across the system and route those patients to postpartum care. They may also route existing patients to postpartum care and subsequent primary care in a medical home. Through encounters in the medical home setting and with navigators, chronic conditions can also be addressed through education and access to care. Strategic areas within Urban Health System to engage women and place them into care include areas where pregnancy testing occurs, postpartum and NICU inpatient units, and women seen in the emergency department (ED) for primary care-related conditions. Special attention and time will be paid to patients in the EDs and NICUs.

The University of Texas School of Public Health's 2009 ED analysis of primary care visits to the ED revealed that of the top 20 primary care-related diagnoses in the 18-24 year old Medicaid age group, the top three diagnoses were for pregnancy-related conditions. Moreover, 7 of the top 20 overall were pregnancy-related diagnoses. In the community, CHWs will engage women at external venues, such as apartment complexes, community centers, and local businesses. The team will ensure proper access to care, appointment scheduling, Medicaid/CHIP enrollment, and will use targeted outreach strategies and health education to reach patients early in pregnancy and when they are at risk of leaving the care of Urban Health System. Once recruited, patients will receive follow-up phone calls, communication, education, and support from Navigators to ensure that patients continue prenatal care, delivery, and postpartum follow-ups. Navigation efforts will be aimed at improved birth outcomes for Urban Health System obstetrics patients, such as increased gestational age and birth weight, and low infant and maternal mortality rates. Specific improvement targets are described in the table. "High-risk" mothers will exhibit risk factors relating to medical conditions, previous pre-term birth experience, and/or other socio-economic and psychosocial risk factors. Urban Health System health centers are located in areas of the community with populations at high-risk of

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delivering with poor outcomes. Navigators will use the EPIC EMR to collect data and document patient encounters.

We propose to target zip codes in Urban County with the poorest perinatal outcomes, including: highest rates of pre-term birth, low birth weight, and infant and maternal mortality. In addition, these areas exhibit low rates of entry into prenatal care during the first trimester. These areas coincide with areas of low-income and poor socio-economic status. This data is currently available from the State and internal sources. The attached maps illustrate that all health centers are strategically located to serve the high-risk, pregnant population.

Target Zip Codes:

99999	99999	99999	99999	99999	99999	99999	99999
99999	99999	99999	99999	99999	99999	99999	99999
99999	99999	99999	99999	99999	99999	99999	99999

Goals and Relationship to Regional Goals:

The goal of this project is to use community health workers, case managers, social workers, and registered nurses as patient navigators to provide enhanced care coordination, community outreach, social support, and culturally competent care to vulnerable and/or high-risk obstetrics patients. Patient navigators will help and support these patients to navigate through the continuum of health care services throughout their pregnancy. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to Ob care providers in Urban Health medical home sites, as well as diverting non-urgent obstetrics care from the ED to site-appropriate locations.

Project Goals:

- Increase the number of patients enrolled in prenatal care in the first trimester.
- Increase the percentage of deliveries that have a postpartum visit on or between 21 and 56 days after delivery.
- Decrease singleton pre-term birth rate.
- Decrease percentage of low birth-weight births.

This project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

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The Ob Navigation program uses a patient-centered, coordinated care navigation model that aims to improve perinatal outcomes, improve satisfaction through timely access to appropriate care, and builds on the existing, successful network of Urban Health prenatal care access points. The program leverages the existing Urban Health prenatal care infrastructure to meet the need for increased enrollment in prenatal care with the goal of improving the poor perinatal outcomes currently exhibited in Urban County.

Challenges:

The primary challenge for this project will be to engage and build trust with patients. Targeted communities have historically been difficult to penetrate, but with proper navigator training and effective procedures, the project will be successful. In particular, cultural competency training and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement.

5-Year Expected Outcome for Provider and Patients:

Urban Health System expects to see improvements in perinatal outcomes for patients enrolled in the program and delivering within the Urban Health System. The provider expects to improve perinatal outcomes within the system and community outreach in targeted zip codes. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:

Currently, a patient navigation program does not exist for obstetrics patients at the Urban Health System. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2.

Rationale:

Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by Ob patient navigators will include:

- Coordinating care among providers.
- Arranging financial support and assisting with paperwork.
- Arranging transportation and child care.
- Facilitating follow-up appointments.
- Community outreach and building partnership with local agencies and groups.

Community health workers will have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities. Patient navigators will be:

- Compassionate, sensitive, and culturally attuned to the people and community
- Knowledgeable about the environment and healthcare system
- Connected with critical decision makers inside the system

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A project to develop a navigation team specifically for Ob patients is needed in the Urban County community. Urban County has had an average of 71,000 births per year since 2005 (5.6% of Texas births), with 68,167 births in 2010. In 2010, Urban County's preterm birth rate was 13.3% (9,096 pre-term babies). This rate has decreased slightly since 2005 (13.7%), yet remains above the national rate of 11.99% and the Healthy People 2020 goal of 11.4% (Texas Department of State Health Services, Center for Health Statistics; [http://www.healthypeople.gov/2020/default.aspx]). Within Urban County, there are great disparities regarding preterm birth rates; zip-code level data shows preterm birth rates ranging from 3.8% to 19.8% (Texas Department of State Health Services, Center for Health Statistics).

Since 2005, there has been a steady decline in first trimester prenatal care in Urban County (62% of births, compared to only 52.4% in 2010). Zip-code data identify disparities within the county, with rates for first trimester prenatal care ranging from 32.8% to 74.2%. Approximately 3.8% of the births in 2010 received no prenatal care. Births with no prenatal care range from 0 to 10% at the zip-code level. The infant mortality rate in 2010 was 6.3/1,000 live births, which is above the Healthy People 2020 goal of 6.0/1,000 live births. Fetal mortality is high as well, at 6.2/1,000 live births plus fetal deaths, placing our rates above the Healthy People 2020 goal of 5.6/1,000 live births plus fetal deaths. State estimates for 2010 identify 39.4 % of women in Urban County as not having insurance prior to becoming pregnant, with rates being 27.2% for White or Other, 28.3% for Black, and 51.8% for Hispanic. Without insurance, women with untreated underlying medical conditions could put themselves or their babies at an increased risk for adverse health outcomes.

By comparing the attached maps, which include markers where Urban Health System health centers are located as well as our target zip codes (listed above), it becomes clear that all health centers are strategically located to serve the high-risk, pregnant population.

Project Components:

Through the Ob Navigation Program, we propose to meet all required project components.

a) *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* Patients using the emergency department for primary care services, patients without a designated PCP or medical home, and patients with social or economic barriers to accessing primary care will be offered navigation services. Patient Navigators will create social services notes in the EHR that will be associated with the patients' medical record by medical record number. These notes will include sections on reason for services, assessment, subsequent referrals and follow-up activities. Patients will be provided a copy of these notes as well.

   All of our navigators will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health, community outreach, and chronic disease management.

b) *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* We plan to hire Patient Navigators with a background in community

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health, social services, mental health, or public health with experience providing direct care to disadvantaged populations. These individuals will be bilingual, from our community, and experienced in identifying community resources.

c) *Connect patients to primary and preventive care and d) Increase access to care management and/or chronic care management* – We will have regular contact with area primary care providers for care management services, preventive care, and other educational and social services. Providers will opt into our network, providing description of services, insurance eligibility, language services, current quality data, and location so that we can provide patients with options. We will send an introduction to our services as well as a survey to assess the needs and availability of the network. Navigators will be available to meet with providers to answer any specific questions. The network information surveys will be updated bi-annually.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement* –Our IT department will design a reporting template for the Patient Navigator notes that will include standardized fields where possible. We will create a data registry for enrolled patients to facilitate follow-up and effectiveness analysis. Reports will be run weekly by the program and shared monthly with ED staff and participating primary care providers. We will hold bi-weekly meetings with program staff and ED providers and quarterly meetings with Network providers to discuss opportunities for program improvement and expansion.

Unique community need identification numbers the project addresses:

- CN.7- High rates of inappropriate emergency department use
- CN.11- High rates of poor birth outcomes and low birth-weight babies
- CN.17- Insufficient access to services for pregnant women, particularly low-income
- CN.22- Lack of patient navigation, patient/family education, and information programs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently, a patient navigation program does not exist for obstetrics patients at the Urban Health System. Our system offers case management services, but this is typically only accessible to admitted patients and requires a physician order. The initiative will improve access for targeted patients while helping the system reach capacity for treating obstetrics patients.

<u>Related Category 3 Outcome Measures:</u>

OD-8 Perinatal Outcomes:
IT-8.1 Timeliness of Prenatal/Postnatal Care

- Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

IT-8.2 Percentage of Low Birth-weight Births: Number of babies born weighing <2,500 grams
IT-8.9 Singleton Pre-Term Birth Rate: Number of babies born prior to 37 weeks gestation

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Reasons/rationale for selecting the outcome measures:

Perinatal outcomes data relating to selected Category 3 outcomes are described above and all are identified as Healthy People 2020 objectives by the federal government. Ob navigators will assist low-income women to secure insurance and/or enter prenatal care timely. According to the Institute of Medicine, prenatal care and specifically, entry into prenatal care in the first trimester, has a positive effect on perinatal outcomes, such as low birth-weight.[1] These factors also reduce births prior to 37 weeks. Moreover, entry into prenatal care and subsequent postpartum care provide significant opportunities to treat co-morbid conditions, to introduce mothers to health education, and to promote wellness through an encounter with a medical home. The incidence of low birth-weight may also have long-term health effects on children.

Relationship to other Projects: This project's focus on cultural competency and emphasis on helping women receive regular care ties to these Category 1 and 2 projects in our RHP: 99999999-1.20 – Enhance culturally competent care; 999999999-1.35 – Collect REAL data to reduce disparities; 999999999.1.40 – enhance performance improvement and reporting capacity; 999999999.2.13 – enhance/expand medical homes. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: No other providers in the RHP are establishing a patient navigation program but many providers are focusing on cultural competency and reducing disparities in care, which are also focuses of this project. Urban health will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, newsletters will be distributed regularly to share data related to the efficacy of various practices.

Project Valuation: [A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.]

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[1] Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes; Behrman RE, Butler AS, editors. *Preterm Birth: Causes, Consequences, and Prevention*. Washington (DC): National Academies Press (US); 2007

Unique identifier: ***999999999.2.5***	***RHP PP Reference number: 2.9.1***	***Project Components:*** ***2.9.1 (a-e)***	***Project Title: Provide navigation services to targeted patients who are at high risk of disconnect form institutionalized health care: Ob Navigation Program***
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 3 Outcome Measure(s):	*999999999.3.12* *999999999.3.13* *999999999.3.14*	*IT-8.1* *IT-8.2* *IT-8.9*	*Timeliness of Prenatal/Postnatal Care* *Percentage of Low Birth-weight Births* *Other Outcome Improvement Target: Singleton Pre-Term Birth Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1]: Provide report identifying the following: • Targeted patient population characteristics • Gaps in services and service needs. • How program will identify, triage and manage target population • Ideal number of patients targeted for enrollment • Number of Patient Navigators needed to be hired • Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients Goal: Produce a comprehensive report documenting all points above.	**Milestone 2** [P-2]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline: At the beginning of DY2, Ob navigators did not exist; therefore, baseline for all is 0. Goal: Develop the training program with procedures and continuing education. Train and deploy a team of 25 navigators comprising of: CHWs, SWs, CMs, and RNs. Data Source: Training and Human Resources documentation Milestone 2 Estimated Incentive Payment: $XXX,XXX	**Milestone 6** [P-3]: Provide navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number of targeted patients enrolled in the Program. Goal: Enroll 3,600 unique, additional women in the Ob Navigation program. (If this goal is met, total enrollment will exceed 3,600, because some women who enrolled in DY 3 will remain in the program.) Data Source: Enrollment reports, EHR Milestone 6 Estimated Incentive Payment: $XXX,XXX **Milestone 7** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator	**Milestone 10** [P-3]: Provide navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number of targeted patients enrolled in the Program. Goal: Enroll 3,600 unique, additional women in the Ob Navigation program. (If this goal is met, total enrollment will exceed 3,600, because some women who enrolled in DY 4 will remain in the program.) Data Source: Enrollment reports, EHR Milestone 9 Estimated Incentive Payment: $XXX,XXX **Milestone 11** [I-X]: Increase number of Ob care provider scheduled and completed appointments for enrolled patients without an Ob care provider. Metric 1 [I-X.1]: Percent of pregnant patients enrolled in the program in the ED without an Ob care provider who are given a scheduled Ob care provider appointment Goal: 10% above baseline

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Unique identifier: ***999999999.2.5***	***RHP PP Reference number: 2.9.1***	***Project Components:*** ***2.9.1 (a-e)***	***Project Title: Provide navigation services to targeted patients who are at high risk of disconnect form institutionalized health care: Ob Navigation Program***
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 3 Outcome Measure(s):	*999999999.3.12* *999999999.3.13* *999999999.3.14*	*IT-8.1* *IT-8.2* *IT-8.9*	*Timeliness of Prenatal/Postnatal Care* *Percentage of Low Birth-weight Births* *Other Outcome Improvement Target: Singleton Pre-Term Birth Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Site gap analysis; Program documentation; EHR; State and county data sources Milestone 1 Estimated Incentive Payment (*maximum amount)*: $XXX,XXX	**Milestone 3** [P-3]: Provide navigation services to targeted patients. Metric 1 [P-3.1]: Increase number of targeted patients enrolled in the Program. Baseline: 0 patients enrolled. Goal: Enroll 1,000 unique women in the Ob Navigation program. Data Source: Enrollment reports, EHR Milestone 3 Estimated Incentive Payment: $XXX,XXX **Milestone 4** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline: Currently, navigation services are not provided to patients using the ED. Goal: Provide patient navigation	services provided. Baseline: Currently, navigation services are not provided to patients using the ED. Goal: Provide patient navigation services to Ob patients in Urban Health EDs. Data Source: Reports documenting services provided to Ob patients. Milestone 7 Estimated Incentive Payment: $XXX,XXX **Milestone 8** [I-X]: Increase number of Ob care provider scheduled and completed appointments for enrolled patients without an Ob care provider. Metric 1 [I-X.1]: Percent of pregnant patients enrolled in the program in the ED without an Ob care provider who are given a scheduled Ob care provider appointment Goal: Increase 5% above baseline Data Source: EHR referral documentation Metric 1 [I-X.2]: Percent of pregnant patients enrolled in the program in the community and facilities without a primary care provider who were	Data Source: EHR Metric 1 [I-X.2]: Percent of pregnant patients enrolled in the program in the community and facilities without a primary care provider who are scheduled and completed an Ob care provider appointment Goal: 10% above baseline Data Source: EHR Milestone 11 Estimated Incentive Payment: $XXX,XXX **Milestone 12** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

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Performing Provider Name: Urban Health System				*TPI - 999999999*
Related Category 3 Outcome Measure(s):	*999999999.3.12* *999999999.3.13* *999999999.3.14*	*IT-8.1* *IT-8.2* *IT-8.9*	*Timeliness of Prenatal/Postnatal Care* *Percentage of Low Birth-weight Births* *Other Outcome Improvement Target: Singleton Pre-Term Birth Rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	services to Ob patients in Urban Health EDs. Data Source: Reports documenting services provided to Ob patients. Milestone 4 Estimated Incentive Payment: $XXX,XXX **Milestone 5 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.		scheduled and completed a Ob care provider appointment Goal: Increase 5% above baseline Data Source: EHR referral documentation Milestone 8 Estimated Incentive Payment: $XXX,XXX **Milestone 9** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 12 Estimated Incentive Payment: $XXX,XXX

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Unique identifier: ***999999999.2.5***	***RHP PP Reference number: 2.9.1***	***Project Components:*** ***2.9.1 (a-e)***	***Project Title: Provide navigation services to targeted patients who are at high risk of disconnect form institutionalized health care: Ob Navigation Program***
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 3 Outcome Measure(s):	*999999999.3.12* *999999999.3.13* *999999999.3.14*	*IT-8.1* *IT-8.2* *IT-8.9*	*Timeliness of Prenatal/Postnatal Care* *Percentage of Low Birth-weight Births* *Other Outcome Improvement Target: Singleton Pre-Term Birth Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $XXX,XXX	Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 9 Estimated Incentive Payment: $XXX,XXX	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $XXX,XXX	Year 3 Estimated Milestone Bundle Amount: $XXX,XXX	Year 4 Estimated Milestone Bundle Amount: $XXX,XXX	Year 5 Estimated Milestone Bundle Amount: $XXX,XXX
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $XXX,XXX			

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Title of Outcome Measure (Improvement Target): IT-8.1- Timeliness of Prenatal/Postnatal Care

Unique RHP outcome identification number(s): 999999999.3.12

Outcome Measure Description:

IT- 8.1- Timeliness of Prenatal/Postnatal Care

- Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates for rate 1 and rate 2
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-8.1 Rate 1: Increase percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 3% above baseline
  - IT-8.1 Rate 2: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 5% above baseline
- DY5:
  - IT-8.1 Rate 1: Increase percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 4% above baseline
  - IT-8.1 Rate 2: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 7% above baseline

Rationale:

Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor timeliness of prenatal and postnatal care within the Urban Health System. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines for Rate 1 and Rate 2 with P-2.

Improvement targets were chosen for Rate 1 and Rate 2 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of an OB navigation program *<Note to providers: Please insert in this section any evidence you have that has led you to pick the improvement target percentages.>* These outcome measures being addressed are largely affected by social determinants other than encounters with navigators. For instance, psychosocial and mental health issues, transportation issues, cultural and behavioral issues, and childcare issues will affect a patient's show rate for appointments.

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Outcome Measure Valuation:

- A narrative that describes the approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets) and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding).]

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Unique Cat 3 ID: 999999999.3.12	*Ref Number from RHP PP: 3.IT-8.1*	*Timeliness of Prenatal/Postnatal Care*	
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier – 999999999.2.5*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $XXX,XXX **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 2 Estimated Incentive Payment: $XXX,XXX	**Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $XXX,XXX **Process Milestone 4** [P-2]: Establish baseline rates for Rate 1 Data Source: EHR; Business Intelligence Process Milestone 4 Estimated Incentive Payment: $XXX,XXX **Process Milestone 5** [P-2]: Establish baseline rates for Rate 2 Data Source: EHR; Business Intelligence Process Milestone 5 Estimated Incentive Payment: $XXX,XXX	**Outcome Improvement Target 1** [IT-8.1 Rate 1]: Timeliness of Prenatal Care Improvement Target: Increase percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 3% above baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 1 Estimated Incentive Payment*:* $XXX,XXX **Outcome Improvement Target 2** [IT-8.1 Rate 2]: Postpartum Care Improvement Target: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 4% above baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 2 Estimated Incentive Payment*:* $XXX,XXX	**Outcome Improvement Target 3** [IT-8.1 Rate 1]: Timeliness of Prenatal Care Improvement Target: Increase percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 5% above baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 3 Estimated Incentive Payment*:* $XXX,XXX **Outcome Improvement Target 4** [IT-8.1 Rate 2]: Postpartum Care Improvement Target: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 7% above baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 4 Estimated Incentive Payment*:* $XXX,XXX

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Unique Cat 3 ID: 999999999.3.12	*Ref Number from RHP PP: 3.IT-8.1*	*Timeliness of Prenatal/Postnatal Care*	
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier – 999999999.2.5*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $XXX,XXX	Year 3 Estimated Outcome Amount: $XXX,XXX	Year 4 Estimated Outcome Amount: $XXX,XXX	Year 5 Estimated Outcome Amount: $XXX,XXX
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $XXX,XXX			

SAMPLE

Title of Outcome Measure (Improvement Target): IT- 8.2 Percentage of Low Birth-Weight Births

Unique RHP outcome identification number(s): 999999999.3.13

Outcome Measure Description:

IT- 8.2 Percentage of Low Birth-Weight Births

Low birth-weight births will be defined as babies born weighing <2,500 grams at birth.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates for rate 1 and rate 2
  - P-3 – Develop and test data systems

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 8.2 Percentage of Low Birth-Weight Births
    - Decrease the percentage of babies born weighing <2,500 grams at birth by 2% below baseline
- DY5:
  - IT- 8.2 Percentage of Low Birth-Weight Births
    - Decrease the percentage of babies born weighing <2,500 grams at birth by 3% below baseline

Rationale:

Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor timeliness percentage of low birth-weight births within the Urban Health System. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish the baseline.

Improvement targets were chosen based on the timeframe allowed to put in place the proper resources and processes needed to collect data. In addition, the outcome measure being addressed is affected by social determinants other than prenatal encounters with navigators and providers. For instance, psychosocial, mental health, demography trends, and behavioral issues will affect the incidence of low birth-weight births. In addition, the long timeframe needed to realize perinatal outcomes results for full-term pregnancies was considered. Patients in the project will be encountered at the beginning of pregnancy and will need to be followed over time. *<Note to providers: Please insert in this section any evidence you have that has led you to pick the improvement target percentages.>*

Outcome Measure Valuation:

- A narrative that describes the approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets) and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding).

SAMPLE

Unique Cat3 ID: 999999999.3.13	*Ref Number from RHP PP: 3.IT-8.2*	*Percentage of Low Birth-Weight Births*	
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 1 or 2 Projects:	*Unique Cat2 ID: 999999999-2.5*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $XXX,XXX **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 2 Estimated Incentive Payment: $XXX,XXX	**Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $XXX,XXX **Process Milestone 4** [P-2]: Establish baseline rate Data Source: EHR; Business Intelligence Process Milestone 4 Estimated Incentive Payment: $XXX,XXX	**Outcome Improvement Target 1** [IT-8.2]: Percentage of Low Birth-Weight Births Improvement Target: Decrease the percentage of babies born weighing <2,500 grams at birth by 2% below baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 1 Estimated Incentive Payment*:* $XXX,XXX	**Outcome Improvement Target 2** [IT-8.2]: Percentage of Low Birth-Weight Births Improvement Target: Decrease the percentage of babies born weighing <2,500 grams at birth by 3% below baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 2 Estimated Incentive Payment*:* $XXX,XXX
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $XXX,XXX	Year 3 Estimated Outcome Amount: $XXX,XXX	Year 4 Estimated Outcome Amount: $XXX,XXX	Year 5 Estimated Outcome Amount: $XXX,XXX
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $XXX,XXX			

SAMPLE

Title of Outcome Measure (Improvement Target): IT- 8.9 – Other outcome improvement target: Singleton Pre-Term Birth Rate

Unique RHP outcome identification number(s): 999999999.3.14

Outcome Measure Description:
IT- 8.9 Singleton Pre-Term Birth Rate
Pre-term birth is defined as the number of singleton babies born prior to 37 weeks gestation. Singleton babies are targeted due to incidence of pre-term birth for multiples.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates for rate 1 and rate 2
  - P-3 – Develop and test data systems

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 8.9 Singleton Pre-Term Birth Rate
    - Decrease singleton pre-term birth rate by 8% below baseline
- DY5:
  - IT- 8.9 Singleton Pre-Term Birth Rate
    - Decrease singleton pre-term birth rate by 9% below baseline

Rationale:

Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure singleton pre-term birth rates within the Urban Health System. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish the baseline.

Improvement targets were chosen based on the timeframe allowed to put in place the proper resources and processes needed to collect data. In addition, the outcome measure being addressed may be affected by social determinants other than prenatal encounters with navigators and providers. For instance, psychosocial, mental health, demography trends, and behavioral issues will affect the incidence of pre-term birth. In addition, the long timeframe needed to realize perinatal outcomes results for full-term pregnancies was considered. Patients in the project will be encountered at the beginning of pregnancy and will need to be followed over time. *<Note to providers: Please insert in this section any evidence you have that has led you to pick the improvement target percentages.>*

Outcome Measure Valuation:

- A narrative that describes the approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets) and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding).

SAMPLE

Unique Cat 3 ID: 999999999.3.14	*Ref Number from RHP PP: 3.IT-8.9*	*Other Outcome Improvement Target: Singleton pre-term birth rate*	
Performing Provider Name: Urban Health System			*TPI - 999999999*
Related Category 1 or 2 Projects:	*Unique Cat 2 ID: 999999999.2.5*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $XXX,XXX **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 2 Estimated Incentive Payment: $XXX,XXX	**Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $XXX,XXX **Process Milestone 4** [P-2]: Establish baseline rates for Rate 1 Data Source: EHR; Business Intelligence Process Milestone 4 Estimated Incentive Payment: $XXX,XXX	**Outcome Improvement Target 1** [IT-8.9]: Singleton Pre-Term Birth Rate Improvement Target: Decrease singleton pre-term birth rate by 8% below baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 1 Estimated Incentive Payment*:* $XXX,XXX	**Outcome Improvement Target 2** [IT-8.9]: Singleton Pre-Term Birth Rate Improvement Target: Decrease singleton pre-term birth rate by 9% below baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 2 Estimated Incentive Payment*:* $XXX,XXX
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $XXX,XXX	Year 3 Estimated Outcome Amount: $XXX,XXX	Year 4 Estimated Outcome Amount: $XXX,XXX	Year 5 Estimated Outcome Amount: $XXX,XXX
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $X,XXX,XXX			

SAMPLE