TEXAS Health and Human Services

RHP Plan Update Provider Form

This page provides high-level information on the various inputs that a user will find within this template.

Cell Background	Description
Sample Text	Required user input cell, that is necessary for successful completion
Sample Text	Pre-populated cell that a user CANNOT edit
Sample Text	Pre-populated cell that a user CAN edit
Sample Text	Optional user input cell

DY7-8 Provider RHP Plan Update Template - Provider Entry

Progress Indicators

Section 1: Performing Provider Information	Complete
Section 2: Lead Contact Information	Complete
Section 3: Optional Withdrawal From DSRIP	Complete
Section 4: Performing Provider Overview	Complete
Section 5: DY7-8 DSRIP Total Valuation	Complete

Section 1: Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
TIN:	17460011640002
Physical Street Address:	8000 North Stadium Drive
City:	Houston
Zip:	77054
Primary County:	Harris
Additional counties being served (optional):	

Note: you cannot type county inputs; rather, please select your county from the dropdown menu.

Section 2: Lead Contact Information

	Lead Contact 1	Lead Contact 2	Lead Contact 3
Contact Name:	Judy Harris	Angelina Esparza	William Bryant
Street Address:	8000 N. Stadium Dr., 8th Floor	8000 N. Stadium Dr., 8th Floor	8000 N. Stadium Dr., 8th Floor
City:	Houston	Houston	Houston
Zip:	77054	77054	77054
Email:	Judy.Harris@houstontx.gov	angelina.esparza@houstontx.gov	william.bryant@houstontx.gov
Phone Number:	832-393-4345	832-393-4753	832-393-4612
Phone Extension:			
Lead Contact or Both:	Both	Both	Both

Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Section 3: Optional Withdrawal From DSRIP

Please select an option below. By selecting "Yes - Withdraw from DSRIP," this organization acknowledges it understands that any DY6 DSRIP payments will be recouped as required by the DY6 Program Funding and Mechanics Protocol. This does not include recoupment of DY4-5 payments that may have occurred in DY6 due to allowable carryforward.

Do Not Withdraw from DSRIP

Section 4: Performing Provider Overview

Performing Provider Description:	The City of Houston Health Department (HHD) works in partnership with the community to promote and protect the health and social well-being of all Houstonians. Our vision is to have self-sufficient families and individuals in safe and healthy communities. HHD serves the 2.3 million residents of the City of Houston. Our scope and impact reaches beyond the city limits and extends to Harris County's population of 4.6 million people, due to the work we do through the Harris County Area Agency on Aging, and our population based immunization strategies and HIV/STD surveillance. Additionally, our laboratory serves as a 17 county region reference lab.
Overall DSRIP Goals:	Our overall goals are to 1) navigate clients to needed resources and services; 2) utilize prevention strategies to improve health and manage chronic conditions; 3) improve the quality of services and increase the capacity to meet the needs of our growing populations; and 4) provide cost-savings to the overall health system and clients through targeted evidenced-based interventions.
Alignment with regional community needs assessment:	The services offered by the Houston Health Department (HHD) are alignment with majority of the priority areas identified in the 2017 Southeast Texas RHP3 Community Health Needs Assessment (page 3) published by RHP3 Anchor, Harris Health. The safety net and navigation services offered by the Houston Health Department helps address the needs of vulnerable populations who don't have access to care or lack the knowledge to access care appropriately. Additonally, the services offered help mitigate barriers to care like transportation and cultural and linguistic support. HHD continues to work with local primary care providers to refer clients and we educate providers on our services that help with the management of clients chronic conditions. Screenings, education, and wellness sessions offered by our agency covers the vast majority of health concerns identified in the community needs assessment, i.e., the high prevalences of diabetes, obesity, smokers, individuals with poor nutritional habis, and inactivity amoungst the population.

Section 5: DY7-8 DSRIP Total Valuation

	DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$7,563,669.80	$0.00	$7,563,669.80	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$3,781,834.90	$3,781,834.90	$3,781,834.90	$3,781,834.90
Category C	$20,800,091.95	$28,363,761.75	$24,581,926.85	$32,145,596.65
Category D	$5,672,752.35	$5,672,752.35	$1,890,917.45	$1,890,917.45
Total	$37,818,349.00	$37,818,349.00	$37,818,349.00	$37,818,349.00

Would you like to decrease the total valuation?

No

Have you reviewed and confirmed the valuations listed in the table above and identified available IGT to fund these DSRIP amounts?

Yes

Generate Worksheets

DY7-8 Provider RHP Plan Update Template - Category B

Progress Tracker

Section 1: System Definition	Complete
Section 2: Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category B valuation in DY7:	$3,781,834.90
Category B valuation in DY8:	$3,781,834.90

Section 1: System Definition

Local Health Departments - Required Components

Required System Component	Business Component?
Clinics	Business Component of the Organization

Please enter a description of this System Component.

Our local public health clinics provide safety net services to 1) prevent the spread of disease, and 2) promote the health and well-being of the communities we serve. Here is the list of clinics and the services provided at each one:
Northside
• Family Planning
• STD
• Immunizations
• Tuberculosis
• Dental
La Nueva Casa de Amigos
• Family Planning
• Immunizations
• Dental
Magnolia
• Dental
Sharpstown
• Family Planning
• STD
• Immunizations
• Dental
Sunnyside
• Family Planning
• STD
• Immunizations
• Tuberculosis
Fort Bend Senior Center
• Dental

Required System Component	Business Component?
Immunization Locations	Business Component of the Organization

Please enter a description of this System Component.

Our local public health department provides safety net immunization services for individuals and works closely with local health providers to support their vaccination efforts. They are provided in the following clinics:
• Northside Health Center
• La Nueva Casa de Amigos
• Sharpstown
• Sunnyside

Local Health Departments - Optional Components

Optional System Component	Would you like to select this component?
Mobile Outreach	No

Optional System Component	Would you like to select this component?
Other	Yes

Please list your "Other" system component.

Non-clinical Services

Please enter a description for this "Other" system component.

Our local health department offers educational and other supportive services outside of the clinical setting that promote the health and well-being of the community. These services include, but are not limited to, chronic disease and diabetes self-management education, service navigation, and transitional care services. The diabetes self-management education occurs at Third Ward Multiservice Center. Other settings for the non-clinical services are client homes or in community venues such as community centers, churches, schools, etc.
Please list your "Other" system component.
Please enter a description for this "Other" system component.

Section 2: Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)

	DY5	DY6
MLIU PPP	39,531	39,390
Total PPP	41,456	41,345

Please indicate the population included in the MLIU PPP

MLIU PPP Goal for each DY (DY7 and DY8):	39,461
Average Total PPP	41,401
MLIU percentage of Total PPP	95.31%

*The MLIU percentage is for informational purposes and will help HHSC determine allowable MLIU PPP variation.

Would you like the MLIU PPP Goal to be based on DY5 or DY6 only (as opposed to the average)?	**No**

☑ Medicaid Low-Income (Below 200% FPL)	☐ Dual Eligible (Medicaid and Medicare)	☑ CHIP	☑ Local Coverage Option (Below 200% FPL)	☑ Insured on the Exchange (Below 200% FPL)
	☑ Self-Pay	☑ Uninsured	☐ Other (please explain below)	

DY7-8 Provider RHP Plan Update Template - Category C Selection

Progress Tracker

Section 2: Selection Overview (CMHCs and LHDs only)	Complete	Note: you must confirm selections at the bottom of the page to finish.	MPT	20
Section 3: Selection of Measures for Local Health Departments	Complete		Points Selected	20
Minimum Selection Requirements Met	Yes		Measures Selected	10
MPT Met	Yes		Clinical Outcome Selected	Y
			At least 2 measures selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

If regional private hospital participation requirement is met	Category C valuation in DY7:	$20,800,091.95
	Category C valuation in DY8:	$28,363,761.75
If regional private hospital participation requirement is not met	Category C valuation in DY7:	$24,581,926.85
	Category C valuation in DY8:	$32,145,596.65

MINIMUM POINT THRESHOLD (MPT): 20

Each Performing Provider must select Measure Bundles/measures to meet or exceed their MPT to maintain their valuation that was confirmed on the Provider Entry tab

Section 1: Attributed Population

Attributed Population for Local Health Department (LHD)

Individuals with one eligible encounter during the measurement period

Please describe any other attributed population (optional).

Section 2: Selection Overview

Please describe your rationale for the selected measures, and describe the primary system components (clinics, facilities) that will be used to report on and drive improvement in selected measures.

The measures we selected are geared towards the three core functions of public health: to prevent the spread of disease, and promote and protect the health and wellbeing of people. We selected measures that were not only aligned with our core functions but also aligned with the priorities identified by HHSC, i.e. the Healthy Texans Bundle. The activities towards improving the outcomes of the selected measures occur mainly outside the clinical setting (with the exception of oral health outcomes). The drivers for improvement are geared to educating the targeted population in classroom settings and offering programing that may address/mitigate some of the social determinants of the health of the targeted population. Here is the relevant location where activity will occur to support each measure:

- L1-115 and L1-207 are primarily tied to the DAWN program at the Third Ward Multiservice Center.
- Most patients in L1-105, L1-147, L1-210, and L1-280 will come from Northside, Sunnyside, Sharpstown, and La Casa Nueva de Amigos, though there could be smaller amounts from other clinics listed in our clinic list under category B.
- Activities for L1-224 and L1-225 will occur in the dental clinics at Sharpstown, Magnolia, La Nueva Casa de Amigos, and Northside.
- Activities for L1-235 are conducted by Nurse Family Partnership, a home visitation program, and will therefore occur in the clients' homes
- Tuberculosis Control contributes to L1-347, and happens at Northside and Sunnyside as well as in the homes of the patients receiving directly observed therapy.

Section 3: Selection of Measures for Local Health Departments

Standard LHD Menu Options

Select Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Measure Category*	*Total Points*
No	MLIU denominator with significant volume	L1-103	Controlling High Blood Pressure	Clinical Outcome	3
Yes	MLIU denominator with significant volume	L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	1
No	MLIU denominator with significant volume	L1-107	Colorectal Cancer Screening	Cancer Screening	2
No	MLIU denominator with significant volume	L1-108	Childhood Immunization Status (CIS)	Immunization	1
Yes	MLIU denominator with significant volume	L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Clinical Outcome	3
Yes	MLIU denominator with significant volume	L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	1
No	MLIU denominator with significant volume	L1-160	Follow-Up After Hospitalization for Mental Illness	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-186	Breast Cancer Screening	Cancer Screening	2
No	MLIU denominator with significant volume	L1-205	Third next available appointment	Process	1
Yes	MLIU denominator with significant volume	L1-207	Diabetes care: BP control (<140/90mm Hg)	Clinical Outcome	3
Yes	MLIU denominator with significant volume	L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	1
No	MLIU denominator with significant volume	L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Process	1
Yes	MLIU denominator with significant volume	L1-224	Dental Sealant: Children	Process	1
Yes	MLIU denominator with significant volume	L1-225	Dental Caries: Children	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-227	Dental Caries: Adults	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-231	Preventive Services for Children at Elevated Caries Risk	Process	1
Yes	MLIU denominator with significant volume	L1-235	Post-Partum Follow-Up and Care Coordination	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	Process	1
No	MLIU denominator with significant volume	L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-242	Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	Clinical Outcome	3

No	MLIU denominator with significant volume	L1-268	Pneumonia vaccination status for older adults	Immunization	1
No	MLIU denominator with significant volume	L1-269	Preventive Care and Screening: Influenza Immunization	Immunization	1
No	MLIU denominator with significant volume	L1-271	Immunization for Adolescents	Immunization	1
No	MLIU denominator with significant volume	L1-272	Adults (18+ years) Immunization status	Immunization	1
Yes	MLIU denominator with significant volume	L1-280	Chlamydia Screening in Women (CHL)	Process	1
No	MLIU denominator with significant volume	L1-343	Syphilis positive screening rates	Process	1
No	MLIU denominator with significant volume	L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-345	Gonorrhea Positive Screening Rates	Process	1
No	MLIU denominator with significant volume	L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	Clinical Outcome	3
Yes	MLIU denominator with significant volume	L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	1

Total points from Standard Menu:	20

LHD "Grandfathered" DY6 P4P Measures

These measures are specific to your organization and are different from the standard LHD menu shown above.

Select Measure (Yes/No)	*TPI*	*Performing Provider Name*	*DY6 RHP/Cat 3 ID*	*DY6 Title*	*DY7-8 Point Value*
No	093774008	City of Houston	3_093774008.3.1	Dental Sealant: Children	1
No	093774008	City of Houston	3_093774008.3.10	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	3
No	093774008	City of Houston	3_093774008.3.100	Client Satisfaction Questionnaire 8 (CSQ-8)	3
No	093774008	City of Houston	3_093774008.3.11	Percentage of Low Birth- weight births	3
No	093774008	City of Houston	3_093774008.3.13	Client Satisfaction Questionnaire 8 (CSQ-8)	3
No	093774008	City of Houston	3_093774008.3.15	Cavities: Adults	3
No	093774008	City of Houston	3_093774008.3.2	Cavities: Children	3
No	093774008	City of Houston	3_093774008.3.200	Colorectal Cancer Screening	2
No	093774008	City of Houston	3_093774008.3.201	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	1
No	093774008	City of Houston	3_093774008.3.202	Adults (18+ years) Immunization status	1
No	093774008	City of Houston	3_093774008.3.203	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	1
No	093774008	City of Houston	3_093774008.3.204	Children and Adolescents' Access to Primary Care Practitioners (CAP)	1
No	093774008	City of Houston	3_093774008.3.205	Adults (18+ years) Immunization status	1
No	093774008	City of Houston	3_093774008.3.3	Visit-Specific Satisfaction Instrument (VSQ-9)	3
No	093774008	City of Houston	3_093774008.3.4	Assessment of Quality of Life (AQoL-4D)	3
No	093774008	City of Houston	3_093774008.3.5	Client Satisfaction Questionnaire 8 (CSQ-8)	3
No	093774008	City of Houston	3_093774008.3.500	Patient Health Questionnaire 9 (PHQ-9)	3
No	093774008	City of Houston	3_093774008.3.504	Influenza Immunization -- Ambulatory	1
No	093774008	City of Houston	3_093774008.3.505	Adults (18+ years) Immunization status	1

No	093774008	City of Houston	3_093774008.3.6	Follow-up after Treatment for Primary or Secondary Syphilis	3
No	093774008	City of Houston	3_093774008.3.7	Latent Tuberculosis Infection (LTBI) treatment rate	3
No	093774008	City of Houston	3_093774008.3.9	Diabetes care: HbA1c poor control (>9.0%)	3

Total points from "grandfathered" menu:	0

Total overall selected points:	20

Are you finished making your selections?

Yes

DY7-8 Provider RHP Plan Update Template - Category C Additional Details

Progress Tracker

Section 1: Measure Exemption Requests and Measure Setting System Components — Complete

Section 1: Measure Exemption Requests and Measure Setting System Components

In order to be eligible for payment for a measure's **reporting milestone**, the Performing Provider must report its performance on the all-payer, Medicaid-only, and LIU-only payer types. Performing Providers may request to be exempted from reporting a measure's performance on the Medicaid-only payer type or the LIU-only payer type with good cause, such as data limitations. Note that reporting a measure's all-payer performance is still required to be eligible for payment for a measure's reporting milestone.

Bundle-Measure ID	Measure Name	Baseline Measurement Period	Requesting a shorter or delayed measurement period?	Requesting a reporting milestone exemption?	Requesting a baseline numerator of zero?
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-207	Diabetes care: BP control (<140/90mm Hg)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-224	Dental Sealant: Children	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-225	Dental Caries: Children	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-235	Post-Partum Follow-Up and Care Coordination	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-280	Chlamydia Screening in Women (CHL)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	CY2017: January 1, 2017 - December 31, 2017	No	No	No

DY7-8 Provider RHP Plan Update Template - Category C Valuation

Progress Tracker

Section 1: Measure Bundle/Measure Valuation — Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category C valuation in DY7:	$20,800,091.95
	Category C valuation in DY8:	$28,363,761.75
If regional hospital participation requirement is not met	Category C valuation in DY7:	$24,581,926.85
	Category C valuation in DY8:	$32,145,596.65

Section 1: Measure Bundle/Measure Valuation

Valuation for Selected Measures - Local Health Departments

						If private regional hospital participation requirement is met		If private regional hospital participation requirement is not met	
Measure ID or Cat 3 ID	Denominator Volume	Points	Desired Valuation %	Minimum Valuation % of Total	Maximum Valuation % of Total	Category C Valuation in DY7	Category C Valuation in DY8	Category C Valuation in DY7	Category C Valuation in DY8
L1-105	MLIU denominator with significant volume	1	10.00%	7.50%	10.00%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-115	MLIU denominator with significant volume	3	12.50%	7.50%	12.50%	$2,600,011.49	$3,545,470.22	$3,072,740.86	$4,018,199.58
L1-147	MLIU denominator with significant volume	1	10.00%	7.50%	10.00%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-207	MLIU denominator with significant volume	3	7.50%	7.50%	12.50%	$1,560,006.90	$2,127,282.13	$1,843,644.51	$2,410,919.75
L1-210	MLIU denominator with significant volume	1	10.00%	7.50%	10.00%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-224	MLIU denominator with significant volume	1	10.00%	7.50%	10.00%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-225	MLIU denominator with significant volume	3	10.00%	7.50%	12.50%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-235	MLIU denominator with significant volume	3	10.00%	7.50%	12.50%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-280	MLIU denominator with significant volume	1	10.00%	7.50%	10.00%	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-347	MLIU denominator with significant volume	3	10.00%	7.50%	12.50%	$2,080,009.16	$2,836,376.14	$2,458,192.65	$3,214,559.63
Total	N/A	20	100.00%	N/A	N/A	$20,800,091.95	$28,363,761.75	$24,581,926.85	$32,145,596.65
Difference between selected percent and 100%:			0.00%						

Your valuation allocations add to 100%.

Are you finished allocating your Category C valuations across your selected measures?

Yes

Explanation of Valuation Percent Changes

Overall justification for change in Category C valuation distribution.

HHD selected an equal distribution of all the outcome measures except L1-207 and L1-115. L1-115 and L1-207 both impact the diabetic population served by HHD, however L1-115 impacts the entire diabetic population while L1-207 only impacts the portion of diabetics that also have high blood pressure.

Please address the amount of improvement required for the Measure Bundle(s) with increased valuation including estimated baseline and goals for key measures that may require high amounts of improvement within the bundle.

N/A

Please address the level of effort required for improvement for the Measure Bundle(s) with increased valuation.

N/A

Please describe the size of the population impacted as compared to the size of other selected Measure Bundle(s) for the Measure Bundle(s) with increased valuation.

The diabetic population impacted by L1-115 is larger than the population impacted by L1-207 so HHD is focusing their efforts on impacting L1-115.

DY7-8 Provider RHP Plan Update Template - Category A Core Activities

Progress Tracker

Section 1: Transition from DY2-6 Projects to DY7-8 Provider-Level Outcomes and Core Activities	Complete
Section 2: Core Activities	Complete
All Selected Measure Bundles/Measures Associated with at Least One Core Activity	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

Section 1: Transition from DY2-6 Projects to DY7-8 Provider-Level Outcomes and Core Activities

DY6 Project ID	Project Option	Project Summary	Completed/ Continuing	Enter a description for continuation (optional)
RHP 3_093774008.1.1	1.8.9	Improve dental health in Medicaid/CHIP or indigent populations by 1) expanding oral health services for safety net eligible persons, 2) expanding an evidence-base dental sealant program for children in low income areas, 3) initiating new oral health services for eligible perinatal women.	Continuing as Core Activity in DY7-8	
RHP 3_093774008.1.2	1.7.3	Use telecommunications technologies and connectivity to triage patients with non-life threatening, mild or moderate illnesses via telemedicine with an emergency physician at the City of Houston EMS base station.	Completed in DY26	
RHP 3_093774008.1.3	1.8.11	Improve oral health by providing diagnostic, preventive restorative and surgical oral health services for the elderly to improve the heath and quality of life for Houston area at-risk seniors.	Completed in DY26	
RHP 3_093774008.2.1	2.6.3	Utilize community health workers to provide 24 sessions of essential education and assessment related to fall prevention and safety to low income older adults	Completed in DY26	
RHP 3_093774008.2.10	2.12.2	Utilize Tranistion Coaches 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.	Completed in DY26	
RHP 3_093774008.2.2	2.9.1	Care Houston Links is a new program that will provide care coordination to reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of necessary emergency room care.	Completed in DY26	
RHP 3_093774008.2.3	2.9.1	Use pt navigators to connect new at risk HIV diagnosed individuals to appropriate care. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also identify frequent ED utilizes and use navigators as part of a preventable ED reduction program.	Completed in DY26	
RHP 3_093774008.2.4	2.7.1	Implement interventions to rapidly identify and treat TB to reduce TB morbidity and to shorten recovery time for TB pts by utilizing three testing modalities.	Continuing as Core Activity in DY7-8	
RHP 3_093774008.2.5	2.6.2	Establish self-management programs and wellness using evidence-based designs.	Continuing as Core Activity in DY7-8	
RHP 3_093774008.1.4	1.13.1	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	Completed in DY26	
RHP 3_093774008.2.7	2.7.4	Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.	Continuing as Core Activity in DY7-8	
RHP 3_093774008.2.8	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	Completed in DY26	
RHP 3_093774008.2.9	2.7.1	Implement a new colorectal cancer (CRC) integrated awareness and screening project involving: 1) Awareness raising small media campaign, 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	Completed in DY26	
RHP 3_093774008.2.100	2.9.1	Houston Health Connect will provide navigation support, case management services and evidenced based chronic disease self-management and health education programming to individuals who are uninsured, disconnected from a medical home, referred for follow-up from a health care provider, disconnected or newly connected to a medical home as a result of Affordable Care Act (ACA) Marketplace Exchange enrollment and Medicaid enrollees who are frequent users of hospital and crisis services.	Continuing as Core Activity in DY7-8	

RHP 3_093774008.2.101	2.19.1	HDHHS will implement a project that provides care management services that integrate primary and behavioral health needs of released ex-offenders, parolees and probationers in Houston, Harris County.The Community Re-Entry Network Program (CRNP), Integrated Health Services Project will provide a multi-dimensional clinical approach to assess and address the mental, physical and psychosocial needs of ex-offenders released from prison and probationers in Houston, Harris County.	Completed in DY2 6	

Section 2: Core Activities

Please enter your organization's number of Core Activities: 6

1) Please select the grouping for this Core Activity.
Expansion or Enhancement of Oral Health Services

a) Please select the name of this Core Activity.
Expanded use of existing dental clinics for underserved population

b) Please enter a description of this Core Activity
For this activity, we will expand the use of our four dental clinics throughout Houston to reach at-risk populations. This will entail an increase in the client knowledge/education, increase clinical capacity through workforce development, and increase routine dental examinations of at-risk populations. About ten DDS/DMD and one dental hygienist work on this activity.

i) Please describe the first Secondary Driver for the above Core Activity (required).
Increase awareness on the general knowledge of oral health, importance of oral health and self-efficacy

A) Please list the first Change Idea for the above Secondary Driver (required).
Outreach to vulnerable populations through schools and community events

B) Please list the second Change Idea for the above Secondary Driver (optional).

ii) Please describe the second Secondary Driver for the above Core Activity (optional).
Increase clinic capacity to meet the expansion needs

A) Please list the first Change Idea for the above Secondary Driver (required).
Formalize partnership for workforce development with community stakeholders and dental providers

B) Please list the second Change Idea for the above Secondary Driver (optional).

iii) Please describe the third Secondary Driver for the above Core Activity (optional).
Increase patient recall to ensure clients are meeting suggested dental care guidelines

A) Please list the first Change Idea for the above Secondary Driver (required).
Ensure clients are scheduled and seen every six months for routine cleanings/examinations

B) Please list the second Change Idea for the above Secondary Driver (optional).

iv) Please describe the fourth Secondary Driver for the above Core Activity (optional).

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

L1-224	L1-225		

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.
For this activity, the use of the city dental clinics will be expanded. Interventions include oral health education and treatment. Outreaches in communities and workforce development will increase the at-risk population we engage and serve, respectively. Oral health education will enhance the awareness around the importance of oral health. The adoption of more aggressive follow up scheduling will increase routine dental examinations of at-risk populations. The combination of these efforts will lead to better oral health and decrease untreated cavities in at risk populations.

d) Is this Core Activity provided by a provider that is not included in the Category B System Definition?
No

2) Please select the grouping for this Core Activity.
Access to Primary Care Services

a) Please select the name of this Core Activity.
Provision of screening and follow up services

b) Please enter a description of this Core Activity
Through screening and outreach, we will identify people to offer health education, health promotion, and interventions which will prevent or help clients manage chronic conditions improve health, and enhance the quality of life. For home visitation sessions, a registered nurse will provide, prenatal, infant and childhood education for pregnant women and children. A total of 9 nurses work in the home visitation program. We will also offer educational sessions for clients on oral health, mental health, tobacco cessation, and stress management.

i) Please describe the first Secondary Driver for the above Core Activity (required).
Increase compliance for post-partum care for women seen in home-visitation

A) Please list the first Change Idea for the above Secondary Driver (required).
Strengthen relationships with providers to get glucose screenings

B) Please list the second Change Idea for the above Secondary Driver (optional).

Establish partnerships with behavioral health providers

C) Please list the third Change Idea for the above Secondary Driver (optional).

Assist clients with securing a payer source for primary care services

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

Ensure timeliness of follow-up for post-partum mothers

E) Please list the fifth Change Idea for the above Secondary Driver (optional).

ii) Please describe the second Secondary Driver for the above Core Activity (optional).

Ensure adequate screening for tobacco use, BMI, and blood pressure of clients who access our services in the clinic setting

A) Please list the first Change Idea for the above Secondary Driver (required).

Strengthen screening and follow-up protocol a) provider education; b) QA

B) Please list the second Change Idea for the above Secondary Driver (optional).

Connect clients to care coordination group for service linkage

C) Please list the third Change Idea for the above Secondary Driver (optional).

Standardize tobacco cessation counseling in clinic setting

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

iii) Please describe the third Secondary Driver for the above Core Activity (optional).

Increase awareness on the general knowledge of sexual behaviors and safe-sex, importance of healthy sexual practices and self-efficacy

A) Please list the first Change Idea for the above Secondary Driver (required).

Outreach to women in family planning, e.g. Healthy Texas Women

B) Please list the second Change Idea for the above Secondary Driver (optional).

Provide education to clients on healthy sexual practices

C) Please list the third Change Idea for the above Secondary Driver (optional).

iv) Please describe the fourth Secondary Driver for the above Core Activity (optional).

Continue standardized STD screening processes for clients accessing services

A) Please list the first Change Idea for the above Secondary Driver (required).

Increase clinic capacity to screen population accessing services

B) Please list the second Change Ideas for the above Secondary Driver (optional).

QA to ensure clients are being appropriately screened

C) Please list the third Change Ideas for the above Secondary Driver (optional).

v) Please describe the fifth Secondary Driver for the above Core Activity (optional).

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

L1-235	L1-105	L1-280	L1-147
L1-210			

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.

Through standardized screening for tobacco use, BMI, and blood pressure of clients, high risk populations will be identified and offered counseling and health education on the importance of primary care. The intervention of care navigation can resolve barriers to access to primary care, and thus improve health. For home visitation sessions, a registered nurse will provide prenatal, infant and childhood education for pregnant women and children, as well as refer the client to primary care and other community resources. The interventions will improve pregnancy outcomes by promoting healthly behaviors. Women in family planning will be screened for chlamydia and provided with education on healthy sexual practices. The interventions will increase the general health and self-efficacy of those seen. In summary, the combination of these interventiosn will hopefully improve the health and enhance the quality of life of clients.

d) Is this Core Activity provided by a provider that is not included in the Category B System Definition?

No

3) Please select the grouping for this Core Activity.

Chronic Care Management

a) Please select the name of this Core Activity.

Management of targeted patient populations; e.g., chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services

b) Please enter a description of this Core Activity

Use improved screening tests and shortened treatment course to prevent and treat disease. The use of innovative treatment has reduced traditional treatment visits, thus improving compliance and reduction in administrative costs. This activity occurs throughout the community and in the homes of patients. There are around 15 staff members assigned to support this function.

i) Please describe the first Secondary Driver for the above Core Activity (required).

Increase 3HP enrollment of clients targeted for treatment

A) Please list the first Change Idea for the above Secondary Driver (required).

Identify high risk populations through testing and contact investigations (e.g. congregate settings: homeless shelters, universities, immigrants)

B) Please list the second Change Idea for the above Secondary Driver (optional).

Provide education on 1) importance of treatment; 2) general knowledge of 3HP and DOT

C) Please list the third Change Idea for the above Secondary Driver (optional).

ii) Please describe the second Secondary Driver for the above Core Activity (optional).

Increase clincial evaluation of clients targeted for treatment

A) Please list the first Change Idea for the above Secondary Driver (required).

Provide transportation for clinical appointment for potential clients

B) Please list the second Change Idea for the above Secondary Driver (optional).

Provide translational services to clients trageted for treatment

C) Please list the third Change Idea for the above Secondary Driver (optional).

Provide education on the importance of clinical evaluations

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

iii) Please describe the third Secondary Driver for the above Core Activity (optional).

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

L1-347			

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.

Testing and contact investigation can accurately identify high risk populations with latent tuberculosis infection (LTBI). Education will improve the general knowledge on prescribed treatment regimen, help the clients to understand the benefits of short course therapy. Clinical evaluation will be adopted to ensure accessing services is not hendered by barriers such as transportation and language. All of these efforts will hopefully lead to higher completion rate of LTBI treatment.

d) Is this Core Activity provided by a provider that is not included in the Category B System Definition?

No

4) Please select the grouping for this Core Activity.

Access to Primary Care Services

a) Please select the name of this Core Activity.

Establishment of care coordination and active referral management that integrates information from referrals into the plan of care

b) Please enter a description of this Core Activity

Develop and enhance coordination of providers of the individuals, with diabetes, who request services from our agency to help them manage their disease. Develop and enhance partnerships with key stakeholder who offer programming that help diabetics, pre-diabetics, and their care givers manage their disease. This activity will initiate in the four clinical settings and additional activity will occur throughout the community and in the homes of patients. There are around eight (8) staff members assigned to support this function.

i) Please describe the first Secondary Driver for the above Core Activity (required).

Increase primary care access for clients without medical homes

A) Please list the first Change Idea for the above Secondary Driver (required).

Establish new partnerships with primary care providers

B) Please list the second Change Idea for the above Secondary Driver (optional).

Enhance ongoing relationships with referring providers and PCPs

C) Please list the third Change Idea for the above Secondary Driver (optional).

Enhance bi-directional referral protocol with providers

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

Standardize the referral processes to and from providers

E) Please list the fifth Change Idea for the above Secondary Driver (optional).

ii) Please describe the second Secondary Driver for the above Core Activity (optional).

E) Please list the fifth Change Idea for the above Secondary Driver (optional).

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

L1-115	L1-207		

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.

Diabetes and hypertension are both chronic conditions that may require a variety of interventions to manage, including adhering to prescribed medications and education around appropriate eating and physical activity practices. The establishment and enhancement of relationships with primary care providers and medical homes will strengthen the continuum of care for clients with diabetes. This in turn will hopefully lead to a client's better understanding of and how to manage of their chronic conditions.

d) Is this Core Activity provided by a provider that is not included in the Category B System Definition?

No

5) Please select the grouping for this Core Activity.

Prevention and Wellness

a) Please select the name of this Core Activity.

Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions

b) Please enter a description of this Core Activity

Provide chronic disease and diabetes self-management education and other behavior-change based services to diabetics, individuals with high blood pressure, individuals with BMIs outside of recommended guidelines, and those at risk of developing any of the aforementioned conditions. Services are centered around, but not limited to, self-management education, active living, healthy eating, community engagement, health coaching, and health connections. This activity will occur throughout the community and in our 11 mulitservice centers. There are around six (6) staff members assigned to support this function.

i) Please describe the first Secondary Driver for the above Core Activity (required).

Increase awareness on the general knowledge of diabetes, importance of diabetes management and self-efficacy

A) Please list the first Change Idea for the above Secondary Driver (required).

Provide chronic disease self-management educational sessions and trainings

B) Please list the second Change Idea for the above Secondary Driver (optional).

Monitor blood pressure from all diabetic clients we engage

C) Please list the third Change Idea for the above Secondary Driver (optional).

Offer medication adherance education to participants

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

Implement self-monitoring blood pressure curriculum

E) Please list the fifth Change Idea for the above Secondary Driver (optional).

Capture HbA1c from all diabetic and pre-diabetic clients

ii) Please describe the second Secondary Driver for the above Core Activity (optional).

Expansion of educational services offered by the local health department

A) Please list the first Change Idea for the above Secondary Driver (required).

Develop and update BP, abnormal BMI, tobacco cessation educational tools & materials

B) Please list the second Change Idea for the above Secondary Driver (optional).

Host monthly wellness resource seminars, e.g. BP management, DASH diet, alcohol reduction, nutrition, active living, weight management, tobacco cessation

C) Please list the third Change Idea for the above Secondary Driver (optional).

Conduct evidence-based health education series, e.g. Nutrition Ed/DASH, CDSM, Weight Management

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

Host “Pop-up” Conversation Series on BP, BMI management topics

E) Please list the fifth Change Idea for the above Secondary Driver (optional).

iii) Please describe the third Secondary Driver for the above Core Activity (optional).

Offer tobacco cessation counseling and follow-up to clients

A) Please list the first Change Idea for the above Secondary Driver (required).

Increase collaborations with local resources, e.g. Quit Line, MD Anderson, etc.

B) Please list the second Change Idea for the above Secondary Driver (optional).

Promotion of internal services offered and link to Health Education

C) Please list the third Change Idea for the above Secondary Driver (optional).

iv) Please describe the fourth Secondary Driver for the above Core Activity (optional).

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

L1-115	L1-207	L1-147	L1-210

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.

Development and enhancement of chronic disease and diabetes self-management education will ensure that clients referred for diabetes, weight management, hypertension, and tobacco cessation services will receive appropriate follow-up plans with goals for addressing identified chronic conditions and unhealthy behaviors.

d) Is this Core Activity provided by a provider that is not included in the Category B System Definition?

No

6) Please select the grouping for this Core Activity.

Expansion of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.

Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

b) Please enter a description of this Core Activity

Uses navigators to link clients with acute and chronic conditions and individuals to services that help improve the clients' health and well-being. Outputs from health department programing indicate that most barriers to care are knowledge based and transportation. This activity will initiate in the four clinical settings and additional activity will occur throughout the community and in the homes of patients. There are around eight (8) staff members assigned to support this function.

i) Please describe the first Secondary Driver for the above Core Activity (required).

Offer referrals for pre-hypertensive and hypertensive clients

A) Please list the first Change Idea for the above Secondary Driver (required).

Increase collaborations with local resources for individuals with blood pressure readings outside of the normal parameters

B) Please list the second Change Idea for the above Secondary Driver (optional).

Promotion of internal services offered and link to Health Education

C) Please list the third Change Idea for the above Secondary Driver (optional).

ii) Please describe the second Secondary Driver for the above Core Activity (optional).

Effectiveness of Care Coordination Services offered to clients

A) Please list the first Change Idea for the above Secondary Driver (required).

Ensure staff has/completes Community Health Worker Certification

B) Please list the second Change Idea for the above Secondary Driver (optional).

Training in Patient Navigation and specific subject matters

C) Please list the third Change Idea for the above Secondary Driver (optional).

Develop curriculum for continuing education for staff in care coordination

D) Please list the fourth Change Idea for the above Secondary Driver (optional).

iii) Please describe the third Secondary Driver for the above Core Activity (optional).

Offer referrals for BMIs that are outside of normal parameters

A) Please list the first Change Idea for the above Secondary Driver (required).

Increase collaborations with local resources for individuals with BMIs outside of the normal parameters

B) Please list the second Change Idea for the above Secondary Driver (optional).

Promotion of internal services offered and link to Health Education

C) Please list the third Change Idea for the above Secondary Driver (optional).

iv) Please describe the fourth Secondary Driver for the above Core Activity (optional).

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

L1-105	L1-147	L1-210	

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.

Patient navigators will be used to help develop follow-up plans for clients refeered for weight management, hypertension, diabetes, and tobacco cessation. Navigators will also help clients address any barriers identified to the prevention or managment of the identified condition. These barriers may be social needs, assistance with navigating the health care system, or assistance with accessing appropriate health care setting. To ensure that HHD clients receive the best care possible, it's also imperative that the patient navigators are properly trained and can speak to the barriers and identified for these chronic conditions.

d) Is this Core Activity provided by a provider that is not included in the Category B System Definition?

No

DY7-8 Provider RHP Plan Update Template - Category D

Progress Tracker

Section 2: Verification	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category D valuation in DY7	$5,672,752.35
	Category D valuation in DY8	$5,672,752.35
If regional hospital participation requirement is not met	Category D valuation in DY7	$1,890,917.45
	Category D valuation in DY8	$1,890,917.45

Section 1: Statewide Reporting Measure Bundle for Local Health Departments (LHDs)

Measure	Category D valuation per DY distributed across measures (if regional hospital participation requirement is met)	Category D valuation per DY distributed across measures (if regional hospital participation requirement is not met)
Time Since Routine Checkup	$810,393.19	$270,131.06
High Blood Pressure Status	$810,393.19	$270,131.06
Diabetes Status	$810,393.19	$270,131.06
Overweight or Obese	$810,393.19	$270,131.06
Smoker Status	$810,393.19	$270,131.06
Selected Immunizations	$810,393.19	$270,131.06
Prevention of Sexually Transmitted Diseases	$810,393.21	$270,131.09

Section 2: Verification

Please indicate below that you understand that Category D reporting requires qualitative reporting and data will be provided by HHSC as indicated in the Measure Bundle Protocol.

I understand

DY7-8 Provider RHP Plan Update Template - IGT Entry

Progress Tracker

Section 1: IGT Entities	Complete
Section 2: IGT Funding	Complete
Section 3: Certification	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

Section 1: IGT Entities

In order to delete an existing IGT, delete the name of the IGT from cell G21, G29, etc.

IGT RHP	IGT Name	IGT TPI (if available)	IGT TIN	Affiliation Number
3	City of Houston	N/A	174600116400002	100-13-0000-00134

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Judy Harris	8000 N. Stadium Dr.	Houston	77054	Judy.Harris@houstontx.gov	832-393-4345		Both
2	Jimmie Ng	8000 N. Stadium Dr.	Houston	77054	Jimmie.Ng@houstontx.gov	(832) 393-5011		Both
3	William Bryant	8000 N. Stadium Dr.	Houston	77054	William.Bryant@houstontx.gov	(832) 393-4612		Both

IGT RHP	IGT Name	IGT TPI (if available)	IGT TIN	Affiliation Number

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1								
2								
3								

Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP IGT Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP IGT Distribution List, and will be given access to the DSRIP Online Reporting System.

Section 2: IGT Funding

	IGT Name	IGT TIN	IGT Affiliation #	DY7 % IGT Allocated	DY8 % IGT Allocated	If regional private hospital participation requirement is met: Total Estimated DY7 Allocation (FMAP 56.88/IGT 43.12)	If regional private hospital participation requirement is met: Total Estimated DY8 Allocation (FMAP 57.32/IGT 42.68)	If regional private hospital participation requirement is not met: Total Estimated DY7 Allocation (FMAP 56.88/IGT 43.12)	If regional private hospital participation requirement is not met: Total Estimated DY8 Allocation (FMAP 57.32/IGT 42.68)
RHP Plan Update Submission	City of Houston	174600116400002	100-13-0000-00134	100.00%		$3,261,454.42		$3,261,454.42	
Category B	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$1,630,727.21	$1,614,087.14	$1,630,727.21	$1,614,087.14
L1-105	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-115	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$1,121,124.95	$1,513,206.69	$1,324,965.86	$1,714,967.58
L1-147	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-207	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$672,674.98	$907,924.01	$794,979.51	$1,028,980.55
L1-210	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-224	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-225	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-235	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-280	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.97	$1,210,565.35	$1,059,972.69	$1,371,974.07
L1-347	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$896,899.95	$1,210,565.34	$1,059,972.67	$1,371,974.05
Category D	City of Houston	174600116400002	100-13-0000-00134	100.00%	100.00%	$2,446,090.81	$2,421,130.70	$815,363.60	$807,043.57
Total						$16,307,272.09	$16,140,871.35	$16,307,272.09	$16,140,871.35

Your funding allocations sum to 100%.

Have the IGT Entities and funding percentages been updated?	Yes

Section 3: Certification

By my signature below, I certify the following facts:

- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document:

Name:	Judy Harris
IGT Organization:	City of Houston
Date:	3/9/2018

DY7-8 Provider RHP Plan Update Template -Summary and Certification

Progress Tracker

Section 1: DY7-8 DSRIP Valuation	Complete
Section 2: Category B Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)	Complete
Section 3: Category C Measure Bundles/Measures Selection and Valuation	Complete
Section 4: Category A Core Activities Associated with Category C Measure Bundles/Measures	Complete
Section 5: Category D Valuations	Complete
Section 6: Certification	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

Section 1: DY7-8 DSRIP Valuation

	DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$7,563,669.80	$0.00	$7,563,669.80	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$3,781,834.90	$3,781,834.90	$3,781,834.90	$3,781,834.90
Category C	$20,800,091.95	$28,363,761.75	$24,581,926.85	$32,145,596.65
Category D	$5,672,752.35	$5,672,752.35	$1,890,917.45	$1,890,917.45
Total	$37,818,349.00	$37,818,349.00	$37,818,349.00	$37,818,349.00

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Section 2: Category B Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)

	MLIU PPP	Total PPP	MLIU Percentage of Total PPP
DY5	39,531	41,456	95.36%
DY6	39,390	41,345	95.27%
DY7 Estimated	39,461	41,401	95.31%
DY8 Estimated	39,461	41,401	95.31%

Were DY7-8 maintenance goals based on DY5 or DY6 only?	No

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Section 3: Category C Measure Bundles/Measures Selection and Valuation

						Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
Bundle-Measure ID	Measure Bundle/Measure Name	# of Measures with Requested Achievement of Alternative Denominators	# of Measures with Requested Shorter or Delayed Measurement Periods	# of Measures with Requested Reporting Milestone Exemptions	Points	DY7 Valuation	DY8 Valuation	DY7 Valuation	DY8 Valuation
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0	0	0	1	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0	0	0	3	$2,600,011.49	$3,545,470.22	$3,072,740.86	$4,018,199.58
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0	0	0	1	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-207	Diabetes care: BP control (<140/90mm Hg)	0	0	0	3	$1,560,006.90	$2,127,282.13	$1,843,644.51	$2,410,919.75
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	0	0	0	1	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-224	Dental Sealant: Children	0	0	0	1	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-225	Dental Caries: Children	0	0	0	3	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-235	Post-Partum Follow-Up and Care Coordination	0	0	0	3	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-280	Chlamydia Screening in Women (CHL)	0	0	0	1	$2,080,009.20	$2,836,376.18	$2,458,192.69	$3,214,559.67
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	0	0	0	3	$2,080,009.16	$2,836,376.14	$2,458,192.65	$3,214,559.63
Total	N/A	0	0	0	20	$20,800,091.95	$28,363,761.75	$24,581,926.85	$32,145,596.65

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Section 4: Category A Core Activities Associated with Category C Measure Bundles/Measures

Bundle-Measure ID	Measure Bundle/Measure Name	Associated Core Activities
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	
L1-207	Diabetes care: BP control (<140/90mm Hg)	
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	
L1-224	Dental Sealant: Children	
L1-225	Dental Caries: Children	
L1-235	Post-Partum Follow-Up and Care Coordination	
L1-280	Chlamydia Screening in Women (CHL)	
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	
L1-235	Post-Partum Follow-Up and Care Coordination	
L1-280	Chlamydia Screening in Women (CHL)	
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Section 5: Category D Valuations

Statewide Reporting for LHDs

Measure	Category D valuation per DY distributed across measures (if regional hospital participation requirement is met)	Category D valuation per DY distributed across measures (if regional hospital participation requirement is not met)
Time Since Routine Checkup	$810,393.19	$270,131.06
High Blood Pressure Status	$810,393.19	$270,131.06
Diabetes Status	$810,393.19	$270,131.06
Overweight or Obese	$810,393.19	$270,131.06
Smoker Status	$810,393.19	$270,131.06
Selected Immunizations	$810,393.19	$270,131.06
Prevention of Sexually Transmitted Diseases	$810,393.21	$270,131.09

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Section 6: Certification

By my signature below, I certify the following facts:
• I am legally authorized to sign this document on behalf of my organization;
• I have read and understand this document:
• The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Name:	Judy Harris
Performing Provider:	City of Houston
Date:	3/9/2018

DY7-8 Provider RHP Plan Update Template - Overall Template Progress

PROVIDER RHP PLAN UPDATE TEMPLATE PROGRESS: Template is COMPLETE!

Please confirm that the Provider RHP Plan Update template progress shows complete above. If it shows that the template is not ready for submission, please complete any missing steps and correct any outstanding issues before submitting to HHS.

Provider Entry	
Section 1: Performing Provider Information	Complete
Section 2: Lead Contact Information	Complete
Section 3: Optional Withdrawal From DSRIP	Complete
Section 4: Performing Provider Overview	Complete
Section 5: DY7-8 DSRIP Total Valuation	Complete
Category B	
Section 1: System Definition	Complete
Section 2: Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)	Complete
Category C Selection	
Section 1: Selection Overview (CMHCs and LHDs only)	Complete
Section 3: Selection of Measures for Local Health Departments	Complete
Minimum Selection Requirements Met	Yes
MPT Met	Yes
Category C Additional Details	
Section 1: Measure Exemption Requests and Measure Setting System Components	Complete
Category C Valuation	
Section 1: Measure Bundle/Measure Valuation	Complete
Category A Core Activities	
Section 1: Transition from DY2-6 Projects to DY7-8 Provider-Level Outcomes and Core Activities	Complete
Section 2: Core Activities	Complete
All Selected Measure Bundles/Measures Associated with at Least One Core Activity	Complete
Category D	
Section 1: Statewide Reporting Measure Bundle for Local Health Departments (LHDs)	Complete
Section 2: Verification	Complete
IGT Entry	
Section 1: IGT Entities	Complete
Section 2: IGT Funding	Complete
Section 3: Certification	Complete
Summary and Certification	
Section 1: DY7-8 DSRIP Valuation	Complete
Section 2: Category B Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)	Complete
Section 3: Category C Measure Bundles/Measures Selection and Valuation	Complete
Section 4: Category A Core Activities Associated with Category C Measure Bundles/Measures	Complete
Section 5: Category D Valuations	Complete
Section 6: Certification	Complete