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:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
Ownership:	Non-State Owned Public
TIN:	17415369366324
Physical Street Address:	2525 Holly Hall
City:	Houston
Zip:	77054
Primary County:	Harris
Additional counties being served (optional):	

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

Section 2: Lead Contact Information

	Lead Contact 1	Lead Contact 2	Lead Contact 3
Contact Name:	R. King Hillier	Michelle Eunice	Jessica Hall
Street Address:	9250 Kirby Drive	525 Holly Hall St	9250 Kirby Drive
City:	Houston	Houston	Houston
Zip:	77054	77054	77054
Email:	robert.hillier@harrishealth.org	michelle.eunice@harrishealth.org	jessica.hall@harrishealth.org
Phone Number:	713-566-6425	713-566-6056	713-634-1146
Phone Extension:			
Lead Contact or Both:	Both	Both	Both

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

Section 3: Optional Withdrawal From DSRIP

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

Do Not Withdraw from DSRIP

Section 4: Performing Provider Overview

Performing Provider Description:	Harris Health System is a fully integrated healthcare system that cares for all residents of Harris County, Texas. We are the first accredited healthcare institution in Harris County to be designated by the National Committee for Quality Assurance as a Patient-Centered Medical Home, and are one of the largest systems in the country to achieve the quality standard. Our system includes 18 community health centers, five same-day clinics, five school-based clinics, three multi-specialty clinic locations, a dental center and dialysis center, mobile health units, a rehabilitation and specialty hospital and two full-service hospitals
Overall DSRIP Goals:	Harris Health's DSRIP goals are to transform healthcare delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system. It is our goal to promote a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation and evaluation processes.
Alignment with regional community needs assessment:	Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region and improves health care outcomes and patient satisfaction. Provide access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

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	$44,258,354.01	$0.00	$44,258,354.01	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$22,129,177.01	$22,129,177.01	$22,129,177.01	$22,129,177.01
Category C	$121,710,473.54	$165,968,827.55	$143,839,650.55	$188,098,004.56
Category D	$33,193,765.51	$33,193,765.51	$11,064,588.50	$11,064,588.50
Total	$221,291,770.07	$221,291,770.07	$221,291,770.07	$221,291,770.07

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:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
Ownership:	Non-State Owned Public
Category B valuation in DY7:	$22,129,177.01
Category B valuation in DY8:	$22,129,177.01

Section 1: System Definition

Hospitals - Required Components

Required System Component	Business Component?
Inpatient Services	Business Component of the Organization

Please enter a description of this System Component.

Inpatient service starts when a patient is formally admitted to a hospital with a doctor's order, i.e. care of patients whose condition requires admission to a hospital. Harris Health Hospital Inpatient Services are provided at Ben Taub Hospital, LBJ Hospital, and Quentin Mease Hospital.

Required System Component	Business Component?
Emergency Department	Business Component of the Organization

Please enter a description of this System Component.

This department provides triage, treatment and support for trauma and emergency patients of all ages in an acute care setting. Emergency services are provided at Ben Taub Hospital and LBJ Hospital.

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

Please enter a description of this System Component.

An outpatient clinic is the part of a hospital designed for the treatment of outpatients, but do not require a bed or to be admitted for overnight care. Outpatient services are provided at the following locations: Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Bayland Geriatric Center, Riverside Dialysis Center, Outpatient Specialty Center at LBJ, and Smith Clinic.

Required System Component	Business Component?
Maternal Department	Business Component of the Organization

Please enter a description of this System Component.

The department of a hospital that provides care for women during pregnancy and childbirth as well as for newborn infants. These locations include both Ben Taub and LBJ Hospitals, and all outpatient sites: Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, and Smith Clinic.

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

Hospitals - 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?
School-based Clinics	Yes

Please enter a description of this System Component.

Clinic sites located on school campuses, which provide preventive and primary health care services to children and adolescents. Locations: Almantha Clark Taylor Health Clinic, Goose Creek Health Clinic, Robert Carrasco Health Clinic, Sheldon Health Clinic, and Southside Health Clinic.

Optional System Component	Would you like to select this component?
Contracted Palliative Care Programs	No

Optional System Component	Would you like to select this component?
Contracted Mobile Health 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	269,586	248,396
Total PPP	322,420	307,236

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):	258,991
Average Total PPP	314,828
MLIU percentage of Total PPP	82.26%

*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)?	**Yes - DY6 Only**
DY6 MLIU PPP	248,396
DY6 Total PPP	307,236

Please provide a reason for requesting a different MLIU PPP Goal.

A number of factors may have caused a nearly 10% decrease between DY5 and DY6; however, we would like to choose DY6 as this most accurately reflects the current demographics of the Harris County marketplace.

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.		
Section 2: Selection of Measure Bundles for Hospitals and Physician Practices	Complete		MPT	75
Minimum Selection Requirements Met	Yes		Points Selected	75
MPT Met	Yes		Bundles Selected	7
			Clinical Outcome Selected	Y
			Measure Bundle with PBCO selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
Ownership:	Non-State Owned Public

If regional private hospital participation requirement is met	Category C valuation in DY7:	$121,710,473.54
	Category C valuation in DY8:	$165,968,827.55
If regional private hospital participation requirement is not met	Category C valuation in DY7:	$143,839,650.55
	Category C valuation in DY8:	$188,098,004.56

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 Hospital

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).

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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was essential to also determine the data requirements could be entered and pulled from the electronic health record to measure a baseline and to conitnue monitoring for improvement. The system components that will impact these measures will be primarily ambulatory clinics and the emergency department. The primary system components that will impact this measure are as follows; Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Outpatient Specialty Center at LBJ, and Smith Clinic. This measure bundle addresses the community need to provide services to the high percentage of patients with chronic disease by moving towards a coordinated delivery system which focuses on improving continuous quality care to the individual patient.

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	MLIU denominator with significant volume	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
Yes	B1	Care Transitions & Hospital Readmissions	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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was also essential to determine the data requirements could be entered and pulled from the electronic health record to measure a baseline and to conitnue monitoring for improvement. The primary system components that will impact this measure are the Ben Taub and LBJ Inpatient services and Emergency Departments. Additional follow-up and coordination will be required across ambulatory care services at the following locations: Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Outpatient Specialty Center at LBJ, and Smith Clinic.
This measure bundle was selected as it addresses the community need to provide efficient and effective care through a care system that improves the usage of electronic health records and correct documentation to reduce the amount of unnecessary services and costs to both Harris Health System and the patients it serves.

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	B1-124	Medication Reconciliation Post-Discharge	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: heart failure hospitalization, coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	B1-217	Risk Adjusted All-Cause 30-Day Readmission	Required	P4P	Clinical Outcome	N/A
N/A - Required	MLIU denominator with significant volume	B1-252	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	B1-253	Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility)	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	B1-287	Documentation of Current Medications in the Medical Record	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	B1-352	Post-Discharge Appointment	Required	P4P	Process	N/A

Select Measure Bundle? (Yes/No)	**Measure Bundle ID**	**Measure Bundle Name**	**Measure Bundle Base Points**
No	B2	Patient Navigation & ED Diversion	3
No	C1	Primary Care Prevention - Healthy Texans	12
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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was also essential to determine the data requirements could be entered and pulled from the electronic health record to measure a baseline and to conitnue monitoring for improvement. The system components that will impact these measures will be primarily ambulatory care services. The primary system components that will impact this measure are as follows; Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Outpatient Specialty Center at LBJ, and Smith Clinic. This measure bundle was selected as it addresses the community need to provide a system in which patients' health is adequately tracked and monitored to deliver the proper care at the right time. This will create an improvement to the electronic health record that will impact patients' long term by avoiding critical care conditions that could have been avoided if addressed in primary care settings.

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**
No	C3	Hepatitis C	4
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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was also essential to determine the data requirements could be entered and pulled from the electronic health record to measure a baseline and to conitnue monitoring for improvement. The primary system components that will impact this measure are our ambulatory clinic locations: Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Outpatient Specialty Center at LBJ, and Smith Clinic. The following school-based clinics will also impact the measure bundle: Almantha Clark Taylor Health Clinic, Goose Creek Health Clinic, Robert Carrasco Health Clinic, Sheldon Health Clinic, and Southside Health Clinic. This measure bundle was selected as it addresses the community need to provide improved primary care using best clinical and manage patients into desirable health outcomes. These new practices will aid in coordinating a system that manages patient needs in the most appropriate setting and avoiding unnecessary waste in the emergency department.

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
No	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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was essential to determine the data requirements could be entered and pulled from the electronic health record to set a baseline and to conitnue monitoring for improvement. The system components that will impact these measures will be primarily ambulatory care services and the OB service line. These locations are as follows: Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Outpatient Specialty Center at LBJ, and Smith Clinic. This measure bundle was selected as it addresses the community need to align current standards with the industry standards of care for mothers and infants through pregnancy, childbirth, and the postnatal stages. A system in which patients' are adequately tracked, monitored, and navigated to receiving care in the most appropriate setting will provide long-term benefits to their health.

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
No	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
Yes	G1	Palliative Care	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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was essential to determine the data requirements could be entered and pulled from the electronic health record to set a baseline and to conitnue monitoring for improvement. The system components that will impact these measures will be primarily the Inpatient Intensive Care Units at Ben Taub and LBJ Hospitals as well as the Smith and LBJ Palliative Care clinics. This measure bundle was selected as it addresses the community need to facilitate access to health-related services for patients that promote continuity of care by encouraging health information exchange through improved documentation. This will increase the effective and efficient use of the health care system for patients and practitioners. Additional follow-ups will occur through the House-Calls program in the patients' homes.

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	G1-276	Hospice and Palliative Care – Pain Assessment	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	G1-277	Hospice and Palliative Care – Treatment Preferences	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	G1-278	Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	G1-362	Hospice and Palliative Care - Dyspnea Treatment	Required	P4P	Process	N/A
N/A - Required	MLIU denominator with significant volume	G1-363	Hospice and Palliative Care - Dyspnea Screening	Required	P4P	Process	N/A

Select Measure Bundle? (Yes/No)	Measure Bundle ID	Measure Bundle Name	Measure Bundle Base Points
No	H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	12
No	H2	Behavioral Health and Appropriate Utilization	8

No	H3	Chronic Non-Malignant Pain Management	10
Yes	H4	Integrated Care for People with Serious Mental Illness	5

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.

Harris Health held meetings with key stakeholders for the bundle workgroup to review and identify the metrics that aligned with the best clinical practices for this population or those metrics that could provide overall health improvement for the individuals that Harris Health System serves. Input from IT, administrative, and clinical staff was essential to determine the data requirements could be entered and pulled from the electronic health record to set a baseline and to conitnue monitoring for improvement. The system components that will impact these measures will be Inpatient services at both Ben Taub and LBJ hosptials and the ambulatory health centers: Acres Home Health Center, Aldine Health Center, Baytown Health Center, Casa De Amigo Health Center, Cypress Health Center, Danny Jackson Health Center, E.A. "Squatty" Lyons Health Center, El Franco Lee Health Center, Gulfgate Health Center, Martin Luther King Jr. Health Center, Northwest Health Center, Settegast Health Center, Strawberry Health Center, Thomas Street Health Center, Vallbona Health Center, Margo Hilliard Alford Clinic, Monroe Clinic, Robindell Clinic, Sareen Clinic, Sunset Heights Clinic, Outpatient Specialty Center at LBJ, and Smith Clinic. This measure bundle was selected as it addresses the community need to meet the physical and mental health care needs of patients by providing a healthcare delivery system that integrates both behavioral and primary health care. The currently fragmented and difficult to navigate system will be improved to make health care less challenging to patients in need of services.

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	H4-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Required	P4P	Process	N/A
N/A - Required	Insignificant volume for denominator	H4-258	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)	Required	P4P	Process	N/A
	Please enter an explanation of why the volume is less than significant.	The criteria limits the patient population substantially as compared to the population of Harris Health patients, specific to schizophrenic patients with cardiovascular disease.					
N/A - Required	MLIU denominator with significant volume	H4-260	Annual Physical Exam for Persons with Mental Illness	Required	P4P	Process	N/A

Select Measure Bundle? (Yes/No)	**Measure Bundle ID**	**Measure Bundle Name**	**Measure Bundle Base Points**
No	I1	Specialty Care	2
No	J1	Hospital Safety	10

Total overall selected points:	75

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
B1-124	Medication Reconciliation Post-Discharge	CY2017: January 1, 2017 - December 31, 2017	No	No	No
B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: heart failure hospitalization, coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	CY2017: January 1, 2017 - December 31, 2017	No	No	No
B1-217	Risk Adjusted All-Cause 30-Day Readmission	CY2017: January 1, 2017 - December 31, 2017	No	No	No
B1-252	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
B1-253	Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
B1-287	Documentation of Current Medications in the Medical Record	CY2017: January 1, 2017 - December 31, 2017	No	No	No
B1-352	Post-Discharge Appointment	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
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
D1-400	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
E1-232	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
G1-276	Hospice and Palliative Care – Pain Assessment	CY2017: January 1, 2017 - December 31, 2017	No	No	No
G1-277	Hospice and Palliative Care – Treatment Preferences	CY2017: January 1, 2017 - December 31, 2017	No	No	No
G1-278	Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss	CY2017: January 1, 2017 - December 31, 2017	No	No	No
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	CY2017: January 1, 2017 - December 31, 2017	No	No	No
G1-362	Hospice and Palliative Care - Dyspnea Treatment	CY2017: January 1, 2017 - December 31, 2017	No	No	No
G1-363	Hospice and Palliative Care - Dyspnea Screening	CY2017: January 1, 2017 - December 31, 2017	No	No	No
H4-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
H4-258	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)	CY2017: January 1, 2017 - December 31, 2017	No	No	No

H4-260	Annual Physical Exam for Persons with Mental Illness	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:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category C valuation in DY7:	$121,710,473.54
	Category C valuation in DY8:	$165,968,827.55
If regional hospital participation requirement is not met	Category C valuation in DY7:	$143,839,650.55
	Category C valuation in DY8:	$188,098,004.56

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	25.33%	19.00%	31.67%	$30,829,262.95	$42,039,904.02	$36,434,583.48	$47,645,224.56
B1	Care Transitions & Hospital Readmissions	11	14.67%	11.00%	18.34%	$17,854,926.47	$24,347,627.00	$21,101,276.74	$27,593,977.27
C2	Primary Care Prevention - Cancer Screening	6	8.00%	6.00%	8.00%	$9,736,837.88	$13,277,506.20	$11,507,172.04	$15,047,840.36
D1	Pediatric Primary Care	18	24.00%	18.00%	30.00%	$29,210,513.65	$39,832,518.61	$34,521,516.13	$45,143,521.09
E1	Improved Maternal Care	10	13.33%	10.00%	16.67%	$16,224,006.12	$22,123,644.71	$19,173,825.42	$25,073,464.01
G1	Palliative Care	6	8.00%	6.00%	8.00%	$9,736,837.88	$13,277,506.20	$11,507,172.04	$15,047,840.36
H4	Integrated Care for People with Serious Mental Illness	5	6.67%	5.00%	6.67%	$8,118,088.59	$11,070,120.81	$9,594,104.70	$12,546,136.91
	Total	75	100.00%	N/A	N/A	$121,710,473.54	$165,968,827.55	$143,839,650.55	$188,098,004.56
	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

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:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
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_133355104.1.1	1.1.1	Expand the capacity of primary care by establishing an adult-focused primary care same day access clinic near the Gulfgate Health Center that offers same day visits during extended hours.	Completed in DY26	
RHP 3_133355104.1.10	1.12.2	Enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting. Therapists and psychiatrists will be added (13.4 Psychiatry and Behavioral Health FTEs).	Completed in DY26	
RHP 3_133355104.1.11	1.3.1	Develop a disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patients.	Completed in DY26	
RHP 3_133355104.1.12	1.10.2	Establish a Center of Innovation to expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.	Completed in DY26	
RHP 3_133355104.1.13	1.9.2	Increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics.	Completed in DY26	
RHP 3_133355104.1.14	1.1.1	Expand the capacity of primary care by establishing an adult-focused primary care near the current Casa de Amigos Health Center that offers same day visits during extended hours.	Completed in DY26	
RHP 3_133355104.1.15	1.8.6	Expand adult dental services by establishing additional sites and expanding services at current sites. Services will be added or expanded at 6 health centers.	Completed in DY26	
RHP 3_133355104.2.8	2.2.1	Expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients with multiple chronic conditions who are homebound or have extreme difficulties getting to clinic visits due to their health status	Completed in DY26	
RHP 3_133355104.1.2	1.1.1	Expand the capacity of primary care by establishing an adult-focused primary care same day access clinic near the People's Health Center that offers same day visits during extended hours to meet demand.	Completed in DY26	
RHP 3_133355104.1.3	1.1.2	Expand the existing capacity of primary care by adding FTE primary care providers to meet the adult primary care demand surround the Health Centers.	Completed in DY26	
RHP 3_133355104.1.4	1.1.1	Expand the capacity of primary care by adding the West and Northwest 1 Area Health Centers to the complement of existing health centers to establish Medical Homes primarily for the adult population.	Completed in DY26	
RHP 3_133355104.1.5	1.1.1	Expand the capacity of primary care by adding the Northwest 2 Area Health Center to the complement of existing health centers to establish Medical Homes primarily for the adult population.	Completed in DY26	
RHP 3_133355104.1.6	1.1.1	Expand the capacity of primary care by establishing adult-focused primary care clinics that offer same day visits during extended hours to meet demand.	Completed in DY26	
RHP 3_133355104.2.9	2.8.8	Address the inefficiency of specialty clinics (focusing primarily on diabetes and rheumatology clinics) by making possible ordering best practices diagnostic algorithmic workups and eliminating the current practice of sequential ordering of individual tests.	Completed in DY26	
RHP 3_133355104.1.8	1.1.2	Develop a seamless referral process by which Harris Health can refer primary care patients to FQHCs.	Completed in DY26	
RHP 3_133355104.1.9	1.12.2	Address the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across nine facilities within the system. Add 3.7 FTE's of psychiatry and 7.6 FTE's of behavioral therapy.	Completed in DY26	
RHP 3_133355104.2.1	2.5.3	Create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24 hour turnaround time and mail order capability.	Completed in DY26	
RHP 3_133355104.2.2	2.9.1	Target ED frequenters and ensure they are managed appropriately through a navigation system.	Completed in DY26	
RHP 3_133355104.2.3	2.8.6	Improve emergency center throughput and reduce inappropriate use of emergency centers in the system through the implementation of a provider-in-triage model.	Completed in DY26	
RHP 3_133355104.2.4	2.9.1	Improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman's pregnancy, with a focus on high-risk mothers.	Completed in DY26	
RHP 3_133355104.2.5	2.2.1	Expand point-of-care services provided by clinic pharmacists for the chronic management of pts receiving anticoagulation therapy and create an educational website.	Completed in DY26	

RHP 3_133355104.2.7	2.10.1	Implement a palliative care program to address end-of-life decisions and care needs	Completed in DY2 6	

Section 2: Core Activities

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

1) Please select the grouping for this Core Activity.

Chronic Care Management

a) Please select the name of this Core Activity.

Provision of services to individuals that address social determinants of health.

b) Please enter a description of this Core Activity

Implement a comprehensive, patient-centered care and support system to address potentially preventable hospitalizations and to prevent uncontrolled diabetes from progressing to a disease state with long term complications. In DY6, we implemented a multidisciplinary approach to diabetes management with the addition of CHWs to our community health center staff to address the Category 3 uncontrolled diabetes HbA1c >9 project by assessing and providing in-home interventions for the social determinants of health. This intervention will be expanded to include all 14 ambulatory health centers and 2 specialty locations with care also being provided in the patients' homes. Approximately 200 providers will be committed to the improvement efforts.

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

Further coordination of care for the Diabetes Multidisciplinary Program to bridge clinical practice and self management in order to improve quality of care, patient outcomes, and system capacity.

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

Utilize case management to assess barriers associated with achieving optimal health outcomes

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

Integrate point of care pharmacy to assist with medication adherence and adjustments as needed.

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

Same-day access to patient education and/or nutrition counseling to promote diabetes self-management

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

Nursing staff to provide patients with a DM program education folder that will serve as a source of information to help guide and organize self-management

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

PCP initiated intervention (lab orders, referrals, medications, etc.) to improve health outcomes

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

Expansion of Community Health Worker Home Visit program to increase knowledge, teaching skills, addressing psychosocial needs, and providing social and environmental support to improve self-management among those with Type 2 Diabetes, as well as prevention among those with high-risk indicators.

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

Community Health Worker home assessment of diabetes knowledge and self-management behaviors to drive educational and clinical interventions.

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

Screening for social determinants of health to identify barriers and provide resources in order to improve self-management.

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).

Incentivize patient participation in their own health outcomes by creating a "Wall of Wellness" at each of our health center locations to showcase patients who have managed and improved their A1c scores.

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

Reward patients that have managed their diabetes and improved their HbA1c goals by 2 percent with a recognition presentation, small gifts, and displaying their picture on the "Wall of Wellness" with success stories meant to inspire other patients to take control of their 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).

Staff development and education to ensure appropriate management and navigation of patients to the right care at the right time

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

Standardize system-wide protocols for the appropriate management and coordination of services

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

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

Identification of appropriate documentation practices to capture accurate patient data in order to monitor patient adherance and track outcomes

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

Update existing methods for capturing specific data elements to facilitate the monitoring of patient outcomes

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

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

A1			

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

Provision of a patient-centered care framework in which Community Health Workers bridge clinical practice and self-management in order to improve quality of care, patient outcomes, and system capacity while utilizing evidence-based strategies to improve chronic disease and risk management in alignment with our DSRIP bundle measures.

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

No

2) Please select the grouping for this Core Activity.

Access to Primary Care Services

a) Please select the name of this Core Activity.

Provision of screening and follow up services

b) Please enter a description of this Core Activity

Implement interventions that increase the use of appropriate intervals of care and screenings within the primary care setting through an organized, team-based system of care. These interventions will be applied to all 14 ambulatory health centers and 2 specialty locations. Approximately 200 providers will be committed to the improvement efforts.

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

Improved tracking systems to identifiy patients needing screening and follow-up

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

Utilizing Health Information Technology to identify patients in need of screenings and/or follow-up services.

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

Implement notification process to communicate effective messages that promote screening compliance behaviors.

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).

Intensive outreach and patient education interventions to reach the most marginalized patients.

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

Provide a team-based approach to identifying patients that require cancer screening and include patient navigators/CHWs for outreach and education

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

Implement notification process to communicate effective messages that promote screening compliance behaviors.

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.

C2			

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

The implementation of these interventions will increase the percentage of patients receiving cancer screenings and follow-up services regardless of barriers to access.

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.

Availability of Appropriate Levels of Behavioral Health Care Services

a) Please select the name of this Core Activity.

Utilization of Care Management function that integrates primary and behavioral health needs of individuals

b) Please enter a description of this Core Activity

Promote the management of physical health conditions of patients diagnosed with serious mental illness through the integration of primary and behavioral health services. This will be achieved through effective planning and implementation of protocols for patients in need of care of secondary medical conditions. These interventions will be applied to all 14 ambulatory health centers and will have an impact on Inpatient services at both Ben Taub and LBJ hospitals. Approximately 22 outpatient providers and all admitting inpatient providers will contribute to these improvements.

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

Reliable planning, communication, and collaboration across operational service areas

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

Training in effective communications, care transition, and discharge planning

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).

Improved tracking systems for the identification of patients needing screening and follow-up

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

Utilizing Health Information Technology to identify patients in need of screenings and/or follow-up services.

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

Implement notification process to communicate effective messages that promote screening compliance behaviors.

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.

H4			

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

Integrating an accurate and effective process that identifies, tracks, and reminds patients will encourage patients to complete any recommended screenings and adoption of these processes allows Harris Health to promote self-management and preventive care in all settings.

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.

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

Promote effective population health that shifts the focus of primary care to prevention and lifestyle modification for the prevention and management of disease by effectively navigating patients to the appropriate care based on the individual needs of the patient. This will be applied in all 14 ambulatory health centers, and 5 school-based clinics with approximately 30 providers committed to these interventions.

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

Data driven decision making to determine the best strategies to achieve the triple aim of reducing healthcare costs, advance population health, and improve the experience of care

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

Utilize health information data that influences and informs policy and operational decision making

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

Appropriate stakeholder engagement to support efforts and inspire change

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).

Integration and coordination of preventive care services in the primary care setting

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

Analyze programs and clinical practices to target high cost populations and services to align with metrics

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

Workforce education and development to improve workflows that align operations with best practices

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

Identification of barriers to patients' access to care

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

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

Improved tracking systems to identify patients that meet the criteria for appointments and immunizations

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

Apply best practice advisories to patients that meet certain requirements for scheduling appointments and ordering medications or immunizations

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.

D1			

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

Through the use of health information data reports, we will be able to identify patients that meet criteria for preventive care appointments and immunizations based on their medical history. This also addresses the aim of the measure bundle by establishing standards for navigating patients to the appropriate services in order to provide the most comprehensive care available.

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.

Expansion of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.

Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.

b) Please enter a description of this Core Activity

Enhance programs to facilitate access to health-related programs and services for patients and care providers that promotes continuity of care by identifying and removing barriers and providing effective and efficient use of the health care system for patients, caregivers, and practitioners. The system components that will impact these measures will be primarily inpatient services and the emergency department at Ben Taub and LBJ hospitals. Additional follow-ups will occur at the 14 ambulatory health centers and in patients' homes. All admitting inpatient and EC providers will be committed to these interventions.

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

Develop an infrastructure for transitions that promotes quality care and effective communication

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

Assign responsibilities to appropriate staff to ensure that the patient recieves the proper care

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

Provision of up-to-date, accessible information about patients and plans of care

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).

Develop integrated workflows that promote effective and collaborative multi-disciplinary functionality

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

Educate staff on the importance of effective communication, integrated workflows, and how to drive improvement

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

Reinforce effective communication, planning, and collaboration of the multi-disciplinary teams

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).

Provide standardized, patient-centered care that encourages responsibility and preventive care

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

Involve patients and family in shared goal setting process

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

Identify expressed wishes and ensure these are communicated within care teams

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

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

Modify discharge planning processes to include case management of high risk patients and those most likely to readmit

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

Modify discharge summary to include specified components related to the continued care of the patient

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

Apply action plan to address medication management and reconciliation during the inpatient event and prior to discharge.

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

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

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

B1	G1		

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

The aim of the Care Transitions and Coordination bundle is addressed through the effective collaboration of multidisciplinary teams and case management as well as improved documentation of specific health information components in the patient's medical record.

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

No

6) Please select the grouping for this Core Activity.

Maternal and Infant Health Care

a) Please select the name of this Core Activity.

Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (Early Elective Delivery, Hemorrhage, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans)

b) Please enter a description of this Core Activity

Reassess existing and evaluate new protocols to align with industry standards of care and prevention to obtain the desired outcomes for mothers and newborns throughout pregnancy, childbirth, and the postnatal stages that address associated clinical outcomes. These interventions will be applied across the inpatient OB, all 14 ambulatory locations, as well as the emergency departments with approximately 200 providers committed to the interventions.

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

Implement tracking systems to identify patients that meet the criteria for follow-up appointments and screenings

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

Identify standardized screening tools and establish a response protocol for every clinical setting

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

Educate clinicians and office staff on use of the identified screening tools and response protocol

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

Modify documentation practices to capture specified components related to the continuum of care of the patient

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

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

Effective prevention and management of conditions during pregnancy, childbirth and the early newborn period

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

Integration and coordination of services with primary and specialty care based on maternal early warning signs (MEWS)

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

Provide appropriately timed perinatal depression and anxiety awareness education to women and family members

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.

E1			

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

The implementation of these interventions will increase the percentage of patients receiving appropriate screenings and follow-up services regardless of barriers to access.

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 Hospitals	Complete
Section 2: Verification	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category D valuation in DY7	$33,193,765.51
	Category D valuation in DY8	$33,193,765.51
If regional hospital participation requirement is not met	Category D valuation in DY7	$11,064,588.50
	Category D valuation in DY8	$11,064,588.50

Section 1: Statewide Reporting Measure Bundle for Hospitals

Measure	Category D valuation per DY distributed across measures (if regional hospital participation valuation is met)	Category D valuation per DY distributed across measures (if regional hospital participation requirement is not met)
Potentially preventable admissions (PPAs)	$6,638,753.10	$2,212,917.70
Potentially preventable 30-day readmissions (PPRs)	$6,638,753.10	$2,212,917.70
Potentially preventable complications (PPCs)	$6,638,753.10	$2,212,917.70
Potentially preventable ED visits (PPVs)	$6,638,753.10	$2,212,917.70
Patient satisfaction	$6,638,753.11	$2,212,917.70
Requesting HCAHPS exemption - my organization does not report HCAHPS as part of the Medicare Inpatient Prospective Payment System due to low volume or other exempt status	No	

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:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
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	Harris County Hospital District	N/A	17415369366324	100-13-0000-00131

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Joe Dygert	2525 Holly Hall Drive	Houston	77054	joseph.dygert@harrishealth.org	(713) 566-6021		Both
2	Victoria Nikitin	2525 Holly Hall Drive	Houston	77054	victoria.nikitin@harrishealth.org	(713) 566-6939		Both
3	Mike Norby	2525 Holly Hall Drive	Houston	77054	michael.norby@harrishealth.org	(713) 566-6790		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	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%		$19,084,202.25		$19,084,202.25	
Category B	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$9,542,101.13	$9,444,732.75	$9,542,101.13	$9,444,732.75
A1-112	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,658,715.64	$3,588,526.21	$3,142,118.48	$4,066,996.37
A1-115	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,658,715.64	$3,588,526.21	$3,142,118.48	$4,066,996.37
A1-207	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,658,715.64	$3,588,526.21	$3,142,118.48	$4,066,996.37
A1-500	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,658,715.64	$3,588,526.21	$3,142,118.48	$4,066,996.37
A1-508	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,658,715.64	$3,588,526.21	$3,142,118.47	$4,066,996.37
B1-124	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.65	$1,682,444.21
B1-141	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.65	$1,682,444.21
B1-217	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.65	$1,682,444.21
B1-252	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.65	$1,682,444.21
B1-253	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.65	$1,682,444.21
B1-287	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.65	$1,682,444.21
B1-352	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,099,863.47	$1,484,509.60	$1,299,838.64	$1,682,444.22
C2-106	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,399,508.17	$1,888,946.55	$1,653,964.19	$2,140,806.09
C2-107	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,399,508.17	$1,888,946.55	$1,653,964.19	$2,140,806.09
C2-186	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,399,508.16	$1,888,946.55	$1,653,964.20	$2,140,806.09
D1-108	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-211	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-212	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-237	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-271	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-284	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-400	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.69	$2,125,064.87	$1,860,709.72	$2,408,406.85
D1-503	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,574,446.67	$2,125,064.86	$1,860,709.71	$2,408,406.84
E1-232	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,331,930.48	$3,147,457.19	$2,755,917.84	$3,567,118.15
E1-235	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,331,930.48	$3,147,457.19	$2,755,917.84	$3,567,118.15
E1-300	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$2,331,930.48	$3,147,457.18	$2,755,917.84	$3,567,118.14
G1-276	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$699,754.08	$944,473.27	$826,982.10	$1,070,403.04
G1-277	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$699,754.08	$944,473.27	$826,982.10	$1,070,403.04
G1-278	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$699,754.08	$944,473.27	$826,982.10	$1,070,403.04
G1-361	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$699,754.08	$944,473.27	$826,982.10	$1,070,403.04
G1-362	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$699,754.08	$944,473.27	$826,982.10	$1,070,403.04
G1-363	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$699,754.09	$944,473.27	$826,982.09	$1,070,403.05
H4-182	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,458,549.92	$2,165,500.13	$1,723,740.81	$2,454,233.48
H4-258	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$583,419.97	$393,727.30	$689,496.32	$446,224.27
H4-260	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$1,458,549.92	$2,165,500.13	$1,723,740.81	$2,454,233.48
Category D	Harris County Hospital District	17415369366324	100-13-0000-00131	100.00%	100.00%	$14,313,151.69	$14,167,099.12	$4,771,050.56	$4,722,366.37
Total						$95,421,011.26	$94,447,327.47	$95,421,011.26	$94,447,327.47

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:	Mike Norby
IGT Organization:	Harris County Hospital District
Date:	4/16/2018

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:	133355104 - Harris County Hospital District
Performing Provider Type:	Hospital
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	$44,258,354.01	$0.00	$44,258,354.01	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$22,129,177.01	$22,129,177.01	$22,129,177.01	$22,129,177.01
Category C	$121,710,473.54	$165,968,827.55	$143,839,650.55	$188,098,004.56
Category D	$33,193,765.51	$33,193,765.51	$11,064,588.50	$11,064,588.50
Total	$221,291,770.07	$221,291,770.07	$221,291,770.07	$221,291,770.07

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	269,586	322,420	83.61%
DY6	248,396	307,236	80.85%
DY7 Estimated	248,396	307,236	80.85%
DY8 Estimated	248,396	307,236	80.85%

Were DY7-8 maintenance goals based on DY5 or DY6 only?	Yes - DY6 Only

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	$30,829,262.95	$42,039,904.02	$36,434,583.48	$47,645,224.56
B1	Care Transitions & Hospital Readmissions	0	0	0	11	$17,854,926.47	$24,347,627.00	$21,101,276.74	$27,593,977.27
C2	Primary Care Prevention - Cancer Screening	0	0	0	6	$9,736,837.88	$13,277,506.20	$11,507,172.04	$15,047,840.36
D1	Pediatric Primary Care	0	0	0	18	$29,210,513.65	$39,832,518.61	$34,521,516.13	$45,143,521.09
E1	Improved Maternal Care	0	0	0	10	$16,224,006.12	$22,123,644.71	$19,173,825.42	$25,073,464.01
G1	Palliative Care	0	0	0	6	$9,736,837.88	$13,277,506.20	$11,507,172.04	$15,047,840.36
H4	Integrated Care for People with Serious Mental Illness	0	0	0	5	$8,118,088.59	$11,070,120.81	$9,594,104.70	$12,546,136.91
Total	N/A	0	0	0	75	$121,710,473.54	$165,968,827.55	$143,839,650.55	$188,098,004.56

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	Provision of services to individuals that address social determinants of health.

B1	Care Transitions & Hospital Readmissions	Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
C2	Primary Care Prevention - Cancer Screening	Provision of screening and follow up services
D1	Pediatric Primary Care	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
E1	Improved Maternal Care	Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (Early Elective Delivery, Hemorrhage, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans)
G1	Palliative Care	Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
H4	Integrated Care for People with Serious Mental Illness	Utilization of Care Management function that integrates primary and behavioral health needs of individuals

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 Hospitals

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)
Potentially preventable admissions (PPAs)	$6,638,753.10	$2,212,917.70
Potentially preventable 30-day readmissions (PPRs)	$6,638,753.10	$2,212,917.70
Potentially preventable complications (PPCs)	$6,638,753.10	$2,212,917.70
Potentially preventable ED visits (PDVs)	$6,638,753.10	$2,212,917.70
Patient satisfaction	$6,638,753.11	$2,212,917.70

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:	Michael Norby
Performing Provider:	Harris Health
Date:	4/16/2018

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 Hospitals	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