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	Status
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

Field	Value			
RHP:	3			
TPI and Performing Provider Name:	158771901 - Harris County			
Performing Provider Type:	Local Health Department (LHD)			
Ownership:	Non-State Owned Public			
TIN:	17604545149159			
Physical Street Address:	2223 W Loop S Ste 7000			
City:	Houston			
Zip:	77027			
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:	Les Becker	Umair Shah	William Hudson
Street Address:	2223 W Loop S Ste 7000	2223 W Loop S Ste 7000	7457 Harwin Dr
City:	Houston	Houston	Houston
Zip:	77027	77027	77036
Email:	lbecker@hcphes.org	ushah@hcphes.org	whudson@hcphes.org
Phone Number:	713-439-6004	713-439-6016	713-274-8506
Phone Extension:			
Lead Contact or Both:	Both	Lead Contact	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:	Harris County Public Health & Environmental Services (HCPHES) is a comprehensive local health department serving the third most populous county in the United States. It spans over 1700 square miles, and its land area is larger than the state of Rhode Island. The HCPHES jurisdiction includes approximately 2 million people within Harris County's unincorporated areas and over 30 small municipalities located in Harris County (not including the city of Houston). For certain public health services such as vector/mosquito control, Ryan White/Title I HIV funding, and refugee health screening, the HCPHES jurisdiction encompasses the entire county including the city of Houston, therefore providing services to over 4 million people in total. Since being chartered in 1942 by Harris County Commissioners Court, HCPHES has provided leadership in a wide range of public health activities and programming including but not limited to communicable disease control; veterinary and environmental public health; and clinical preventive services. These services include strong programming in immunizations, oral health, tuberculosis prevention & treatment, and nutrition/wellness through a variety of efforts including the HCPHES Women, Infants, & Children (WIC) program. Across this broad organizational framework, HCPHES has engaged in significant departmental strategic planning activities, including the development of the HCPHES Strategic Plan 2013-2018 which is grounded in the "Essential Public Health Services" model (e.g., assessment, policy development and education, and assurance activities). These categories allow HCPHES to engage within a variety of public health sectors including the services provided through its clinical programs. The mission statement of HCPHES is "Promoting a Healthy and Safe Community, Preventing Illness and Injury, Protecting You, HCPHES, Your Department for Life" while its clear vision is "Healthy People, Healthy Communities ... a Healthy Harris County." The HCPHES staff (over 700) are public health professionals in the truest sense of the word and have a broad range of expertise in various public health program areas. HCPHES staff pride themselves in upholding the organizational values which they helped to craft: Excellence, Compassion, Flexibility, Integrity, Accountability, Professionalism, and Equity. With a current annual operating budget of $100 million, HCPHES is organized into three offices that apply specific skills broadly across all public health activities (Communication Education and Engagement, Policy and Planning, and Public Health Preparedness & Response); five divisions that focus on specific programmatic disciplines (Disease Control & Clinical Prevention, Environmental Public Health, Mosquito Control, Nutrition and Chronic Disease Prevention and Veterinary Public Health); and a state-of-the-art Operations & Finance Division that manages its business infrastructure (e.g. financial services, information technology, human resources, etc.). HCPHES is highly regarded both nationally and state-wide for its continued leadership in the field of public health and is well-positioned as a model agency for public health services in the local community.

Overall DSRIP Goals:	• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay. • Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system • Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Alignment with regional community needs assessment:	The HCPHES clinical care system has over 40 years of experience in providing quality, cost-effective preventive clinical services to the Harris County community. Thus, HCPHES has been considered a trusted leader in public health service provision in the community for several decades. HCPHES views its role similar to the Institute of Medicine definition of public health, " ... to assure the conditions in which people can be healthy." HCPHES focuses on population-based approaches to meeting the public health needs of the Harris County community. HCPHES- similar to other local health departments across the country- often thus serves as the "safety net" provider to many community members who may not have any other way of receiving needed health services. Safety net issues are thus taken into consideration during HCPHES policy deliberations. As a safety net provider and local health department for the unincorporated areas of Harris County and for certain public health services such as vector/mosquito control, Ryan White/Title I HIV funding, and refugee health screening, the HCPHES system encounters first hand core regional issues outlined in the most recent Regional Community Health Needs Assessment. Insufficient Access to Care and Inadequate Transportation options have long been an issue facing residence in unincorporated areas of Harris County. Lack of access to reliable and affordable transportation is a challenge that Harris County residents encounter while seeking healthcare services. Issues with transportation lead to missed or rescheduled appointments and lack of any future attempt to seek care. In order to mitigate this issue and address the goal of Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay. HCPHES plans to continue to leverage the expanded reach of the mobile health clinic to provide prescreen eligibility, insurance enrollment assistance, direct service, educational and clinical outreach activities to those residents without immediate access to care. Additional HCPHES will continue to forge its mission to “bring public health to the public” through the continuation and expansion of school and community based medical, dental, and health education services, as well as expansion of technological improvements such as tele-health interventions. Developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, will further address access to care issues, as well as make it easier for providers to address the diverse populations with varying culture and socio-economic backgrounds. Moreover, for services not provided directly to clients, HCPHES partners with other governmental and community based agencies to assist in bridging the gap for the provision of comprehensive health services to Harris County residents. However the scope of the challenge is great with approximately 28% of Harris County residents lacking adequate health insurance. These collaborations have been both deliberative and strategic in nature. As a local health department, HCPHES focuses on population- based approaches to meet the public health needs of the community. Through an

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

Initial DY9 DSRIP Valuation	Initial DY10 DSRIP Valuation	Initial DY9-10 MPT
$8,328,373.44	$7,104,529.61	14

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:	
No	$7,249,999.99	14	<-- Note: This is your current MPT
No	$7,749,999.99	15	
No	$8,249,999.99	16	
No	$8,749,999.99	17	
No	$9,249,999.99	18	
No	$9,749,999.99	19	
Yes	$10,249,999.99	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%	$832,837.34	$710,452.96
Category C	75%	$6,246,280.08	$5,328,397.21
Category D	15%	$1,249,256.02	$1,065,679.44
Total	100%	$8,328,373.44	$7,104,529.61

Original MPT:	14
Adjusted MPT based on updated valuation:	14

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:	158771901 - Harris County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category B valuation in DY9:	$832,837.34
Category B valuation in DY10:	$710,452.96

Section 1: System Definition

Would you like to modify the System Definition?

No

Local Health Departments - Required Components

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

Please enter a description of this System Component.

Harris County Public Health operates three grant based community clinics (Listed Below). Clinics are non-primary care, offering preventative wellness interventions, screenings, assessments, and education. Services include, DSHS Family planning, Title X reproductive health, and Title V dental services (Only provided at 1.5 clinics). In addition HCPH operates one refugee health screening, and one TB chest clinic (Listed below).

Community Clinics

Baytown Health Clinic
1000 Lee Drive
Baytown, Texas 77520

Baytown, Texas 77520

Humble Health Clinic
1730 Humble Place Drive
Humble, Texas 77338

Southeast Health Clinic
3737 Red Bluff
Pasadena, Texas 77503

Dental Clinics

Humble Dental Clinic
1730 Humble Place Drive
Humble, Texas 77338

Southeast Dental Clinic
3737 Red Bluff

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

Please enter a description of this System Component.

Immunizations are provided at the three Harris County community based clinics and Refugee Health Clinic
Community Clinics

Baytown Health Clinic
1000 Lee Drive
Baytown, Texas 77520

Humble Health Clinic
1730 Humble Place Drive
Humble, Texas 77338

Southeast Health Clinic
3737 Red Bluff
Pasadena, Texas 77503

Refugee Health

Refugee Outreach Center
7447 Harwin Drive
Houston, Texas 77036

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.

Waiver 1.0 made way for Harris County Public Health to break away from the fixed clinical establishment, and take essential wellness educations and screenings outside the fixed structure and into the community. The mobile outreach team is comprised of the following programs (Childhood Obesity Reduction, Tobacco Counseling, Mobile Health, Child school-based Dental Screenings, Lead poisoning education). HCPH made heavy investments in mobile outreach through the purchase of one medical specialty unit and one dental specialty unit. Both to allow for expansion of service offerings.

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

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

	DY7	DY8
MLIU PPP	36,775	28,340
Total PPP	37,913	29,641

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	8,502
Estimated Low-income or Uninsured Individuals served in DY7	19,838
Estimated Medicaid individuals served in DY8	8,502
Estimated Low-income or Uninsured Individuals served in DY8	19,838
MLIU PPP Goal for each DY (DY9 and DY10):	28,340
Forecasted Medicaid individuals served in each DY for DY9-10	8,502
Forecasted Low-income or Uninsured individuals served in each DY for DY9-10	19,838
Average Total PPP in each DY	29,641
MLIU percentage of Total PPP	95.61%
Allowable Variation	2.78%

*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

		Note: you must confirm selections at the bottom of the page to finish.		
			MPT	14
Section 2: Selection of Measures for Local Health Departments	Complete		Points Selected	18
Section 3: Selection Overview	Complete		Measures Selected	16
Section 4: Measure Exemption Requests	Complete		Maximum Deletions Met	Y
Minimum Selection Requirements Met	Yes		Clinical Outcome Selected	Y
MPT Met	Yes		At least 2 measures selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	158771901 - Harris County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category C valuation in DY9:	$6,246,280.08
Category C valuation in DY10:	$5,328,397.21

MINIMUM POINT THRESHOLD (MPT): 14

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
No	MLIU denominator with significant volume	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
No	MLIU denominator with significant volume	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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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
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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-268	Pneumonia vaccination status for older adults	Immunization	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-269	Preventive Care and Screening: Influenza Immunization	Immunization	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-271	Immunization for Adolescents	Immunization	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	L1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	1

Total points from Standard Menu:	16

LHD "Grandfathered" DY6 P4P Measures

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

Continue Measure (Yes/No)	*Measure ID & Title*	*Measure Class*	*DY9-10 Point Value*
Yes	L1-IT-7.11 - Utilization of Services: Children	Process	1
Yes	L1-IT-8.23 - Children and Adolescents' Access to Primary Care Practitioners (CAP)	Process	1

Total points from "grandfathered" menu:	2

Total overall selected points:	**18**

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:	158771901 - Harris County
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		L1-108, 211, 237, 271, 400		L1-224, 225, 227, 231	
			Adult Primary Care Prevention and Chronic Disease Management (LHD)		Pediatric Primary Care (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	Before DSRIP	Implemented throughout system	Before DSRIP	Implemented throughout system	Not applicable	Not applicable
1.01	Night and/or weekend appointments in the outpatient setting	Access to Care	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting	Access to Care	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	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 throughout system	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system
1.40	Integration or co-location of primary care and dental services in the outpatient setting	Access to Care					Planned for DY9-10	Not yet implemented
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist	Access to Care					Planned for DY9-10	Not yet implemented
2.00	Culturally and linguistically appropriate care planning for patients	Care Coordination	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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 throughout system	Before DSRIP	Implemented throughout system	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
2.30	Formal closed loop process for scheduling referral visits as needed	Care Coordination	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data	Care Coordination	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	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	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care	Care Coordination			Not applicable	Not applicable		

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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
3.10	Database or registry to track quality and clinical outcomes data on patients	Data Analytics	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
3.20	Analysis of appointment "no-show" rates	Data Analytics	DY7-8	Implemented throughout system	DY7-8	Implemented throughout system	DY7-8	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			DY1-6	Implemented throughout system	DY1-6	Implemented in small scale
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
4.02	Care team includes a registered dietician(s)	Disease Management	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)	Disease Management	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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 throughout system	DY1-6	Implemented throughout system	Planned for DY9-10	Not yet implemented
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking	Disease Management	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system	Planned for DY9-10	Not yet implemented
4.32	Classes for patients focused on physical activity	Disease Management	DY1-6	Implemented throughout system	DY1-6	Implemented throughout system	Not applicable	Not applicable
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)	Disease Management	DY1-6	Implemented throughout system	DY1-6	Implemented in small scale	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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	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
5.00	Screening patients for food insecurity	Social Determinants of Health	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	DY7-8	Implemented throughout system	DY7-8	Implemented throughout system	Planned for DY9-10	Not yet implemented
5.10	Screening patients for housing needs	Social Determinants of Health	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
5.12	Screening patients for housing quality needs	Social Determinants of Health	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Before DSRIP	Implemented throughout system	Planned for DY9-10	Not yet implemented
5.20	Screening patients for transportation needs	Social Determinants of Health	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented	Planned for DY9-10	Not yet implemented
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			DY1-6	Implemented throughout system	DY1-6	Implemented throughout system

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:	158771901 - Harris County
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? No

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.

Expansion of school based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.

b) Please enter a description of this Core Activity

HCPHES proposes to expand its current oral health outreach and treatment services in a focused effort to provide preventive dental screenings and fluoride varnishes, oral health education, and navigator-assisted referrals to community dental providers, including clinic-based HCPHES dental services. HCPHES staff will cultivate relationships with target schools, school districts, and community organizations to implement a school-based dental assessment and fluoride varnish program to deliver services directly to children where they attend school or congregate. The targeted population for this project is lower income individuals and the project will use the proportion of free and/or reduced lunch students as a proxy measure to identify where project impacts will be most beneficial. The oral health prevention team will be staffed by dental hygienists, dental assistants, community health workers, and program administrators. The proposed project will endeavor to deliver oral health assessments and fluoride treatments twice per school year, reinforced by educational activities and client follow-up. Oral health screenings will consist of inspections for tooth decay, assessment of early periodontal disease (gingivitis), and

consist of inspections for tooth decay, assessment of early periodontal disease (gingivitis), and physical and visual oral cancer screenings. During the summer months, when schools are not in session, project staff will evaluate findings, coordinate future school-based programming, and coordinate community events to larger audiences. HCPHES has seen year over year growth with the expansion and depth of the school based oral health program. It is expected that by the end of 2018, HCPHES will have the program established in 25-30 low income schools through out the HCPHES jursidication, in addition to expanding to low- income after school programs and daycare centers. As the program enlarges the expectation is to add additional dental clinicians to meet the need. Currently the activities utilizes one supervising licensed dentist, four hygentist, and a host of community health workers and project assistants across 15 school based sites and various low income daycare center sites.

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

The utilization of Community Health Workers to aid in partnership development and case management.

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

Community Health Workers (CHW) will be an integral component of the project and will be utilized to strengthen relationships with schools and communities, assist in event planning logistics, and most importantly, provide navigation and referral services to participants to guide them to additional preventive and treatment options. CHW will follow-up with clients following each assessment to evaluate their progress and offer guidance and navigation to the next level of care, as applicable. CHW will have a demonstrated presence in this project and are well suited to interact with community partners and project participants to ensure the project is administered in a way that is culturally and linguistically appropriate to the targeted population.

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).

HCPHES will utilize a stage gate approach in applying project management best practices in implementing the youth dental program specifically utilizing a phased release process over the lifecycle of the program.

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

In each stage gate we will focus on continuous stakeholder feedback from various data collection points including iterative reviews of lessons learned captured from project deliverables in remediating any future challenges and/or risks. In addition, given the majority of the population we serve are Medicaid/low income uninsured individuals, our program will be tailored to overcome the unique challenges/barriers that may exist such as transportation, communication, availability, and location.

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.

L1-231			

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

Through the expansion and continuation of this core activity HCPHES will be able to provide essential preventative oral health services to MLIU students with in the HCPHES jurisdiction and ensure they are provided with a first line of defense against tooth decay and childhood carries, in addition to navigating the MLIU students to an appropriate dental home.

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.

Other

i) Please enter the name of this "Other" grouping.

Expansion of preventative health screenings and vaccinations to underserved population

a) Please select the name of this Core Activity.

Other

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

Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.

b) Please enter a description of this Core Activity

HCPHES plans to continue mobile health services to targeted Harris County communities by providing immunizations, health and wellness screenings, health promotion/education activities, while also enrolling individuals and their families into private and public health insurance programs, and guide participants to additional care, as appropriate. The project will capitalize on relationships with community partners, old and new, to plan and implement community events that draw in residents that may not have access to basic health screenings and prevention. HCPHES has expanded the clinical provider base with the addition of one full-time chronic disease physician, and one part time family nurse practitioner, supported by a knowledgeable clinical support staff (RN, LVN, MA, and registration specialist). IN the last demonstration year the mobile health team conducted over 140 unique screening and wellness events through out the HCPHES jurisdiction, in addition to maintaining immunization and screening activities in three community fixed sites and a refugee health program. With provisions and incentive payments captured through waiver 1.0 HCPHES has been able to purchase a two opertory medical coach to provide direct service in underserved communities to mitigate access to care issues caused by transportation and resource limitations.

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

Optimize the use and accessibility of mobile screening and vaccination clinics

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

A significant proportion of Harris County residents are uninsured and many lack the resources or face geographic and logistical barriers in accessing primary health care and basic health screenings. The project seeks to intervene within the HCPHES jurisdiction by delivering high quality screenings, immunizations for eligible children and adults, and track referral services offered to communities and residents directly. HCPHES plans to continue to collect and capture data related to the number of unique community/ mobile events conducted each quarter, number of unique individual impacted, and school based immunization compliance rates within targeted MLIU schools.

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).

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).

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.

L1-269	L1-271	L1-280	L1-343
L1-268	L1-272	L1-345	

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

This core activity impacts the measures seleted by removing the barriers to care identified in the most recent CHNA caused by transportation and resource deficits. This approach makes it easier for the target population to access wellness services, immunizations, STI/D screening services, preventative health education and navigation to essential resources.

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.

Prevention and Wellness

a) Please select the name of this Core Activity.

Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)

b) Please enter a description of this Core Activity

HCPHES, through the utilization of mobile and fixed clinics, will increase access to the vital services necessary to reduce childhood and adolescent obesity rates in the target communities by providing screenings, health promotion education, and a robust referral program into applicable services such as integrated care programs, primary care providers and treatment programs, as applicable. HCPHES aims to reduce childhood and adolescent obesity, which has been identified by the American Heart Association, Centers for Disease Control and Prevention, American College of Cardiology, and the National Institutes of Health along with many other health and research agencies nationally and internationally, as an elevated risk factor associated with and causing cardiovascular disease and disorders, including but not limited to, coronary heart disease, heart failure, and sudden death. Participants will be recruited through current clinical services, community-based events, and other HCPHES community-based programs. Physical locations for the proposed evidence based program sessions will be identified that best meets the needs of the participants and their families. HCPHES proposes to partner with local agencies that may also offer physical space for this initiative.

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

Optimize the use and enrollment of "at-risk" age appropriate children into the evidence based intervention.

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

Increase the number of school based intervention sites within MLIU communities to increase enrollment and program completion.

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).

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).

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.

L1-147	L1-IT-7.11	L1-210	L1-IT-8.23
L1-211			

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

This project is an ever evolving innovative step for HCPHES as an expansion of community-focused intervention aimed at reducing childhood and adolescent obesity. Prior to the launch of this intervention in waiver 1.0, previous outreach efforts consisted of the dissemination of information and program administration from fixed clinical establishments, that did not interface with a large populous of the targeted community. This project has expand services to include mobile clinical operations to meet accessibility needs, and offers additional services to the targeted population, including community based group programs, individualized exercise programs and individualized follow-up by community health workers and registered dietitians.

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? 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

HCPHES will adopt and implement a 2As and R (Ask, Advice, and Refer) tobacco intervention and deliver an evidence based group tobacco cessation program. Modified from the evidence based 5As model (Ask, Advice, Assess, Assist, Arrange), the 2As and R is a more practical program approach for clinical settings. The 2As and R is a brief tobacco intervention delivered by providers (designated clinical staff across all clinical programs) that has been shown to significantly increase the likelihood that a client will make an attempt to quit smoking/ tobacco use. The intervention will also be

delivered in community settings by community health workers and trained program facilitators (approx. 15 trained resources). HCPHES will continue to utilize the Freshstart program as a reference framework due to the programs notable outcomes. The Freshstart evidence-based approach is geared to help participants increase their motivation to quit, learn effective approaches for quitting and guide them in making a successful quit attempt.

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

Enhance the provision of tobacco prevention efforts to current/former/and would be smokers

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

Monitor the number of individuals receiving the 2A's and R intervention and enrolling into fresh start

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

Increase the number of trained fresh start facilitators.

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).

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).

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.

L1-105	L1-400		

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

The selected core activity impacts the selected measures by providing access to evidence based interventions, which have been proven to deter smoking activities and lead to positive quit attempts.

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? No

5) Please select the grouping for this Core Activity.

Access to Specialty Care Services

a) Please select the name of this Core Activity.

Use telemedicine/telehealth to deliver specialty services.

b) Please enter a description of this Core Activity

Patients will be given specially adapted cell phones and will record themselves taking each dose of medication. The video will upload automatically through a secure server and will then be downloaded and viewed at the performing providers office by an outreach worker,nurse, or mid level provider (approx. 10 dedicated resources) who can confirm the dose was taken. This process will enhance adherence by allowing the patient to take the medication at a time and in a location convenient to him/her, based on mealtime, commute schedule and work schedule. This will make it easier for the patient to complete treatment on time, with fewer missed doses, and prevent the development of drug resistance as well as hospitalization for relapse due to inadequate treatment. Service area will cover HCPH jurisdiction.

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

Provide education to patients on proper utilization of VDOT system and tools.

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

VDOT program will be evaluated for medication adherance

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).

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).

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.

The performing provider will improve adherence with treatment in the target population by implementing video-based directly observed therapy (VDOT) for qualified tuberculosis (TB) patients. This project will thereby increase the number of patients who are adequately treated for active TB disease and TB infection and ultimately decrease potentially preventable hospitalizations for tuberculosis as well as costs for treating drug-resistant TB. VDOT will be reserved for patients who have been diagnosed with TB and can spread the bacteria to others. Factoring in travel and personnel cost, patient cost is estimated at $27K to treat TB, and $130K to treat Multidrug resistant TB. According to the Verizon Foundation, the VDOT program will reduce cost by 30% to health departments using this program. The use of this program will also increase the number of patients who stick with the proper medication treatment by nearly 50%.

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:	158771901 - Harris County
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	**$832,837.34**	**$710,452.96**
L1-105	$390,392.50	$333,024.83
L1-147	$390,392.50	$333,024.83
L1-210	$390,392.50	$333,024.83
L1-211	$390,392.50	$333,024.83
L1-231	$390,392.50	$333,024.83
L1-268	$390,392.50	$333,024.83
L1-269	$390,392.50	$333,024.83
L1-271	$390,392.50	$333,024.83
L1-272	$390,392.50	$333,024.83
L1-280	$390,392.50	$333,024.83
L1-343	$390,392.50	$333,024.83
L1-345	$390,392.50	$333,024.83
L1-347	$390,392.50	$333,024.83
L1-400	$390,392.56	$333,024.76
L1 Total	**$5,465,495.06**	**$4,662,347.55**
L1-IT-7.11	$390,392.51	$333,024.83
L1-IT-8.23	$390,392.51	$333,024.83
Category C Total:	**$6,246,280.08**	**$5,328,397.21**
Time Since Routine Checkup	$178,465.15	$152,239.92
High Blood Pressure Status	$178,465.15	$152,239.92
Diabetes Status	$178,465.15	$152,239.92
Overweight or Obese	$178,465.15	$152,239.92
Smoker Status	$178,465.15	$152,239.92
Selected Immunizations	$178,465.15	$152,239.92
Prevention of Sexually Transmitted Diseases	$178,465.12	$152,239.92
Category D Total:	**$1,249,256.02**	**$1,065,679.44**
DSRIP Total	**$8,328,373.44**	**$7,104,529.61**

Section 2: Category C Milestone Valuation

		DY9 Category C Valuation: $6,246,280.08							**DY10 Category C Valuation: $5,328,397.21**					
		DY9 Measure	*DY9 Milestone IDs*						DY10 Measure	*DY10 Milestone IDs*				
Bundle-Measure ID	Denominator Volume	Total	RM-1.B	RM-4	AM-9.1	AM-9.2	AM-9.3	IM-3	Total	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)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-147	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-210	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-211	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$97,598.13	$97,598.13	$97,598.11	$0.00	$333,024.83	$83,256.21	$83,256.21	$83,256.21	$83,256.20	$0.00
L1-231	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-268	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-269	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00

L1-271	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-272	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-280	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-343	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-345	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-347	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.50	$0.00	$97,598.13	$292,794.37	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-400	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.56	$0.00	$97,598.13	$292,794.43	$0.00	$0.00	$0.00	$333,024.76	$83,256.21	$249,768.55	$0.00	$0.00	$0.00
L1-IT-7.11	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.51	$0.00	$97,598.13	$292,794.38	$0.00	$0.00	$0.00	$333,024.83	$83,256.21	$249,768.62	$0.00	$0.00	$0.00
L1-IT-8.23	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$390,392.51	$0.00	$97,598.13	$97,598.13	$97,598.13	$97,598.12	$0.00	$333,024.83	$83,256.21	$83,256.21	$83,256.21	$83,256.20	$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:	158771901 - Harris 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 F21, F29, etc.

IGT RHP	IGT Name	IGT TPI (if available)	IGT TIN	Affiliation Number
3	Harris County	158771901	17604545149159	100-14-0000-00010

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Harold Dutton	2223 West Loop South	Houston	77027	hdutton@hcphes.org	713-439-6011		Both
2	William Hudson	2223 West Loop South	Houston	77027	whudson@hcphes.org	713-439-6160		Both
3	Harold Dutton	2223 West Loop South	Houston	77027	hdutton@hcphes.org	713-439-6011		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	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$325,722.68	$277,858.15
L1-105	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-147	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-210	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-211	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-231	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-268	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-269	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-271	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-272	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-280	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-343	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-345	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-347	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-400	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.53	$130,245.98
L1-IT-7.11	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
L1-IT-8.23	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$152,682.51	$130,246.01
Category D	Harris County	17604545149159	100-14-0000-00010	100.00%	100.00%	$488,584.03	$416,787.23
Total						$3,257,226.85	$2,778,581.53

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:	Harold Dutton
IGT Organization:	Harris County
Date:	11/6/2019

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

Progress Tracker

Section	Status
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:	158771901 - Harris County
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	$832,837.34	$710,452.96
Category C	$6,246,280.08	$5,328,397.21
Category D	$1,249,256.02	$1,065,679.44
Total	$8,328,373.44	$7,104,529.61

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?	No

	Forecasted Medicaid	Forecasted LIU	MLIU PPP	Total PPP	MLIU Percentage of Total PPP	Allowable Variation %
DY9 Estimated	8,502	19,838	28,340	29,641	95.61%	2.78%
DY10 Estimated	8,502	19,838	28,340	29,641	95.61%	2.78%

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	$390,392.50	$333,024.83
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0	0	0	1	$390,392.50	$333,024.83
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	0	0	0	1	$390,392.50	$333,024.83
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0	0	0	1	$390,392.50	$333,024.83
L1-231	Preventive Services for Children at Elevated Caries Risk	0	0	0	1	$390,392.50	$333,024.83
L1-268	Pneumonia vaccination status for older adults	0	0	0	1	$390,392.50	$333,024.83
L1-269	Preventive Care and Screening: Influenza Immunization	0	0	0	1	$390,392.50	$333,024.83
L1-271	Immunization for Adolescents	0	0	0	1	$390,392.50	$333,024.83
L1-272	Adults (18+ years) Immunization status	0	0	0	1	$390,392.50	$333,024.83
L1-280	Chlamydia Screening in Women (CHL)	0	0	0	1	$390,392.50	$333,024.83
L1-343	Syphilis positive screening rates	0	0	0	1	$390,392.50	$333,024.83
L1-345	Gonorrhea Positive Screening Rates	0	0	0	1	$390,392.50	$333,024.83
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	0	0	0	3	$390,392.50	$333,024.83
L1-400	Tobacco Use and Help with Quitting Among Adolescents	0	0	0	1	$390,392.56	$333,024.76

L1-IT-7.11	Utilization of Services: Children	0	0	0	1	$390,392.51	$333,024.83
L1-IT-8.23	Children and Adolescents' Access to Primary Care Practitioners (CAP)	0	0	0	1	$390,392.51	$333,024.83
Total	N/A	0	0	0	18	$6,246,280.08	$5,328,397.21

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)
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
L1-231	Preventive Services for Children at Elevated Caries Risk	Expansion of school based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.
L1-268	Pneumonia vaccination status for older adults	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.
L1-269	Preventive Care and Screening: Influenza Immunization	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.
L1-271	Immunization for Adolescents	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.

L1-272	Adults (18+ years) Immunization status	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.
L1-280	Chlamydia Screening in Women (CHL)	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.
L1-343	Syphilis positive screening rates	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.
L1-345	Gonorrhea Positive Screening Rates	Other - Expansion of mobile community/school based preventative health screening services and vaccination services to underserved, under insured, low-income, medicaid eligible populations through partnerships with LHD's, immunization coalitions, and public/private community partnerships.
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Use telemedicine/telehealth to deliver specialty services.
L1-400	Tobacco Use and Help with Quitting Among Adolescents	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-IT-7.11	Utilization of Services: Children	Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
L1-IT-8.23	Children and Adolescents' Access to Primary Care Practitioners (CAP)	Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)

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	$178,465.15	$152,239.92
High Blood Pressure Status	$178,465.15	$152,239.92
Diabetes Status	$178,465.15	$152,239.92
Overweight or Obese	$178,465.15	$152,239.92
Smoker Status	$178,465.15	$152,239.92
Selected Immunizations	$178,465.15	$152,239.92
Prevention of Sexually Transmitted Diseases	$178,465.15	$152,239.92

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:	William Hudson
Performing Provider:	Harris County Public Health
Date:	11/6/2019

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

Category C Selection

Section	Status
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	Status
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