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:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
TIN:	17460019692066
Physical Street Address:	4520 Reading Rd. Suite A100
City:	Rosenberg
Zip:	77471
Primary County:	Fort Bend
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:	Connie Almeida	Mary desVignes-Kendrick	Kaye Reynolds
Street Address:	301 Jackson St., Ste 520	4520 Reading Road, Suite A-100	4520 Reading Road, Suite A-100
City:	Richmond	Rosenberg	Rosenberg
Zip:	77469	77471	77471
Email:	connie.almeida@fortbendcountytx.gov	md.kendrick@fortbendcountytx.gov	kaye.reynolds@fortbendcountytx.gov
Phone Number:	281-238-3078	281-238-3589	281-238-3519
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:	Fort Bend County Health & Human Services Department and Behavioral Health Services Department jointly created a government, community agency and private provider collaboration to improve the health outcomes of residents using innovative programs. The collaboration includes formal contractual agreements, sub-county department partnerships, and community agency referrals, shared resources and partnerships.
Overall DSRIP Goals:	The overall DSRIP goals are based on the Fort Bend County vision for health care transformation to Right Care, Right Place, Right Time. The objective is to develop a system of care, collaborated through the various community programs and agencies that identifies clients and families needing health improvement and to provide the coordinated and appropriate level of care and support, addresses social determinants of health, supports ongoing recovery and wellness, reduces episodic crisis care, incarceration and unnecessary hospitalization.
Alignment with regional community needs assessment:	Access to Care: • Expand availability and access to healthcare services including behavioral health services. • Continue to extend office hours for primary care providers to increase the number of available appointments including after hours. • Grow navigation services to help patients identify available services and programs, especially for low-income individuals. • Continue to support and develop the network of public health and social service organizations to enhance safety net services for uninsured/under-served populations. Inadequate Transportation Options for Individuals Needing Health Care Services: • Identify transportation problems within specific communities and develop local solutions Chronic Disease and Poor Health: • Proactively identify barriers to self-management of chronic diseases and behavioral health conditions such as appropriate access to care, obtaining prescriptions and maintaining long term medication adherence (such as affordability or access to a local pharmacy). Develop solutions to increase access to the right level of care and support, improve medication adherence, which will lead to improved health outcomes and prevent complications as well as avoidable hospital admissions.

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	$1,129,995.80	$0.00	$1,129,995.80	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$564,997.90	$564,997.90	$564,997.90	$564,997.90
Category C	$3,107,488.45	$4,237,484.25	$3,672,486.35	$4,802,482.15
Category D	$847,496.85	$847,496.85	$282,498.95	$282,498.95
Total	$5,649,979.00	$5,649,979.00	$5,649,979.00	$5,649,979.00

Would you like to decrease the total valuation?

No

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

Yes

Generate Worksheets

DY7-8 Provider RHP Plan Update Template - Category B

Progress Tracker

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

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category B valuation in DY7:	$564,997.90
Category B valuation in DY8:	$564,997.90

Section 1: System Definition

Local Health Departments - Required Components

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

Please enter a description of this System Component.

FBC Clinical Health Services (CHS) outpatient locations
Fort Bend County clinic services are provided in two county buildings. In the main clinic location (Rosenberg Annex), TB prevention and control, STD treatment and partner elicitation, and HIV risk reduction services are provided. At the second clinic location (Missouri City Annex), TB prevention and control and HIV risk reduction services are provided. FBC does not own or operate any primary care clinics.

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

Please enter a description of this System Component.

FBC Clinical Health Services (CHS) immunization locations
Fort Bend County offers immunizations in three county buildings: Nancy Drake Clinic (Rosenberg, TX), Fort Bend County Missouri City Annex (Missouri City, TX), and Fort Bend County North Annex (Katy, TX)
Vaccines provided by the Texas Vaccines for Children program are offered only to individuals who are uninsured or Medicaid recipients. Only flu vaccine purchased by the county is offered without restriction to payer type. Part of the program mandate is to encourage all recipients to develop a relationship with a medical home because FBC CHS does not provide any primary care services. The locations are for immunizations only with no medical assessment or diagnostic work available. FBC does not own or operate any primary care clinics.

Local Health Departments - Optional Components

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

Please enter a description of this System Component.

• Mobile Outreach: Crisis Intervention Services (CIT)
o CIT is jointly administered by the FBC Sherriff's office and Behavioral Health Services. The program involves law enforcement officers trained in mental health crises, answering mental health related 911 calls, and redirecting mental health issues away from the criminal justice system and toward appropriate mental healthcare. Other Sherriff's office mobile services are not connected to mental or physical healthcare and should not be considered part of FBC's client care landscape.
• Mobile Outreach: EMS
o Fort Bend County's emergency medical services respond to 911 health emergencies. Fort Bend County considers EMS pre-hospital care and transportation to care.
o Fort Bend County EMS and CIT are both components of the County's emergency response system activated through the 911 communication system. As a result, both entities may respond to the same call for service, however, Fort Bend County HHS and BHS have worked to delineate calls at dispatch level to avoid unnecessary multiple first responders arriving at the scene.

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

Please list your "Other" system component.

Access Health FQHC Adult Family Practice Clinics in Richmond and Missouri City

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

FBC contracts with Access Health FQHC in Richmond and Missouri City for adult care only. Access Health's clinics have adult-only clinics within them. Children and OB/GYN are services within Access Health but are not contracted services with FBC so they are excluded from the FBC DSRIP system.

Please list your "Other" system component.

FBC Behavioral Health Services Department

Please enter a description for this "Other" system component.
o FBC Behavioral Health Services Department, located at 301 Jackson Street is an intake office. Much of the care provided after intake is in other community-based settings. FBC includes these service delivery sites in the system definition. o Organizationally, Behavioral Health Services is part of Fort Bend County's Administration of Justice Division, not part of FBC Health and Human Services. It is owned and operated by FBC. The following services are part of Behavioral Health Services: o Recovery and reintegration: for adults with mental health disorders who are involved in criminal justice and need intensive case management and wrap around services. Services originate upon intake at 301 Jackson Street but also occur in the home, in court, and in jail. This population is part of the DSRIP projects. o Juvenile diversion: same as above but for children. Services originate upon intake at 301 Jackson Street but also occur in the home, in court, in school, and in jail. This population is part of the DSRIP projects. o Crisis Intervention Team: jointly administered with the FBC Sherriff's office. Clients do not originate in intake at 301 Jackson St. They originate from CIT responding to mental health crises throughout the county as a result of 911 calls. o Individuals receiving court ordered forensic assessment services (e.g. compentency to stand trial assessments) are not included in our system definition. o Children and parents involved in our CPS courts that receive court ordered services are not included in our system definition.

Please list your "Other" system component.

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

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

	DY5	DY6
MLIU PPP	27,145	27,366
Total PPP	40,345	42,301

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):	27,256
Average Total PPP	41,323
MLIU percentage of Total PPP	65.96%

*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	MPT	11
Section 2: Selection Overview (CMHCs and LHDs only)	Complete	confirm selections	Points Selected	13
Section 3: Selection of Measures for Local Health Departments	Complete	at the bottom of the	Measures Selected	6
Minimum Selection Requirements Met	Yes	page to finish.	Clinical Outcome Selected	Y
MPT Met	Yes		At least 2 measures selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

If regional private hospital participation requirement is met	Category C valuation in DY7:	$3,107,488.45
	Category C valuation in DY8:	$4,237,484.25
If regional private hospital participation requirement is not met	Category C valuation in DY7:	$3,672,486.35
	Category C valuation in DY8:	$4,802,482.15

MINIMUM POINT THRESHOLD (MPT): 11

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

Section 1: Attributed Population

Attributed Population for Local Health Department (LHD)

Individuals with one eligible encounter during the measurement period

Please describe any other attributed population (optional).

Section 2: Selection Overview

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

The system components include our local FQHC, mobile units, and behavioral health crisis response system as well as recovery and support programs. Below is a listing of the system components:
• The FQHC is AccessHealth located in Fort Bend County
• Mobile units include Fort Bend County Community Paramedics, Fort Bend County EMS and Fort Bend County Crisis Intervention Team
• Behavioral health crisis response and intervention are administered at the Fort Bend County Behavioral Health Services located at 301 Jackson Street, Richmond, TX
• Behavioral health recovery, support and jail/ detention diversion programs are administered at the Fort Bend County Behavioral Health Services located at 301 Jackson Street, Richmond, TX
Below is a list of the measure selections:
• L1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
o Process for Selection: While our integration of behavioral health into primary care addresses identification of various substance use issues that impact patient health and the ability to follow through with a medical plan, tobacco is the most commonly identified substance use in the patient population. Measuring the outcome of intervention on this one behavioral health issue is a marker for the overall effort of addressing substance use in the population.
o System Components: Family practice adult patients at the FQHC, AccessHealth

• L1-107: Colorectal Cancer Screening
o Process for Selection: Colorectal cancer is among the top five causes of death due to cancer in Fort Bend County. The uninsured population is most at risk for late diagnosis and missed prevention opportunities due to the high cost of

o Process for Selection: Colorectal cancer is among the top five causes of death due to cancer in Fort Bend County. The uninsured population is most at risk for late diagnosis and missed prevention opportunities due to the high cost of screening. Improving the screening rate in a clinic population, which is predominately uninsured, will assist in lowering the death rate due to this disease in the population.
o System Components: Family practice adult patients at the FQHC, AccessHealth

• L1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
o Process for Selection: Diabetes care continues to be a priority within Fort Bend County. The collaboration with our Local FQHC, AccessHealth, enhances the ability to model an appropriate, pro-active, comprehensive treatment approach for the high risk diabetic population through coordinated care and nutrition services.
o System Components: Family practice adult patients at the FQHC, AccessHealth; Fort Bend County Community Paramedic program

• L1-205: Third next available appointment
o Process for Selection: Timely access to primary care is a critical component of an effective healthcare delivery system, especially in the uninsured population. Available appointments when needed for sick care may avoid high cost resources, such as emergency departments. Third next available appointment measures timely available access to primary care and promotes continuity of care in a medical home.
o System Components: Family practice adult patients at the FQHC, AccessHealth

Section 3: Selection of Measures for Local Health Departments

Standard LHD Menu Options

Select Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Measure Category*	*Total Points*
No	MLIU denominator with significant volume	L1-103	Controlling High Blood Pressure	Clinical Outcome	3
Yes	MLIU denominator with significant volume	L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	1
Yes	MLIU denominator with significant volume	L1-107	Colorectal Cancer Screening	Cancer Screening	2
No	MLIU denominator with significant volume	L1-108	Childhood Immunization Status (CIS)	Immunization	1
Yes	MLIU denominator with significant volume	L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	1
No	MLIU denominator with significant volume	L1-160	Follow-Up After Hospitalization for Mental Illness	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-186	Breast Cancer Screening	Cancer Screening	2
Yes	All-payer denominator with significant volume	L1-205	Third next available appointment	Process	1
Yes	MLIU denominator with significant volume	L1-207	Diabetes care: BP control (<140/90mm Hg)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	1
No	MLIU denominator with significant volume	L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Process	1
No	MLIU denominator with significant volume	L1-224	Dental Sealant: Children	Process	1
No	MLIU denominator with significant volume	L1-225	Dental Caries: Children	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-227	Dental Caries: Adults	Clinical Outcome	3

No	MLIU denominator with significant volume	L1-231	Preventive Services for Children at Elevated Caries Risk	Process	1
No	MLIU denominator with significant volume	L1-235	Post-Partum Follow-Up and Care Coordination	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	Process	1
Yes	MLIU denominator with significant volume	L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-242	Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-268	Pneumonia vaccination status for older adults	Immunization	1
No	MLIU denominator with significant volume	L1-269	Preventive Care and Screening: Influenza Immunization	Immunization	1
No	MLIU denominator with significant volume	L1-271	Immunization for Adolescents	Immunization	1
No	MLIU denominator with significant volume	L1-272	Adults (18+ years) Immunization status	Immunization	1
No	MLIU denominator with significant volume	L1-280	Chlamydia Screening in Women (CHL)	Process	1
No	MLIU denominator with significant volume	L1-343	Syphilis positive screening rates	Process	1
No	MLIU denominator with significant volume	L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-345	Gonorrhea Positive Screening Rates	Process	1
No	MLIU denominator with significant volume	L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	1

Total points from Standard Menu:	13

LHD "Grandfathered" DY6 P4P Measures

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

Select Measure (Yes/No)	*TPI*	*Performing Provider Name*	*DY6 RHP/Cat 3 ID*	*DY6 Title*	*DY7-8 Point Value*
No	296760601	Fort Bend County	3_296760601.3.1	Reduce Emergency Department visits for Behavioral Health/Substance Abuse	3

No	296760601	Fort Bend County	3_296760601.3.10	Third next available appointment	1
No	296760601	Fort Bend County	3_296760601.3.100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	3
No	296760601	Fort Bend County	3_296760601.3.11	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000	3
No	296760601	Fort Bend County	3_296760601.3.2	Diabetes care: HbA1c poor control (>9.0%)	3

Total points from "grandfathered" menu:	0

Total overall selected points:	13

Are you finished making your selections?

Yes

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

Progress Tracker

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

Section 1: Measure Exemption Requests and Measure Setting System Components

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

Bundle-Measure ID	Measure Name	Baseline Measurement Period	Requesting a shorter or delayed measurement period?	Requesting a reporting milestone exemption?	Requesting a baseline numerator of zero?
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-107	Colorectal Cancer Screening	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-205	Third next available appointment	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-207	Diabetes care: BP control (<140/90mm Hg)	CY2017: January 1, 2017 - December 31, 2017	No	No	No
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	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:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category C valuation in DY7:	$3,107,488.45
	Category C valuation in DY8:	$4,237,484.25
If regional hospital participation requirement is not met	Category C valuation in DY7:	$3,672,486.35
	Category C valuation in DY8:	$4,802,482.15

Section 1: Measure Bundle/Measure Valuation

Valuation for Selected Measures - Local Health Departments

						If private regional hospital participation requirement is met		If private regional hospital participation requirement is not met	
Measure ID or Cat 3 ID	Denominator Volume	Points	Desired Valuation %	Minimum Valuation % of Total	Maximum Valuation % of Total	Category C Valuation in DY7	Category C Valuation in DY8	Category C Valuation in DY7	Category C Valuation in DY8
L1-105	MLIU denominator with significant volume	1	16.67%	12.50%	16.67%	$518,018.32	$706,388.62	$612,203.47	$800,573.77
L1-107	MLIU denominator with significant volume	2	16.65%	12.50%	16.67%	$517,396.83	$705,541.13	$611,468.98	$799,613.28
L1-115	MLIU denominator with significant volume	3	16.67%	12.50%	20.84%	$518,018.32	$706,388.62	$612,203.47	$800,573.77
L1-205	All-payer denominator with significant volume	1	16.67%	12.50%	16.67%	$518,018.32	$706,388.62	$612,203.47	$800,573.77
L1-207	MLIU denominator with significant volume	3	12.50%	12.50%	20.84%	$388,436.06	$529,685.53	$459,060.79	$600,310.27
L1-241	MLIU denominator with significant volume	3	20.84%	12.50%	20.84%	$647,600.60	$883,091.73	$765,346.17	$1,000,837.29
Total	N/A	13	**100.00%**	N/A	N/A	$3,107,488.45	$4,237,484.25	$3,672,486.35	$4,802,482.15
Difference between selected percent and 100%:			**0.00%**						

Your valuation allocations add to 100%.

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

Explanation of Valuation Percent Changes

Overall justification for change in Category C valuation distribution.
L1-241:Valuation increase to reflect the IGT investment, the scope of services and costs of core activites related to behavioral health services essential to meet the desired outcomes. The demand for services related to this measure is projected to increase overtime with the significant population growth in Fort Bend County.
L1-207: Valuation decrease to reflect the enhancement of and assurance of health improvement best practices for the existing diabetes care model and not a unique activity.

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.
Review of DY5 and DY6 data indicated an increase in the number of individuals with potentially preventable admissions and readmissions into the criminal justice system for both adults and youth. The provider, Fort Bend County Behavioral Health Services, has worked to establish processes and services to improve on this outcome. Continued and enhanced support for these activities justify the increased valuation for this measure. As a local health department, we have a limited selection of measures related to behavioral health even though many of our DSRIP projects have addressed this essential need in our community. An increasing demand in services and the significant population growth will require an even greater effort in order to maintain successful outcomes, which also justifies the increased valuation of L1-241.

Please address the level of effort required for improvement for the Measure Bundle(s) with increased valuation.
Maintain current effort with increasing population growth and demand for service

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.
This measure impacts more individuals than any of the other measures.

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:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

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

DY6 Project ID	Project Option	Project Summary	Completed/ Continuing	Enter a description for continuation (optional)
RHP 3_296760601.1.1	1.13.1	Develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links persons with their most appropriate level of care. 1) Assessment and enhancement of 911 dispatch system to identify and respond to behavioral health crises, 2) development of specialized crisis intervention team within Fort Bend County Sheriff's Office and 3) implementation of cross systems training and linkages to appropriate services and supports.	Continuing as Core Activity in DY7-8	
RHP 3_296760601.1.2	1.1.2	Expand the hours of operation of the local Federally Qualified Health Center to increase access to primary care for the Medicaid, uninsured and underinsured population in the county.	Continuing as Core Activity in DY7-8	
RHP 3_296760601.2.1	2.9.1	Expand patient navigation services to a subset of the uninsured and underinsured population in the county which uses EMS and ED services inappropriately for non-emergent conditions and has no means to pay for the services	Continuing as Core Activity in DY7-8	
RHP 3_296760601.2.2	2.13.1	Design, implement and evaluate a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual development disabilities, substance abuse and physical health issue from initial or further involvement with juvenile.	Continuing as Core Activity in DY7-8	
RHP 3_296760601.2.3	2.3.2	Provide primary care to individuals who call 9-1-1 for non-emergent conditions.	Continuing as Core Activity in DY7-8	
RHP 3_296760601.2.4	2.7.1	In cooperation with local health care providers, provide colonoscopy screening to uninsured and underinsured populations who meet the criteria for this procedure.	Continuing as Core Activity in DY7-8	
RHP 3_296760601.2.100	2.15.1	The proposed project will enhance the current health care delivery system by adding a Screening, Brief Intervention and Referral to Treatment model (SBIRT) in the AccessHealth FQHC clinic in Richmond, Texas. This evidence-based model includes: Screening: Universal screening for quickly assessing use and severity of alcohol, illicit drugs, and prescription drug abuse.	Continuing as Core Activity in DY7-8	
RHP 3_296760601.2.101	2.13.1	Fort Bend County proposes to develop a continuum of care that is based on evidence based practices for target group (persons with severe mental illness and / or mental illness and physical health conditions) identified as high risk for recidivism due to homeless/ lack of stable housing, prior history of non compliance, lack of access to services, complex trauma, lack of family supports and /or lack of integrated care to address complex needs.	Continuing as Core Activity in DY7-8	

Section 2: Core Activities

Please enter your organization's number of Core Activities: 8

1) Please select the grouping for this Core Activity.

Expansion of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

Identification and referral of frequent or inappropriate users of the Emergency Medical Service transport system or Emergency Department care setting for chronic conditions that would be better managed in a medical home with proactive care, coaching and resolution of one or more negative social determinants of health, thus avoiding episodic crisis interventions.

Number of providers committed: AccessHealth, FQHC (1 LVN - Care Coordination Manager, Director of Reporting and Analytics, 1 Dietician, 1 LVN, 2 CHWs), Fort Bend County (1 Special Projects Coordinator)
Locations impacted: AccessHealth, FQHC Adult Clinic at Richmond and Missouri City locations

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

Establish engagement with referred clients by enrolling them into a navigation team approach to improve health outcomes for the client

A) Please list the first Change Idea for the above Secondary Driver (required).
Consistent medical home with proactive care provided by a navigation team

B) Please list the second Change Idea for the above Secondary Driver (optional).
Establish connections with specialty care providers, such as urology, optometry, wound care, general surgery, hematology and cardiology

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).
Improving chronic disease understanding and self-management

A) Please list the first Change Idea for the above Secondary Driver (required).
Incentivized chronic disease education and self-management courses

B) Please list the second Change Idea for the above Secondary Driver (optional).
Establishing patient specific goals (e.g. weight, exercise, nutrition)

C) Please list the third Change Idea for the above Secondary Driver (optional).
Availability to patients of a registered dietician to better assist them with nutrition and their diets

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).
Community Health Worker assessment and referral for mitigation of health impacting social determinants

A) Please list the first Change Idea for the above Secondary Driver (required).
Collaboration with and referral to social service agencies within the community

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

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

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

L1-115	L1-207		

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.
One of the chronic diseases impacting many of our patients is uncontrolled diabetes. Access to care driven by a proactive team approach improves disease knowledge and self-management, assures access to medical appointments, prescribed medications, dietician counseling, disease education courses and individualized health improvement goals, including exercise. The patients will improve various health markers and specifically will lower their HgbA1c levels and blood pressure.

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.
Behavioral Health Crisis Stabilization Services

a) Please select the name of this Core Activity.
Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model).

b) Please enter a description of this Core Activity
Fort Bend County Crisis Intervention Team consists of a specialized team of officers that work closely with Fort Bend County Behavioral Health Services, the local mental health authority, psychiatric hospitals, emergency rooms, emergency medical services (EMS) and community service organizations. The Fort Bend CIT responds to behavioral health crises in the community, provides stabilization services, directs individuals to the appropriate level of care, reduces unnecessary incarceration and emergency room utilization, provides follow up services and connects individuals with needed clinical and social services.

Number of providers committed: Fort Bend County Behavioral Health Services (Director of BHS & Project Specialist) and Crisis Intervention Team (1 Captain, 1 Lieutenent, 10 Deputies, 2 Sergeants)
Locations impacted: Zips codes within Fort Bend County (77053, 77406, 77407, 77417, 77420, 77430, 77441, 77444, 77451,77459, 77461, 77464, 77469, 77471, 77476, 77477, 77478, 77479, 77481, 77485, 77487, 77489, 77494, 77496, 77497, 77498,77545,77583)

i) Please describe the first Secondary Driver for the above Core Activity (required).
Specialized Crisis Intervention Team (CIT) that is trained and supported to address behavioral health crises, in the community.

A) Please list the first Change Idea for the above Secondary Driver (required).
Provide ongoing training to CIT to support response and intervention system

B) Please list the second Change Idea for the above Secondary Driver (optional).
Expand crisis intervention training to first responders to enhance cross systems knowledge and coordinated response

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).

A network of needed clinical and support services, in the community, for individuals and families.

A) Please list the first Change Idea for the above Secondary Driver (required).
Establish collaborative partnerships and information sharing to expand clinical resources and social supports

B) Please list the second Change Idea for the above Secondary Driver (optional).
Follow up and continuity of care to connect individuals and families to needed supports and services

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.

L1-241			

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.
This core activity responds to behavioral health crises and connects individuals with the appropriate level of care reducing the unnecessary incarceration and escalation of dangerous behavior. The Crisis Intervention Team provides specialized response, stabilization, and follow up services. The Fort Bend County CIT is a critical component of the county's emergency response system and Ft. Bend County's Behavioral Health Services. Timely and appropriate response system is critical to preventing unnecessary criminal justice involvement for individuals with behavioral health disorders.

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.
Expansion of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.
Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.

b) Please enter a description of this Core Activity
Identify individuals frequently or inappropriately using EMS transport and ED care for episodic crisis care of chronic medical conditions better managed in a medical home. Paramedics provide assessment and care to identified individuals. Community Paramedics will connect the patients to the local Federally Qualified Health Center to establish a medical home. The project will promote the medical home and serve as a community based navigation system.

Number of providers committed: Fort Bend County EMS (1 Deputy Chief- Clinical) and Fort Bend County Community Paramedic team (1 Community Paramedic Coordinator, 2 Community Paramedics), Fort Bend County (1 Special Projects Coordinator)
Locations impacted: Zips codes within Fort Bend County (77053, 77406, 77407, 77417, 77420, 77430, 77441, 77444, 77451,77459, 77461, 77464, 77469, 77471, 77476, 77477, 77478, 77479, 77481, 77485, 77487, 77489, 77494, 77496, 77497, 77498,77545,77583)

i) Please describe the first Secondary Driver for the above Core Activity (required).
Engage clients in chronic illness self- management, healthy lifestyles, preventive care, and positive healthcare decisions

A) Please list the first Change Idea for the above Secondary Driver (required).
Provide comprehensive chronic disease education course

B) Please list the second Change Idea for the above Secondary Driver (optional).
Establish patient specific goals (e.g. weight, exercise, nutrition)

C) Please list the third Change Idea for the above Secondary Driver (optional).
Empower the client for good medication management: the right way to administer, when it needs to be administered, proper storage, handling, disposal, etc.

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).
Identify patients who are at risk for inequalities in social determinants of health that are impacting their health through coordination of care, referrals for service provision

A) Please list the first Change Idea for the above Secondary Driver (required).
Implement use of a standarized tool to identify at risk clients

B) Please list the second Change Idea for the above Secondary Driver (optional).
Collaboration with and referral to social service agencies within the community

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.

L1-115	L1-207		

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

Clients who are disconnected from a medical home may present for episodic crisis care for their chronic condition through the EMS pre-hospital care and ED systems. While care provided in these systems may be excellent, the patient often returns to no ongoing care. The active identification of such patients, proactive linkage to a medical home, provision of navigation services and addressing appropriate social determinants of health can improve health status and health outcomes for these patients. The measures selected reflect improvement in a common chronic disease of diabetes in the target population.

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.

Prevention and Wellness

a) Please select the name of this Core Activity.

Implementation of strategies to reduce tobacco use (Example of evidence based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)

b) Please enter a description of this Core Activity

Use of the SBIRT (Screening, Brief Intervention, Referral to Treatment) model integrated in the local FQHC designed to identify, reduce, and prevent problematic substance use disorders. The program is designed to identify individuals with substance use and to effectively help them stop or reduce the current use before they need more extensive or specialized treatment, and to improve their overall health.

Number of providers committed: AccessHealth, FQHC (1 SBIRT Counselor & 1 Chief Program Officer), Fort Bend County (1 Special Projects Coordinator)
Locations impacted: AccessHealth, FQHC Adult Clinic at Richmond and Missouri City locations

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

Systematically screen all clients to identify those who need further intervention

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

Monitor the number of CAGE AID screening assessments performed. CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug abuse. This four item screening tool takes approximately 1 minute to administer and score. The target population for the CAGE-AID is adult patients and can be administered by patient interview or self-report in a primary care setting.

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

Connect the client with appropriate level 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).

Reduce tobacco, drug and alcohol use in identified patients

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

Engage patients in motivational interviewing and cessation classes

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

Provide medication to assist with reduction of tobacco, drug and alcohol use

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.

L1-105			

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

This core activity provides infrastructure to integrate substance use recognition and treatment into the FQHC through the SBIRT program. This includes tobacco, alcohol and other drug screening into the standard of care for all family practice adult patients (18 and older). Through the systematic integration of screening into the FQHC, we identify and engage patients in education and intervention.

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.

Expanded Practice Access (e.g., increased hours, telemedicine, etc.)

b) Please enter a description of this Core Activity

Expand the hours of operation of the local Federally Qualified Health Center to increase access to primary care for the Medicaid, uninsured and underinsured population in Fort Bend County. A standard 7 a.m. to 7 p.m. weekday schedule and a Saturday morning schedule from 8 a.m. to 12 p.m.

Number of providers committed: AccessHealth, FQHC (1 Family Practice Provider, 1 LVN, 2 Medical Assitants, 3 Front Desk/ Eligibility Staff), Fort Bend County (1 Special Projects Coordinator)
Locations impacted: AccessHealth, FQHC Adult Clinic at the Richmond location

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

Same day appointment availability slots to expand access

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

Monthly reports on availability and usage of same day appointment slots

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

Develop a contingency plan for days (or parts of the day) when demand far outstrips the availability of physicians

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).

Maintain a full provider team dedicated to the expanded clinic hours

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

Develop a contingency plan for days when providers are out of office to ensure there are enough available providers for the capacity need

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

Dashboard report of staff capacity and usage of same day appointment slots

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.

L1-205			

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

Availability and management of early morning, evening and Saturday appointmens as well as additional staff capacity, during the regular hours, are key to improving access to timely care.

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.

Availability of Appropriate Levels of Behavioral Health Care Services

a) Please select the name of this Core Activity.

Provision of services to individuals that address social determinants of health and/or family support services.

b) Please enter a description of this Core Activity

Assessing the social determinants of health is an integral part of our service delivery system. Addressing needs such as housing, transportation, food insecurity, and poverty requires collaboration and information sharing with other county departments and community organizations.

Number of providers committed: Fort Bend County Behavioral Health Services (Director of BHS, 1 Project Specialist, 1 Recovery & Reintegration Specialist, 1 Case Manager Specialist, 2 Clinical Care Coordinators)
Locations impacted: Fort Bend County Behavioral Health Services located in Richmond, TX

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

Screen clients (youth and adults) enrolled in Behavioral Health Services for social determinants of health.

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

Process for integrating social determinants of health data into program management

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

Expand resources for meeting social determinants of health

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 case management services provided to clients

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

Connect individuals (youth and adults) and families to needed supports and services, provide follow up and evaluate needs on an ongoing basis to ensure that social determinants of health are met.

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

Process for information sharing among agencies that provide services that address social determinants of health, in order to facilitate access to those services and supports

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.

L1-241			

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

This core activity connects clients to appropriate wraparound services. Reducing risk factors for recidivism such as the lack of safe and stable housing, employment, and social isolation are essential to improvements in the selected measure.

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

No

7) Please select the grouping for this Core Activity.

Behavioral Health Crisis Stabilization Services

a) Please select the name of this Core Activity.

Implement models supporting recovery of individuals with behavioral health needs.

b) Please enter a description of this Core Activity

Behavioral Health Services provides intensive case management, strengths-based planning, wraparound supports, wellness curriculum, and individual and family centered services. The focus of our programs for youth and adults are on recovery, reintegration into the community, keeping families together and reduction of incarceration/detention.

Number of providers committed: Fort Bend County Behavioral Health Services (Director of BHS, 1 Project Specialist, 1 Recovery & Reintegration Specialist, 1 Case Manager Specialist, 2 Clinical Care Coordinators)
Locations impacted: Fort Bend County Behavioral Health Services located in Richmond, TX

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

Complete the CANS (Child and Adolescents Needs and Strengths) and ANSA (Adult Needs and Strengths Assessment) to assess needs and strengths. These assessments are multi-purpose tools developed for

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

Use CANS and ANSA data to assess individual outcomes and modify service plans, accordingly

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).

Patient support/continuity of care of services for clients enrolled in the program

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

Develop, implement and evaluate the follow up/after care process and use the data to assess client functioning/recovery and identify additional needed services and supports, for clients enrolled in the program

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.

L1-241			

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

The comprehensive individual and family services provided are essential to reducing incarceration/detention. Our programs include follow up and after care supports, also essential to recovery and reducing incarceration.

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

No

8) Please select the grouping for this Core Activity.

Prevention and Wellness

a) Please select the name of this Core Activity.

Other

i) Please enter the name of this "Other" Core Activity.

Implement Evidence-based Disease Prevention Programs – Colonoscopy Screening

b) Please enter a description of this Core Activity

Provide a colonoscopy screening to uninsured and underinsured populations who meet the American Cancer Society criteria for this procedure but have no resources to pay for it. Some patients will receive polypectomies for pre-cancerous polyps, thus preventing a future cancer while

patients will receive polypectomies for pre-cancerous polyps, thus preventing a future cancer while others may be diagnosed and treated for cancer at an earlier stage than if it was not diagnosed until symptomatic. The FQHC, AccessHealth will identify and refer for colonoscopy screening patients meeting the ACS criteria for colorectal cancer routine screening.

Number of providers committed: , Fort Bend County (1 Special Projects Coordinator), AccessHealth, FQHC (8 Physicians, Director of Reporting and Analytics, 1 Referral Clerk Supervisor, 1 Referral Clerk & COO), 2 Contracted Gastroenterologists, 1 Contracted Hospital (surgical suite, pathology, radiology, anesthesiologist) & 1 Contracted Outpatient Surgical Center
Locations impacted: AccessHealth, FQHC Adult Clinic at Richmond and Missouri City locations

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

Assess and reduce patient barriers to completion of screening procedure

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

Educate patients at the time of referral as to the complete expectations of colonosocpy screening, which included an effective bowl preparation prior to reporting for the procedure. The clinic will ensure brochure availabilty and address patient concerns at the time of the referral.

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

Connect with community resources for education regarding the need for colonoscopy screening and to counteract fear.

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).

Leverage the Health Information Technology Systems

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

Implement reports to identify and notify patients due for screening and patients that are hard to reach

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

Ensure current and reliable data of family history, diagnoses, and symptoms

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.

L1-107			

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

Access to colorectal cancer screening is driven by a proactive team approach which improves knowledge of the colorectal cancer screening process and ensures access to a gastroenterologist. Successful implementation of this activity will improve colorectal cancer screening rates at the FQHC.

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

No

DY7-8 Provider RHP Plan Update Template - Category D

Progress Tracker

Section 2: Verification	Complete

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

If regional hospital participation requirement is met	Category D valuation in DY7	$847,496.85
	Category D valuation in DY8	$847,496.85
If regional hospital participation requirement is not met	Category D valuation in DY7	$282,498.95
	Category D valuation in DY8	$282,498.95

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

Measure	Category D valuation per DY distributed across measures (if regional hospital participation requirement is met)	Category D valuation per DY distributed across measures (if regional hospital participation requirement is not met)
Time Since Routine Checkup	$121,070.98	$40,356.99
High Blood Pressure Status	$121,070.98	$40,356.99
Diabetes Status	$121,070.98	$40,356.99
Overweight or Obese	$121,070.98	$40,356.99
Smoker Status	$121,070.98	$40,356.99
Selected Immunizations	$121,070.98	$40,356.99
Prevention of Sexually Transmitted Diseases	$121,070.97	$40,357.01

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:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

Section 1: IGT Entities

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

IGT RHP	IGT Name	IGT TPI (if available)	IGT TIN	Affiliation Number
3	Fort Bend County	296760601	17460019692066	100-13-0000-00125

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Mary desVignes-Kendrick	4520 Reading Road, Suite A-100	Rosenberg	77471	md.kendrick@fortbendcountytx.gov	281-238-3589		Both
2	Kaye Reynolds	4520 Reading Road, Suite A-100	Rosenberg	77471	kaye.reynolds@fortbendcountytx.gov	(281) 238-3519		Both
3	Connie Almeida	301 Jackson St, Suite 520	Richmond	77469	connie.almeida@fortbendcountytx.gov	(281) 238-3078		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	Fort Bend County	17460019692066	100-13-0000-00125	100.00%		$487,254.19		$487,254.19	
Category B	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$243,627.09	$241,141.10	$243,627.09	$241,141.10
L1-105	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$223,369.50	$301,486.66	$263,982.14	$341,684.89
L1-107	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$223,101.51	$301,124.95	$263,665.42	$341,274.95
L1-115	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$223,369.50	$301,486.66	$263,982.14	$341,684.89
L1-205	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$223,369.50	$301,486.66	$263,982.14	$341,684.89
L1-207	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$167,493.63	$226,069.78	$197,947.01	$256,212.42
L1-241	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$279,245.38	$376,903.55	$330,017.27	$427,157.36
Category D	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$365,440.64	$361,711.66	$121,813.55	$120,570.55
Total						$2,436,270.94	$2,411,411.04	$2,436,270.94	$2,411,411.04

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:	Dr. Connie Almeida
IGT Organization:	Fort Bend County
Date:	3/9/2018

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

Progress Tracker

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

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

Section 1: DY7-8 DSRIP Valuation

	DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$1,129,995.80	$0.00	$1,129,995.80	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$564,997.90	$564,997.90	$564,997.90	$564,997.90
Category C	$3,107,488.45	$4,237,484.25	$3,672,486.35	$4,802,482.15
Category D	$847,496.85	$847,496.85	$282,498.95	$282,498.95
Total	$5,649,979.00	$5,649,979.00	$5,649,979.00	$5,649,979.00

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

Yes

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

	MLIU PPP	Total PPP	MLIU Percentage of Total PPP
DY5	27,145	40,345	67.28%
DY6	27,366	42,301	64.69%
DY7 Estimated	27,256	41,323	65.96%
DY8 Estimated	27,256	41,323	65.96%

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

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

Yes

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

						Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
Bundle-Measure ID	Measure Bundle/Measure Name	# of Measures with Requested Achievement of Alternative Denominators	# of Measures with Requested Shorter or Delayed Measurement Periods	# of Measures with Requested Reporting Milestone Exemptions	Points	DY7 Valuation	DY8 Valuation	DY7 Valuation	DY8 Valuation
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0	0	0	1	$518,018.32	$706,388.62	$612,203.47	$800,573.77
L1-107	Colorectal Cancer Screening	0	0	0	2	$517,396.83	$705,541.13	$611,468.98	$799,613.28
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0	0	0	3	$518,018.32	$706,388.62	$612,203.47	$800,573.77
L1-205	Third next available appointment	0	0	0	1	$518,018.32	$706,388.62	$612,203.47	$800,573.77
L1-207	Diabetes care: BP control (<140/90mm Hg)	0	0	0	3	$388,436.06	$529,685.53	$459,060.79	$600,310.27
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	0	0	0	3	$647,600.60	$883,091.73	$765,346.17	$1,000,837.29
Total	N/A	0	0	0	13	$3,107,488.45	$4,237,484.25	$3,672,486.35	$4,802,482.15

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

Yes

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

Bundle-Measure ID	Measure Bundle/Measure Name	Associated Core Activities
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Implementation of strategies to reduce tobacco use (Example of evidence based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)
L1-107	Colorectal Cancer Screening	Other - Implement Evidence-based Disease Prevention Programs – Colonoscopy Screening
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others); Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.
L1-205	Third next available appointment	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)
L1-207	Diabetes care: BP control (<140/90mm Hg)	Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others); Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model).; Provision of services to individuals that address social determinants of health and/or family support services.; Implement models supporting recovery of individuals with behavioral health needs.

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

Yes

Section 5: Category D Valuations

Statewide Reporting for LHDs

Measure	Category D valuation per DY distributed across measures (if regional hospital participation requirement is met)	Category D valuation per DY distributed across measures (if regional hospital participation requirement is not met)
Time Since Routine Checkup	$121,070.98	$40,356.99
High Blood Pressure Status	$121,070.98	$40,356.99
Diabetes Status	$121,070.98	$40,356.99
Overweight or Obese	$121,070.98	$40,356.99
Smoker Status	$121,070.98	$40,356.99
Selected Immunizations	$121,070.98	$40,356.99
Prevention of Sexually Transmitted Diseases	$121,070.97	$40,357.01

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:	Dr. Connie Almeida
Performing Provider:	Fort Bend County
Date:	3/9/2018

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

PROVIDER RHP PLAN UPDATE TEMPLATE PROGRESS: Template is COMPLETE!

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

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