Chronic Care Project Summaries

#	Provider	Project Option	Sub-category	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	2.6.3	Health Education	• IT 10.1.a.I Assessment of Quality of Life(AQoL-4D)	• Utilize community health workers to provide 24 sessions of essential education and assessment related to fall prevention and safety • Provide intervention to reduce hazards in the home to 100 of the 500 low income older adults initially recruited into the program.	Individuals	Number of individuals served	500	525	550	1575	$ 7,888,709
2	City of Houston Department of Health and Human Services	2.12.3	Health Education	• IT 10.1.a.I Assessment of Quality of Life(AQoL-4D)	• Engage community health workers in an evidence-based program to increase health literacy of a targeted population • Utilize case managers, coaches and navigators to improve transitions of patients from the inpatient hospital setting to other care settings, improve quality of care, reduce avoidable readmissions for high risk heart failure beneficiaries and document measurable savings to the Medicare program.	Individuals	Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines	360	480	600	1440	$ 4,451,417
3	City of Houston Department of Health and Human Services	2.6.4	Health Education	• IT 8.2 Percentange of Low Birth-weight births	• Implement interventions to provide an expansion of an evidence-based home visitation program for 100 first time mothers in an underserved area. consisting of 64 home visits over two and one half years for each client enrolled in the program with visits conducted weekly, bi-monthly and monthly.	Individuals	Number of women enrolled in Nurse Family Partnership based on milestone described above.	200	210	220	630	$ 10,019,935
4	OakBend Medical Center	2.6.1	Health Education	• IT 8.19 Risk Adjusted Congestiive Heart Failure(CHF) 30-day Readmission Rate	• Educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding. • Partner with Fort Bend Family Health Center (FBFHC) to educate their staff and the community on the importance of initiating early breastfeeding. • Develop educational materials in both Spanish and English.	Individuals	Increase percentage of target population reached	None	58	97	155	$ 2,180,264
5	OakBend Medical Center	2.14.3	Health Education	• IT 3.3 Risk Adjusted Congestiive Heart Failure(CHF) 30-day Readmission Rate	• Formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, Weight Watchers, OBMC (OakBend Medical Group) and other agencies. • Form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program in English and Spanish would be beneficial.	Individuals	Increase percentage of target population reached.	None	677	1,083	1,760	$ 1,449,939
6	Rice Medical Center	2.6.2	Health Education	• IT 1.10 Diabetes care: HbA1C poor control (>9.0%)	• Develop a Certified Diabetes Teaching Center to educate and assist patients with managing their chronic disease. • Provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients. • Promote self-management for diabetic patients to achieve individualized behavioral and treatment goals that optimize health outcomes	Individuals	Number of individuals served	400	600	800	1800	$ 151,769
7	Harris Health System	2.2.1	Management	• IT 1.25 Adult Tobacco Use	• Expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy • Create an educational website.	Individuals	Documentation of increased number of unique patients served by innovative program.	100	200	300	600	$ 10,048,795
8	Matagorda Regional Medical Center	1.9.2	Management	• IT 2.21 Ambulatory Care Sensitive Conditions Admissions Rate	Management Improve access to specialty care - Expansion of Specialty Care providers according to the community needs assesment.	Encounters	Documentation of increase number of visits.	None	2000	3000	5000	$ 4,277,533
9	Memorial Hermann Northwest Hospital	2.2.5	Management	• IT 9.4e Reduce Emergency Department (ED) visits for Behavioral Health/Substance Abuse	• Provide frequent emergency room patients with more individualized treatment for their conditions • Provide these patients with options for seeking treatment in more appropriate settings.	Individuals	Increase percentage of target population reached.	250	600	1200	2050	$ 15,497,594

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10	Rice Medical Center	2.2.2	Management	• IT 1.11 Diabetes care: BP control (<140/90mm Hg)	• Partner with the Colorado County Health Department and other local stakeholders to provide an organized, systematic approach to chronic disease outreach, reduction, and management using the Care Management Model. • Identify patients with conditions or health statuses that place them at high risk for hospitalization, acute episodes, diminished quality of life, and long-term interventions (i.e. reduction in ADLs, inability to live independently, progression of the disease at a fast pace). Other potential targets will be patients with hypertension, heart disease, COPD, or other conditions identified as prevalent and placing patients at risk for costly and invasive health care interventions.	Individuals	Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC	None	745	320	1065	$ 165,567
11	St. Luke's Episcopal Hospital	2.2.2	Management	• IT 15.18 Hepatitus C Cure Rate	• Provide screening and treatment for a defined population of patients at risk for and/or diagnosed with Hepatitis C.	Individuals	Documentation of increased number of unique patients served by the innovative program	3500	5000	8000	16500	$ 3,216,809
12	The University of Texas Health Science Center - Houston	2.2.1	Management	• IT 6.1.d.i CG-CAHPS Visit Survey 2.0: Timeliness of Appointments, Care, & Information	• Redesign the outpatient delivery system of UT Physicians to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model and using evidence-based standards of care for each of the targeted diseases.	Individuals	Additional patients receiving care under the Chronic Care Model.	250	4,570	9,250	14,250	$ 11,440,132
13	The University of Texas Health Science Center - Houston	2.11.1	Management	• IT 1.2 Annual monitoring for patients on persistent medications- Angiotsein Converting Enzyme(ACE) inhibitors or Angiotesin Receptoer Blockers (ARBs) • IT 1.3 Annual monitoring for patients on persistent medications- Digoxin • IT 1.4 Annual monitoring for patients on persistent medications-Diuretic	• Implement a technologically driven patient-centered medication therapy management program. • Use allscripts analytics tool to enable staff to identify patients at high risk for developing complications and co-morbidities, and patients that have not refilled their medications. • Use root cause analysis will be used to identify potential medication errors and quality improvement processes will be used to address the causes.	Individuals	Additional patients receiving care under the Chronic Care Model.	250	2,500	4,500	7,250	$ 7,203,047
14	Harris Health System	2.10.2	Palliative Care	• IT 13.4 Hospice and Pallative Care- Proportion admitted to the ICU in the last 30 days of life	• Expand our comprehensive palliative care program through the expansion of an integrated, interprofessional house call team of specially trained providers.	Encounters	Improved access to PC Services for residents that did not have access	270	1000	1300	2570	$ 11,217,312
15	Memorial Hermann Hospital	2.10.1	Palliative Care	• IT 13.3 Hospice and Pallative Care- Proportion with more than one emergency room visit in the last days of life	• Implement a comprehensive palliative care program that will engage patients with life threatening, acute or chronic conditions. • Educate health care professionals so they can better advise their patients who need end of life care outside an acute care setting.	Encounters	Palliative care discharges to home care, hospice, or SNF	None	2275	3300	5575	$ 15,128,755
16	The University of Texas Health Science Center - Houston	2.10.1	Palliative Care	• IT 13.4 Hospice and Pallative Care- Proportion admitted to the ICU in the last 30 days of life	• Provide palliative care consultation to any adult ICU at Memorial Herman Hospital-TMC who is at high risk of death in or soon after hospitalization to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility.	Encounters	Palliative care consults meet targets established by the program.	2786	2786	2786	8358	$ 6,567,483
17	City of Houston Department of Health and Human Services	2.2.6	Prevention Center	• IT 1.10 Diabetes care: HbA1C poor control (>9.0%)	• Implement the Diabetes Awareness and Wellness Network (DAWN) Center, which will provide complementary wellness programming and offer prevention and intervention services and coordination of care for those with diabetes or at risk for diabetes • Recruit participants from 3 FQHC's, County Hospital based diabetes center and one dialysis center that all serve low income Medicaid patients.	Individuals	Number of unique patients receiving evidence based intervention	500	525	550	1575	$ 9,946,983

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18	Harris Health System	1.3.2	Registry	• IT 3.3 Risk Adjusted Congestiive Heart Failure(CHF) 30-day Readmission Rate	• Implement and Enhance Chronic Disease Management Registry • Develop a chronic disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patient.	Encounters	Documentation of increased number of visits.	1000	10000	20000	31000	$ 29,164,032
19	OakBend Medical Center	1.3.1	Registry	• IT 3.17 Risk Adjusted Chronic Obstructivve Pulmonary Disease(COPD) 30-day Readmission Rate	• Develop a chronic disease registry to use county wide to ensure providers and clinical staff with access to determine clinical outcomes and to identify physician, psychological and emotional needs of chronically ill patients.	Individuals	Improvement in enrollment in the registry over baseline as measured by number of patients entered in the registry with targeted chronic diseases	None	1,484	3,712	5,196	$ 3,602,979
20	Rice Medical Center	2.7.1	Registry	• IT 12.6 Influenza Immunization--Ambulatory IT 12.8 Immunization for Adolescents-Tdap/TD and MCV IT 12.11 HPV vaccine for adolescents	• Implement across-the-board tracking of patients' immunization schedules and completed immunizations in order to avoid duplication and tardiness, and to promote preventative health care.	Individuals	Number of individuals served by the project	360	240	240	840	$ 82,783
21	The University of Texas Health Science Center - Houston	1.3.1	Registry	• IT 1.7 Controlling high blood pressure	• Use data entered into a unique chronic disease registry to proactively contact, educate and track patients by disease status, risk status, self management status, community, and family need • Use reports drawn from the registry to develop and implement targeted quality improvement plans for diabetes, hypertension, asthma, COPD, and CHF.	Individuals	Number of unique individuals managed in the registry.	None	8600	9460	18060	$ 7,987,519
22	City of Houston Department of Health and Human Services	2.7.1	Screening	• IT 10.1.a.I Assessment of Quality of Life(AQoL-4D)	• Provide colorectal cancer (CRC) FIT screeningin twelve spatially identified, primarily African American, high risk zip codes • Raise small media campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol as appropriate, and 7) Patient Care Navigation for getting individuals situated in a medical home in the targeted zip codes.	Individuals	The number of individuals of target population reached with innovative intervention consistent with evidence-based model (FIT screening).	300	320	460	1080	$ 2,498,709
23	Fort Bend County Clinical Health Services	2.7.1	Screening	• IT 12.16 High-risk Colorectal Cancer Follow-up rate within one year • IT 12.3 Colorectal Cancer Screening	Screening Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)	Individuals	Document implementation strategy and testing outcomes	50	75	75	200	$ 475,276
24	University of Texas M.D. Anderson Cancer Center	2.7.1	Screening	• IT 6.2a Client Satisfaction Questionnaire 8 (CSQ-8)	• Expand a two-year Colorectal Cancer (CRC) screening program in Federally Qualified Health Centers (FQHCs) in Harris County into other RHP3 counties. • Target low-income and underinsured populations with the intent of increasing adherence by distributing Fecal Immunochemical Test (FIT) take-home tests at the time of annual flu innoculation. • Provide patients with a FIT test with verbal and written instructions on how to complete the test, brief verbal messages reinforcing the importance of screening (e.g., "an annual FOBT (FIT) test is as important as an annual flu shot"), educational materials, and clinic phone numbers should questions arise.	Individuals	Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years	2000	2100	2205	6305	$ 7,220,391
25	University of Texas M.D. Anderson Cancer Center	2.7.1	Screening	• IT 6.2a Client Satisfaction Questionnaire 8 (CSQ-8)	• Expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured, low-income or Medicaid eligible women, ages 40 to 69 in Houston, to the RHP3's coverage area.	Individuals	Number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model	680	1020	1275	2975	$ 6,154,291

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26	City of Houston Department of Health and Human Services	2.7.1	Screening and Treatment	• IT 15.17 Latent Tuberculosis Infection (LTBI) treatment rate	• Implement interventions to rapidly identify, treat and short recovery to reduce TB morbidity for TB patients, contacts of foreign born TB cases and suspected cases enrolled in this project by utilizing three testing and technology (Nucleic Amplification Test, QuantiFERON test and combined INH and RPT tests) to meet its goal.	Individuals	Number of individuals served	230	242	254	726	$ 9,946,509
27	University of Texas M.D. Anderson Cancer Center	2.7.2	Tobacco Control	• IT 6.2a Client Satisfaction Questionnaire 8 (CSQ-8)	• Implement an evidence-based smoking cessation program for persons living with HIV/AIDS at the Legacy Community Health Services sites.	Individuals	Document implementation strategy and testing outcomes	500	500	500	1500	$ 3,529,434
28	University of Texas M.D. Anderson Cancer Center	2.7.2	Tobacco Control	• IT 6.2a Client Satisfaction Questionnaire 8 (CSQ-8)	• Utilize ASPIRE (A Smoking Prevention Interactive Experience) program to reach Medicaid eligible/indigent youth at various access points in RHP3 counties. • Recruit and train RHP 3 providers who work with Medicaid patients to consistently screen adolescents and families for tobacco use, employing a carbon monoxide breath test for those ages 11 to 18, advising patients to adopt a nonsmoking lifestyle, referring patients proactively with links to the evidence-based ASPIRE program.	Individuals	Document implementation strategy and testing outcomes	12500	2400	350	15250	$ 16,464,727
29	University of Texas M.D. Anderson Cancer Center	2.7.2	Tobacco Control	• IT 6.2a Client Satisfaction Questionnaire 8 (CSQ-8)	• Deliver Advise Connect (AAC) in four Federally Qualified Health Centers (FQHCs) in Harris County by implementing clinical practice guidelines and promoting health system supports in electronic health records. • Ask all adult patients at every visit about their smoking status at the time that vital signs are assessed, provide brief advice to all smokers to quit, offer cessation assistance via the Quitline, and directly connect patients willing to accept assistance with the Quitline.	Individuals	Determine smoking prevalence for 50% of adult patients	11555	17333	8666	37554	$ 4,887,399
30	St. Luke's Episcopal Hospital	2.12.1	Transition Care	• IT 3.2 Congestive Heart Failure (CHF) 30-day Readmission Rate	• Build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). • Target patients with CHF cared for in the SLEH acute inpatient setting for an index admission • Reduce readmissions.	Individuals	Number over time of those patients in target population receiving standardized, evidence-based interventions	750	1500	1500	3750	$ 15,944,233
											Total Specialty Care Incentive Payment	**$ 228,810,323**

Chronic Care Project Subcategory	Total Projects in the Sub-category	Total Subcategory Incentive Payment Amount DY2-5 Category 1 and 2
Health Education	6	$ 26,142,032
Management	7	$ 51,849,477
Palliative Care	3	$ 32,913,550
Prevention Center	1	$ 9,946,983
Registry	4	$ 40,837,312
Screening	4	$ 16,348,667
Screening and Treatment	1	$ 9,946,509
Tobacco Control	3	$ 24,881,560
Transition Care	1	$ 15,944,233
TOTAL	**30**	**$ 228,810,323**

QPI Grouping Type	Total QPI Target per HHSC: DY3	Total QPI Target per HHSC: DY4	Total QPI Target per HHSC: DY5	Cumulative total for QPI measures
Encounters	4056	18061	30386	52503
Individuals	35235	52504	56167	144086
Grand Total	**39291**	**70565**	**86553**	**196589**