RHP 7 3-YEARS DSRIP PROJECT SUMMARY for CCC Centering Pregnancy Project

Project and Provider Information:

Title of Project: Centering Pregnancy
Unique RHP Project Identification Number (TPI.1.1): 307459301.2.100
Performing Provider Name/TPI: Community Care Collaborative/307459301
Project Option: 2.7.3: Implement innovative evidence-based strategies to increase early enrollment in prenatal care

Brief Provider Description:

The Community Care Collaborative (CCC) is a 501(c)(3) public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and developmental disorder services for Travis County, has also joined the CCC as a partner.

The CCC's overarching goal is to provide high quality, cost effective, patient-centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

Description of the Intervention:

The proposed intervention is to implement a Centering Pregnancy program tailored to meet the needs of the Travis County low income uninsured and Medicaid women with a focus on the African American population. African American women have a disproportionate percentage of pre-term births which result in higher rates of NICU utilization (see Need for Project section below). Centering Pregnancy is an evidence-based, multifaceted model of prenatal care that integrates three major components of care: health assessment, education and support. Following the IOM Rules for Healthcare Redesign, Centering Pregnancy offers these components in a unified program within a group setting designed to empower women to choose health-promoting behaviors and improve health outcomes for pregnancy. Centering Pregnancy care starts around the beginning of the second trimester and goes through delivery. Eight to twelve women with similar gestational ages meet together, learn care skills, participate in a facilitated discussion, and develop a support network with other group members. Specific topics covered in the group sessions will include: the importance of breast-feeding; finding social supports; birth spacing and contraceptive options. The practitioner, within the group space, completes one-on-one standard physical health assessments. Each Pregnancy group meets for a total of 10 sessions throughout pregnancy and early postpartum.

The specific goals for the intervention include:

1. Enrolling 170 women into the Centering Pregnancy program;
2. Reducing the preterm birth rate in our target population.

3. Improve satisfaction with prenatal care by creating a patient-centered experience unique to the needs of low income uninsured and Medicaid women with a focus on the African American population.
4. Creating an evidence-based curriculum for Centering Pregnancy focused on African Americans which can be disseminated nationwide through the Centering Healthcare Institute, in the hopes of improving outcomes on a national level.

Need for the Project:
The preterm birth rate among African-Americans in central Texas mirrors the national rate, at about 16.8% births occurring before 37 weeks, compared to 10% for the White population. Preterm birth is highly correlated with low birth weight, infant mortality, and long-term disability; in Austin, African-Americans represent only 8% of births, but 14% of admissions to the NICU, and have a rate of infant mortality 2.5 times higher than Whites and Hispanics. This disparity in birth outcomes is not only a pressing medical issue, but also has a significant economic impact.

Unique Community Identification Number:
CN.12- Lack of adequate prenatal care

Target Population:
The target populations for this program ~~is~~ are low income uninsured and Medicaid pregnant women with a focus on the African American population. It is anticipated that 170 women will receive services under the Centering Pregnancy program -- 20 individuals in DY3, 50 in DY4, and 100 in DY5.

Category 1 or 2 Measures:

Expected patient benefit: By encouraging early and evidence-based prenatal services, this intervention aims to reduce the potentiality of pre-term births and high-risk births. The Centering Pregnancy program aims to achieve these measures by using evidence-based guidelines and patient empowerment tools. It expands quality preventive services in clinical and community settings, helps participants make healthy choices, and helps to reduce health disparities.

Description of the QPI (Quantifiable Patient Impact) metric(s): Number of unique individuals receiving services/intervention (20 in DY3, 50 in DY4 and 100 in DY5).

Selected Category 3 Measure: 8.11: Healthy Term Newborns; the report on this population-based measure will be accompanied by a program evaluation (SA-3) in DY5.

RHP 7 3-YEARS DSRIP PROJECT NARRATIVE for CCC Centering Pregnancy Project

Project and Provider Information:

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Project Description:

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)(3) public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and developmental disorder services for Travis County, is also a CCC partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

This DSRIP project will implement an evidence-based Centering Pregnancy project, which provides health assessment, education, and support to pregnant women in a facilitated group environment to expand access to prenatal care and empower women to make healthy choices to reduce pre-term and/or low-birth weight births and improve health status. This initiative will tailor a Centering Pregnancy program to meet the needs low income uninsured and Medicaid eligible women, with a focus on the African American population. Taken with the fourteen other DSRIP projects that the CCC is implementing, these women will have better access to a range of care services.

These fourteen other CCC DSRIP projects are:

Chronic Care Management	Patient-Centered Medical Homes
Disease Management Registry	Expanded Hours at Community Clinics
Mobile Care Teams to Underserved Areas	Dental Care Expansion
Patient Navigation	Paramedic Navigation
Gastroenterology in Community Clinics	Pulmonology in Community Clinics
Integrated Behavioral Health for Diabetics	Telepsychiatry in Community Clinics
STI Screening, Treatment and Prevention	Pregnancy Planning

Centering Pregnancy is an evidence-based, multifaceted model of prenatal care that integrates three major components of care: health assessment, education and support. Following the IOM Rules for Healthcare Redesign, Centering Pregnancy offers these components in a unified program within a group setting.

Centering Pregnancy care starts around the beginning of the second trimester and goes through delivery. Eight to twelve women with similar gestational ages meet together, learn care skills, participate in a facilitated discussion, and develop a support network with group members. Specific topics covered in the group sessions include: the importance of breast-feeding; finding social supports; birth spacing and pregnancy planning options. The practitioner, within the group space, completes one-on-one standard physical health assessments. Each group meets for a total of 10 sessions throughout pregnancy and early postpartum.

The Centering Healthcare Institute, which provides training, materials, data collection and reporting, consultation and site approval services for Centering Pregnancy and Parenting programs, describes how each of the three core component services are implemented.

> Assessment is provided by a licensed health care provider during the group time and in the group space. Each patient has a brief individual check-up with the provider and participates in self-care activities including assessing their own weight and blood pressure. Both patients and provider contribute to data on patient charts.
>
> Education is conducted in a facilitative rather than didactic style. Two facilitators lead each group. There are content guidelines for every session, but the actual group discussion is determined largely by the interests, needs, and concerns of the group.
>
> Support, friendships, and community-building are important to the Centering model. These are fostered by group stability, interactive activities, and regularly-scheduled sessions.

The CMS Innovation Center has recognized the Centering Pregnancy program as an evidence-based strategy to reduce pre-term births and improve health outcomes for mothers and children and has awarded multiple grants for these programs through its Strong Start for Mothers and Children Initiative. Further, a 2007 multi-site randomized controlled trial on Group Prenatal Care published in the *American Journal of Obstetrics & Gynecology* found that participation in Centering Pregnancy care reduced the risk of premature birth by 33 percent compared to traditional prenatal care.

To implement this project locally, the CCC will work with a community based health center to implement the Centering Pregnancy program. Clinical staff are currently in place to facilitate the program; additional staff will be hired for overall program coordination and patient outreach and recruitment.

As a best practice, all patients will be referred to specialists should their prenatal care require it. The narrative has been updated with this change. High risk patients will be referred to appropriate specialists such as the community-based high risk OB clinic operated by a CCC contracted provider.

Support activities will be designed to make the group a convivial experience. They are tailored to each group's needs. Activities include guest speakers on health care topics, educational videos, baby showers, birthday parties, and other pregnancy-related social activities that encourage bonding among group members.

Target Population

The CCC Centering Pregnancy intervention will be targeted to low-income, Medicaid or uninsured women with a focus on African American women. Based on historical percentages from a clinic system based in Travis County, we expect that approximately half of the project enrollees will be Medicaid beneficiaries and approximately half will be low-income uninsured.

This population and intervention are proposed to address existing, documented disparities in birth health outcomes for the target population as well as to help address the economic impact of preterm births.

Health Disparities

- Preterm Birth Rate -- The preterm birth rate among African-Americans in Central Texas mirrors the national rate, at about 16.8% births occurring before 37 weeks, compared to 10% for the White population. Preterm birth is highly correlated with low birth weight, infant mortality, and long-term disability.
- NICU Utilization/Infant Mortality -- In Austin, state health data indicates that African-Americans represent only 8% of births, but 14% of admissions to NICUs, and have an infant mortality rate 2.5 times higher than Whites and Hispanics.
- Repeat Preterm Births – A February 2007 study published in the American Journal of Obstetrics & Gynecology found that African American mothers were five times more likely than White mothers to have repeated premature births. While all women who initially delivered a premature infant at 20-34 weeks of gestation were more likely to do so again, the rate for Caucasian women was 9.2% while the rate for African American women was 21.5%.
- Very Preterm Births -- The March of Dimes reports that African American women have the highest Very Preterm Birth Rate at 18.5%. "Very Preterm" is defined as babies born at less than 32 weeks of pregnancy.

Economic Impact

The March of Dimes reports that in 2005, costs associated with preterm births for the nation exceeded $26.2 billion in medical care, educational costs and lost productivity. Average first-year medical costs were about 10 times greater for preterm than for full-term infants.

Project Goal(s):

1. Enroll 170 women into the Centering Pregnancy program.
2. Reduce the preterm birth rate in our target population.
3. Improve satisfaction with prenatal care by creating a patient-centered experience unique to the needs of low income uninsured and Medicaid women with a focus on the African American population.

4. Create an evidence-based curriculum for Centering Pregnancy with elements specific to African Americans which can be disseminated nationwide through the Centering Healthcare Institute, in the hopes of improving outcomes on a national level.

Challenges or Issues faced by the Performing Provider:
Challenges and Issues include --

- Training staff on the Centering Pregnancy model;
- Implementing scheduling changes for provider to allow for group sessions;
- Effectively promoting the program to the target population and ensuring that materials are culturally relevant; and
- Identifying the best meeting day, time, and location for the target population.

How the Challenges will be Addressed:
This project will address these challenges by --

- Working with the Centering Healthcare Institute on obtaining training, materials, site approval, and consultation on other implementation issues as needed;
- Reviewing findings from other studies in which Centering Pregnancy programs have successfully targeted low-income, African American women, such as the *Introduction of Centering Pregnancy in a Public Health Clinic* by Klima which was published in the January/February 2009 edition of the Journal of Midwifery and Women's Health; and
- Learning from other Centering Pregnancy programs being piloted in the local area.

3-Year Expected Outcome:
This project expects to increase the number of low income uninsured and Medicaid women receiving Centering Pregnancy services from 0 to 170 by DY5. It is anticipated that a majority of these women will be African American. These patients will benefit from increased perinatal assessment, education and group support, and greater understanding of healthy behaviors and improved health outcomes.

How Project is related to Regional Goal:
The project aligns with RHP Goals 1-5 --

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 population to include the right mix of providers, better data, and service delivery locations that are more accessible.
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
3. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
4. Bolster individual and population health by improving chronic disease management.
5. Support prevention education and healthy lifestyles to improve population health.

Starting Point/Baseline:
The baseline for this project is 73 women. This represents the number of women in DY2 who completed a minimum of 5 sessions of the 10 session curriculum. While a Centering Pregnancy program is being implemented at a CCC provider, that program's population served is different than that proposed for this project.

Quantifiable Patient Impact: (# served – QPI Measure)
The QPI measure to be tracked for this project is I-5.2 – Increase in the number of the target population participating in the intervention.

A total of 170 pregnant women will receive care under the model -- with a planned enrollment of 20 individuals in DY3, 50 in DY4, and 100 participants in DY5. It is anticipated that a majority of these patients will be African American.

Rationale:
Reasons for Selection of Project Option and Components
The Centers for Disease Control and Prevention (CDC) reports on its website that each year, preterm birth affects nearly 500,000 babies or 1 of every 8 infants born in the United States. Preterm birth is the birth of an infant prior to 37 weeks of pregnancy. Preterm-related causes of death together accounted for 35% of all infant deaths in 2009 and are a leading cause of long-term neurological disabilities in children.

The preterm birth rate among African-Americans in Central Texas is at about 16.8% compared to 10% for the White population. In Austin, African-Americans represent only 8% of births, but have 14% of admissions to NICUs, and have an infant mortality rate 2.5 times higher than Whites and Hispanics. This disparity in birth outcomes is not only a pressing social justice issue, but also has a significant economic impact.

Centering Pregnancy facilitates timely access to prenatal care and empowers participants to choose health-promoting behaviors. Prior studies on this program have shown that participants have better health outcomes for pregnancies, specifically increasing birth weight and gestational age of mothers that deliver preterm.

No other federal funds will be used to support this project.

Reason for Selection of Milestone and Metrics
Milestones identified for DY3-5 include metrics to measure program implementation, number of individuals reached, and participation in the RHP 7 learning collaborative. Specifically, the CCC will track the implementation of evidence-based innovational project for targeted population (P-2). For the QPI measure, the CCC will measure the increase in the number of the target population participating in the intervention (I-5.2), and CCC providers selected for this intervention will actively participate in face-to-face learning (P-7) through the RHP 7 learning collaborative. Additionally, in DY4 and 5, the CCC will execute an evaluation of the project (P-4) to adjust services according to information learned through evaluation.

This combination of milestones will allow the CCC to ensure the effective implementation of the program, assess its effectiveness for the target population, adjust as necessary, increase the number served through the program, and learn best practices from our regional partners.

Unique Community Need Identification Number
CN.12- Lack of adequate prenatal care

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery reform initiative
This project significantly enhances the existing delivery system by expanding critical prenatal assessment, education, and support services to additional low-income women to promote a full-term birth and increase the likelihood of a safe delivery and healthy child.

Project Core Components:
The CCC will implement the required core component of conducting continuous quality improvement (CQI) activities for the project through systematic data collection, analysis and assessment, improvement identification, process design, communication, and ongoing evaluation of outcomes to ensure high quality health services. The CQI program combines compliance, risk and quality oversight and includes data-driven and data-based performance measurements. Clinical care data is monitored and evaluated through regular meetings of a clinical core team (VP of Health Services, Chief Medical Officer, CQI staff and health center directors) to formulate improvement plans. For this project, CQI will also include a survey of providers, staff, and patients to determine efficacy of project education and group implementation and refine future interventions based on survey results.

Customizable Process or Improvement Milestones: N/A

Related Category 3 Outcome Measure(s): 8.11: Healthy Term Newborns; the report on this population-based measure will be accompanied by a program evaluation (SA-3) in DY5.

Relationship to Other Projects:
This project has a similar target population and/or service focus to the City of Austin Health & Human Services Department's Prenatal & Postnatal Improvement Program (201320302.2.4), Healthy Families Program Expansion (201320302.2.5), and proposed 3-Year project on Teen Pregnancy Prevention using Peer Education. It also has a similar target population to University Medical Center Brackenridge's project for OB Navigation (137265806.2.1) and St. Mark's Medical Center's project on Expanding Access to Specialty Care (Obstetrics) (176692501.1.1).

Plan for Learning Collaborative:
RHP 7 providers recognize the importance of learning from each other's implementation experiences. RHP 7's Learning Collaborative will focus on patient engagement and will adapt the IHI's Model for Improvement as the basis for our work. This model will require us to: set standard measures; quickly test interventions; report data frequently; and work together to learn from each other and improve one another. CCC will participate in face-to-face meetings or seminars organized by the RHP at least twice per year.

RHP providers believe that patient engagement is a leading indicator for success in almost all selected Category 3 measures -- increased patient engagement can improve patient experience and patient adherence to medication and treatment regimens reduce length of stay, lower cost per case and decrease adverse events (Charmel P HFM and Egman-Levitan, CAHPS).

According to the Institute for Family Centered Care, key aspects of patient engagement include: 1) dignity and respect; 2) information sharing; 3) participation in care and decision-making; and 4) collaboration. Thus, possible aims for the region include improvement in patient activation, increase in the number of patients with self-management goals documented reduction in the no-show rate and improved patient experience.

Project Valuation:

In valuing its projects, the CCC considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment in terms of personnel, equipment, time, and complexity was also considered. The CCC reflected on the scope of the project including number of patients impacted; number of patient encounters; number of new staff needed; any costs to be avoided as a result of the project; and the "ripple effect" on the healthcare system. These factors were weighed against the amount of funds available.