Navigation Project Summaries

#	Provider	Project Option	Subcategory	Cat 3 Measure	Description	QPI - Individuals or encounters	QPI Metric Description	QPI Target DY3	QPI Target DY4	QPI Target DY5	CUMULATIVE DY5 QPI	Total Incentive Payment DY2-5 Cat 1 or 2
1	City of Houston Department of Health and Human Services	2.9.1	Expand/Establish Navigation Services	• IT 6.2.a Client Satisfaction Questionaire 8(CSQ-8)	• Implement CareHouston Links, a new program that proposes to provide care coordination and navigation that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.	Individuals	Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period	960	1008	1056	3,024	$ 9,731,918
2	City of Houston Department of Health and Human Services	2.9.1	Expand/Establish Navigation Services	• IT 15.11 Follow-up after Treatment for Primary or Secondary Syphilis	• Implement HIV Service Linkage Project will use patient navigators to connect 270 new at risk HIV diagnosed individuals to appropriate care in the baseline year. • Refer patients to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing • Identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.	Individuals	DY3-Increase in the number or percent of targeted patients enrolled in the program DY4&5-Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period.	275	288	303	866	$ 9,130,068
3	Fort Bend County Clinical Health Services	2.9.1	Expand/Establish Navigation Services	• IT 1.10 Diabetes care: HbA1C poor control (>9.0%)	• Expand patient navigation services to a subset of the uninsured and underinsured population in the county which uses EMS and ED services inappropriately for non-emergent conditions and has no means to pay for the services. • Refer identified patients into the navigation system to promote a medical home and provide primary care, prevention services and chronic condition management. • Provide linkages to social service agencies to resolve other issues • Include follow up for appointment and medication compliance.	Individuals	Increase in the number or percent of targeted patients enrolled in the program	50	75	94	219	$ 2,595,969
4	Harris Health System	2.9.1	Expand/Establish Navigation Services	• IT 9.4b Reduce Emergency Department visits for Diabetes	• Target top EC frequenters and ensure they are managed appropriately to receive the right care in the right setting through a navigation program.	Individuals	Increase in the number of targeted patients enrolled in the program	200	300	400	900	$ 12,801,250
5	Matagorda Regional Medical Center	2.9.1	Expand/Establish Navigation Services	• IT 9.2 Reduce Emergency Department(ED) Visits for Ambulatory Care Sensitve Conditions(ASC) per 100,000	• Establish a patient care navigation program to navigate high risk / high ED utilizing patients to establish medical homes and decrese ED utilization.	Individuals	DY4 Increase in the number or percent of targeted patients enrolled in the program DY5 Improvements in access to care of patients receiving patient navigation services using innovative project option	0	180	200	380	$ 676,986
6	Memorial Hermann Hospital	2.9.2	Expand/Establish Navigation Services	• IT 9.2 Reduce Emergency Department(ED) Visits for Ambulatory Care Sensitve Conditions(ASC) per 100,000	• Expand COPE and ER Navigation programs within all Memorial facilities in Region 3 • Expand COPE staff.	Individuals	Increase in the number or percent of targeted patients enrolled in the program	6,600	9,100	11,250	26,950	$ 15,435,419
7	OakBend Medical Center	2.9.1	Expand/Establish Navigation Services	• IT 3.3 Risk Adjusted Congestiive Heart Failure(CHF) 30-day Readmission Rate	• Establish a Patient Care Navigation Program - Patient to support patients to navigate through the continuum of health care services. • Ensure that patients receive coordinated, timely, and site-appropriate health care services. • Assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.	Individuals	Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services	0	107	115	222	$ 2,967,158
8	The University of Texas Health Science Center - Houston	2.9.1	Expand/Establish Navigation Services	• IT 3.5 Risk Adjusted Diabetes 30-day Readmission Rate	• Establish/expand A4 UTHealth Regional Patient Navigation to target patients at high risk of disconnect from institutionalized health care • Support these patients to navigate through the continuum of health care services, ensuring that patients receive coordinated, timely, and site & appropriate health care services.	Individuals	Number of patients receiving navigation services.	12,480	12,480	12,480	37,440	$ 12,711,258

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9	The University of Texas Health Science Center - Houston	2.12.2	Expand/Establish Navigation Services	• IT 12.16 High-risk Colorectal Cancer Follow-up rate within one year	• Implement/expand A3 UTHealth General Care Transitions to ensure that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge • Implement with UT Physicians' network of hospitalists with 24/7 management of inpatients with specific medical and surgical conditions.	Individuals	Target population reached with evidence-based care transitions services.Number of patients in targeted populations having received evidence-based care transitions services.	250	750	1000	2,000	$ 11,863,840
10	Harris Health System	2.9.1	OB Patient Navigation Services	• IT 8.12 Pre-term birth rate	• Improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman's pregnancy, with a focus on high-risk mothers.	Individuals	Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period	200	600	1250	2,050	$ 21,023,764
											Total Navigation Projects Incentive	**$ 98,937,630**

Navigation Project Sub-categories	Total Projects in the Sub-category	Total Sub-category Incentive Payment Amount
Expand/Establish Navigation Services	9	$77,913,866
OB Patient Navigation Services	1	$21,023,764
TOTAL	10	$98,937,630

QPI Grouping Type	Total QPI Target per HHSC: DY3	Total QPI Target per HHSC: DY4	Total Target per HHSC: DY5	Cumulative total for QPI measures
Individuals	21015	24888	28148	74051
Grand Total	**21015**	**24888**	**28148**	**74051**