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:	111810101 - Unv of Tx HSC at Houston-UTHSC Sponsored Projects			
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)			
Ownership:	Non-State Owned Public			
TIN:	17417613092000			
Physical Street Address:	1200 Binz Street, Suite 730			
City:	Houston			
Zip:	77004			
Primary County:	Harris			
Additional counties being served (optional):	Fort Bend	Jefferson		

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:	Andrew Casas	Sahar M. Qashqai	
Street Address:	6410 Fannin	1200 Binz Street Suite 730	
City:	Houston	Houston	
Zip:	77030	77004	
Email:	Andrew.Casas@uth.tmc.edu	sahar.m.qashqai@uth.tmc.edu	
Phone Number:	832-325-7317	713-486-3860	
Phone Extension:			
Lead Contact or 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:	As the medical group practice of McGovern Medical School, UT Physicians is a national leader in the delivery of integrated, personalized care, with many of our doctors listed among the "Best Doctors in America." With more than 1,500 providers certified in 80 medical specialties and subspecialties and more than 100 clinic locations, UT Physicians provides multi-specialty care for the entire family. Our community based clinics are located throughout Harris and Fort Bend counties. Our care specialties include: family medicine, pediatrics, internal medicine, behavioral health, adult and pediatric psychiatry, cardiology, endocrinology, pulmonary, allergy/immunology, obstetrics/gynecology. Since Demonstration Year 3, we have implemented 22 DSRIP projects to improve access to primary and specialty care, using a patient-centered approach. We provide approximately 300,000 encounters annually. To address the high levels of uninsured among low-income Texans, UT Physicians instituted a financial assistance program in order to make healthcare affordable to all. Through our DSRIP projects, we provide our patients with access to evening and weekend appointments, access to a 24/7 nurse triage phone line, care coordination, medication management, integrated primary and behavioral healthcare, and patient education. To continue to expand patient care, we are instituting a medical-legal partnership that will address social determinants of health and will also add telehealth programs to our community based clinics to serve patients in the communities where they live.
Overall DSRIP Goals:	UT Physicians employs a patient-centered model of care that provides high quality, evidence-based care to all patients; coordinates healthcare across the medical neighborhood; increases access through enhanced technology; and empowers patient to be active partners in care. To that end, through multidisciplinary care teams and ongoing quality improvement activities, UT Physicians is committed to implementing chronic disease management interventions that improve health outcomes for diabetic and hypertensive patients. This also includes preventing disease sequelae and reducing unnecessary utilization for emergency care. Preventive care, including immunizations, wellness visits, disease testing, and cancer screening are an important part of primary care services for Texans. We will continue to provide care coordination for pediatric, pregnant, and adult Texans under the patient-centered medical home model. For the last several years, we have co-located physical and behavioral health so that screening and treatment of high risk patients occur in an integrated setting. UT Physicians will continue managing behavioral health patients in a primary care setting including focusing on depression and ADHD. Using the integrated model, both primary care providers and behavioral health specialists will share timely updates and treatment plans for shared patients.
Alignment with regional community needs assessment:	The 2017 regional community health needs assessment (CHNA) showed that the funding and implementation of DSRIP programs have made several improvements in the health of residents living in our region. Since DSRIP began in Texas, we improved access to primary and specialty care, evidenced by the addition of more than 2,800 primary care and specialty care providers from 2012-2016. The region has also seen decreases in adult smokers from 18% in 2013 to 15% in 2017. A similar reduction in preventable hospital stays for ambulatory-care sensitive conditions among Medicare enrollees occurred between 2012 and 2016. However, Region 3 still has significant unmet needs that we will address during DY7-10. There remains significant gaps in care related to behavioral health, teen pregnancy and births, and high prevalence of chronic disease and poor overall health. The CHNA also cites insufficient access to care, inadequate transportation options for individuals needing health care, inadequate education and services to provide support for healthy environments and health outcomes of an ever growing and more diverse population. UT Physicians has made strides to improve maternal health, behavioral health, and prevention/management of chronic diseases. Since program inception, we have transformed health care delivery by diversifying our workforce. We have added community health workers, case managers, social workers, clinical pharmacists, and community health education specialists. These additional roles allow each clinician to work at the top of his/her license while supporting traditional providers to comprehensively address most factors influencing patient health. For example, to improve management of patients with diabetes, UT Physicians provides patients with expanded access to specialists, nutrition support and education via certified diabetes educators and community health education specialists, and medication education and management via clinical pharmacists.

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	$18,368,173.34	$0.00	$18,368,173.34	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$9,184,086.67	$9,184,086.67	$9,184,086.67	$9,184,086.67
Category C	$50,512,476.68	$68,880,650.02	$59,696,563.35	$78,064,736.69
Category D	$13,776,130.00	$13,776,130.00	$4,592,043.33	$4,592,043.33
Total	$91,840,866.69	$91,840,866.69	$91,840,866.69	$91,840,866.69

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:	111810101 - Unv of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
Ownership:	Non-State Owned Public
Category B valuation in DY7:	$9,184,086.67
Category B valuation in DY8:	$9,184,086.67

Section 1: System Definition

Physician Practices - Required Components

Required System Component	Business Component?
Owned or Operated Primary Care Clinics	Business Component of the Organization

Please enter a description of this System Component.

All primary care (e.g., family medicine, internal medicine, pediatrics) clinic locations owned by UT Physicians.

Required System Component	Business Component?
Owned or Operated Specialty Care Clinics	Business Component of the Organization

Please enter a description of this System Component.

All multi-specialty (e.g., behavioral health, psychiatry, obstetrics/gynecology, endocrinology, cardiology, hepatology) clinic locations owned by UT Physicians.

Required System Component	Business Component?
Owned or Operated Hospital	Not a Business Component of the Organization

Required System Component	Business Component?
Owned or Operated Urgent Care Clinics	Not a Business Component of the Organization

Physician Practices - Optional Components

Optional System Component	Would you like to select this component?
Contracted Specialty Clinics	No

Optional System Component	Would you like to select this component?
Contracted Primary Care Clinics	No

Optional System Component	Would you like to select this component?
Contracted Community-based Programs	No

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

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

	DY5	DY6
MLIU PPP	49,783	56,439
Total PPP	297,943	311,366

Please indicate the population included in the MLIU PPP

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

MLIU PPP Goal for each DY (DY7 and DY8):	53,111
Average Total PPP	304,655
MLIU percentage of Total PPP	17.43%

*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**

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

Progress Tracker

		Note: you must confirm selections at the bottom of the page to finish.	MPT	75
			Points Selected	87
Section 2: Selection of Measure Bundles for Hospitals and Physician Practices	Complete		Bundles Selected	7
Minimum Selection Requirements Met	Yes		Clinical Outcome Selected	Y
MPT Met	Yes			
			Measure Bundle with PBCO selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	111810101 - Unv of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
Ownership:	Non-State Owned Public

If regional private hospital participation requirement is met	Category C valuation in DY7:	$50,512,476.68
	Category C valuation in DY8:	$68,880,650.02
If regional private hospital participation requirement is not met	Category C valuation in DY7:	$59,696,563.35
	Category C valuation in DY8:	$78,064,736.69

MINIMUM POINT THRESHOLD (MPT): 75

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 Physician Practice affiliated with an Academic Health Science Center (AHSC)

For Hospital organizations and Physician Practices, the DSRIP attributed population includes individuals from the DSRIP system defined in Category B that meet at least one of the criteria below. Individuals do not need to meet all or multiple criteria to be included.

a. Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the performing providers DSRIP defined system OR

b. Individuals enrolled in a local coverage program (for example, a county-based indigent care program) assigned to a PCP, medical home, or clinic in the performing providers DSRIP defined system OR

c. One preventive service provided during the measurement period (Includes value sets of visit type codes for annual wellness visit, preventive care services - initial office visit, preventive care services - established office visit, preventive care individual counseling) OR

d. One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year OR

e. Two ambulatory encounters during the measurement year OR

f. Other populations managed with chronic disease in specialty care clinics in the performing providers DSRIP defined system

g. One emergency department visit during the measurement year OR

h. One admission for inpatient or observation status during the measurement year OR

i. One prenatal or postnatal visit during the measurement year OR

j. One delivery during the measurement year OR

k. One dental encounter during the measurement year OR

l. Enrolled in a palliative care or hospice program during the measurement year

Please describe any other attributed population (optional).

Our attributed population will draw from criterion c, d or e.

Section 2: Selection of Measure Bundles for Hospitals and Physician Practices

Measure Bundles for Hospitals & Physician Practices

Select Measure Bundle? (Yes/No)	Measure Bundle ID	Measure Bundle Name	Measure Bundle Base Points
Yes	A1	Improved Chronic Disease Management: Diabetes Care	11

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

Nationally, approximately 30.3 million Americans (9.4% of the population) are diagnosed with diabetes and each year there are 1.5 million new cases. In the state of Texas, 14% of the adult population has diabetes. In Harris County, diabetes is the leading cause of death (DSHS 2013). Closer to home at UT Physicians, diabetes is the second most prevalent chronic disease affecting approximately 25% of our adult patients.

Individuals at risk for diabetes are on the rise. One in three adults is diagnosed with pre-diabetes which presents opportunities for prevention. Diabetes disproportionately impacts low socioeconomic groups and racial ethnic minorities. Low-income individuals (above 400% FPL) with diabetes experience poorer health compared to those with higher socioeconomic status. Hispanics, Native Americans, and blacks carry the burden of disease more than any other ethnic minority.

The incidence of diabetes goes underreported. Of the 2.8 million diabetics in Texas, at least 663,000 were at risk and did not know they had diabetes. Additionally, combatting the disease is costing the state $23.7 billion each year. Much of this can be traced to loss of productivity and serious complications requiring expensive procedures delivered in acute, specialized settings.

For the past several years, we have successfully addressed poor control of diabetes through a multi-pronged approach including self-management, social support, nutrition and gardening programs, and medication management. Multidisciplinary care teams assess for barriers and deliver a coordinated plan of culturally relevant education, support and monitoring. As our American Diabetes Association recognized program grows, we will enhance more multidisciplinary care teams with certified diabetes educators for one-on-one and group counseling. Wellness programs, such as the Diabetes Empowerment Education Program (DEEP) program, designed to reach at-risk communities, will be offered onsite and in locales in closer proximity to neighborhoods in need.

The primary system components that we select for this measure bundle are our primary and multi-specialty community-based clinics that serve adult patients. Locations include: Bayshore, Bellaire, Bellaire-Dashwood, Cinco Ranch, Sienna, Heights, Greens, Southwest, Victory, Jensen, Rosenberg and UT Professional Building.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	MLIU denominator with significant volume	A1-112	Comprehensive Diabetes Care: Foot Exam	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	A1-207	Diabetes care: BP control (<140/90mm Hg)	Required	P4P	Clinical Outcome	N/A
No		A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	Optional	P4P	Process	1
N/A - Required	MLIU denominator with significant volume	A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	Required	P4P	Population Based Clinical Outcome	4
N/A - Required	MLIU denominator with significant volume	A1-508	Reduce Rate of Emergency Department visits for Diabetes	Required	P4P	Population Based Clinical Outcome	4

Select Measure Bundle? (Yes/No)	Measure Bundle ID	Measure Bundle Name	Measure Bundle Base Points
No	A2	Improved Chronic Disease Management: Heart Disease	8
No	B1	Care Transitions & Hospital Readmissions	11
No	B2	Patient Navigation & ED Diversion	3
Yes	C1	Primary Care Prevention - Healthy Texans	12

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

UT Physicians is a physician practice that provides multi-specialty patient-centered care in ambulatory, outpatient settings. The 2017 RHP3 community needs assessment reports a high prevalence of chronic disease (i.e., diabetes, heart disease) and poor health with some healthcare needs still remaining unmet in our region. UT Physicians implemented several DSRIP projects aimed to increase access to primary care and has been successful in showing improvements in preventive care, screening and immunization uptakes rates during DY4-DY6. As a result of conducting program evaluations in DY6, we discovered significant cost-savings are associated with increases in pneumonia vaccination among older adults. To address the high prevalence of chronic diseases, we implemented a chronic disease registry, care coordination via care teams, medication management, and patient education and self-management classes. We are confident that we can apply the best practices and lessons learned during the first six years of DSRIP to create improvements in primary care prevention across our system during DY7-DY8.

The primary system components that we select for this measure bundle are our primary and multi-specialty community-based clinics that serve adult patients. Locations include: Bayshore, Bellaire, Bellaire-Dashwood, Cinco Ranch, Sienna, Heights, Greens, Southwest, Victory, Jensen, Rosenberg and UT Professional Building. Selection of the Primary Care Prevention aligns with UT Physicians' goal to deliver and improve services that focus on prevention and screening.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	MLIU denominator with significant volume	C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	C1-268	Pneumonia vaccination status for older adults	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	C1-269	Preventive Care and Screening: Influenza Immunization	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	C1-272	Adults (18+ years) Immunization status	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	C1-280	Chlamydia Screening in Women (CHL)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	C1-389	Human Papillomavirus Vaccine (age 18 -26)	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	Required	P4P	Population Based Clinical Outcome	4

Select Measure Bundle? (Yes/No)	Measure Bundle ID	Measure Bundle Name	Measure Bundle Base Points
Yes	C2	Primary Care Prevention - Cancer Screening	6

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

Cancer is the second leading cause of death in the U.S., claiming the lives of more than half a million Americans each year. If detected early, chances are greatly increased for successful treatment. The ability for individuals to have access to affordable cancer screening, especially for those diseases that have widespread population impacts like that of breast, cervical and colorectal cancer, is of utmost importance.

Over the last four demonstration years, we built screening programs throughout our community-based clinics that target these cancers. These efforts were part of our Category 3 Outcome measures that are now transitioning to Category C measure bundles. Significant amounts of time and energy were spent on developing these programs, which included: hiring and training staff, obtaining the necessary equipment/resources to conduct screenings, establishing referral pathways for screenings that had to be conducted outside of community-based clinics and making modifications to our EMR that allow us to track and document patient screening encounters. As we move to the second phase of the Waiver, it is without hesitation that we continue these critical services, and identify ways to improve existing processes and procedures.

The primary system components that we select for this measure bundle are our primary and multi-specialty community-based clinics that serve adult patients. Locations include: Bayshore, Bellaire, Bellaire-Dashwood, Cinco Ranch, Sienna, Heights, Greens, Southwest, Victory, Jensen, Rosenberg and UT Professional Building.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	MLIU denominator with significant volume	C2-106	Cervical Cancer Screening	Required	P4P	Cancer Screening	N/A
N/A - Required	MLIU denominator with significant volume	C2-107	Colorectal Cancer Screening	Required	P4P	Cancer Screening	N/A
N/A - Required	MLIU denominator with significant volume	C2-186	Breast Cancer Screening	Required	P4P	Cancer Screening	N/A

Select Measure Bundle? (Yes/No)	Measure Bundle ID	Measure Bundle Name	Measure Bundle Base Points
Yes	C3	Hepatitis C	4

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

Hepatitis C is the most common chronic blood-borne pathogen in the U.S. and is a leading cause of complications from chronic liver disease. Approximately 1.6% of noninstitutionalized individuals in the U.S. have hepatitis C antibodies, indicating current or prior infection. There were an estimated 16,000 new cases of hepatitis C infection in 2009 and 15,000 deaths in 2007. Hepatitis C accounts for more than 30% of liver transplant cases in U.S. adults. Hepatitis C also accounts for about one half of the rising incidence of hepatocellular carcinoma.

Many individuals with chronic hepatitis C infection are unaware of their condition. Considering the high accuracy of the screening test and the availability of effective

and safe treatment, screening for hepatitis C is beneficial for populations at high risk for infection. Given the fact that we serve approximately 300,000 patients on a yearly basis throughout the greater Houston area, there is great opportunity to capture and serve patients affected by Hepatitis C. Furthermore, we currently screen for Hepatitis C presence in our patients, thus, this is an opportunity to build upon existing practices and make a better impact on this group of patients. Lastly, we will use the Extension for Community Healthcare Outcomes (ECHO) model (https://echo.unm.edu/) to deliver high quality treatment for hepatitis C in the communities in which patients live. A team of liver specialists will use live videoconferencing to conduct patient case discussions with primary care providers at our community based clinics, who in turn will treat their own patients for hepatitis C. This model of care not only produces excellent patient outcomes, but also exponentially increases workforce capacity to provide hepatitis C treatment care (i.e. is sustainable) and reduces health disparities.

The primary system components that we select for this measure bundle are our primary and multi-specialty community-based clinics that serve adult patients. Locations include: Bayshore, Bellaire, Bellaire-Dashwood, Cinco Ranch, Sienna, Heights, Greens, Southwest, Victory, Jensen, Rosenberg and UT Professional Building.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	MLIU denominator with significant volume	C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection (eMeasure)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	C3-368	Hepatitis C: Hepatitis A Vaccination	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	C3-369	Hepatitis C: Hepatitis B Vaccination	Required	P4P	Immunization	N/A

Select Measure Bundle? (Yes/No)	**Measure Bundle ID**	**Measure Bundle Name**	**Measure Bundle Base Points**
Yes	D1	Pediatric Primary Care	14

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

We selected the D1-Pediatric Primary Care measure bundle for several reasons:

First, this measure bundle aligns with our region's community needs. The 2017 RHP3 community needs assessment reports that while the region's aggregate quality outcome performance shows that more than half of quality funds were achieved (indicating health improvement), patient health in certain outcome domains tied to DSRIP projects improved more than others. As a matter of fact, based on DY4 and DY5 goal achievement, the quality outcome domains with the most challenges include primary care and child health.

Second, this measure bundle aligns with our overall DSRIP goals. From DY3 to DY6, UT Physicians implemented several DSRIP projects aimed at increasing access to high-quality, wellness-oriented primary care services including well-child care, immunizations, acute care visits, visits for ongoing management of asthma, ADHD, behavioral concerns, and screening for overweight, blood pressure, and anemia. Moreover, we have been successful in showing improvements in child-centered preventive care, screening and immunization uptake rates during DY4-DY6.

Finally, the selection of this measure bundle will allow us to continue to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system. We are confident that we can apply the best practices and lessons learned during the first six years of DSRIP to create improvements in pediatric primary care across our system during DY7-DY10.

The primary system components that will be used to report on and drive improvements in this measure bundle are our primary and multi-specialty community-based clinics that serve pediatric patients. Locations include: Bay Area Pediatric Associates (BAPA), Bellaire, Bellaire-Dashwood, Cinco Ranch, Sienna, Heights, Greens, Southwest, Victory, Jensen, Rosenberg and UT Professional Building

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	MLIU denominator with significant volume	D1-108	Childhood Immunization Status (CIS)	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	D1-212	Appropriate Testing for Children With Pharyngitis	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	D1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	D1-271	Immunization for Adolescents	Required	P4P	Immunization	N/A
N/A - Required	MLIU denominator with significant volume	D1-284	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	D1-400	Tobacco Use and Help with Quitting Among Adolescents	Required	P4P	Process	N/A
No	MLIU denominator with significant volume	D1-301	Maternal Depression Screening	Optional	P4P	Process	1
Yes	MLIU denominator with significant volume	D1-389	Human Papillomavirus Vaccine (age 15-18)	Optional	P4P	Immunization	1
N/A - Required	MLIU denominator with significant volume	D1-503	PDI 91 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	Required	P4P	Population Based Clinical Outcome	4
No	MLIU denominator with significant volume	D1-T01	Innovative Measure: Behavioral Health Counselling for Childhood Obesity	Optional	P4R	Innovative	0

Select Measure Bundle? (Yes/No)	**Measure Bundle ID**	**Measure Bundle Name**	**Measure Bundle Base Points**
No	D3	Pediatric Hospital Safety	10
No	D4	Pediatric Chronic Disease Management: Asthma	9
No	D5	Pediatric Chronic Disease Management: Diabetes	8
Yes	E1	Improved Maternal Care	10

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

UT Physicians is a physician practice that provides multi-specialty patient-centered care in ambulatory, outpatient settings. The 2017 RHP3 community needs assessment reports that the State of Texas has the fourth highest birth rate and fifth highest pregnancy rates among teenage girls, ages 15-19. UT Physicians implemented a comprehensive DSRIP project to improve maternal care and has been successful in improving maternal health outcomes during DY4-DY6. Specifically, a larger proportion of our female post-partum patients are receiving follow-up visits and care coordination. Other aspects of our existing maternal health program assess and provide preconception and postpartum contraceptive counseling, behavioral health support, and support for intimate partner violence. We are confident that we can apply the best practices and lessons learned during the first six years of DSRIP to create improvements in maternal health across our system.

The primary system components that we select for this measure bundle are our multi-specialty and specialty community-based clinics that serve Ob/Gyn patients. Locations include: Bayshore, Bellaire, Cinco Ranch, Sienna, Heights, Greens, Victory, Rosenberg and UT Professional Building.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	Medicaid-only denominator with significant volume	E1-232	Timeliness of Prenatal	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	E1-235	Post-Partum Follow-Up and Care Coordination	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	E1-300	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)	Required	P4P	Process	N/A
Yes	MLIU denominator with significant volume	E1-193	Contraceptive Care – Postpartum Women Ages 15–44 (CCP-AD)	Optional	P4P	Process	1

Select Measure Bundle? (Yes/No)	**Measure Bundle ID**	**Measure Bundle Name**	**Measure Bundle Base Points**
No	E2	Maternal Safety	8
No	F1	Improved Access to Adult Dental Care	7
No	F2	Preventive Pediatric Dental	2
No	G1	Palliative Care	6
Yes	H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	12

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

Since inception, we have built and developed integrated services in our clinics as a frontline response to the need for increased access to behavioral health screening, identification, referral, shared treatment planning and integration meetings. The need for this expansion has been indicated through multiple community needs assessments. For example, the monthly average number of poor mental health days reported in 2012 and in 2016 remains steady (3 per month), a third of local teens report feeling sad every day over a two week period, and service access remains an issue. Texas has a higher proportion of psychiatrists who use a cash only payment system and do not take insurance. The integrated service offerings in our clinics, which include financial counselors, mitigate these barriers while addressing behavioral health needs across the life span. We continue to standardize clinical pathways relative to depression treatment and remission, screening for substance use, and inattention problems in youth across the practice plan.

The primary system components that we select for this measure bundle are our multi-specialty and specialty community-based clinics that serve primary care and behavioral health patients. Locations include: Bay Area Pediatric Associates, Bayshore, Cinco Ranch and Cinco Ranch Pediatrics, Dashwood-Bellaire, Sienna Village, Southwest, Victory, Jensen, Greens, and Heights and UT Professional Building.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	MLIU denominator with significant volume	H1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	H1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	H1-286	Depression Remission at Six Months	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Required	P4P	Process	N/A
No	MLIU denominator with significant volume	H1-T04	Innovative Measure: Engagement in Integrated Behavioral Health	Optional	P4R	Innovative	0

Select Measure Bundle? (Yes/No)	**Measure Bundle ID**	**Measure Bundle Name**	**Measure Bundle Base Points**
No	H2	Behavioral Health and Appropriate Utilization	8
No	H3	Chronic Non-Malignant Pain Management	10
No	H4	Integrated Care for People with Serious Mental Illness	5
No	I1	Specialty Care	2
No	J1	Hospital Safety	10

Total overall selected points:	87

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?
A1-112	Comprehensive Diabetes Care: Foot Exam	CY2017: January 1, 2017 - December 31, 2017	No	No	No
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
A1-207	Diabetes care: BP control (<140/90mm Hg)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
A1-508	Reduce Rate of Emergency Department visits for Diabetes	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-268	Pneumonia vaccination status for older adults	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-269	Preventive Care and Screening: Influenza Immunization	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-272	Adults (18+ years) Immunization status	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-280	Chlamydia Screening in Women (CHL)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-389	Human Papillomavirus Vaccine (age 18 -26)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C2-106	Cervical Cancer Screening	CY2017: January 1, 2017 - December 31, 2017	No	No	No

C2-107	Colorectal Cancer Screening	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C2-186	Breast Cancer Screening	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection (eMeasure)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C3-368	Hepatitis C: Hepatitis A Vaccination	CY2017: January 1, 2017 - December 31, 2017	No	No	No
C3-369	Hepatitis C: Hepatitis B Vaccination	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-108	Childhood Immunization Status (CIS)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-212	Appropriate Testing for Children With Pharyngitis	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-271	Immunization for Adolescents	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-284	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-389	Human Papillomavirus Vaccine (age 15-18)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-400	Tobacco Use and Help with Quitting Among Adolescents	CY2017: January 1, 2017 - December 31, 2017	No	No	No
D1-503	PDI 91 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
E1-193	Contraceptive Care – Postpartum Women Ages 15–44 (CCP-AD)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
E1-232	Timeliness of Prenatal	CY2017: January 1, 2017 - December 31, 2017	No	No	No
E1-235	Post-Partum Follow-Up and Care Coordination	CY2017: January 1, 2017 - December 31, 2017	No	No	No

E1-300	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
H1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
H1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
H1-286	Depression Remission at Six Months	CY2017: January 1, 2017 - December 31, 2017	No	No	No
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	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:	111810101 - Univ of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category C valuation in DY7:	$50,512,476.68
	Category C valuation in DY8:	$68,880,650.02
If regional hospital participation requirement is not met	Category C valuation in DY7:	$59,696,563.35
	Category C valuation in DY8:	$78,064,736.69

Section 1: Measure Bundle/Measure Valuation

Valuation for Selected Measure Bundles - Hospitals & Physician Practices

						If regional private hospital participation requirement is met		If regional private hospital participation requirement is not met	
Measure Bundle ID	Measure Bundle Name	Points	Desired Valuation Percentage	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
A1	Improved Chronic Disease Management: Diabetes Care	19	24.52%	16.37%	27.30%	$12,385,659.28	$16,889,535.38	$14,637,597.33	$19,141,473.44
C1	Primary Care Prevention - Healthy Texans	16	20.10%	13.79%	22.99%	$10,153,007.81	$13,845,010.65	$11,999,009.23	$15,691,012.07
C2	Primary Care Prevention - Cancer Screening	6	6.90%	5.17%	6.90%	$3,485,360.89	$4,752,764.85	$4,119,062.87	$5,386,466.83
C3	Hepatitis C	4	4.60%	3.44%	4.60%	$2,323,573.93	$3,168,509.90	$2,746,041.91	$3,590,977.89
D1	Pediatric Primary Care	19	16.37%	16.37%	27.30%	$8,268,892.43	$11,275,762.41	$9,772,327.42	$12,779,197.40
E1	Improved Maternal Care	11	13.72%	9.48%	15.81%	$6,930,311.80	$9,450,425.18	$8,190,368.49	$10,710,481.87
H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	12	13.79%	10.34%	17.25%	$6,965,670.54	$9,498,641.65	$8,232,156.10	$10,765,127.19
	Total	87	100.00%	N/A	N/A	$50,512,476.68	$68,880,650.02	$59,696,563.35	$78,064,736.69
	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 measure bundles?
Yes

Explanation of Valuation Percent Changes

Overall justification for change in Category C valuation distribution.

UT Physicians is a physician practice that provides community-based, outpatient care to residents throughout Harris, Fort Bend, and Jefferson counties. We see approximately 300,000 unique patients on an annual basis, with the vast majority consisting of adults aged 18 years and above. Consequently, we choose to increase the valuation distribution of bundles (A1, C1, E1) that reflect the demographics of our patient population.

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.

For the A1 bundle, we are sustaining the improvement in hemoglobin A1c control for diabetic patients achieved over the last several years (A1-115). Some efforts the focus on blood pressure control in diabetic patients (A1-207) would help improve the measure; baseline is 68.95% with a DY7 goal of 75.64% MPL. Multidisciplinary care teams, made up of certified diabetes educators, will support patient self-management of diabetes and its complications. We will deploy wide scale training on proper and consistent documentation.

For the C1 bundle, there is room for improvement on every measure. Our estimated baseline for C1-113: Comprehensive Diabetes Care: Hemoglobin (HbA1c) testing is approximately 79.88% with a DY7 goal of meeting MPL which is 82.92%. We will need to work strenuously to improve the testing rates for eligible patients using a multi-method strategy: educate patients, provide patients with follow up reminders, and educate staff on proper documentation.

For the E1 bundle, we will devote significant effort to improving E1-232: Timeliness of Prenatal Care. This measure comprises two rates: timeliness of prenatal care and timeliness of postpartum care. Although the American College of Obstetricians and Gynecologists recommends prenatal care within the first trimester, approximately 13% of mothers living Houston receive either no or late prenatal care (Kids Count data center, 2016). This issue is confounded by the fact that more than half of pregnancies in the United States are unintended which may also lead to delays in prenatal care. To improve on this measure, we will use care teams to actively engage with pregnant patients to receive timely prenatal care as soon as they establish care with UT Physicians.

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

The level of effort required for improvement in bundles A1, C1, and E1 is moderate to high. Fortunately, several of our DSRIP 1.0 projects built an infrastructure of activities that support our measure bundle selections, including quality improvement initiatives. Over the past several years, we strengthened our care coordination efforts with the establishment of care teams that will support the work needed to improve the outcomes of our selected measure bundles.

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.

UT Physicians provides care to over 300,000 unique patients each year. The majority of our patients are adults whereas only 23% of our patients are children (ages 0-17). To reflect the demographics of our patient population, we choose to slightly increase the valuation allocation of A1: Diabetes care, C1: Primary Care Prevention – Healthy Texans, and E1: Improved Maternal Care. Approximately 25% of our adult patients have diabetes; therefore we increased the valuation of the A1 bundle to correlate with our patients' profiles. Approximately 19% of our patients meet the target population for improved maternal care; consequently, we request an increase of the valuation of the E1 bundle.

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:	111810101 - Unv of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
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_111810101.1.1	1.1.2	Expand primary care specialty at each of its 4 outlying clinics. Space will be purchased for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays.	Continuing as Core Activity in DY7-8	Through this project, the UT Physicians community based clinics (CBCs) at Bayshore, Bellaire-Dashwood, Cinco Ranch and Sienna Village, will continue to improve access to comprehensive, integrated and coordinated primary care services that are focused on patient-centered preventive care. Also, the UT Physicians CBCs will continue to promote and expand access to care by providing patients with scheduling options on evenings and Saturdays, a 24/7 continuous access to a Nurse Triage Line and, the UT Physicians patient portal. A multitude of primary care services, including provision of screenings and vaccinations to target population, will contribute to the achievement of clinical outcomes and immunization measures included in C1 and D1 measure bundles, as well as cancer screening measures included in the C2 measure bundle. In addition, these CBCs will continue to provide integrated physical and behavioral services which will help to improve the measures listed in the
RHP 3_111810101.1.10	1.9.2	Recruit specialists for the new primary care clinic in North Harris County. The new primary care clinic's service hours will be extended to provide evening and weekend appointment options, which will be covered by the UTP specialty services as well. Standardized referral systems will be put in place to ensure access to these specialists.	Continuing as Core Activity in DY7-8	UT Physicians will maintain providers and support staff to continue providing specialty care services in the Heights and Greens clinics. Services offered will include cardiology, endocrinology, pulmonary and rheumatology. We will also continue to provide obstetrics/gynecology and gastrointestinal services. The two clinics will continue to provide patients with access to extended weekday and weekend appointments and, a 24/7 nurse triage line. The continuation of this project will contribute to our success in achieving some of the clinical outcomes contained within the DY7 and DY8 measure bundles. The specialty care project will allow us to address measures in A1 measure bundle through our endocrinologists.
RHP 3_111810101.1.2	1.2.1	Train residents in the "new primary care" model that is capable of staffing enhanced medical homes.	Completed in DY2-6	
RHP 3_111810101.1.3	1.2.2	Partner with Gateway to Care, Harris Health System, and UT Physicians to increase the number of certified CHWs in the region (currently approx 500) and respond to specific continuing education needs. In addition, providers and clinic staff will be trained on how to integrate CHWs as members of the health care team.	Continuing as Core Activity in DY7-8	During DY2-6, this project focused on increasing the number of certified community health workers (CHWs) in the region, provided specific continuing education needs identified by providers and CHWs and trained providers and clinic staff on how to integrate CHWs as members of the health care team. Moving forward, we continue to provide skilled CHWs across clinics to assist in achieving the region's goal to transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes.

RHP 3_111810101.1.4	1.3.1	Data entered into a unique chronic disease registry will be use to proactively contact, educate, and track pts by disease status, risk status, self management status, community and family need. Reports drawn from the registry will be used to develop and implement targeted quality improvement plans for diabetes, hypertension, asthma, COPD, and CHF.	Continuing as Core Activity in DY7-8	The Chronic Disease Registry (CDR) will continue to be employed as a tool for staff and providers to track and manage patient populations with one or more chronic disease/s. Case managers as well as other staff use the CDR to reach out to patients with care gaps in order to prevent complications as well as emergency care utilization. The CDR will have its greatest impact on the metrics in bundles A1 (Chronic Disease Management: Diabetes Care) as diabetes is one of the six chronic conditions currently tracked in the CDR. In order to ensure that the CDR continues to successfully serve DSRIP and organizational aims, the CDR team will assess ways to modify the software so that some of the new Category C metrics can be tracked and impacted.
RHP 3_111810101.1.5	1.6.2	Expand access to medical advice and guidance to the appropriate level of care in order to reduce emergency dept use for non-emergent conditions by implementing a nurse-line medical triage call center that will be staffed 24/7/365.	Continuing as Core Activity in DY7-8	The principal objective of the Nurse Triage line is to reduce utilization of the emergency department by either scheduling same day appointments with a UT provider or by servicing patients with non-emergent medical needs by providing sound home care advice to self-treat health conditions. This supports the Primary Care services core activity of Expanding Practice Access by providing services, both during and beyond clinic hours, including 24-hour medical advice and education services, answers to health related questions, home care advice, scheduling of urgent/sick appointments and addressing concerns regarding the effects of medication.
RHP 3_111810101.1.6	1.1.1	Establish a new primary care clinic in the Northwest area of Houston. Space will be acquired for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays	Continuing as Core Activity in DY7-8	Through this project, UT Physicians at the Heights Clinic will continue to address the inadequate access to primary care and high rates of inappropriate emergency department utilization for our target population. This project provides quality access to comprehensive and coordinated primary care services focused on patient-centered preventive care for adult and pediatric patients. Additionally, our patients will continue to have access to: extended weekday and weekend appointments, a 24/7 nurse triage line and a care coordination team which includes a case manager, social worker and community health worker. A multitude of primary care services including provisions of screenings and vaccinations to our target population, will contribute to the achievement of clinical outcomes and immunization measures included in C1 and D1 measure bundles, as well as cancer screening measured including in the C2 measure bundle. In addition, this clinic will continue to provide integrated

RHP 3_111810101.1.7	1.9.2	Recruit specialists for outlying clinics. Clinic service hours will be extended to provide evening and weekend appt. options. Standardized referral systems will be put in place to ensure access to these specialists.	Continuing as Core Activity in DY7-8	UT Physicians will maintain providers and support staff to continue providing specialty care services in the four outlying clinics: Bayshore multispecialty, Dashwood multispecialty, Cinco Ranch and Sienna Village clinics. Services offered will include cardiology, endocrinology, pulmonary and rheumatology. We will also continue to provide obstetrics/gynecology and gastrointestinal services. The clinics will continue to provide patients with access to extended weekday and weekend appointments and, a 24/7 nurse triage line. The continuation of this project will contribute to our success in achieving some of the clinical outcomes contained within the DY7 and DY8 measure bundles. The specialty care project will allow us to address measures in A1 measure bundle through our endocrinologists.
RHP 3_111810101.1.8	1.10.2	Develop a regional systems engineering center, that will recruit systems engineers to integrate with healthcare QI teams to cross train by applying systems engineering science to healthcare processes and develop interdisciplinary courses for health professional, students, engineers and administrative healthcare leadership.	Completed in DY2 6	
RHP 3_111810101.1.9	1.1.1	Establish the North Harris County Primary Care Clinic. Space will be leased to open the clinic.	Continuing as Core Activity in DY7-8	Through this project, UT Physicians Greens Clinic will continue to address the inadequate access to primary care and high rates of inappropriate emergency department utilization for our target population. This project provides quality access to comprehensive and coordinated primary care services focused on patient-centered preventive care for adult and pediatric patients. Additionally, our patients will continue to have access to: extended weekday and weekend appointments, a 24/7 nurse triage line and a care coordination team which includes a case manager, social worker and community health worker. A multitude of primary care services including provisions of screenings and vaccinations to our target population, will contribute to the achievement of clinical outcomes and immunization measures included in C1 and D1 measure bundles, as well as cancer screening measured including in the C2 measure bundle. In addition, this clinic will continue to provide integrated
RHP 3_111810101.2.1	2.1.3	The UT medical homes will include services in the areas of dentistry, women's' health, maternal-fetal health, trauma and rehabilitation, sports medicine/ orthopedics, behavioral & mental health, cardiovascular diseases, neurosciences, pediatrics and geriatrics. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home". Patients will be assigned to a primary care provider within the UT Physicians system of primary & specialty care physicians.	Continuing as Core Activity in DY7-8	The patient-centered medical home (PCMH) project will continue as a core activity as it is UT Physicians' model of comprehensive primary care delivery. As more primary care clinics employ this model and pursue PCMH recognition through the National Committee for Quality Assurance, it is critical to continue developing coordinated services for medically complex patients delivered by multidisciplinary care teams. Services such as pre-visit planning, self-management support, disease education, empanelment, care transitions, and integrated resource referrals are important components to this core activity. These services, and others, will help improve clinical outcomes outlined in the diabetes (A1) measure bundle.

RHP 3_111810101.2.2	2.2.1	The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes and hypertension), based on Wagner's chronic care model.	Continuing as Core Activity in DY7-8	The chronic care coordination program will continue as a core activity to support UT Physicians' provision of chronic care management services, including education in chronic disease self-management, to the target population. Disease-specific protocols and services help to support high-risk patients meeting care goals, including transitioning patients back to the patient-centered medical home after unplanned ED visits and hospitalizations. Delivered by a multidisciplinary care team, evidence-based care management such as care planning, chronic disease education, monitoring, and psychosocial support, will target diabetic and hypertensive patients, and those who have congestive heart failure and angina. In this way, this program can positively impact achieving measure bundle A1.
RHP 3_111810101.2.3	2.9.1	Target pts at high risk of disconnect from institutionalized health care; specifically, patients admitted to Memorial Hermann Hospital-TMC, and/or potentially other health systems in our region, who do not have a primary care provider. Care navigators will support these pts to navigate through the continuum of health care services.	Completed in DY2 6	
RHP 3_111810101.2.4	2.10.1	Patients admitted to any adult or pediatric ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization will receive a palliative care consultation 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.	Completed in DY2 6	
RHP 3_111810101.2.5	2.11.1	Implement a technologically driven patient-centered medication therapy management program. Allscripts analytics tool will enable staff to identify pts at high risk for developing complications and co-morbidities, and pts that have not refilled their medications	Continuing as Core Activity in DY7-8	The medication therapy management program will continue as a core activity to support UT Physicians' provision of chronic care management services, including education in chronic disease self-management, to the target population. The program will expand his scope with the utilization of pharmacist-led chronic disease medication management services through the implementation of Collaborative Drug Therapy Management agreements between clinical pharmacist(s) and primary care providers. The continuation of the medication management program will contribute to improving management of diabetes, heart disease and comorbidities, as well as improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary ED utilization. Therefore, the program will help to address and improve some of the clinical outcome measures included in the A1 measure bundle.
RHP 3_111810101.2.6	2.12.2	Implement a comprehensive transitions of care program which will ensure that pts have an appt 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.	Completed in DY2 6	
RHP 3_111810101.2.7	2.15.1	Implement and evaluate a project that will integrate primary and behavioral healthcare services within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A behavioral health provider will be placed in the primary care setting to provide patients with behavioral health services at their usual source of health care.	Continuing as Core Activity in DY7-8	During DY2-6, this project focused upon a building and establishing an integrated care service line. In this time, we have established protocols for documenting behavioral health screening, referrals, and developed integrated treatment plans. Moving forward, we continue to standardize pathways across clinics and intensify interdisciplinary collaboration efforts. This project has laid the foundation for our selection of the H1 bundle focused on integration of behavioral health in a primary or specialty care setting.
RHP 3_111810101.2.8	2.15.1	Implement and evaluate a project that will integrate primary and behavioral healthcare services for children and adolescents within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A pediatric behavioral health provider will be placed in the primary care setting to children and adolescents with behavioral health services at their usual source of health care.	Continuing as Core Activity in DY7-8	During DY2-6, this project focused upon a building and establishing an integrated care service line. In this time, we have established protocols for documenting behavioral health screening, referrals, and developed integrated treatment plans. Moving forward, we continue to standardize pathways across clinics and intensify interdisciplinary collaboration efforts.

RHP 3_111810101.1.100	1.12.2	The program will expand capacity and access to Trauma Informed care (TIC) mental health services for children and adolescents and will conduct mental health assessments, and provide a number of interventions with a particular focus on addressing trauma in underserved children. The TIC primary intervention offered will include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice and general counseling (such as Cognitive Behavioral Therapy). In order to expand access and capacity, these interventions will be anchored in DePelchin satellite clinics in proximity to several areas of socioeconomic need and will then progressively expand to community settings such as schools and primary care clinics. Developing a telemedicine capability for children in Foster Care.	Completed in DY2 6	
RHP 3_111810101.1.101	1.1.1	This project seeks to establish a prevention and wellness community health center (CHWC) in a low income areas in our region along with the provision of wellness services provided by ACPs. This center will operate using expanded hours that include evening and weekend hours. The center will be well integrated with existing resources in the community. Community leaders and stakeholders will be included in identifying gaps and priority services needed, as well as in the planning and implementation of support services	Continuing as Core Activity in DY7-8	UT Physicians - Southwest will continue to improve access to comprehensive, integrated and coordinated primary care services that are focused on patient-centered preventive care. Our patients also have access to: expanded evening and Saturday hours, a 24/7 Nurse Triage Line, and health education and wellness programs. A multitude of primary care services including provision of screenings and vaccinations to target population which will contribute to the achievement of clinical outcomes and immunization measures included in C1 and D1 measure bundles, cancer screening measures included in the C2 measure bundle and the hepatitis screening and vaccination measures in the C3 bundle. In addition, UT Physicians - Southwest will continue to provide integrated physical and behavioral services which will help to improve the measures listed in the H1 measure bundle.
RHP 3_111810101.2.100	2.7.4	UTP will implement four evidence-based interventions that will ensure that women receive quality preconception, prenatal, intrapartum, postpartum, and interconception care. These interventions include: 1) the CHOICES Plus program for women at-risk of alcohol- and/or tobacco-exposed pregnancies and women who are obese, 2) care coordination for pregnant women and/or care navigation for women having received minimal or no prenatal care, 3) home visits during pregnancy and postpartum period using evidence-based and piloted home visitation program, and 4) nutrition and physical activity promotion programs – A Legacy of Health (Un Legado de Salud) and The Happy Kitchen (La Cocina Alegre®).	Continuing as Core Activity in DY7-8	During DY2-6, this project focused on implementing four evidence-based interventions in clinics that serve a population of women with high rates of risk factors for adverse pregnancy outcomes, including low income status, lack of health insurance, high rates of chronic disease, and high prevalence of smoking, alcohols abuse, and obesity. Moving forward, we'll continue to provide these services to deliver comprehensive preconception, prenatal, postpartum, and interconception care that includes health promotion and psychosocial intervention to improve birth outcomes as it has laid the framework to achieve outcomes in the E1: Improved Maternal Care bundle.
RHP 3_111810101.2.101	2.1.2	The UT medical homes for post-detention adolescents and at-risk youth will provide all medical and psycho-social services for this population. Our innovative program involves facilitating access to the medical home by assisting youths and their guardians in arranging clinic visits, transportation, overcoming language barriers, and other challenges that may interfere with clinic visits.	Continuing as Core Activity in DY7-8	This project will continue as a core activity to support UT Physicians' provision of medical and psycho-social services to the pediatric and adolescent population. The teen clinic will continue to expand patient access to primary care services and promote wellness through the following activities: provision of a 24/7 nurse triage line, conducting of preventive screenings, coordination of primary care and behavioral health services, and implementation of evidence-based strategies to prevent obesity and decrease risky behavior. The continuation of this project will support the achievement of clinical outcomes and immunization measures included in the D1 measure bundle through the provision of weight assessments, counseling for nutrition and physical activity, adolescent well-care visits and provision of immunizations. Similarly, the project will contribute to the achievement of measures contained in the H1 measure bundle through provision of screening and counseling for unhealthy alcohol use

Section 2: Core Activities

Please enter your organization's number of Core Activities: 5

1) 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

Preventive services, such as screening tests, for the early detection of disease are associated with dramatic reductions in morbidity and mortality. Our UT Physicians primary care practitioners are the frontline providers who identify patients with potential risks to develop a disease.

Screening programs such as cancer screenings (i.e., Pap smear, mammography, colonoscopy or FOBT), cardiovascular and smoking-related disease, obesity, depression or anxiety, have been developed and implemented in the UT Physicians clinics during the first part of the waiver. Our providers will continue to educate patients on the importance of screenings, perform screenings on site when possible, and make referrals as needed. Workflows have been designed and implemented in order to retrieve screening results when performed outside of UT Physicians. Follow-up services will continue to be offered based on screening results. Those who screen positive will receive referrals for appropriate intervention and/or treatment.

About 100 primary care providers along with their care team members (e.g., community health worker, referral coordinator, case manager, social worker) across 15 UT Physicians locations will be working on improving the health outcomes in the measure bundles impacted by this core activity.

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

Identify patients who are eligible for screening and offer eligible patients an appointment

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

Provide providers and clinic staff with access to preventive care dashboards including gap assessments. Dashboards provide real time visualizations for health outcomes that highlights individual-, clinic-, and department-level performance. Additionally, providers can drill down to the patient as the unit of analysis.

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).

Educate patients on importance and benefits of screening

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

Maximize patient education opportunities during pre- and post- visit planning and provide screening reminders

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

Provide patients with educational brochures and other visual cues (e.g., posters in waiting rooms, point of care report)

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

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

Improve time to referral and follow up by enlisting support from referral coordinator and/or care teams

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

Update referral and follow up procedures and workflows to ensure referral status is checked regularly, in addition to at pre- and post- visit planning

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.

C1	C2	C3	D1
E1	H1		

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

The provision of screening and follow up services is a core tenet of primary care, especially prevention. The drivers and change ideas identified above serve as a roadmap to improve screening (e.g., cancer, substance use including tobacco, depression, hepatitis, chlamydia) and follow up rates of children and adults seen at UT Physicians. Physicians will work collaboratively with patients and their care teams to identify who is eligible for screening and to ensure timely referral and follow up post-screening. Increases in screening may lead to earlier detection and treatment which potentially can contain healthcare costs and the negative and, often, severe consequences of undetected/untreated illness.

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.

Patient Centered Medical Home

a) Please select the name of this Core Activity.

Provision of coordinated services for patients under Patent Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care

b) Please enter a description of this Core Activity

At UT Physicians, the PCMH model is the gold standard for which comprehensive, coordinated, high quality care is delivered. A central tenet of this model is empanelment which enables physicians and teams to provide continuous care across the medical neighborhood. Care teams will manage patient panels that can be categorized by chronic diseases and preventive care. At least 15 primary care clinics and approximately 100 primary care providers recognize this model to deliver coordinated care.

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

Assign each patient to a single provider panel with consent from patient to initiate patient centered planning

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

Employ Murray 4-cut method to those patients without a documented primary care provider (PCP). This method is evidence-based and systematic for assigning patients to a single provider after a thorough assessment of supply and demand is conducted. This recognized linkage between the provider and patient promotes continuity of care.

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

Obtaining consent for provider assignment will be reviewed with clinic staff and patients.

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).

Assess practice supply and demand regularly and re-balance patient load as needed

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

Determine ideal panel sizes for each practice; reconcile actual versus ideal panel sizes

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).

Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, need, etc.

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

Manage panels across a comprehensive set of disease and risk levels (population health)

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.

A1	C1	D1	

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

The PCMH model makes the primary care practice the hub for all medical care for children and adults. Adult and pediatric primary care measure bundles (C1, D1) will benefit from provider assignment which facilitates continuity of care. The model is especially important for patients with chronic diseases because there is often the need to coordinate care across specialties. Therefore, the diabetes care (A1) measure bundle will be impacted by primary and specialty care. This core activity describes how teams monitor patient panels using registries to proactively engage patients in needed care.

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.

Utilization of care management and/or chronic care management services, including education in chronic disease self-management

b) Please enter a description of this Core Activity

UT Physicians patients often relay a variety of social, economic, and educational barriers to effectively managing their health. Due to the limited time providers have during the medical appointment, team-based care offers relevant and targeted approaches to addressing patient health needs. These non-physician staff can provide education, skill building, monitoring and resources outside the medical appointment and help navigate the overwhelming healthcare system. Tailored care teams will partner with over 100 providers in at least 15 primary care clinics to comprehensively address health barriers.

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

Establish scope of practice and define roles for care teams that reflect the skills and abilities of team members

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

Set expectations for care delivered outside of the clinic

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

Evaluate capacity for internal/external referrals and modify care team duties accordingly

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).

Provide convenient access points to link patients to provider and care team whenever possible

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

Expand implementation of same-day appointments to additional clinic location(s)

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

Utilize the nurse triage line (available 24 hours per day/7 days per week) for urgent clinical advice after hours

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

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

Establish and provide organizational support for care teams that are accountable to patient panels

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

Assess training needs regularly and provide cross training to ensure care teams are able to meet patient needs consistently

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.

A1	H1		

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

UT Physicians adopts the team-based approach to addressing the needs of complex diabetic and hypertensive patients. Given the comorbidities that often accompany heart disease and diabetes, care teams are poised to support transitions of care, screening, behavioral health integration and management of blood pressure and hemoglobin A1c. Also, care teams will be accessible to both providers and patients to deliver care via phone, messaging, home visits, and in the clinic. Similarly, since behavioral health is co-located with physical health, teams can seamlessly offer continuous healthcare.

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.

Provision of vaccinations to target population

b) Please enter a description of this Core Activity

Vaccinations are one of the best ways to protect individuals from preventable diseases that could ultimately lead to death. Thus, they are highly recommended for individuals of all age groups including infants, children, adolescents, adults and older adults. Also, some vaccines wear off over time so maintenance and follow-up care for individuals of all ages is critically important. Through this core activity, UT Physicians providers will continue to educate our patients on the importance of vaccinations and will provide the recommended immunizations for eligible children, teens and adults. In addition, our care teams will be used to identify patients who are due for an immunization or a booster. They will reach out to patients and offer an appointment with a provider.

About 100 primary care and specialty care providers along with their care team members, including family medicine, internal medicine and pediatrics, will be participating in this core activity, impacting 15 UT Physicians locations.

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

Educate patients/parents on the importance of immunizations

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

Train care teams on educating patients on the importance of maintaining vaccinations up-to-date

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).

Use care teams to identify and reach out to patients who are due for immunization/booster

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

Train clinic leadership (e.g., physicians, case managers, practice managers) on the use of web-based dashboards/smart registries that can identify gaps in care

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

Train clinical staff (e.g., community health workers, medical assistants) on verifying immunization status at pre visit phone calls

C) Please list the third 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.

C1	C3	D1	

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

The provision of vaccinations is a core tenet of primary care services, especially prevention. Through this core activity, UT Physicians providers and care teams will educate patients on the importance of vaccinations and will provide the recommended immunizations for children, teens and adults. Also, based on age, health condition, and other factors like job or travel, immunizations against pneumonia, influenza, human

papillomavirus, hepatitis A and B will be recommended and delivered. This will allow us to successfully achieve immunization measures for children, adolescents and adults included in C1, C3 and D1 measure bundles.

Increases in vaccination compliance will lead to better protection of the population against potentially harmful diseases, which will eventually lead to an improved health for the population and a decreased heath costs related to preventable diseases.

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.

Access to Primary Care Services

a) Please select the name of this Core Activity.

Integrated physical and behavioral health care services

b) Please enter a description of this Core Activity

Integrating both physical (PH) and behavioral health (BH) services in one setting allows for more accessible, acceptable, and less costly care to patients. Through integrated care services, patients are able to receive care that is more convenient (located within their community and in a clinic offering extended hours) and coordinated (ability to address PH and BH conditions in a single visit) intervention in a setting that reduces the stigma of receiving BH services. UT Physicians has implemented and will continue to offer an integrated PH and BH care program for both children and adults.

At least 15 primary care clinics and approximately 30 behavioral health as well as primary care providers will be participating in this core activity.

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

Enhance integration meetings among primary care providers and behavioral health providers on a regular basis

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

Train primary care providers and staff on behavioral health assessment and treatment

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

Train behavioral health providers in short duration treatment and in physical health diagnosis, especially for common chronic conditions

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).

Document integrated treatment plans in the electronic health record

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

Educate providers on how to use and properly document in the integrated treatment plan

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).

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.

H1			

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

UT Physicians established protocols for documenting behavioral health screening, referrals, and developed integrated treatment plans during DY3-6. Moving forward, we continue to standardize pathways across clinics and intensify interdisciplinary collaboration efforts. We are certain that the best practices we established during DY3-6 will lead to increased screening and better management of depression in the population served by UT Physicians.

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 1: Statewide Reporting Measure Bundle for Physician Practices	Complete
Section 2: Verification	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	111810101 - Unv of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category D valuation in DY7	$13,776,130.00
	Category D valuation in DY8	$13,776,130.00
If regional hospital participation requirement is not met	Category D valuation in DY7	$4,592,043.33
	Category D valuation in DY8	$4,592,043.33

Section 1: Statewide Reporting Measure Bundle for Physician Practices

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)
Diabetes Short-term Complications Admission Rate	$1,059,702.31	$353,234.10
Perforated Appendix Admission Rate	$1,059,702.31	$353,234.10
Diabetes Long-term Complications Admission Rate	$1,059,702.31	$353,234.10
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	$1,059,702.31	$353,234.10
Hypertension Admission Rate	$1,059,702.31	$353,234.10
Heart Failure Admission Rate	$1,059,702.31	$353,234.10
Low Birth Weight Rate	$1,059,702.31	$353,234.10
Dehydration Admission Rate	$1,059,702.31	$353,234.10
Bacterial Pneumonia Admission Rate	$1,059,702.31	$353,234.10
Urinary Tract Infection Admission Rate	$1,059,702.31	$353,234.10
Uncontrolled Diabetes Admission Rate	$1,059,702.31	$353,234.10
Asthma in Younger Adults Admission Rate	$1,059,702.31	$353,234.10
Lower-Extremity Amputation among Patients with Diabetes Rate	$1,059,702.28	$353,234.13

How do your selected Core Activities impact the Prevention Quality Indicators (PQIs) listed above?

Our core activities focus on long term disease management provided under the patient-centered medical home model. Multidisciplinary care teams prioritize chronic disease patients, such as those with hypertension, diabetes, or respiratory conditions, with self-management education, follow-up and support as they transition from acute care back to the outpatient setting. Considering our scope of practice, our efforts may contribute to improvements in the admission rates for the following Prevent Quality Indicators: Diabetes Short-Term Complications, Diabetes Long-term Complications, COPD or Asthma, Hypertension, Heart Failure, Low Birth Weight, and Uncontrolled Diabetes.

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:	111810101 - Univ of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
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	University of Texas Health Science Ctr at Houston UTHSC	N/A	17417613092000	100-13-0000-00133

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Sahar Qashqai	1200 Binz St., Suite 730	Houston	77004	Sahar.m.qashqai@uth.tmc.edu	713-486-3860		Both
2	Andrew Casas	6410 Fannin, Suite 1500	Houston	77030	Andrew.Casas@uth.tmc.edu	832-325-7317		Both
3	Julie T. Page	P.O. Box 203382	Houston	77216-3382	julie.t.page@uth.tmc.edu	713-500-5169		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	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%		$7,920,356.34		$7,920,356.34	
Category B	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$3,960,178.17	$3,919,768.19	$3,960,178.17	$3,919,768.19
A1-112	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$1,068,139.26	$1,441,690.74	$1,262,346.40	$1,633,916.17
A1-115	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$1,068,139.26	$1,441,690.74	$1,262,346.40	$1,633,916.17
A1-207	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$1,068,139.26	$1,441,690.74	$1,262,346.40	$1,633,916.17
A1-500	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$1,068,139.26	$1,441,690.74	$1,262,346.40	$1,633,916.17
A1-508	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$1,068,139.25	$1,441,690.73	$1,262,346.39	$1,633,916.17
C1-105	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-113	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-147	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-268	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-269	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-272	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-280	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-389	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.89	$656,561.17	$574,885.87	$744,102.66
C1-502	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$486,441.88	$656,561.16	$574,885.86	$744,102.65
C2-106	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$500,962.54	$676,160.01	$592,046.64	$766,314.68
C2-107	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$500,962.54	$676,160.01	$592,046.64	$766,314.68
C2-186	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$500,962.54	$676,160.01	$592,046.63	$766,314.68
C3-203	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$250,481.27	$338,080.01	$296,023.32	$383,157.34
C3-328	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$250,481.27	$338,080.01	$296,023.32	$383,157.34
C3-368	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$250,481.27	$338,080.01	$296,023.32	$383,157.34
C3-369	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$250,481.27	$338,080.00	$296,023.31	$383,157.34
D1-108	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-211	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-212	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-237	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-271	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-284	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-389	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-400	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.83	$534,721.71	$468,203.07	$606,017.94
D1-503	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$396,171.81	$534,721.71	$468,203.06	$606,017.95
E1-193	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$747,087.61	$1,008,360.37	$882,921.72	$1,142,808.42
E1-232	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$747,087.61	$1,008,360.37	$882,921.72	$1,142,808.42
E1-235	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$747,087.61	$1,008,360.37	$882,921.72	$1,142,808.42
E1-300	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$747,087.61	$1,008,360.36	$882,921.73	$1,142,808.41
H1-146	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$750,899.29	$1,013,505.06	$887,426.43	$1,148,639.07
H1-255	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$750,899.29	$1,013,505.06	$887,426.43	$1,148,639.07
H1-286	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$750,899.29	$1,013,505.06	$887,426.43	$1,148,639.07
H1-317	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$750,899.28	$1,013,505.07	$887,426.42	$1,148,639.07
Category D	University of Texas Health Science Ctr at Houston UTHSC	17417613092000	100-13-0000-00133	100.00%	100.00%	$5,940,267.26	$5,879,652.28	$1,980,089.08	$1,959,884.09
Total						$39,601,781.72	$39,197,681.90	$39,601,781.72	$39,197,681.90

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:	Andrew Casas
IGT Organization:	University of Texas Health Science Ctr at Houston UTHSC
Date:	4/3/2018

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:	111810101 - Unv of Tx HSC at Houston-UTHSC Sponsored Projects
Performing Provider Type:	Physician Practice affiliated with an Academic Health Science Center (AHSC)
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	$18,368,173.34	$0.00	$18,368,173.34	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$9,184,086.67	$9,184,086.67	$9,184,086.67	$9,184,086.67
Category C	$50,512,476.68	$68,880,650.02	$59,696,563.35	$78,064,736.69
Category D	$13,776,130.00	$13,776,130.00	$4,592,043.33	$4,592,043.33
Total	$91,840,866.69	$91,840,866.69	$91,840,866.69	$91,840,866.69

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	49,783	297,943	16.71%
DY6	56,439	311,366	18.13%
DY7 Estimated	53,111	304,655	17.43%
DY8 Estimated	53,111	304,655	17.43%

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
A1	Improved Chronic Disease Management: Diabetes Care	0	0	0	19	$12,385,659.28	$16,889,535.38	$14,637,597.33	$19,141,473.44
C1	Primary Care Prevention - Healthy Texans	0	0	0	16	$10,153,007.81	$13,845,010.65	$11,999,009.23	$15,691,012.07
C2	Primary Care Prevention - Cancer Screening	0	0	0	6	$3,485,360.89	$4,752,764.85	$4,119,062.87	$5,386,466.83
C3	Hepatitis C	0	0	0	4	$2,323,573.93	$3,168,509.90	$2,746,041.91	$3,590,977.89
D1	Pediatric Primary Care	0	0	0	19	$8,268,892.43	$11,275,762.41	$9,772,327.42	$12,779,197.40
E1	Improved Maternal Care	0	0	0	11	$6,930,311.80	$9,450,425.18	$8,190,368.49	$10,710,481.87
H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	0	0	0	12	$6,965,670.54	$9,498,641.65	$8,232,156.10	$10,765,127.19
Total	N/A	0	0	0	87	$50,512,476.68	$68,880,650.02	$59,696,563.35	$78,064,736.69

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

A1	Improved Chronic Disease Management: Diabetes Care	
C1	Primary Care Prevention - Healthy Texans	
C2	Primary Care Prevention - Cancer Screening	
C3	Hepatitis C	
D1	Pediatric Primary Care	
E1	Improved Maternal Care	
H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	

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 Physicians Practices

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)
Diabetes Short-term Complications Admission Rate	$1,059,702.31	$353,234.10
Perforated Appendix Admission Rate	$1,059,702.31	$353,234.10
Diabetes Long-term Complications Admission Rate	$1,059,702.31	$353,234.10
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	$1,059,702.31	$353,234.10
Hypertension Admission Rate	$1,059,702.31	$353,234.10
Heart Failure Admission Rate	$1,059,702.31	$353,234.10
Low Birth Weight Rate	$1,059,702.31	$353,234.10
Dehydration Admission Rate	$1,059,702.31	$353,234.10
Bacterial Pneumonia Admission Rate	$1,059,702.31	$353,234.10
Urinary Tract Infection Admission Rate	$1,059,702.31	$353,234.10
Uncontrolled Diabetes Admission Rate	$1,059,702.31	$353,234.10
Asthma in Younger Adults Admission Rate	$1,059,702.31	$353,234.10
Lower-Extremity Amputation among Patients with Diabetes Rate	$1,059,702.28	$353,234.13

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:	Andrew Casas
Performing Provider:	University of Texas Health Science Ctr at Houston UTHSC
Date:	4/3/2018

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 2: Selection of Measure Bundles for Hospitals and Physician Practices	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 Physician Practices	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