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

DY9-10 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: DY9-10 Total Valuation and Updated Minimum Point Threshold (MPT)	Complete

Section 1: Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
TIN:	17460011640002
Physical Street Address:	8000 N. Stadium Dr., 8th Floor
City:	Houston
Zip:	77054
Primary County:	Harris
Additional counties being served (optional):	

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

Section 2: Lead Contact Information

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

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

Section 3: Optional Withdrawal From DSRIP

Please select an option below. By selecting “Yes - Withdraw from DSRIP”, this organization acknowledges it understands that any DY9-10 DSRIP funds will be redistributed within the RHP and it will no longer have access to those DSRIP funds.

Do Not Withdraw from DSRIP

Section 4: Performing Provider Overview

Performing Provider Description:	The City of Houston Health Department (HHD) works in partnership with the community to promote and protect the health and social well-being of all Houstonians. Our vision is to have self-sufficient families and individuals in safe and healthy communities. HHD serves the 2.3 million residents of the City of Houston. Our scope and impact reaches beyond the city limits and extends to Harris County's population of 4.6 million people, due to the work we do through the Harris County Area Agency on Aging, and our population based immunization strategies and HIV/STD surveillance. Additionally, our laboratory serves as a 17 county region reference lab.

Overall DSRIP Goals:	Our overall goals are to 1) navigate clients to needed resources and services; 2) utilize prevention strategies to improve health and manage chronic conditions; 3) improve the quality of services and increase the capacity to meet the needs of our growing populations; and 4) provide cost-savings to the overall health system and clients through targeted evidenced-based interventions.

Alignment with regional community needs assessment:	The services offered by the Houston Health Department (HHD) are alignment with majority of the priority areas identified in the 2017 Southeast Texas RHP3 Community Health Needs Assessment (page 3) published by RHP3 Anchor, Harris Health. The safety net and navigation services offered by the Houston Health Department helps address the needs of vulnerable populations who don't have access to care or lack the knowledge to access care appropriately. Additonally, the services offered help mitigate barriers to care like transportation and cultural and linguistic support. HHD continues to work with local primary care providers to refer clients and we educate providers on our services that help with the management of clients chronic conditions. Screenings, education, and wellness sessions offered by our agency covers the vast majority of health concerns identified in the community needs assessment, i.e., the high prevalences of diabetes, obesity, smokers, individuals with poor nutritional habis, and inactivity amoungst the population.

Section 5: DY9-10 Total Valuation and Updated Minimum Point Threshold (MPT)

Initial DY9 DSRIP Valuation	Initial DY10 DSRIP Valuation	Initial DY9-10 MPT
$35,564,311.88	$30,338,181.72	20

Would you like to decrease the total valuation?

No

If a provider withdraws in your RHP, would you be willing to increase the total valuation and MPT by the following?

Provider Selection:	Increase DY10 Valuation up to:	Updated MPT:	
Yes	$30,749,999.99	20	<-- Note: This is your current MPT
Yes	$31,249,999.99	20	
Yes	$31,749,999.99	20	
Yes	$32,249,999.99	20	
Yes	$32,749,999.99	20	
Yes	$33,249,999.99	20	
Yes	$33,749,999.99	20	

At this point, please stop and submit your RHP Plan Update to your RHP's Anchor Entity for calculating available funds for redistribution.
Once you receive information from your Anchor regarding additional funds available, you may continue.

Have you received information from your Anchor regarding additional funds available?

Yes

	DY9	DY10
Additional DSRIP Funds from Withdrawn Providers	$0.00	$0.00

	Category Percentage (%)	DY9-10 DSRIP Valuation Distribution	
		DY9	DY10
Category A	0%	$0.00	$0.00
Category B	10%	$3,556,431.19	$3,033,818.17
Category C	75%	$26,673,233.91	$22,753,636.29
Category D	15%	$5,334,646.78	$4,550,727.26
Total	100%	$35,564,311.88	$30,338,181.72

Original MPT:	20
Adjusted MPT based on updated valuation:	20

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

Yes

Generate Worksheets

DY9-10 Provider RHP Plan Update Template - Category B

Progress Tracker

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

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category B valuation in DY9:	$3,556,431.19
Category B valuation in DY10:	$3,033,818.17

Section 1: System Definition

Would you like to modify the System Definition?

Yes

Local Health Departments - Required Components

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

Please enter a description of this System Component.

Our local public health clinics provide safety net services to 1) prevent the spread of disease, and 2) promote the health and well-being of the communities we serve. Here is the list of clinics and the services provided at each one:

Northside

- Family Planning
- STD
- Immunizations
- Tuberculosis
- Dental

La Nueva Casa de Amigos
• Family Planning
• Immunizations
• Dental
Magnolia
• Dental
Sharpstown
• Family Planning
• STD
• Immunizations
• Dental
Sunnyside
• Family Planning
• STD
• Immunizations
• Tuberculosis

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

Please enter a description of this System Component.

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

Local Health Departments - Optional Components

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

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

Please list your "Other" system component.

Other - Non-clinical Services

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

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

Please list your "Other" system component.

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

Please summarize and explain the changes to your system definition

The smallest dental clinic, the Fort Bend Senior Center, was closed.

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

	DY7	DY8
MLIU PPP	39,461	39,461
Total PPP	41,401	41,401

Please indicate the population included in the MLIU PPP

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

Would you like to modify the MLIU PPP goal and/or Total PPP?

No

Please fill out the applicable fields below:

Estimated Medicaid individuals served in DY7	9,887
Estimated Low-income or Uninsured Individuals served in DY7	30,105

Estimated Medicaid individuals served in DY8	8,699
Estimated Low-income or Uninsured Individuals served in DY8	30,762
MLIU PPP Goal for each DY (DY9 and DY10):	39,461
Forecasted Medicaid individuals served in each DY for DY9-10	8,699
Forecasted Low-income or Uninsured individuals served in each DY for DY9-10	30,762
Average Total PPP in each DY	41,401
MLIU percentage of Total PPP	95.31%
Allowable Variation	2.00%

*The MLIU percentage and forecasted Medicaid and LIU counts are for informational purposes only.

DY9-10 Provider RHP Plan Update Template - Category C Selection

Progress Tracker

Section 2: Selection of Measures for Local Health Departments	Complete
Section 3: Selection Overview	Complete
Section 4: Measure Exemption Requests	Complete
Minimum Selection Requirements Met	Yes
MPT Met	Yes

Note: you must confirm selections at the bottom of the page to finish.

MPT	20
Points Selected	20
Measures Selected	10
Maximum Deletions Met	Y
Clinical Outcome Selected	Y
At least 2 measures selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	093774008 - City of Houston
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category C valuation in DY9:	$26,673,233.91
Category C valuation in DY10:	$22,753,636.29

MINIMUM POINT THRESHOLD (MPT): 20

Each Performing Provider must maintain or select Measure Bundles/measures to meet or exceed their MPT to maintain their valuation that was confirmed on the Provider Entry tab.
A maximum of 20 points from DY7-8 to DY9-10 may be deleted with good cause. There is no limit on the number of added bundles or measures.

Section 1: Attributed Population

Attributed Population for Local Health Department (LHD)

a. Individuals with one eligible encounter during the measurement period OR
b. Other populations defined by the LHD in the RHP Plan Submission and approved by HHSC

Section 2: 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 - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	1
No	MLIU denominator with significant volume	L1-107	Colorectal Cancer Screening	Cancer Screening	2
No	MLIU denominator with significant volume	L1-108	Childhood Immunization Status (CIS)	Immunization	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Clinical Outcome	3

Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	1
No	MLIU denominator with significant volume	L1-160	Follow-Up After Hospitalization for Mental Illness	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-186	Breast Cancer Screening	Cancer Screening	2
No	MLIU denominator with significant volume	L1-205	Third next available appointment	Process	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-207	Diabetes care: BP control (<140/90mm Hg)	Clinical Outcome	3
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	1
No	MLIU denominator with significant volume	L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Process	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-224	Dental Sealant: Children	Process	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-225	Dental Caries: Children	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-227	Dental Caries: Adults	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-231	Preventive Services for Children at Elevated Caries Risk	Process	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-235	Post-Partum Follow-Up and Care Coordination	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	Process	1
No	MLIU denominator with significant volume	L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-242	Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-262	Assessment of Risk to Self/ Others	Process	1
No	MLIU denominator with significant volume	L1-263	Assessment for Psychosocial Issues of Psychiatric Patients	Process	1
No	MLIU denominator with significant volume	L1-265	Housing Assessment for Individuals with Schizophrenia	Process	1
No	MLIU denominator with significant volume	L1-268	Pneumonia vaccination status for older adults	Immunization	1
No	MLIU denominator with significant volume	L1-269	Preventive Care and Screening: Influenza Immunization	Immunization	1
No	MLIU denominator with significant volume	L1-271	Immunization for Adolescents	Immunization	1
No	MLIU denominator with significant volume	L1-272	Adults (18+ years) Immunization status	Immunization	1

Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-280	Chlamydia Screening in Women (CHL)	Process	1
No	MLIU denominator with significant volume	L1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	Process	1
No	MLIU denominator with significant volume	L1-343	Syphilis positive screening rates	Process	1
No	MLIU denominator with significant volume	L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-345	Gonorrhea Positive Screening Rates	Process	1
No	MLIU denominator with significant volume	L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	Clinical Outcome	3
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	1

Total points from Standard Menu:	**20**

LHD "Grandfathered" DY6 P4P Measures

You do not have any ''grandfathered'' measures for DY9-DY10.

Total overall selected points:	**20**

You have met the minimum selection requirements.

You have selected enough measures to meet or exceed your organization's MPT.

Are you finished making your selections?

Yes

Section 4: Measure Exemption Requests

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.

No new bundles/measures were selected for DY9-DY10, therefore this section is not applicable

DY9-10 Provider RHP Plan Update Template - Category C Related Strategies

Progress Tracker

Section 1: Related Strategies	Complete

Performing Provider Information

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

Section 1: Related Strategies

Instructions: The following Related Strategies Lists are associated with the DY9-10 Measure Bundle/measure selections you made in the "Category C Selection" tab. To complete this section, two reporting indications regarding the strategy's implementation (e.g., Implementation Date and Implementation Status) must be made for all of the individual Related Strategies within each of the required Lists.

Of note, if "Before DSRIP; DY1-6; or DY7-8" is selected for "Implementation Date", then the options for "Implementation Status" will automatically be restricted to "Implemented in small scale; Implemented throughout system; or Implemented then discontinued". If instead, "Planned for DY9-10" is selected for "Implementation Date", then the option for "Implementation Status" will automatically select "Not yet implemented". If instead, "Not applicable" is selected for "Implementation Date", then the option for "Implementation Status" will automatically select "Not applicable".

Related Strategies			Related Strategies Lists					
			L1-103, 115, 210, 105, 107, 147, 186, 268, 269, 272, 280, 343, 344, 345, 346, 347, 207		L1-235		L1-224, 225, 227, 231	
			Adult Primary Care Prevention and Chronic Disease Management (LHD)		Maternal Care and Safety (LHD)		Dental Care (LHD)	
Related Strategies ID	Related Strategies Description	Related Strategies Theme	Implementation Date	Implementation Status	Implementation Date	Implementation Status	Implementation Date	Implementation Status
1.00	Same-day and/or walk-in appointments in the outpatient setting	Access to Care	DY1-6	Implemented in small scale	Not applicable	Not applicable	Before DSRIP	Implemented in small scale
1.01	Night and/or weekend appointments in the outpatient setting	Access to Care	DY1-6	Implemented in small scale	Not applicable	Not applicable	Not applicable	Not applicable
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting	Access to Care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider	Access to Care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)	Access to Care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting	Access to Care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist	Access to Care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)	Access to Care	DY1-6	Implemented in small scale	Not applicable	Not applicable	Before DSRIP	Implemented in small scale
1.40	Integration or co-location of primary care and dental services in the outpatient setting	Access to Care					Not applicable	Not applicable
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist	Access to Care					Not applicable	Not applicable
2.00	Culturally and linguistically appropriate care planning for patients	Care Coordination	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)	Care Coordination	Before DSRIP	Implemented in small scale	Not applicable	Not applicable	Before DSRIP	Implemented throughout system
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)	Care Coordination	DY1-6	Implemented in small scale	Before DSRIP	Implemented throughout system	DY1-6	Implemented throughout system
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)	Care Coordination	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)	Care Coordination	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.	Care Coordination	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified	Care Coordination	Planned for DY9-10	Not yet implemented	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented in small scale
2.30	Formal closed loop process for scheduling referral visits as needed	Care Coordination	DY1-6	Implemented in small scale	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented in small scale
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data	Care Coordination	Not applicable	Not applicable	Not applicable	Not applicable	Planned for DY9-10	Not yet implemented
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records	Care Coordination	DY1-6	Implemented in small scale	Not applicable	Not applicable	DY1-6	Implemented in small scale
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records	Care Coordination	Not applicable	Not applicable	Not applicable	Not applicable	DY1-6	Implemented in small scale

3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)	Data Analytics	DY1-6	Implemented in small scale	Not applicable	Not applicable	Not applicable	Not applicable
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)	Data Analytics	DY1-6	Implemented in small scale	Not applicable	Not applicable	Not applicable	Not applicable
3.10	Database or registry to track quality and clinical outcomes data on patients	Data Analytics	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system
3.20	Analysis of appointment "no-show" rates	Data Analytics	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc.	Data Analytics					Planned for DY9-10	Not yet implemented
4.00	Care team includes a clinical pharmacist(s)	Disease Management	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.	Disease Management	Not applicable	Not applicable	DY1-6	Implemented throughout system	Not applicable	Not applicable
4.02	Care team includes a registered dietician(s)	Disease Management	DY1-6	Implemented in small scale	Before DSRIP	Implemented in small scale	Not applicable	Not applicable
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences	Disease Management	DY1-6	Implemented in small scale	Not applicable	Not applicable	Not applicable	Not applicable
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)	Disease Management	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented throughout system	Not applicable	Not applicable
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)	Disease Management	DY1-6	Implemented in small scale	Before DSRIP	Implemented throughout system	Not applicable	Not applicable
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking	Disease Management	DY1-6	Implemented in small scale	Before DSRIP	Implemented in small scale	Not applicable	Not applicable
4.32	Classes for patients focused on physical activity	Disease Management	DY1-6	Implemented in small scale	Planned for DY9-10	Not yet implemented	Not applicable	Not applicable
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)	Disease Management	DY1-6	Implemented in small scale	Not applicable	Not applicable	Not applicable	Not applicable
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence	Disease Management	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)	Disease Management	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place	Disease Management			Not applicable	Not applicable		
5.00	Screening patients for food insecurity	Social Determinants of Health	DY1-6	Implemented in small scale	Before DSRIP	Implemented throughout system	Not applicable	Not applicable
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)	Social Determinants of Health	DY1-6	Implemented in small scale	Before DSRIP	Implemented throughout system	Not applicable	Not applicable
5.10	Screening patients for housing needs	Social Determinants of Health	DY7-8	Implemented in small scale	Before DSRIP	Implemented in small scale	Not applicable	Not applicable
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)	Social Determinants of Health	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
5.12	Screening patients for housing quality needs	Social Determinants of Health	Not applicable	Not applicable	Planned for DY9-10	Not yet implemented	Not applicable	Not applicable
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)	Social Determinants of Health	Not applicable	Not applicable	Planned for DY9-10	Not yet implemented	Not applicable	Not applicable
5.20	Screening patients for transportation needs	Social Determinants of Health	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented in small scale
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)	Social Determinants of Health	DY1-6	Implemented in small scale	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented in small scale
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.)	Social Determinants of Health					Not applicable	Not applicable

DY9-10 Provider RHP Plan Update Template - Category A Core Activities

Progress Tracker

Section 1: Core Activities	Complete
All Selected Measure Bundles/Measures Associated with at Least One Core Activity	Complete

Performing Provider Information

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

Section 1: Core Activities

Previous Core Activities

Core Activity #1

Do you want to edit or delete this Core Activity? Edit

Please explain the changes made to the Core Activity and why it was changed

City of Houston ran five dental clinics between 10/1/2018 and 9/30/2019, not four clinics as prevsioulsy stated. They are Sunnyside, La Nueva Casa de Amigos Dental Clinic, Northside, Sharpstown, and Magnolia Dental Clinic.

1) Please select the grouping for this Core Activity.

Expansion or Enhancement of Oral Health Services

a) Please select the name of this Core Activity.

Expanded use of existing dental clinics for underserved population

b) Please enter a description of this Core Activity

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

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

Increase awareness on the general knowledge of oral health, importance of oral health and self-efficacy

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

Outreach to vulnerable populations through schools and community events

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

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

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

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

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

Increase clinic capacity to meet the expansion needs

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

Formalize partnership for workforce development with community stakeholders and dental providers

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

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

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

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

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

Increase patient recall to ensure clients are meeting suggested dental care guidelines

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

Ensure clients are scheduled and seen every six months for routine cleanings/examinations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L1-225	L1-224		

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

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

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

No

Core Activity #2

Do you want to edit or delete this Core Activity? No

2) Please select the grouping for this Core Activity.

Access to Primary Care Services

a) Please select the name of this Core Activity.

Provision of screening and follow up services

b) Please enter a description of this Core Activity

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

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

Increase compliance for post-partum care for women seen in home-visitation

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

Strengthen relationships with providers to get glucose screenings

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

Establish partnerships with behavioral health providers

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

Assist clients with securing a payer source for primary care services

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

Ensure timeliness of follow-up for post-partum mothers

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

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

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

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

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

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

Connect clients to care coordination group for service linkage

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

Standardize tobacco cessation counseling in clinic setting

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

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

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

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

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

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

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

Provide education to clients on healthy sexual practices

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

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

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

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

Continue standardized STD screening processes for clients accessing services

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

Increase clinic capacity to screen population accessing services

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

QA to ensure clients are being appropriately screened

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No

Core Activity #3

Do you want to edit or delete this Core Activity? No

3) Please select the grouping for this Core Activity.

Chronic Care Management

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

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

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

Increase 3HP enrollment of clients targeted for treatment

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

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

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

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

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

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

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

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

Increase clincial evaluation of clients targeted for treatment

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

Provide transportation for clinical appointment for potential clients

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

Provide translational services to clients trageted for treatment

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

Provide education on the importance of clinical evaluations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L1-347			

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

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

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

No

Core Activity #4

Do you want to edit or delete this Core Activity? Edit

Please explain the changes made to the Core Activity and why it was changed

A second secondary driver was added to focus on the internal referral process from other HHD programs to the HHD Care Coordination program. Care Coordination can offer clients additional resources on health coverage and help link clients to a medical home or primary care physician if needed.

4) Please select the grouping for this Core Activity.

Access to Primary Care Services

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

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

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

Increase primary care access for clients without medical homes

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

Establish new partnerships with primary care providers

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

Enhance ongoing relationships with referring providers and PCPs

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

Enhance bi-directional referral protocol with providers

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

Standardize the referral processes to and from providers

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

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

Establish partnership with local Care Navigation teams (e.g. Links, Connect)

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

Enhance bidirectional referral protocols for individuals with pre-diabetes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L1-115	L1-207		

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

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

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

No

Core Activity #5

Do you want to edit or delete this Core Activity? Edit

Please explain the changes made to the Core Activity and why it was changed

Some change ideas under the first secondary driver were not able to be carried out due to decreases in personnel capacity -- specifically, the Conversation Series and in-house tools were not implemented during the measurement period.

5) Please select the grouping for this Core Activity.

Prevention and Wellness

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

Provide chronic disease and diabetes self-management education and other behavior-change based

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

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

Expansion of educational services offered by the local health department

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

Develop and update BP, abnormal BMI, tobacco cessation and prevention activities

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

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

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

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

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

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

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

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

Offer tobacco cessation counseling and follow-up to clients

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

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

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

Promotion of internal services offered and link to Health Education

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

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

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

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

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

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

Monitor blood pressure from all diabetic clients we engage

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

Offer medication adherance education to participants

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

Implement self-monitoring blood pressure curriculum

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

Capture HbA1c from all diabetic and pre-diabetic clients

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

Provide chronic disease self-management educational sessions and trainings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No

Core Activity #6

Do you want to edit or delete this Core Activity? No

6) Please select the grouping for this Core Activity.

Expansion of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

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

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

Offer referrals for pre-hypertensive and hypertensive clients

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

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

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

Promotion of internal services offered and link to Health Education

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

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

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

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

Offer referrals for BMIs that are outside of normal parameters

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

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

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

Promotion of internal services offered and link to Health Education

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

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

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

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

Effectiveness of Care Coordination Services offered to clients

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

Ensure staff has/completes Community Health Worker Certification

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

Training in Patient Navigation and specific subject matters

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

Develop curriculum for continuing education for staff in care coordination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L1-105	L1-147	L1-210	

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

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

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

No

New Core Activities

Please enter your organization's number of new Core Activities to add: 0

DY9-10 Provider RHP Plan Update Template - DSRIP Valuation Summary

Performing Provider Information

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

Section 1: Valuation by Category and Measure

Category / Measure / Measure Bundle Item:	DY9	DY10
Category B - MLIU PPP	**$3,556,431.19**	**$3,033,818.17**
L1-105	$2,667,323.39	$2,275,363.63
L1-115	$2,667,323.39	$2,275,363.63
L1-147	$2,667,323.39	$2,275,363.63
L1-207	$2,667,323.39	$2,275,363.63
L1-210	$2,667,323.39	$2,275,363.63
L1-224	$2,667,323.39	$2,275,363.63
L1-225	$2,667,323.39	$2,275,363.63
L1-235	$2,667,323.39	$2,275,363.63
L1-280	$2,667,323.39	$2,275,363.63
L1-347	$2,667,323.40	$2,275,363.62
L1 Total	**$26,673,233.91**	**$22,753,636.29**
Category C Total:	**$26,673,233.91**	**$22,753,636.29**
Time Since Routine Checkup	$762,092.40	$650,103.89
High Blood Pressure Status	$762,092.40	$650,103.89
Diabetes Status	$762,092.40	$650,103.89
Overweight or Obese	$762,092.40	$650,103.89
Smoker Status	$762,092.40	$650,103.89
Selected Immunizations	$762,092.40	$650,103.89
Prevention of Sexually Transmitted Diseases	$762,092.38	$650,103.92
Category D Total:	**$5,334,646.78**	**$4,550,727.26**
DSRIP Total	**$35,564,311.88**	**$30,338,181.72**

Section 2: Category C Milestone Valuation

Bundle-Measure ID	Denominator Volume	DY9 Category C Valuation: $26,673,233.91							DY10 Category C Valuation: $22,753,636.29					
		DY9 Measure Total	*DY9 Milestone IDs*						DY10 Measure Total	*DY10 Milestone IDs*				
			RM-1.B	RM-4	AM-9.1	AM-9.2	AM-9.3	IM-3		RM-5	AM-10.1	AM-10.2	AM-10.3	IM-4
L1-105	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-115	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-147	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-207	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-210	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-224	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-225	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-235	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00
L1-280	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.39	$0.00	$666,830.85	$2,000,492.54	$0.00	$0.00	$0.00	$2,275,363.63	$568,840.91	$1,706,522.72	$0.00	$0.00	$0.00

L1-347	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$2,667,323.40	$0.00	$666,830.85	$2,000,492.55	$0.00	$0.00	$0.00	$2,275,363.62	$568,840.91	$1,706,522.71	$0.00	$0.00	$0.00

DY9-10 Provider RHP Plan Update Template - IGT Entry

Progress Tracker

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

Performing Provider Information

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

Section 1: IGT Entities

In order to delete an existing IGT, delete the name of the IGT from cell F21, F29, etc.

IGT RHP	IGT Name	IGT TPI (if available)	IGT TIN	Affiliation Number
3	City of Houston	093774008	17460011640002	100-13-0000-00134

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Jimmie Ng	8000 N. Stadium Dr.	Houston	77054	Jimmie.Ng@houstontx.gov	838-393-5011		Both
2	Judy Harris	8000 N. Stadium Dr.	Houston	77054	Judy.Harris@houstontx.gov	832-393-4345		Both
3	William Bryant	8000 N. Stadium Dr.	Houston	77054	william.bryant@houstontx.gov	832-393-4612		Both

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

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

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

Section 2: IGT Funding

Funding Category	IGT Name	IGT TIN	IGT Affiliation #	DY9 % IGT Allocated	DY10 % IGT Allocated	Total Estimated DY9 Allocation (FMAP 60.89/IGT 39.11)	Total Estimated DY10 Allocation (FMAP 60.89/IGT 39.11)
Category B	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,390,920.24	$1,186,526.29
L1-105	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-115	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-147	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-207	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-210	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-224	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-225	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-235	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-280	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.72
L1-347	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$1,043,190.18	$889,894.71
Category D	City of Houston	17460011640002	100-13-0000-00134	100.00%	100.00%	$2,086,380.36	$1,779,789.43
Total						$13,909,202.38	$11,865,262.87

Your funding allocations sum to 100%.

Have the IGT Entities and funding percentages been reviewed and updated as needed?	Yes

Section 3: Certification

By my signature below, I certify the following facts:
- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document.

Name:	Judy Harris
IGT Organization:	City of Houston
Date:	11/14/2019

DY9-10 Provider RHP Plan Update Template -Summary and Certification

Progress Tracker

Section 1: DY9-10 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	Complete
Section 6: Certification	Complete

Performing Provider Information

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

Section 1: DY9-10 DSRIP Valuation

	DY9-10 DSRIP Valuation Distribution	
	DY9	DY10
Category A	$0.00	$0.00
Category B	$3,556,431.19	$3,033,818.17
Category C	$26,673,233.91	$22,753,636.29
Category D	$5,334,646.78	$4,550,727.26
Total	$35,564,311.88	$30,338,181.72

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)

Did provider request a modification to the System Definition for DY9-10?	Yes

	Forecasted Medicaid	Forecasted LIU	MLIU PPP	Total PPP	MLIU Percentage of Total PPP	Allowable Variation %
DY9 Estimated	8,699	30,762	39,461	41,401	95.31%	2.00%
DY10 Estimated	8,699	30,762	39,461	41,401	95.31%	2.00%

Did provider request a modification to MLIU PPP for DY9-10?	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

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	DY9 Valuation	DY10 Valuation
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0	0	0	1	$2,667,323.39	$2,275,363.63
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0	0	0	3	$2,667,323.39	$2,275,363.63
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0	0	0	1	$2,667,323.39	$2,275,363.63
L1-207	Diabetes care: BP control (<140/90mm Hg)	0	0	0	3	$2,667,323.39	$2,275,363.63
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	0	0	0	1	$2,667,323.39	$2,275,363.63
L1-224	Dental Sealant: Children	0	0	0	1	$2,667,323.39	$2,275,363.63
L1-225	Dental Caries: Children	0	0	0	3	$2,667,323.39	$2,275,363.63
L1-235	Post-Partum Follow-Up and Care Coordination	0	0	0	3	$2,667,323.39	$2,275,363.63
L1-280	Chlamydia Screening in Women (CHL)	0	0	0	1	$2,667,323.39	$2,275,363.63
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	0	0	0	3	$2,667,323.40	$2,275,363.62
Total	N/A	0	0	0	20	$26,673,233.91	$22,753,636.29

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	Provision of screening and follow up services; 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)
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Establishment of care coordination and active referral management that integrates information from referrals into the plan of care; Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Provision of screening and follow up services; Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions; 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)
L1-207	Diabetes care: BP control (<140/90mm Hg)	Establishment of care coordination and active referral management that integrates information from referrals into the plan of care; Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Provision of screening and follow up services; Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions; 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)
L1-224	Dental Sealant: Children	Expanded use of existing dental clinics for underserved population
L1-225	Dental Caries: Children	Expanded use of existing dental clinics for underserved population
L1-235	Post-Partum Follow-Up and Care Coordination	Provision of screening and follow up services
L1-280	Chlamydia Screening in Women (CHL)	Provision of screening and follow up services
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Management of targeted patient populations; e.g., chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services

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

Statewide Reporting for LHDs

Measure	Category D DY9 Valuation	Category D DY10 Valuation
Time Since Routine Checkup	$762,092.40	$650,103.89
High Blood Pressure Status	$762,092.40	$650,103.89
Diabetes Status	$762,092.40	$650,103.89
Overweight or Obese	$762,092.40	$650,103.89
Smoker Status	$762,092.40	$650,103.89
Selected Immunizations	$762,092.40	$650,103.89
Prevention of Sexually Transmitted Diseases	$762,092.40	$650,103.89

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.

Yes

Section 6: Certification

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

Name:	Judy Harris
Performing Provider:	City of Houston
Date:	11/14/2019

DY9-10 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: DY9-10 Total Valuation and Updated Minimum Point Threshold (MPT)	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 Measures for Local Health Departments	Complete
Section 3: Selection Overview	Complete
Section 4: Measure Exemption Requests	Complete
Minimum Selection Requirements Met	Yes
MPT Met	Yes

Category C Related Strategies	
Section 1: Related Strategies	Complete

Category A Core Activities	
Section 1: Core Activities	Complete
All Selected Measure Bundles/Measures Associated with at Least One Core Activity	Complete

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

Summary and Certification	
Section 1: DY9-10 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	Complete
Section 6: Certification	Complete