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:	296760601 - Fort Bend County			
Performing Provider Type:	Local Health Department (LHD)			
Ownership:	Non-State Owned Public			
TIN:	17460019692066			
Physical Street Address:	301 Jackson St., Ste 520			
City:	Richmond			
Zip:	77469			
Primary County:	Fort Bend			
Additional counties being served (optional):				

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

Section 2: Lead Contact Information

	Lead Contact 1	Lead Contact 2	Lead Contact 3
Contact Name:	Connie Almeida	Mary desVignes-Kendrick	Kaye Reynolds
Street Address:	301 Jackson St., Ste 520	4520 Reading Road, Suite A-100	4520 Reading Road, Suite A-100
City:	Richmond	Rosenberg	Rosenberg
Zip:	77469	77471	77471
Email:	connie.almeida@fortbendcountytx.gov	md.kendrick@fortbendcountytx.gov	kaye.reynolds@fortbendcountytx.gov
Phone Number:	281-238-3078	281-238-3589	281-238-3519
Phone Extension:			
Lead Contact or Both:	Both	Both	Both

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

Section 3: Optional Withdrawal From DSRIP

Please select an option below. By selecting “Yes - Withdraw from DSRIP”, this organization acknowledges it understands that any 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:	Fort Bend County Health & Human Services Department and Behavioral Health Services Department jointly created a government, community agency and private provider collaboration to improve the health outcomes of residents using innovative programs. The collaboration includes formal contractual agreements, sub-county department partnerships, and community agency referrals, shared resources and partnerships.
Overall DSRIP Goals:	The overall DSRIP goals are based on the Fort Bend County vision for health care transformation to Right Care, Right Place, Right Time. The objective is to develop a system of care, collaborated through the various community programs and agencies that identifies clients and families needing health improvement and to provide the coordinated and appropriate level of care and support, addresses social determinants of health, supports ongoing recovery and wellness, reduces episodic crisis care, incarceration and unnecessary hospitalization.
Alignment with regional community needs assessment:	Access to Care: • Expand availability and access to healthcare services including behavioral health services. • Continue to extend office hours for primary care providers to increase the number of available appointments including after hours. • Grow navigation services to help patients identify available services and programs, especially for low-income individuals. • Continue to support and develop the network of public health and social service organizations to enhance safety net services for uninsured/under-served populations. Inadequate Transportation Options for Individuals Needing Health Care Services: • Identify transportation problems within specific communities and develop local solutions Chronic Disease and Poor Health: • Proactively identify barriers to self-management of chronic diseases and behavioral health conditions such as appropriate access to care, obtaining prescriptions and maintaining long term medication adherence (such as affordability or access to a local pharmacy). Develop solutions to increase access to the right level of care and support, improve medication adherence, which will lead to improved health outcomes and prevent complications as well as avoidable hospital admissions.

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

Initial DY9 DSRIP Valuation	Initial DY10 DSRIP Valuation	Initial DY9-10 MPT
$5,313,230.76	$4,532,458.29	9

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	$4,749,999.99	9	<-- Note: This is your current MPT
Yes	$5,249,999.99	10	
Yes	$5,749,999.99	11	
Yes	$6,249,999.99	12	
No	$6,749,999.99	13	

No	$7,249,999.99	14
No	$7,749,999.99	15

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%	$531,323.08	$453,245.83
Category C	75%	$3,984,923.07	$3,399,343.72
Category D	15%	$796,984.61	$679,868.74
Total	100%	$5,313,230.76	$4,532,458.29

Original MPT:	9
Adjusted MPT based on updated valuation:	9

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:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category B valuation in DY9:	$531,323.08
Category B valuation in DY10:	$453,245.83

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.

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

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

Please enter a description of this System Component.

FBC Clinical Health Services (CHS) immunization locations
Fort Bend County offers immunizations in three county buildings: Nancy Drake Clinic (Rosenberg, TX), Fort Bend County Missouri City Annex (Missouri City, TX), and Fort Bend

County North Annex (Katy, TX)
Vaccines provided by the Texas Vaccines for Children program are offered only to individuals who are uninsured or Medicaid recipients. Only flu vaccine purchased by the county is offered without restriction to payer type. Part of the program mandate is to encourage all recipients to develop a relationship with a medical home because FBC CHS does not provide any primary care services. The locations are for immunizations only with no medical assessment or diagnostic work available. FBC does not own or operate any primary care clinics.

Local Health Departments - Optional Components

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

Please enter a description of this System Component.

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

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

Please list your "Other" system component.

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

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

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

Please list your "Other" system component.

Other - FBC Behavioral Health Services Department

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

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

Please list your "Other" system component.

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

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

	DY7	DY8
MLIU PPP	20,086	20,086
Total PPP	28,919	28,919

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	1,997
Estimated Low-income or Uninsured Individuals served in DY7	18,579
Estimated Medicaid individuals served in DY8	2,086
Estimated Low-income or Uninsured Individuals served in DY8	18,000
MLIU PPP Goal for each DY (DY9 and DY10):	20,086
Forecasted Medicaid individuals served in each DY for DY9-10	2,086
Forecasted Low-income or Uninsured individuals served in each DY for DY9-10	18,000
Average Total PPP in each DY	28,919
MLIU percentage of Total PPP	69.46%
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

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	9
Points Selected	13
Measures Selected	6
Maximum Deletions Met	Y
Clinical Outcome Selected	Y
At least 2 measures selected	Y

Performing Provider Information

RHP:	3
TPI and Performing Provider Name:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public
Category C valuation in DY9:	$3,984,923.07
Category C valuation in DY10:	$3,399,343.72

MINIMUM POINT THRESHOLD (MPT): 9

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
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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

No	MLIU denominator with significant volume	L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	1
No	MLIU denominator with significant volume	L1-160	Follow-Up After Hospitalization for Mental Illness	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-186	Breast Cancer Screening	Cancer Screening	2
Yes - Continue Measure	HHSC has approved as Standard P4P (A: All Payer; R: All Payer)	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
No	MLIU denominator with significant volume	L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	1
No	MLIU denominator with significant volume	L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Process	1
No	MLIU denominator with significant volume	L1-224	Dental Sealant: Children	Process	1
No	MLIU denominator with significant volume	L1-225	Dental Caries: Children	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-227	Dental Caries: Adults	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-231	Preventive Services for Children at Elevated Caries Risk	Process	1
No	MLIU denominator with significant volume	L1-235	Post-Partum Follow-Up and Care Coordination	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	Process	1
Yes - Continue Measure	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	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
No	MLIU denominator with significant volume	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
No	MLIU denominator with significant volume	L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	Clinical Outcome	3
No	MLIU denominator with significant volume	L1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	1

Total points from Standard Menu:	**13**

LHD "Grandfathered" DY6 P4P Measures

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

Total overall selected points:	**13**

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:	296760601 - Fort Bend 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		L1-205, L1-342		L1-241	
			Adult Primary Care Prevention and Chronic Disease Management (LHD)		Access to Care (LHD)		Criminal Justice (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	DY1-6	Implemented in small scale	Not applicable	Not applicable
1.01	Night and/or weekend appointments in the outpatient setting	Access to Care	DY1-6	Implemented in small scale	DY1-6	Implemented in small scale	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	Not applicable	Not applicable	Not applicable	Not applicable	DY1-6	Implemented in small scale
2.00	Culturally and linguistically appropriate care planning for patients	Care Coordination	DY1-6	Implemented in small scale			DY1-6	Implemented in small scale
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			DY1-6	Implemented in small scale
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			Not applicable	Not applicable
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 in small scale			DY1-6	Implemented in small scale
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 in small scale			DY1-6	Implemented in small scale
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
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
2.30	Formal closed loop process for scheduling referral visits as needed	Care Coordination	Not applicable	Not applicable			Not applicable	Not applicable
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
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
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
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	Not applicable	Not applicable	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	Not applicable	Not applicable	DY1-6	Implemented in small scale
3.20	Analysis of appointment "no-show" rates	Data Analytics	Before DSRIP	Implemented in small scale	Before DSRIP	Implemented in small scale	Not applicable	Not applicable
4.00	Care team includes a clinical pharmacist(s)	Disease Management	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			Before DSRIP	Implemented in small scale
4.02	Care team includes a registered dietician(s)	Disease Management	DY1-6	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	Not applicable	Not applicable			DY1-6	Implemented in small scale
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)	Disease Management	DY1-6	Implemented in small scale			DY1-6	Implemented in small scale
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			DY1-6	Implemented in small scale
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking	Disease Management	DY1-6	Implemented in small scale			Not applicable	Not applicable
4.32	Classes for patients focused on physical activity	Disease Management	Not applicable	Not applicable			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
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
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)	Disease Management	DY1-6	Implemented in small scale			DY1-6	Implemented in small scale
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place	Disease Management					DY1-6	Implemented in small scale
4.71	Medication-Assisted Treatment (MAT) services actively offered	Disease Management					Not applicable	Not applicable
5.00	Screening patients for food insecurity	Social Determinants of Health	DY7-8	Implemented in small scale			DY7-8	Implemented in small scale
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 in small scale			DY7-8	Implemented in small scale
5.10	Screening patients for housing needs	Social Determinants of Health	DY7-8	Implemented in small scale			DY7-8	Implemented in small scale
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			DY1-6	Implemented in small scale
5.12	Screening patients for housing quality needs	Social Determinants of Health	Not applicable	Not applicable			DY7-8	Implemented in small scale
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			Not applicable	Not applicable
5.20	Screening patients for transportation needs	Social Determinants of Health	DY7-8	Implemented in small scale	DY1-6	Implemented in small scale	DY1-6	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	DY7-8	Implemented in small scale	DY1-6	Implemented in small scale	DY1-6	Implemented in small scale

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:	296760601 - Fort Bend 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 of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

Identification and referral of frequent or inappropriate users of the Emergency Medical Service transport system or Emergency Department care setting for chronic conditions that would be better managed in a medical home with proactive care, coaching and resolution of one or more negative social determinants of health, thus avoiding episodic crisis interventions.Number of providers committed: AccessHealth, FQHC (1 LVN - Care Coordination Manager, Director of Reporting and Analytics, 1 Dietician, 1 LVN, 2 CHWs), Fort Bend County (1 Special Projects Coordinator)Locations impacted: AccessHealth, FQHC Adult Clinic at Richmond and Missouri City locations

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

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

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

Consistent medical home with proactive care provided by a navigation team

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

Establish connections with specialty care providers, such as urology, optometry, wound care, general surgery, hematology and cardiology

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

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).

Improving chronic disease understanding and self-management

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

Incentivized chronic disease education and self-management courses

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

Establishing patient specific goals (e.g. weight, exercise, nutrition)

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

Availability to patients of a registered dietician to better assist them with nutrition and their diets

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

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).

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

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

Collaboration with and referral to social service agencies within the community

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

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.

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

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

No

Core Activity #2

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

2) Please select the grouping for this Core Activity.

Behavioral Health Crisis Stabilization Services

a) Please select the name of this Core Activity.

Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model).

b) Please enter a description of this Core Activity

Fort Bend County Crisis Intervention Team consists of a specialized team of officers that work closely with Fort Bend County Behavioral Health Services, the local mental health authority, psychiatric hospitals, emergency rooms, emergency medical services (EMS) and community service organizations. The Fort Bend CIT responds to behavioral health crises in the community, provides stabilization services, directs individuals to the appropriate level of care, reduces unnecessary incarceration and emergency room utilization, provides follow up services and connects individuals with needed clinical and social services.Number of providers committed: Fort Bend County Behavioral Health Services (Director of BHS & Project Specialist) and Crisis Intervention Team (1 Captain, 1 Lieutenent, 10 Deputies, 2 Sergeants)Locations impacted: Zips codes within Fort Bend County (77053, 77406, 77407, 77417, 77420, 77430, 77441, 77444, 77451,77459, 77461, 77464, 77469, 77471, 77476, 77477, 77478, 77479, 77481, 77485, 77487, 77489, 77494, 77496, 77497, 77498,77545,77583)

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

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

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

Establish collaborative partnerships and information sharing to expand clinical resources and social supports

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

Follow up and continuity of care to connect individuals and families to needed supports and services

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

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).

Specialized Crisis Intervention Team (CIT) that is trained and supported to address behavioral health crises, in the community.

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

Provide ongoing training to CIT to support response and intervention system

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

Expand crisis intervention training to first responders to enhance cross systems knowledge and coordinated response

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

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.

L1-241

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

This core activity responds to behavioral health crises and connects individuals with the appropriate level of care reducing the unnecessary incarceration and escalation of dangerous behavior. The Crisis Intervention Team provides specialized response, stabilization, and follow up services. The Fort Bend County CIT is a critical component of the countys emergency response system and Ft. Bend Countys Behavioral Health Services. Timely and appropriate response system is critical to preventing unnecessary criminal justice involvement for individuals with behavioral health disorders.

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

No

Core Activity #3

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

3) Please select the grouping for this Core Activity.

Expansion of Patient Care Navigation and Transition Services

a) Please select the name of this Core Activity.

Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.

b) Please enter a description of this Core Activity

Identify individuals frequently or inappropriately using EMS transport and ED care for episodic crisis care of chronic medical conditions better managed in a medical home. Paramedics provide assessment and care to identified individuals. Community Paramedics will connect the patients to the local Federally Qualified Health Center to establish a medical home. The project will promote the medical home and serve as a community based navigation system.Number of providers committed: Fort Bend County EMS (1 Deputy Chief- Clinical) and Fort Bend County Community Paramedic team (1 Community Paramedic Coordinator, 2 Community Paramedics), Fort Bend County (1 Special Projects Coordinator)Locations impacted: Zips codes within Fort Bend County (77053, 77406, 77407, 77417, 77420, 77430, 77441, 77444, 77451,77459, 77461, 77464, 77469, 77471, 77476, 77477, 77478, 77479, 77481, 77485, 77487, 77489, 77494, 77496, 77497, 77498,77545,77583)

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

Engage clients in chronic illness self- management, healthy lifestyles, preventive care, and positive healthcare decisions

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

Provide comprehensive chronic disease education course

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

Establish patient specific goals (e.g. weight, exercise, nutrition)

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

Empower the client for good medication management: the right way to administer, when it needs to be administered, proper storage, handling, disposal, etc.

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

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).

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

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

Implement use of a standarized tool to identify at risk clients

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

Collaboration with and referral to social service agencies within the community

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

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.

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

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

No

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

Use of the SBIRT (Screening, Brief Intervention, Referral to Treatment) model integrated in the local FQHC designed to identify, reduce, and prevent problematic substance use disorders. The program is designed to identify individuals with substance use and to effectively help them stop or reduce the current use before they need more extensive or specialized treatment, and to improve their overall health. Number of providers committed: AccessHealth, FQHC (1 SBIRT Counselor & 1 Chief Program Officer), Fort Bend County (1 Special Projects Coordinator)Locations impacted: AccessHealth, FQHC Adult Clinic at Richmond and Missouri City locations

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

Systematically screen all clients to identify those who need further intervention

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

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

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

Connect the client with appropriate level of care

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

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).

Reduce tobacco, drug and alcohol use in identified patients

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

Engage patients in motivational interviewing and cessation classes

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

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

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

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			

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

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

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

No

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 Primary Care Services

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

Expand the hours of operation of the local Federally Qualified Health Center to increase access to primary care for the Medicaid, uninsured and underinsured population in Fort Bend County. A standard 7 a.m. to 7 p.m. weekday schedule and a Saturday morning schedule from 8 a.m. to 12 p.m.Number of providers committed: AccessHealth, FQHC (1 Family Practice Provider, 1 LVN, 2 Medical Assitants, 3 Front Desk/ Eligibility Staff), Fort Bend County (1 Special Projects Coordinator)Locations impacted: AccessHealth, FQHC Adult Clinic at the Richmond location

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

Same day appointment availability slots to expand access

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

Monthly reports on availability and usage of same day appointment slots

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

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

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

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).

Maintain a full provider team dedicated to the expanded clinic hours

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

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

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

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

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

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.

L1-205			

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

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

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

No

Core Activity #6

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

6) Please select the grouping for this Core Activity.

Availability of Appropriate Levels of Behavioral Health Care Services

a) Please select the name of this Core Activity.

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

b) Please enter a description of this Core Activity

Assessing the social determinants of health is an integral part of our service delivery system. Addressing needs such as housing, transportation, food insecurity, and poverty requires collaboration and information sharing with other county departments and community organizations. Number of providers committed: Fort Bend County Behavioral Health Services (Director of BHS, 1 Project Specialist, 1 Recovery & Reintegration Specialist, 1 Case Manager Specialist, 2 Clinical Care Coordinators)Locations impacted: Fort Bend County Behavioral Health Services located in Richmond, TX

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

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

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

Process for integrating social determinants of health data into program management

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

Expand resources for meeting social determinants of health

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

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).

Intensive case management services provided to clients

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

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

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

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

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

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.

L1-241			

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

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

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

No

Core Activity #7

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

7) Please select the grouping for this Core Activity.

Behavioral Health Crisis Stabilization Services

a) Please select the name of this Core Activity.

Implement models supporting recovery of individuals with behavioral health needs.

b) Please enter a description of this Core Activity

Behavioral Health Services provides intensive case management, strengths-based planning, wraparound supports, wellness curriculum, and individual and family centered services. The focus of our programs for youth and adults are on recovery, reintegration into the community, keeping families together and reduction of incarceration/detention.Number of providers committed: Fort Bend County Behavioral Health Services (Director of BHS, 1 Project Specialist, 1 Recovery & Reintegration Specialist, 1 Case Manager Specialist, 2 Clinical Care Coordinators)Locations impacted: Fort Bend County Behavioral Health Services located in Richmond, TX

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

Complete the CANS (Child and Adolescents Needs and Strengths) and ANSA (Adult Needs and Strengths Assessment) to assess needs and strengths. These assessments are multi-purpose tools developed for behavioral health services to support decision making in level of care and individualized service planning, which facilitates quality improvement initiatives and allows for monitoring of the outcomes of services.

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

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

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

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).

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

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

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

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

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.

L1-241			

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

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

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

No

Core Activity #8

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

8) Please select the grouping for this Core Activity.

Prevention and Wellness

a) Please select the name of this Core Activity.

Other

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

Implement Evidence-based Disease Prevention Programs Colonoscopy Screening

b) Please enter a description of this Core Activity

Provide a colonoscopy screening to uninsured and underinsured populations who meet the American Cancer Society criteria for this procedure but have no resources to pay for it. Some

patients will receive polypectomies for pre-cancerous polyps, thus preventing a future cancer while others may be diagnosed and treated for cancer at an earlier stage than if it was not diagnosed until symptomatic. The FQHC, AccessHealth will identify and refer for colonoscopy screening patients meeting the ACS criteria for colorectal cancer routine screening.Number of providers committed: , Fort Bend County (1 Special Projects Coordinator), AccessHealth, FQHC (8 Physicians, Director of Reporting and Analytics, 1 Referral Clerk Supervisor, 1 Referral Clerk & COO), 2 Contracted Gastroenterologists, 1 Contracted Hospital (surgical suite, pathology, radiology, anesthesiologist) & 1 Contracted Outpatient Surgical CenterLocations impacted: AccessHealth, FQHC Adult Clinic at Richmond and Missouri City locations

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

Assess and reduce patient barriers to completion of screening procedure

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

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

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

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

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

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).

Leverage the Health Information Technology Systems

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

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

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

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

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

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.

L1-107			

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

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

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

No

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:	296760601 - Fort Bend 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	**$531,323.08**	**$453,245.83**
L1-105	$664,153.85	$566,557.29
L1-107	$664,153.85	$566,557.29
L1-115	$664,153.85	$566,557.29
L1-205	$664,153.85	$566,557.29
L1-207	$664,153.85	$566,557.29
L1-241	$664,153.82	$566,557.27
L1 Total	**$3,984,923.07**	**$3,399,343.72**
Category C Total:	**$3,984,923.07**	**$3,399,343.72**
Time Since Routine Checkup	$113,854.94	$97,124.11
High Blood Pressure Status	$113,854.94	$97,124.11
Diabetes Status	$113,854.94	$97,124.11
Overweight or Obese	$113,854.94	$97,124.11
Smoker Status	$113,854.94	$97,124.11
Selected Immunizations	$113,854.94	$97,124.11
Prevention of Sexually Transmitted Diseases	$113,854.97	$97,124.08
Category D Total:	**$796,984.61**	**$679,868.74**
DSRIP Total	**$5,313,230.76**	**$4,532,458.29**

Section 2: Category C Milestone Valuation

Bundle-Measure ID	Denominator Volume	DY9 Category C Valuation: $3,984,923.07							DY10 Category C Valuation: $3,399,343.72					
		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)	$664,153.85	$0.00	$166,038.46	$498,115.39	$0.00	$0.00	$0.00	$566,557.29	$141,639.32	$424,917.97	$0.00	$0.00	$0.00
L1-107	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$664,153.85	$0.00	$166,038.46	$498,115.39	$0.00	$0.00	$0.00	$566,557.29	$141,639.32	$424,917.97	$0.00	$0.00	$0.00
L1-115	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$664,153.85	$0.00	$166,038.46	$498,115.39	$0.00	$0.00	$0.00	$566,557.29	$141,639.32	$424,917.97	$0.00	$0.00	$0.00
L1-205	HHSC has approved as Standard P4P (A: All Payer; R: All Payer)	$664,153.85	$0.00	$166,038.46	$498,115.39	$0.00	$0.00	$0.00	$566,557.29	$141,639.32	$424,917.97	$0.00	$0.00	$0.00
L1-207	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$664,153.85	$0.00	$166,038.46	$498,115.39	$0.00	$0.00	$0.00	$566,557.29	$141,639.32	$424,917.97	$0.00	$0.00	$0.00
L1-241	HHSC has approved as Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	$664,153.82	$0.00	$166,038.46	$498,115.36	$0.00	$0.00	$0.00	$566,557.27	$141,639.32	$424,917.95	$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:	296760601 - Fort Bend County
Performing Provider Type:	Local Health Department (LHD)
Ownership:	Non-State Owned Public

Section 1: IGT Entities

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

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

Contact #	Contact Name	Street Address	City	Zip	Email	Phone Number	Phone Extension	Lead Contact or Both
1	Connie Almeida	301 Jackson Street, Suite 701	Richmond	77469	Connie.Almeida@fortbendcountytx.gov	281-238-3078		Both
2	Kaye Reyonolds	4520 Reading Road, Suite A-100	Rosenberg	77471	Kaye.Reynolds@fortbendcountytx.gov	281-238-3519		Both
3	Mary desVignes-Kendrick	4520 Reading Road, Suite A-100	Rosenberg	77471	md.kendrick@fortbendcountytx.gov	281-238-3589		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	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$207,800.46	$177,264.44
L1-105	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$259,750.57	$221,580.56
L1-107	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$259,750.57	$221,580.56
L1-115	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$259,750.57	$221,580.56
L1-205	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$259,750.57	$221,580.56
L1-207	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$259,750.57	$221,580.56
L1-241	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$259,750.56	$221,580.55
Category D	Fort Bend County	17460019692066	100-13-0000-00125	100.00%	100.00%	$311,700.68	$265,896.66
Total						$2,078,004.55	$1,772,644.44

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:	Kaye Reynolds, DrPH
IGT Organization:	Fort Bend County
Date:	10/31/2019

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:	296760601 - Fort Bend 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	$531,323.08	$453,245.83
Category C	$3,984,923.07	$3,399,343.72
Category D	$796,984.61	$679,868.74
Total	$5,313,230.76	$4,532,458.29

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 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	2,086	18,000	20,086	28,919	69.46%	2.78%
DY10 Estimated	2,086	18,000	20,086	28,919	69.46%	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	$664,153.85	$566,557.29
L1-107	Colorectal Cancer Screening	0	0	0	2	$664,153.85	$566,557.29
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0	0	0	3	$664,153.85	$566,557.29
L1-205	Third next available appointment	0	0	0	1	$664,153.85	$566,557.29
L1-207	Diabetes care: BP control (<140/90mm Hg)	0	0	0	3	$664,153.85	$566,557.29
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	0	0	0	3	$664,153.82	$566,557.27
Total	N/A	0	0	0	13	$3,984,923.07	$3,399,343.72

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

Bundle-Measure ID	Measure Bundle/Measure Name	Associated Core Activities
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Implementation of strategies to reduce tobacco use (Example of evidence based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)
L1-107	Colorectal Cancer Screening	Other - Implement Evidence-based Disease Prevention Programs Colonoscopy Screening
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others); Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.
L1-205	Third next available appointment	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)

L1-207	Diabetes care: BP control (<140/90mm Hg)	Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others); Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model).; Provision of services to individuals that address social determinants of health and/or family support services.; Implement models supporting recovery of individuals with behavioral health needs.

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

Yes

Section 5: Category D

Statewide Reporting for LHDs

Measure	Category D DY9 Valuation	Category D DY10 Valuation
Time Since Routine Checkup	$113,854.94	$97,124.11
High Blood Pressure Status	$113,854.94	$97,124.11
Diabetes Status	$113,854.94	$97,124.11
Overweight or Obese	$113,854.94	$97,124.11
Smoker Status	$113,854.94	$97,124.11
Selected Immunizations	$113,854.94	$97,124.11
Prevention of Sexually Transmitted Diseases	$113,854.94	$97,124.11

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:	Kaye Reynolds, DrPH
Performing Provider:	Fort Bend County
Date:	10/31/2019

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