Texas Delivery System Reform Incentive Payment Program
Mid-Point Assessment of Projects

For the Reporting Period Ending
April 30, 2014
To the Texas Health and Human Services Commission (HHSC):

Myers and Stauffer LC (Myers and Stauffer) has completed the Mid-Point Assessment of projects which can earn incentive payments through combined state and federal funds made through the Texas 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) program. The purpose of this engagement was to meet the requirements of Texas Administrative Code (TAC) §354.1624 of the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) and the Program Funding and Mechanics Protocol (PFM) to initiate a mid-point assessment of the Category 1 and 2 DSRIP projects. The Mid-Point Assessment is a review of the DSRIP projects for the following elements:

- Compliance with the approved Regional Healthcare Partnership (RHP) plan for that project.
- Compliance with the required core components described in the RHP Planning Protocol, including continuous quality improvement activities.
- Ensuring that activities funded through DSRIP do not duplicate activities funded through other federal funds.
- The clarity of the improvement milestones for the fourth and fifth demonstration years and those milestones’ connection to DSRIP project activities and patient impact.
- The benefit of the DSRIP project to the patients served by the project, including the Medicaid and uninsured populations.
- The opportunity for DSRIP project improvement by identifying lessons learned.

Our assessment was primarily based on the semi-annual progress reports submitted by the DSRIP participating providers for the period from October 2012 to April 2014.

Our assessment was based on a project’s level of compliance with the six elements described above and the resulting risk that a project may not meet its overall project goals and objectives resulting from any noncompliance with these elements at this stage of the project’s life cycle. This assessment provides the user of this report with an overview of the status of the projects in the DSRIP program as of April 2014. As such, we did not conduct an audit or other attest engagement of the DSRIP program. Since we did not conduct an audit, our engagement did not include testing the operating effectiveness of controls or operational processes; therefore, the risks identified in this mid-point assessment do not necessarily reflect actual weaknesses or problems with the DSRIP providers’ processes or controls. The items we identified reflect potential risk areas of noncompliance with the above-described six elements, based upon the results of the procedures we performed, and information and documentation we reviewed.

This report is intended solely to meet the requirements of TAC §354.1624 and the PFM and for the information and use of HHSC in the management of the Texas DSRIP program.

Austin, TX
May 27, 2015
# Table of Contents

Executive Summary .................................................................................................................. 1  
  Introduction .......................................................................................................................... 1 
  Objectives, Scope and Methodology ..................................................................................... 1 
Background .............................................................................................................................. 6 
Overall Mid-Point Assessment Conclusion .......................................................................... 8 
Detailed Results Per RHP ....................................................................................................... 12 
HHSC Response ...................................................................................................................... 52 
Appendix 1 ............................................................................................................................. 57 
Appendix 2 ............................................................................................................................. 108
Executive Summary

Introduction

In December 2011, the Texas Health and Human Services Commission (HHSC) received approval for a Section 1115 Waiver (Waiver) from the federal Centers for Medicare and Medicaid Services (CMS) for the Texas Healthcare Transformation and Quality Improvement Program (THTQIP). The Waiver included the Program Funding and Mechanics Protocol (PFM) that contains the Delivery System Reform Incentive Payment (DSRIP) program guidelines as agreed-upon by HHSC and CMS.

Included in the Waiver was the requirement that HHSC have an Independent Assessor, an entity contracted to provide assistance with the Mid-Point Assessment and ongoing compliance monitoring. HHSC contracted Myers and Stauffer LC to be the Independent Assessor as of May 2014.

Myers and Stauffer created an assessment and compliance program that was utilized to measure DSRIP project implementation progress and compliance with the PFM requirements. Myers and Stauffer made recommendations that included prospective plan modifications that would be effective for demonstration year (DY) 4 and 5, including adjustments to project metrics if the performance of the project had substantially deviated from what was approved.

Objectives, Scope and Methodology

The purpose of this engagement was to meet the requirements of TAC §354.1624 and the PFM, to initiate a mid-point assessment of the DSRIP projects. The Mid-Point Assessment is a review of DSRIP projects for the following elements:

- Compliance with the approved Regional Healthcare Partnership (RHP) plan for that project.
- Compliance with the required core components described in the RHP Planning Protocol, including continuous quality improvement activities.
- Ensuring that activities funded through DSRIP do not duplicate activities funded through other federal funds.
- The clarity of the improvement milestones for the fourth and fifth demonstration years and those milestones’ connection to DSRIP project activities and patient impact.
- The benefit of the DSRIP project to the patients served by the project, including the Medicaid and uninsured populations.
- The opportunity for DSRIP project improvement by identifying lessons learned.

All projects selected for review were assessed based on their level of compliance with the criteria established by these six elements. Reporting information submitted by the provider was also reviewed to determine the existence of other challenges the projects might have encountered.
have encountered and the status of progress made toward accomplishing outcomes. These three assessment areas were then combined to determine the overall risk ranking of the progress of the project for purposes of the Mid-Point Assessment.

Our assessment was conducted from October 2014-March 2015 to review project activities through the mid-point of DY 3, which included the status of the projects through April 30, 2014.

The state of Texas (State) has 1,491 DSRIP projects (as of July 2014), which include, for example, behavioral health, primary care, specialty care, telemedicine and chronic disease management. Over 300 providers perform these projects across the 20 RHPs. These providers consist of hospitals, physician practice groups (largely associated with academic health science centers), community mental health centers, and local health departments.

**Sampling Methodology**

Given the large population of projects in the state, this Mid-Point Assessment was conducted on a sample of projects and included a desk review and selected site visits. The sample was selected utilizing a statistically valid sampling methodology that enabled us to summarize our conclusions by RHP. Additional projects were selected and added to the projects to be reviewed in the sample based upon CMS and HHSC input, as well as from a high-level assessment of all projects that had any reported information available. This high-level review of all projects was conducted by Myers and Stauffer during the period July through August of 2014. A more detailed assessment was conducted on the projects included in the sample during the period October 2014 through March 2015. The final total number of projects included in the Mid-Point Assessment was 677.

**Site Visits**

All RHPs received at least one site visit, and regions with a greater number of projects received more than one visit for a total of 33 site visits. The purpose of the site visit was to obtain additional information from the provider regarding project activities and address any potential risks or challenges noted by the provider during the Waiver reporting period. The selection of projects for site visits was based on the following factors:

- Non-compliance or concerns with core components
- Duplicate federal funding
- Underperforming projects
- Valuation outliers
- High value projects
- Unique project options to the region where selection of the project type was limited to a small number of providers statewide
- Supporting documentation concerns
- Low/High quantifiable patient impact (QPI) goals
Criteria was also developed to ensure the selection of projects receiving a site visit was consistent and to ensure that useful information was obtained and communicated to both HHSC and CMS regarding project performance and execution in the State.

**Risk Assessment Methodology**

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements, as well as a risk assessment related to any project challenges noted by the provider and/or identified during our review. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. Each step was finalized by assigning a risk assessment ranking for that step and then a final overall risk assessment ranking was determined by averaging the two rankings.

**Step One: Compliance with the PFM and Assessment of Project Challenges**

We assessed project compliance with the PFM elements and other significant challenges or issues that could affect the provider’s ability to accomplish project goals and objectives.

Compliance: All projects selected for review were assessed based on the level of compliance with the criteria established by the six elements set forth in the PFM and described above. Each element was assessed independently and then assigned a compliance rank according to the following scale:

- 1 = Fully satisfies the applicable criteria
- 2 = Partially satisfies the applicable criteria
- 3 = Does not satisfy the applicable criteria

For projects in which it was determined that noncompliance with established PFM criteria could affect the accomplishment of project goals, we conducted a follow-up with the providers. The purpose of the follow-up was to obtain additional information to assist in the development of any recommendations that could assist the provider in addressing the specific compliance element.

Challenges: In addition to the compliance assessment, we also assessed other risk factors that may have the potential to affect the provider’s ability to accomplish its planned performance outcomes. These risk factors included challenges and issues specific to the project, such as the provider’s ability to hire practitioners, secure additional space and expand clinic hours, and the ability to acquire technological capabilities in a timely manner. In addition to challenges reported by the provider, we also may have identified other potential challenges based on the nature of the project’s reported goals and metrics, including the provider’s ability to obtain
data necessary to accurately measure project outcomes and QPI.

To determine the risk assessment ranking for Step One, issues identified during the compliance review were included, along with any noted challenges, and assigned a 5-point risk assessment ranking (see table below). The ranking was determined based on a judgmental assessment of factors that could affect the provider’s ability to accomplish the intended project goals. It should be noted that projects assessed as compliant with the PFM elements could be assigned a higher ranking due to other project challenges noted during the assessment; although compliance itself may not have been determined to be a risk, the presence of other challenges may have increased the risk ranking for Step One. For example, a project may have been assessed at the levels of 1s or 2s in terms of compliance, but if a provider noted challenges such as difficulty acquiring clinic space or hiring practitioners, these issues may prevent the provider from meeting the overall goals of the project (i.e., to increase access to primary care). As a result, the risk of this project not meeting its goals and objectives was assessed to be higher and thus a higher risk assessment ranking would have been assigned for Step One.

Step Two: Assessment of Project Progress and Status

We also assessed the progress of the project based on the results of the provider’s activities as reported to HHSC during the semi-annual reporting periods. Progress was assessed based on the number of metrics and milestones completed as of April 2014. For projects not yet reporting completion of some or all metrics, we assessed the provider’s progress towards completion of individual metrics and whether or not the provider was likely to complete the metric by the end of the year reporting deadline. Project progress was then judgmentally assigned a separate 5-point risk assessment ranking (see table below) based on the level of perceived risk identified.

Overall Risk Assessment Ranking:

Based on the project’s compliance and challenges assessment, as well as the assessment of project progress, an overall risk assessment ranking was assigned to the project indicating the level of risk of a project not accomplishing its planned performance outcomes. The overall risk assessment ranking assigned to each project was derived by weighting the risk assessment rankings for Step One and Step Two equally (see Appendix 1).
<table>
<thead>
<tr>
<th>Overall Assigned Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = On Track – Very low risk indicating project is more than likely to meet intended goals.</td>
</tr>
<tr>
<td>2 = Very Likely To Be On Track – Low risk indicating project more than likely to meet intended goals with minimal challenges.</td>
</tr>
<tr>
<td>3 = Likely To Be On Track – Medium risk indicating project could meet intended goals, but some challenges must be overcome.</td>
</tr>
<tr>
<td>4 = Needs Work to Get On Track – High risk indicating project could meet intended goals, but will require significant modifications or improvements in performance to do so.</td>
</tr>
<tr>
<td>5 = Off Track – Very high risk indicating project will more than likely not meet intended goals due to significant challenges, even with modifications and improvements in performance.</td>
</tr>
</tbody>
</table>

Based on the results of our assessment, we developed specific recommendations for providers as either plan modifications to address areas of potential non-compliance with the project narrative or technical changes to address corrections needed to project plans, metrics and milestones to ensure alignment with the project’s stated performance outcomes (see Appendix 2). Appendix 2 includes HHSC responses to recommendations made by Myers and Stauffer. HHSC’s responses were not part of our assessment and are included for informational purposes only.

In a few cases, we recommended that projects be considered for potential withdrawal if the provider reported significant challenges that were substantially delaying the progress of the project or if the provider had determined that it would voluntarily withdraw from the program due to lack of progress or other factors. In each case, we obtained a project status update from the provider applicable to questions from the April 2014 reporting period. If the provider noted that the project had overcome noted challenges and made progress, we considered that additional information in our assessment and did not recommend withdrawal.

Our assessment also resulted in the identification of “benchmark projects,” which we considered to be projects noted in our review exhibiting performance that exceeded expectations or projects applying effective and innovative processes in relation to other similar projects reviewed. Factors contributing to high performing projects and effective processes present a possibility for replication in the planning and operations of other similar projects that might be struggling. To determine which projects were noted as benchmarks, we reviewed the reporting information submitted by the provider; therefore, our ability to identify benchmark projects was limited to the data reported by the providers. Certain providers reported a comprehensive status update, from which we were able to determine performance that exceeded expectations. Other providers reported limited information, from which such an assessment was not possible. As a result, certain regions had fewer or no benchmark projects identified. This does not mean that projects within these regions were not high performing projects.
Background

The Waiver was approved in December 2011 and will expire in September 2016. The Waiver allowed for a DSRIP funding pool that would incentivize hospitals and other providers to transform their service delivery practices consistent with the CMS Triple Aim to improve the experience of care, improve the health of populations, and to reduce the cost of health care without compromising quality.

The Waiver period is divided into DYs upon which DSRIP payments are calculated and paid to providers. The DY is the 12-month period beginning October 1. Therefore, DY 1 is the measurement period from October 2011 – September 2012; DY 2 is the measurement period from October 2012 – September 2013; DY 3 is the measurement period from October 2013 – September 2014; DY 4 is the measurement period from October 2014 – September 2015; and DY 5 is the measurement period from October 2015 – September 2016.

The Waiver requires program participants to participate in an RHP in order to receive DSRIP payments. Within a partnership, participants include governmental entities providing public funds known as intergovernmental transfers (IGT), Medicaid providers, and other stakeholders. Participants are required to develop a regional plan identifying partners, community needs, and the proposed projects.

Each partnership must have one anchoring entity that would act as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating development of a regional plan. Prior to the start of Waiver activities, responsibilities of the anchoring entities included coordination of the community needs assessment development of the RHP plan. As of the mid-point assessment, the anchoring entity was providing technical assistance to providers, as well as monitoring reporting activities performed by participating providers, to assist with compliance with HHSC requirements.

Prior to the commencement of the providers’ DSRIP project activities, the anchoring entity was tasked with coordinating the development of the community needs assessment for the region. The specific procedures for conducting the needs assessment were determined by each regional anchoring entity. During the planning phase of the Waiver, the anchoring entities also coordinated the development of the RHP plan in collaboration with regional stakeholders. This process included incorporating elements identified in the community needs assessment into the RHP plan.

Since the start of the Waiver projects, including measurement and reporting activities, the anchoring entities have provided on-going technical assistance to performing providers. The anchoring entity may provide assistance by reviewing providers’ mid-year and end-of-year reports and documentation to ensure reports meet all HHSC reporting requirements. The anchoring entity may also monitor project performance and status throughout the demonstration year to assist performing providers with being on track to complete required milestones and metrics and to address any issues or challenges noted during the measurement periods. Finally, the anchoring entity will often communicate to performing providers any changes to reporting and other Waiver requirements from HHSC.

Texas has 1,491 Category 1 and 2 DSRIP projects, which include, for example, behavioral health, primary care, specialty care, telemedicine and chronic disease management. The projects are organized into categories as follows:
**Category 1** - Infrastructure development lays the foundation for delivery system transformation through investments in people, places, processes and technology.

**Category 2** - Program innovation and redesign includes the piloting, testing, and replicating of innovative care models.

**Category 3** - Outcomes associated with Category 1 and 2 projects. All performing providers (both hospital and non-hospital providers) select outcomes and establish improvement targets that tie to their projects in Category 1 and 2.

**Category 4** - Reporting on population-focused measures by hospitals (unless exempt).

Over 300 providers perform these projects across the 20 RHPs (as illustrated in the map below). These providers consist of hospitals, physician practice groups (largely associated with academic health science centers), community mental health centers, and local health departments.
Overall Mid-Point Assessment Conclusion

The statewide results of the review of the 677 DSRIP projects included in our sample for the six compliance elements established by the PFM criteria were (Specific project results are included in Appendix 1):

- **Compliance with the approved RHP plan**: We found that 57 projects (8 percent) in our sample did not conduct activities as described in the approved project narrative. Issues noted included material changes to target populations, clinic locations, and project interventions.
- **Compliance with the required core components described in the RHP Planning Protocol, including continuous quality improvement activities**: We found that 9 projects (1 percent) in our sample did not implement the required core components or did not describe plans for implementing core component activities.
- **Ensuring that activities funded through DSRIP do not duplicate activities funded through other federal funds**: As a result of our review of independent federal funding data and follow-up with providers, we determined that none of the projects in our sample received additional federal funds for the same activities.
- **The clarity of the improvement milestones for the fourth and fifth demonstration years and those milestones’ connection to DSRIP project activities and patient impact**: We found that 255 projects (38 percent) in our sample had one or more milestones that did not relate to project activities, did not clearly describe how DSRIP project goals would be measured, or were not being measured in accordance with the metric specified by the category menu.
- **The benefit of the DSRIP project to the patients served by the project, including the Medicaid and uninsured populations**: We found that 39 projects (6 percent) in our sample had not yet started serving patients or did not report progress on activities as of April 2014 that could benefit the health outcomes of the overall patient population or the Medicaid/Low-Income Uninsured population.
- **The opportunity for DSRIP project improvement by identifying lessons learned**: We found that 30 projects (4 percent) in our sample did not identify lessons learned during the semi-annual reporting periods.

After considering our determinations relating to the six compliance elements and assessing the risks relating to specific project challenges and progress, we assessed each project’s risk of not being On Track in meeting the project’s overall goals and outcomes (see Appendix 2). Based on this overall assessment, the results of the Mid-Point Assessment on a statewide basis indicate that:

- Approximately 7 percent of projects were assessed as On Track and were assigned an overall risk ranking of 1, indicating very low risk of those projects not meeting their project outcome objectives.
- Approximately 43 percent of projects were assessed as being Very Likely To Be On Track and were assigned an overall risk ranking of 2, indicating low risk of those projects not meeting their project outcome objectives.
- Approximately 29 percent of projects were assessed as being Likely To Be On Track and were assigned an overall risk ranking of 3 indicating moderate risk of those projects not meeting their project outcome objectives.
Approximately 19 percent of projects were assessed as Needs Work to Get On Track and were assigned an overall risk ranking of 4, indicating high risk of those projects not meeting their project outcome objectives.

Approximately 2 percent of projects were assessed as being Off Track and were assigned an overall risk ranking of 5, indicating very high risk of those projects not meeting their project outcome objectives.

On a statewide basis, with approximately 79 percent of the projects being at low or moderate risk, meaning that they are on track for meeting their project outcome objectives, it appears that the State’s Category 1 and 2 DSRIP projects are well on their way to achieving the intended project goals and those of the Triple Aim, which are to improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of communities.

While the majority of projects in Texas were assessed as low or moderate risk, 13 projects (2 percent) of the projects in our sample were identified as having the potential for withdrawal from the waiver program. These projects had made little or no progress on the achievement of their metrics, due to significant challenges encountered in implementing their plans. Most of the projects identified for possible withdrawal related to the expansion of primary and specialty care in the more rural areas of the state. Providers noted difficulties with recruiting and hiring general and specialty practitioners. Also, many rural areas have experienced a decrease in the overall population; therefore, projects may not be able to serve the volume of patients necessary to achieve their goals. In addition to primary and specialty care projects, various other project options were recommended for withdrawal due to the provider not having the necessary foundation, personnel and/or infrastructure necessary to complete the project. HHSC is reviewing the October 2014 reporting and if the provider is now making progress on a project, HHSC is not requesting that the provider withdraw from the DSRIP program.

We also identified projects that we classified as “benchmark projects.” These were projects noted in our assessment that were exhibiting performance that exceeded expectations or projects applying effective and innovative processes in relation to other similar projects reviewed. The identification of these projects was not limited to a specific project option. Benchmark projects were also projects that demonstrated the importance of the coordination of care and patient-centered care models through unique approaches. In addition, projects may also have been noted as a benchmark project if the provider chose an effective combination of menu milestones and developed meaningful and measureable customizable milestones. Providers may have also used a unique intervention that would affect either patient outcomes or achievement of project goals and objectives, such as national recruiting efforts and other operational processes. Our ability to identify benchmark projects was limited to the data reported by the providers. Certain providers reported a comprehensive status update, from which we were able to determine performance that exceeded expectations. Other providers reported limited information, from which such an assessment was not possible. As a result, certain regions had fewer or no benchmark projects identified. This does not mean that projects within these regions were not performing in a manner that exceeded expectations and could have been considered as benchmark projects had that information been reported.

In addition to quantitative data gathered during our assessment relating to compliance (and illustrated in the summary of relative project risk provided by these numbers above), we were also able to compile some qualitative information during our site visits. This information should be considered in assessing the progress made by providers in meeting the stated outcomes for their projects, which also reflect on the progress for the DSRIP program in the State as a whole.
The site visits conducted on selected projects generally demonstrated that there was more positive progress made toward meeting project plans and accomplishing project objectives since the reporting period for our review (April 2014) and the date of our site visits, which occurred during the period November 2014 – March 2015. In addition, RHP anchors and project providers demonstrated a positive reception of DSRIP project initiatives, as well as impact of project results, especially given the positive impact and results being realized in this intended vulnerable population. Much of the successful progress reflected in the results of our assessment can be attributed to extensive work in developing and implementing the program processes and commitment to quality and success, exhibited by the highly knowledgeable and skilled HHSC DSRIP team. From team leadership to staff, the HHSC team implemented a process where they worked to accurately assess all aspects of the projects (from project plan approval and valuation to the facilitation of project plan modifications and other technical changes), all with the goal of giving project providers the best chance of success possible to meet their planned outcomes through achievement of their metrics and milestones. Additionally, HHSC’s conduct of semi-monthly conference calls with all 20 anchors across the state to communicate information related to DSRIP, as well as answer any questions that anchors may have from their participating providers, facilitated the potential for success of projects throughout the state. During site visits, anchors stated that the semi-monthly calls were extremely valuable and facilitated consistency of project implementation and compliance across their regions.
The table below indicates the overall results at the RHP level of all sampled projects assessed during the Mid-Point Assessment.

<table>
<thead>
<tr>
<th>RHP</th>
<th># of Providers in RHP</th>
<th># of Projects in RHP</th>
<th>Allocated Category 1-2 DY2-5 DSRIP Funds ($)</th>
<th># of Projects in Mid-Point Assessment</th>
<th>% of Projects in Mid-Point Assessment</th>
<th># of Site Visits in RHP</th>
<th>% of Projects Ranked Low Risk (1)</th>
<th>% of Projects Ranked Low Risk (2)</th>
<th>% of Projects Ranked Medium Risk (3)</th>
<th>% of Projects Ranked High Risk (4)</th>
<th>Projects Ranked Highest Risk (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>28</td>
<td>103</td>
<td>337,353,431</td>
<td>39</td>
<td>38%</td>
<td>2</td>
<td>5%</td>
<td>21%</td>
<td>33%</td>
<td>31%</td>
<td>10%</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>85</td>
<td>293,444,017</td>
<td>30</td>
<td>35%</td>
<td>2</td>
<td>10%</td>
<td>34%</td>
<td>30%</td>
<td>23%</td>
<td>3%</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>179</td>
<td>1,683,843,730</td>
<td>109</td>
<td>61%</td>
<td>4</td>
<td>3%</td>
<td>38%</td>
<td>31%</td>
<td>27%</td>
<td>1%</td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>91</td>
<td>315,542,183</td>
<td>37</td>
<td>41%</td>
<td>2</td>
<td>24%</td>
<td>30%</td>
<td>30%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>79</td>
<td>481,197,517</td>
<td>32</td>
<td>41%</td>
<td>1</td>
<td>19%</td>
<td>34%</td>
<td>16%</td>
<td>28%</td>
<td>3%</td>
</tr>
<tr>
<td>6</td>
<td>25</td>
<td>128</td>
<td>882,370,495</td>
<td>61</td>
<td>48%</td>
<td>2</td>
<td>0%</td>
<td>72%</td>
<td>18%</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td>77</td>
<td>494,880,423</td>
<td>35</td>
<td>45%</td>
<td>2</td>
<td>0%</td>
<td>60%</td>
<td>40%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>8</td>
<td>12</td>
<td>41</td>
<td>90,438,511</td>
<td>14</td>
<td>34%</td>
<td>1</td>
<td>14%</td>
<td>36%</td>
<td>36%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>9</td>
<td>26</td>
<td>131</td>
<td>1,083,956,688</td>
<td>74</td>
<td>56%</td>
<td>2</td>
<td>1%</td>
<td>35%</td>
<td>35%</td>
<td>28%</td>
<td>1%</td>
</tr>
<tr>
<td>10</td>
<td>29</td>
<td>126</td>
<td>829,731,893</td>
<td>61</td>
<td>48%</td>
<td>4</td>
<td>7%</td>
<td>50%</td>
<td>26%</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>11</td>
<td>19</td>
<td>44</td>
<td>94,068,543</td>
<td>20</td>
<td>45%</td>
<td>1</td>
<td>5%</td>
<td>30%</td>
<td>40%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>12</td>
<td>38</td>
<td>100</td>
<td>315,369,790</td>
<td>33</td>
<td>33%</td>
<td>1</td>
<td>15%</td>
<td>49%</td>
<td>27%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>13</td>
<td>17</td>
<td>38</td>
<td>60,188,246</td>
<td>13</td>
<td>34%</td>
<td>1</td>
<td>15%</td>
<td>47%</td>
<td>15%</td>
<td>23%</td>
<td>0%</td>
</tr>
<tr>
<td>14</td>
<td>12</td>
<td>58</td>
<td>192,195,137</td>
<td>17</td>
<td>29%</td>
<td>1</td>
<td>6%</td>
<td>52%</td>
<td>18%</td>
<td>18%</td>
<td>6%</td>
</tr>
<tr>
<td>15</td>
<td>8</td>
<td>59</td>
<td>380,598,629</td>
<td>34</td>
<td>58%</td>
<td>2</td>
<td>3%</td>
<td>56%</td>
<td>29%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>16</td>
<td>8</td>
<td>35</td>
<td>118,148,410</td>
<td>11</td>
<td>31%</td>
<td>1</td>
<td>0%</td>
<td>27%</td>
<td>46%</td>
<td>27%</td>
<td>0%</td>
</tr>
<tr>
<td>17</td>
<td>11</td>
<td>32</td>
<td>66,392,053</td>
<td>15</td>
<td>47%</td>
<td>1</td>
<td>7%</td>
<td>53%</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>18</td>
<td>7</td>
<td>23</td>
<td>95,408,770</td>
<td>13</td>
<td>57%</td>
<td>1</td>
<td>8%</td>
<td>23%</td>
<td>38%</td>
<td>23%</td>
<td>8%</td>
</tr>
<tr>
<td>19</td>
<td>14</td>
<td>37</td>
<td>78,695,333</td>
<td>18</td>
<td>49%</td>
<td>1</td>
<td>17%</td>
<td>38%</td>
<td>28%</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>20</td>
<td>8</td>
<td>25</td>
<td>75,409,165</td>
<td>11</td>
<td>44%</td>
<td>1</td>
<td>19%</td>
<td>27%</td>
<td>36%</td>
<td>18%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Detailed Results Per RHP

**RHP 1**


**Population:** 1,289,873 residents

**Total of Projects in RHP:** 103

**Total DSRIP Funds:** $337,353,431.43

**Anchor:** University of Texas Health Northeast, Tyler, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals; however, there were projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care and specialty care providers, as well as expanding clinic space and/or clinic hours.

Our assessment of 39 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 5 percent were assigned an overall ranking of 1.
- 21 percent were assigned an overall ranking of 2.
- 33 percent were assigned an overall ranking of 3.
- 31 percent were assigned an overall ranking of 4.
- 10 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary and specialty care expansion projects, as well as various innovation and redesign projects implemented by the participating hospital entities, physician practices associated with academic health centers, and community mental health centers. The innovation and redesign projects specific to the region included patient navigation and care transition programs, establishment of telemedicine services, behavioral health interventions, and cost savings and performance improvement. DSRIP projects for three community mental health centers were selected for review and included expansion of outpatient behavioral health services and population-based interventions aimed at improving the functional status of the specified population.

**Higher Risk Projects:** As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

---

1 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Project(s) Recommended for Potential Withdrawal: After our project status review, our assessment is that 5 of the 39 projects in our sample are determined to be at risk for withdrawal from the Waiver program due to substantial lack of progress on DY2 and/or DY3 milestones. These projects are:

- East Texas Medical Center - Tyler (020812601.1.3). The intent of the project was to expand psychiatric services by hiring a psychiatrist. Provider reported challenges with securing the services of a psychiatrist and submitted a plan modification to adjust its baseline to include visits to the entire psychiatric department; however, the purpose of the project was to expand psychiatric services by recruiting a full-time psychiatrist for outpatient and partial hospitalization services. Measuring existing services will not show an expansion and thus, not accomplish this outcome goal.

- East Texas Medical Center – Clarksville (130862905.1.1). The intent of the project was to expand primary care capacity by hiring a new primary care physician and expanding clinic hours. Provider reported near completion of its quantifiable patient impact (QPI) goals at mid-point without hiring a new provider and by expanding its clinic by only four hours. The provider reported that the clinic closed on 12/31/14 and all patients were transferred to another location; therefore, an official withdrawal from the Waiver program should be considered.

- Community Healthcare (137921608.1.3). The intent of the project was to deliver ambulatory detox services in conjunction with a medical provider. Project is assessed as high risk due to the original hosting site (UT Health Northeast) denying the provider clinic space to operate the ambulatory detox program. Community Healthcare had a preliminary agreement with UT Health to co-locate the intended services prior to the Waiver program; however, no written agreements were developed and executed. Provider stated that it is currently searching for another site. Provider noted that it could not provide ambulatory detox without the participation of a medical practice/clinic/hospital. Project has potential for withdrawal if medical services cannot be provided.

- Titus Regional Medical Center (138913209.1.2). The intent of the project was to expand specialty care services by hiring an endocrinologist; however, the provider reported that it was not able to hire the required specialist as of April 2014. The provider’s DY3 metric was to establish a baseline for the measurement of QPI metrics in DY4 and DY5. Without the required specialist, the provider cannot measure patient impact.

- East Texas Medical Center – Gilmer (168447401.1.1). The intent of the project was to expand primary care capacity by expanding clinic hours. Provider had not yet met the DY2 metric of expanding clinic hours. When the East Texas Medical Center System Waiver contact was notified of site visit selection of this project in November of 2014, the contact informed us that this clinic location would close in January of 2015; therefore, an official withdrawal from the Waiver program should be considered.
**Project(s) Considered as Benchmark Projects:** The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Hunt Regional Medical Center Greenville (131038504.1.1). The project is for the expansion of its primary care capacity. The provider reported completing 1,979 visits out of a goal of 2,400 visits at mid-point for metric I-12.1. Provider intends to further increase visits in DY4 and DY5 by referring patients to the primary care clinic from the provider’s patient navigation and transition care Waiver projects. This project was assessed as a benchmark for a primary care project because of the connection to the development and implementation of navigation and transition care programs as a way to increase primary care visits. Other providers have found it challenging to specify how they intend to increase primary care visits over multiple demonstration years beyond simply increasing the number of doctors or expanding hours. Several primary care projects in RHP 1 reported significant challenges (see Project Withdrawal section above) in this area.
RHP 2


Population: 1,460,000 residents

Total Number of Projects in RHP: 85

Total DSRIP Funds: $293,444,016.62²

Anchor: University of Texas Medical Branch at Galveston, Galveston, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals. Although our sample included several primary care expansion projects, only one provider noted challenges with recruiting and hiring physicians. In addition, the University of Texas Medical Branch, the academic health science center in the region, is operating several projects that require data from a regional level and while challenges have been identified, there were no significant risks that would prevent the provider from achieving its metrics and milestones.

Our assessment of 30 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 10 percent were assigned an overall ranking of 1.
- 34 percent were assigned an overall ranking of 2.
- 30 percent were assigned an overall ranking of 3.
- 23 percent were assigned an overall ranking of 4.
- 3 percent were assigned an overall ranking of 5.

In our sample, examples of Category 1 projects included expansion of primary and specialty care; the Category 2 projects included patient navigation and care transition programs, implementation of patient-centered medical homes, chronic care and medication management programs, and various behavioral health services and population-based interventions. DSRIP projects for three community mental health centers (CMHCs) were part of our mid-point assessment review. Ten of the 30 RHP projects in our sample were Waiver projects executed by the CMHCs. Most of these projects implemented a behavioral health intervention for a targeted population, including a residential housing program, evidence-based outpatient therapy services, and a wellness program for individuals with developmental disabilities (IDD). Other projects are aimed at expanding access to behavioral health services for individuals who do not meet the state-specific criteria for services.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- University of Texas Medical Branch (UTMB) Hospital (094092602.1.7)

² This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
• Baptist Hospitals of Southeast Texas (094148602.2.2)
• Spindletop Center (096166602.1.1)
• Spindletop Center (096166602.2.10)
• Physician Practice Affiliated with UTMB (109372601.1.1)
• Physician Practice Affiliated with UTMB (109372601.2.2)
• Burke Center (136367307.2.100)

Project(s) Recommended for Potential Withdrawal: After our project status review and any risks noted by the provider, one project was determined as having the potential for withdrawal from the Waiver program due lack of progress on DY2 and/or DY3 milestones and metrics.

Coastal Health and Wellness Center’s primary care expansion project (019053001.1.1) proposed to increase access to primary care by hiring additional physicians and support staff. As of the mid-point DY3 reporting period, the provider had not been able to expand its existing clinic due to the inability to hire additional staff. In addition to hiring additional primary care physicians (PCPs), the provider intends to add clinic hours using mobile clinics. However, provider has not been able to complete the hiring of providers to staff the mobile clinics. As a result, the ability to meet the QPI metric (I-12.1) in DY4 and DY5 is at risk.

Provider provided an update of its project to us and noted that the required staff was hired at the end of DY3, fulfilling the DY2 carryover metric; however, the provider has experienced turnover of those positions since the October reporting period. Provider did not report the number of increased visits due to the expansion and has yet to increase hours using the mobile clinic option.

Project(s) Considered as Benchmark Projects: The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

• The University of Texas Medical Branch (UTMB) (094092602.1.10). The project was established to create an educational and training program to address Burn and Trauma Care in collaboration with Shriners Hospital for Children in Galveston and has been identified as a benchmark project within RHP 2. In addition to reporting significant progress, this project was chosen as a benchmark for the following reasons:
  o While the provider has chosen a customizable milestone to measure the QPI of the project, the milestone is descriptive and clearly indicates how the metric will be measured, including the specific target population and associated intervention.
  o Provider included a process milestone along with the QPI improvement milestones in DY3-DY5 to show how the provider intends to increase its QPI. In this case, the provider is using the option of expanded specialty care training, one of the few providers that use such a milestone for the 1.9 project options. This project option clearly explains the importance of increased residency training as a method for expanding specialty care. UTMB has grasped the importance of this aspect with this project. The Category 1 Menu for this project option explains the need for residency training in Texas. As an academic health center, UTMB is executing this project according to the objective and goal of the RHP Planning Protocol menu.
RHP 3

Location: Nine counties in Southeast Texas: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, and Wharton.

Population: Over 4,800,000 residents

Total Number of Projects in RHP: 179 projects

Total DSRIP Funds: $1,683,843,730³

Anchor: Harris County Hospital District (Harris Health System), Houston, TX

Overall RHP Mid-Point Assessment RHP: Based on our assessment of the region, it appears that the majority of the projects are on track to be completed and meet the intended goals.

Our assessment of 109 projects in the region resulted in the following overall risk ranking (see Appendix 1 for specific project rankings):

- 3 percent were assigned an overall ranking of 1.
- 38 percent were assigned an overall ranking of 2.
- 31 percent were assigned an overall ranking of 3.
- 27 percent were assigned an overall ranking of 4.
- 1 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary and specialty care expansion projects as well as innovation and redesign projects being implemented by the participating hospital entities, physician practices associated with academic health science centers, community mental health centers, and city and county health departments within the region. Several oral health projects were reviewed, as well as projects for cost containment, including the establishment of a central fill pharmacy. Many providers noted difficulties with obtaining permits for new construction due to backlogs in permitting and approvals at the City of Houston, establishing the necessary IT infrastructure, and the recruiting and hiring of primary care and specialty care providers.

High Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Texana Center (081522701.1.3)
- City of Houston Department of Health and Human Services (093774008.1.3)
- Baylor College of Medicine (082006001.1.1)
- City of Houston Department of Health and Human Services (093774008.1.2)
- City of Houston Department of Health and Human Services (093774008.1.3)
- City of Houston Department of Health and Human Services (093774008.2.2)
- City of Houston Department of Health and Human Services (093774008.2.4)
- City of Houston Department of Health and Human Services (093774008.2.8)
- City of Houston Department of Health and Human Services (093774008.2.9)

³ This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Project(s) Recommended for Potential Withdrawal: After our review of the project and any risks noted by the provider, 1 project (131044305.1.1 – Tomball Regional Hospital) out of the 108 projects in RHP 3 was determined to have the potential for withdrawal from the Waiver due to lack of progress on DY2 and/or DY3 milestones and metrics. The intent of the project was to expand existing primary care capacity by hiring a nurse practitioner for the expansion of evening clinic hours. The provider has reported no progress towards the project activities to date. The provider states that they were unable to find a full time nurse practitioner to commit to work evening shifts at the indigent clinic. Without this position being filled, this project is unable to progress and is likely to not be able to meet any of their metrics going forward.

Project(s) Considered as Benchmark Projects: The following projects were assessed as benchmarks due to their success in accomplishing their project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of their projects. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Harris County Hospital District Ben Taub General Hospital (133355104.2.9). The project is to improve access to care through pre-consult evaluations to facilitate efficient specialty care. This project was identified as a benchmark project due to the substantial lessons learned that were reported in April DY3. Some of these lessons learned include the value of using "Performance Logic" for communication among team members, the early detection and correction of errors in baselines, early engagement of stakeholders, and the need of a patient navigator for the project.
- The University of Texas Health Science Center - Houston (111810101.2.6). The project is to implement a care transitions program. This project was identified as a benchmark project due to significant progress towards the achievement of DY3 metrics, excellent lessons learned regarding the value of early commitment of stakeholders, and having well documented support for the achievement of their metrics. The provider has completed 2 of 3 DY3 metrics and they reported 144 of 250 individuals served as of April DY3.
Texas Children’s Hospital (139135109.1.12). This project is to expand access to specialty care. This project was identified as a benchmark project due to the significant challenges the project has overcome and the lessons learned. The provider has planned ahead to help overcome significant hiring issues in order to remain on track and they are working to increase access to care through clinic expansion in order to attract new patients from areas that may be underserved, which they identified during their CQI efforts.
RHP 4


Population: 747,000 residents

Total Number of Projects in RHP: 91 projects

Total DSRIP Funds: $315,542,183

Anchor: Nueces County Hospital District, Corpus Christi, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, there were several projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care and specialty care providers, as well as expanding clinic space and/or clinic hours.

Our assessment of 37 projects in the region resulted in the following overall risk ranking (see Appendix 1 for specific project rankings):

- 24 percent were assigned an overall ranking of 1.
- 30 percent were assigned an overall ranking of 2.
- 30 percent were assigned an overall ranking of 3.
- 11 percent were assigned an overall ranking of 4.
- 5 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary and specialty care expansion projects, as well as programs designed to integrate primary and behavioral healthcare. DSRIP projects for three community mental health centers were also reviewed. They included the integration of primary and behavioral healthcare and patient navigation programs. Many providers noted difficulties with the recruiting and hiring of primary care and specialty care providers.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- The Corpus Christi Medical Center - Bay Area (020973601.1.4)
- CHRISTUS Spohn Hospital Corpus Christi (121775403.2.5)
- Driscoll Children's Hospital (132812205.1.5)
- Coastal Plains Community Center (080368601.2.1)
- Memorial Hospital (121785303.2.2)

Project(s) Recommended for Potential Withdrawal: After our review of the project and any risks noted by the provider, the Corpus Christi Medical Center – Bay Area project

---

4 This figure represents Category 1 and 3 funds available to the region and does not represent actual payments made to providers.
(020973601.1.1) was recommended for a potential withdrawal because the provider is having difficulties hiring key staff and this is delaying progress on every DY2-3 milestone.

Memorial Hospital's project (121785303.2.2) stated they withdrew from DSRIP in the summer of 2014, due to lack of interest in the school system proceeding further.

**Project(s) Considered as Benchmark Projects:** There were no projects selected for benchmark for this region.
**RHP 5**

**Location:** 4 Counties in South Texas: Cameron, Hidalgo, Starr, and Willacy.

**Population:** 1,260,000 residents

**Total Number of Projects in RHP:** 79 projects

**Total DSRIP Funds:** $481,197,517

**Anchor:** Hidalgo County, Edinburg, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals; however, there were several projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care and specialty care providers, as well as expanding clinic space and/or clinic hours.

Our assessment of 32 projects in the region resulted in the following overall risk ranking (see Appendix 1 for specific project rankings):

- 19 percent were assigned an overall ranking of 1.
- 34 percent were assigned an overall ranking of 2.
- 16 percent were assigned an overall ranking of 3.
- 28 percent were assigned an overall ranking of 4.
- 3 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary and specialty care expansion patient navigation programs, integrated primary and behavioral healthcare, and establishment of telemedicine services. Many providers noted difficulties with finding qualified providers and staff to relocate to the region.

**Higher Risk Projects:** Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Doctor’s Hospital at Renaissance (160709501.1.101)
- Doctor’s Hospital at Renaissance (160709501.1.3)
- University of Texas Health Science Center San Antonio (085144601.1.100)
- UT Health Science Center San Antonio (085144601.1.3)
- Doctor’s Hospital at Renaissance (160709501.1.106)
- Doctor’s Hospital at Renaissance (160709501.1.100)
- Valley Regional Medical Center (020947001.1.100)
- Border Region Behavioral Health Center (121989102.2.1)
- Border Region Behavioral Health Center (121989102.1.2)
- UT Health Science Center San Antonio (085144601.1.2)

**Project(s) Recommended for Potential Withdrawal:** There were no projects recommended for potential withdrawal in this region.

---

5 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
**Project(s) Considered as Benchmark Projects:** There were no projects noted as benchmark projects for this region.
RHP 6


Population: 2,300,000 residents

Total Number of Projects in RHP: 128

Total DSRIP Funds: $882,370,495

Anchor: University Health System, San Antonio, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed; however, several projects were underperforming due to major challenges. Regionally, providers noted difficulty recruiting and hiring, as well as challenges related to delayed project approval.

Our assessment of 61 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 0 percent were assigned an overall ranking of 1.
- 72 percent were assigned an overall ranking of 2.
- 18 percent were assigned an overall ranking of 3.
- 8 percent were assigned an overall ranking of 4.
- 2 percent were assigned an overall ranking of 5.

The projects assessed this RHP consisted mainly of Category 1 and Category 2 projects being implemented by participating hospital entities, community mental health centers, and physician practices associated with academic health science centers. Category 1 projects in our sample included primary care and specialty care expansion, chronic disease management registry, and implementation of technology-assisted telemedicine service projects. Category 2 projects included care transition, behavioral health intervention, and expansion of medical homes project.

Higher Risk Projects: As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Frio Regional Hospital (112688002.1.1)
- Dimmit County Memorial Hospital (112690603.1.2)
- University of Texas Health Science Center at San Antonio (085144601.1.13)
- The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services (137251808.1.5)
- University of Texas Health Science Center at San Antonio (085144601.2.1)

---

6 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Project(s) Recommended for Potential Withdrawal: The University of Texas Health Science Center at San Antonio’s project (085144601.1.6) stated their intent to withdraw the project due to turnover within the department; therefore, an official withdrawal from the Waiver program should be considered.

Project(s) Considered as Benchmark Projects: The following projects were assessed as benchmarks due to their success in accomplishing their project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of their projects. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- San Antonio Metropolitan Health District (091308902.1.1). This project is to improve access to preventive dental services (dental sealants and fluoride varnish applications) by providing preventive oral health services in non-traditional settings to include early childhood education settings and economically disadvantaged public schools.

  San Antonio Metropolitan Health District’s project (091308902.1.1) was assessed as a benchmark project because its lessons learned mentioned in October DY2 and April reporting may be of benefit to other school-based programs. Some of the lessons learned include:
  
  o In order to overcome the challenge of developing detailed services plans with each school district during the summer months when school administration staff was not available, the provider states “Detailed service plans should be solidified prior to the end of the previous school year, in advance of summer break.”
  o Obtaining consent forms during the enrollment process/back-to-school may yield improved participation rates and improved efficiency in distribution of consent forms/parent information sheets.
  o Teachers, school nurses, and administrators would benefit greatly from informational/training sessions prior to clinic sessions. Through these sessions, district staff will gain a better understanding of the impact of oral disease on students’ ability to learn and will become strong advocates for student participation in the program. The opportunity to review program forms and materials, review facility requirements, and pre-post-clinic activities will improve overall project efficiency.

- Hill Country MHDD Centers (133340307.2.1). The project is to implement two Mobile Crisis Outreach Teams.

  Hill Country MHDD Centers’ project (133340307.2.1) was assessed as a benchmark project because they exceeded their QPI goal in DY3 and requested a plan modification to increase subsequent goals. The project also served over 10 percent more Medicaid/uninsured patients than originally expected (98 percent). No significant risks were identified during the review of this project.
RHP 7

Location: 6 counties in Central Texas: Bastrop, Caldwell, Fayette, Hays, Lee, and Travis.

Population: 1,300,000 residents

Total Number of Projects in RHP: 77

Total DSRIP Funds: $494,880,423

Anchor: Central Health, Austin, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals. Regionally, some providers noted difficulty hiring and challenges with delayed project approval (see Appendix 2 for the detailed analysis and assessment of each project).

Our assessment of 35 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 0 percent were assigned an overall ranking of 1.
- 60 percent were assigned an overall ranking of 2.
- 40 percent were assigned an overall ranking of 3.
- 0 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities, local health departments, and a community mental health center. Category 1 projects in our sample included primary care and specialty care expansion, behavioral health enhancement, and culturally-competent care enhancement projects. Category 2 projects included evidence-based disease prevention, behavioral health intervention, and patient navigation projects.

Higher Risk Projects: As a result of our assessment, there were no projects identified as high and very high risk.

Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmark Projects: There were no projects noted as benchmark projects for this region.

---

7 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
RHP 8

Location: 9 counties in Central Texas: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson.

Population: 860,803 residents

Total Number of Projects in RHP: 41 projects

Total DSRIP Funds: $90,438,511

Anchor: Texas A&M Health Science Center – Round Rock, Round Rock, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, there were several projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care and specialty care providers, as well as expanding clinic space and/or clinic hours.

Our assessment of 14 projects in the region resulted in the following overall risk ranking (see Appendix 1 for specific project rankings):

- 14 percent were assigned an overall ranking of 1.
- 36 percent were assigned an overall ranking of 2.
- 36 percent were assigned an overall ranking of 3.
- 14 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary care expansion projects, patient navigation projects, and process and performance improvement projects. The sample also included establishment of telemedicine and telepsychiatry services, behavioral health interventions, health promotion and disease prevention programs, and performance improvement. Many providers noted difficulties with hiring primary care and specialty care providers, delays in approval causing delays in project implementation, and engagement of stakeholders and patients.

Higher Risk Projects: Our evaluation identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Central Counties Services (081771001.1.2)
- Little River Healthcare (183086102.1.1)

Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmark Projects: The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark

---

8 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Little River Healthcare (183086102.1.1). The project is to expand existing primary care capacity. This project was selected as a benchmark because of the project option and how they implemented the project. This project was very active in their outreach efforts through radio spots, newspaper, and school handouts sent home with students, which allowed the project to surpass their project goals.
RHP 9

Location: 3 counties in North Texas: Dallas, Denton, and Kaufman.

Population (2010): 3,134,103 residents

Total Number of Projects in RHP: 131

Total DSRIP Funds: $1,083,956,688

Anchor: Dallas County Hospital District (Parkland Hospital), Dallas, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals. Regionally, some providers noted difficulties with recruiting primary care and specialty care providers, as well as challenges with obtaining the resources needed for Medicaid/Low-Income Uninsured patient referrals.

Our assessment of 74 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 1 percent were assigned an overall ranking of 1.
- 35 percent were assigned an overall ranking of 2.
- 35 percent were assigned an overall ranking of 3.
- 28 percent were assigned an overall ranking of 4.
- 1 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 projects, including expansion of dental services, primary/specialty care expansion, and physician training. Category 2 innovation and redesign projects included hospital and emergency department (ED) transition care and patient navigation program, health promotion and literacy, and performance improvement projects. DSRIP projects for three community mental health centers were selected for review. Projects reviewed included telemedicine services for behavioral health and increasing access to behavioral health services. Most of these providers implemented a behavioral health intervention for a targeted population, including autism therapy and crisis stabilization services.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Medical City Dallas Hospital (020943901.1.2)
- Las Colinas Medical Center (020979301.2.1)
- Medical Center of Lewisville (094192402.2.1)
- Denton Regional Medical Center (111905902.2.2)
- Baylor Medical Center at Irving (121776204.1.2)
- Baylor Medical Center at Irving (121776204.2.5)
- Baylor Medical Center at Garland (121790303.2.5)
- UT Southwestern Medical Center – Faculty Practice Plan (126686802.1.2)

---

9 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmark Projects: The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Dallas County MHMR (dba Metrocare Services) (137252607.2.4). The project is to provide applied behavior analysis (ABA) to children on the autism spectrum and/or children with other developmental disabilities. The project option allows the provider to provide any type of evidence-based behavioral health intervention to prevent the unnecessary use of other levels of care (i.e., criminal justice admissions and/or inpatient mental health admissions). The project milestones chosen by the provider measure both the number of children enrolled in the program, as well as the initial impact of the intervention (functional status of program enrollees). As of the mid-point of the Waiver, the provider was well on-track to complete enrollment in DY3.
RHP 10

Location: 9 counties in North Central Texas: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, and Wise.

Population (2011): 2,444,642 residents

Total Number of Projects in RHP: 126

Total DSRIP Funds: $829,731,892.81

Anchor: JPS Health Network, Fort Worth, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals. Regionally, some providers noted difficulties with recruiting primary care and specialty care providers, as well as challenges with obtaining the resources needed in which to refer Medicaid/Low-Income Uninsured patients. Tracking patients who use various community services that cross providers and regions was also reported as a challenge as many providers cannot track the care of patients outside of a single provider’s system.

Our assessment of 61 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 7 percent were assigned an overall ranking of 1.
- 50 percent were assigned an overall ranking of 2.
- 26 percent were assigned an overall ranking of 3.
- 15 percent were assigned an overall ranking of 4.
- 2 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of a variety of Category 1 and Category 2 projects. Category 1 infrastructure development projects included the expansion of primary and specialty care, expansion of dental services, and the establishment of chronic disease registries by the participating hospital entities. Waiver projects executed by the participating academic health science center included residency training program and remote patient monitoring programs. Our sample of the region’s Category 2 innovation and redesign projects was varied and included chronic care management, patient navigation and transition care programs, and health promotion and disease prevention programs. The community mental health centers in the region and participating hospital entities both selected various behavioral health projects, including integration of behavioral and primary health care, crisis stabilization services, and interventions to reduce the use of unnecessary levels of care, such as inpatient hospitalization or jail admissions.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Medical Center of Arlington (020950401.2.1)

---

10 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
- Cook Children's Medical Center (021184901.1.1)
- Cook Children's Medical Center (021184901.1.2)
- Cook Children's Medical Center (021184901.1.3)
- Plaza Medical Center of Fort Worth (094193202.2.1)
- Texas Health Harris Methodist Hospital Southwest Fort Worth (120726804.2.4)
- Pecan Valley Centers for Behavioral and Developmental Healthcare (130724106.1.1)
- Texas Health Harris Methodist Hospital Hurst-Euless-Bedford (136326908.2.1)
- Pecan Valley Centers for Behavioral and Developmental Healthcare (130724106.1.1)
- Glen Rose Medical Center (216719901.1.1)

**Project Recommended for Potential Withdrawal:** 1 out of 61 projects was identified for potential withdrawal. Glen Rose Medical Center’s project (216719901.2.1) was to implement initiatives to improve the patient experience and patient satisfaction scores. While the provider’s narrative briefly discusses high-level goals of the project, these interventions are not specific and with limited staff it is unclear as to how the provider plans to implement the project. In addition, the provider has not completed any DY2 or DY3 milestones as of the DY3 April reporting period. Provider cited the resignation of an executive manager as the reason for the delay in project progress. Also, the provider states that the volume of the hospital is very low. This could pose a risk to meeting QPI goals and other future goals. In addition to meeting goals, the use of returned surveys from such a small population may not accurately represent the actual issues and weaknesses as a whole.

**Project(s) Considered as Benchmark Projects:** The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- JPS Health Network (126675104.2.12). The project is to implement an evidence-based early detection and treatment plan for patients presenting in the ED with sepsis. The project option is to implement a performance improvement methodology to decrease not only length of ICU stay, but also the mortality rate associate with sepsis overall. JPS Health Network included milestones and other project activities that are unique, innovative, and that would have a direct impact on patient health and outcomes. First, the provider is utilizing a sepsis team to assist other physicians in diagnosing sepsis. This team also provides training to nurses and technicians to recognize signs and symptoms of sepsis. Second, the project chose to use the 3-hour sepsis treatment bundle instead of the 6-hour treatment bundle. This project was further discussed with the provider during the Myers and Stauffer site visits to RHP 10. Finally, the provider is using PDSA cycles to identify improvements to triage protocols for patients who may be at risk for sepsis. No significant risks were noted that could potentially affect completion of DY4 and DY5 milestones.
RHP 11

**Location:** 15 counties surrounding the Abilene area: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall and Taylor.

**Population:** 316,735 residents

**Total Number of Projects in RHP:** 44

**Total DSRIP Funds:** $94,068,543\(^1\)

**Anchor:** Palo Pinto County Hospital District, Mineral Wells, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, several projects were underperforming due to major challenges. Regionally, some providers noted difficulty recruiting and hiring primary care providers.

Our assessment of 20 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 5 percent were assigned an overall ranking of 1.
- 30 percent were assigned an overall ranking of 2.
- 40 percent were assigned an overall ranking of 3.
- 25 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities and community mental health centers within the region. Category 1 projects in our sample included primary care expansion projects and implementation of technology-assisted telemedicine service projects. Category 2 projects included care coordination, health promotion, and palliative care projects.

**Higher Risk Projects:** As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Comanche County Medical Center (281406301.1.2)
- Haskell Memorial Hospital (112702904.1.2)
- Hamlin Memorial Hospital (094131202.1.3)
- Mitchell County Hospital (136325111.1.2)
- Mitchell County Hospital (136325111.2.1)

**Project(s) Recommended for Potential Withdrawal:** There were no projects recommended for potential withdrawal in this region.

---

\(^1\) This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
**Project(s) Considered as Benchmark Projects:** There were no projects noted as benchmark projects for this region.
**RHP 12**


**Population:** 890,820 residents

**Total Number of Projects in RHP:** 100

**Total DSRIP Funds:** $315,369,790\(^\text{12}\)

**Anchor:** UMC Health System, Lubbock, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, several projects were underperforming due to major challenges. Regionally, some providers noted difficulty in recruiting and hiring.

Our assessment of 33 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 15 percent were assigned an overall ranking of 1.
- 49 percent were assigned an overall ranking of 2.
- 27 percent were assigned an overall ranking of 3.
- 9 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities, academic health science centers, local health departments, and a community mental health center within the region. Category 1 projects in our sample included primary care and specialty care expansion, urgent medical advice enhancement, and quality improvement process enhancement projects. Category 2 projects included patient experience improvement, quality/efficiency improvement, and enhancement of medical homes projects.

**Higher Risk Projects:** As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Memorial Hospital (094121303.2.1)
- City of Amarillo Department of Public Health (065100201.1.1)
- Coon Memorial Hospital and Home (130826407.1.3)

\(^{12}\) This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmark Projects: The following projects were assessed as benchmarks due to their success in accomplishing their project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of their projects. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Cogdell Memorial Hospital (136330107.1.3). The project is to develop and enhance its performance and quality improvement processes.

  Cogdell Memorial Hospital's project (136330107.1.3) is being assessed as a benchmark project because it is on track in its accomplishment of metrics and milestones, as planned. Additionally, the project appears to have selected appropriate menu milestone metrics that clearly and accurately track how the project goal will be met.

- Memorial Hospital (094129602.1.3). The project is to expand its weekend hospitalist program.

  Memorial Hospital’s project (094129602.1.3) is being assessed as a benchmark project because it is also on track in its accomplishment of metrics and milestones as planned. Additionally, the project also appears to have selected appropriate menu milestones metrics that clearly and accurately track how the project goal will be met.
RHP 13

Location: 17 Counties in West Central Texas: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green.

Population: 190,079 residents

Total Number of Projects in RHP: 38

Total DSRIP Funds: $60,188,246

Anchor: McCulloch County Hospital District, Brady, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed; however, several projects were underperforming due to major challenges. Regionally, some providers noted difficulty recruiting and hiring primary care providers as well as challenges obtaining project funding.

Our assessment of 13 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 15 percent were assigned an overall ranking of 1.
- 47 percent were assigned an overall ranking of 2.
- 15 percent were assigned an overall ranking of 3.
- 23 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities and community mental health centers within the region. Category 1 projects in our sample included primary care expansion, chronic disease management registry, and implementation of technology-assisted telemedicine service projects. Category 2 projects included self-management programs, rapid process improvement, and whole health peer support projects.

Higher Risk Projects: As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- North Runnels Hospital (020989201.1.1)
- Schleicher County Medical Center (179272301.2.2)

Project(s) Recommended for Potential Withdrawal: One project was recommended for potential withdrawal due lack of progress on DY2 and DY3 milestones and metrics (North Runnels Hospital’s project 020989201.2.2). The provider intended to reduce patient costs by purchasing a CT-Scan and alleviating the need for patient transport; however, the provider had not completed any milestones or purchased a CT-Scan as of mid-point DY3 reporting period.

---

13 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
Should the Board not approve the purchase of the CT-Scan, the provider may consider the option of withdrawal.

**Project(s) Considered as Benchmark Projects:** There were no projects noted as benchmark projects for this region.
**RHP 14**

**Location:** 16 counties in West Texas: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, and Winkler.

**Population:** 390,978 residents

**Total Number of Projects in RHP:** 58

**Total DSRIP Funds:** $192,195,137

**Anchor:** Medical Center Health System, Odessa, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, several projects were underperforming due to major challenges. Regionally, some providers noted difficulty hiring and challenges with marketing.

Our assessment of 17 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 6 percent were assigned an overall ranking of 1.
- 52 percent were assigned an overall ranking of 2.
- 18 percent were assigned an overall ranking of 3.
- 18 percent were assigned an overall ranking of 4.
- 6 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities, community mental health centers, and academic health science centers within the region. Category 1 projects in our sample included mainly primary care and specialty care expansion projects. Category 2 projects included rapid process improvement and expansion of chronic care management model projects.

**Higher Risk Projects:** As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Winkler County Memorial Hospital (094204701.1.1)
- Medical Center Hospital (135235306.1.1)
- Odessa Regional Medical Center (112711003.1.5)

**Project(s) Recommended for Potential Withdrawal:** Martin County Hospital District’s project (136145310.2.1) to launch a diabetic self-management outreach education program stated they intend to withdraw the project due to difficulty filling the position for someone to manage the project and did not consider the valuation to be worth the effort; therefore, an official withdrawal from the Waiver program should be considered.

---

14 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
**Project(s) Considered as Benchmark Projects:** There were no projects noted as benchmarks for this region.
RHP 15

**Location:** 2 counties in West Texas: El Paso and Hudspeth.

**Population:** 804,147 residents

**Number of Projects in RHP:** 59

**Total DSRIP Funds:** $380,598,629\(^{15}\)

**Anchor:** University Medical Center of El Paso, El Paso, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, several projects were underperforming due to major challenges. Regionally, some providers noted difficulty recruiting and hiring as well as challenges obtaining funding.

Our assessment of 34 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 3 percent were assigned an overall ranking of 1.
- 56 percent were assigned an overall ranking of 2.
- 29 percent were assigned an overall ranking of 3.
- 12 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities, academic health science centers, and community mental health centers, and a local health department within the region. Category 1 projects in our sample included specialty care expansion, collection of race, ethnicity, and language (REAL) data, and culturally-competent care enhancement projects. Category 2 projects included rapid process improvement projects, evidence-based disease prevention projects, and care transition projects.

**Higher Risk Projects:** As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- City of El Paso Department of Public Health (065086301.1.2)
- Texas Tech HS Ctr Family Med (084597603.1.4)
- Las Palmas Medical Center (094109802.1.1)
- Emergence Health Network (127376505.2.2)

**Project(s) Recommended for Potential Withdrawal:** There were no projects recommended for potential withdrawal in this region.

**Project(s) Considered as Benchmark Projects:** The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through

\(^{15}\) This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Las Palmas Medical Center (094109802.2.1). The project is to streamline the discharge process and emergency department management services. This project was identified as a benchmark project within RHP 15 because of the substantial lessons learned from identifying and overcoming the challenge of hiring case managers. Lessons learned include providing candidates a full scope of the position from the start. This would have helped dispel unfounded perceptions regarding what the position entailed. In a market the size of El Paso, candidates communicate regularly and quickly regarding vacancies in other facilities. A wrong perception spreads just as quickly. The provider had to actively recruit through employees and their peers outside of the facility, as well as inquire with those who were part-time or PRN.
**RHP 16**

**Location:** 7 counties in Central Texas: Coryell, Hamilton, Bosque, Hill, Limestone, Falls, and McLennan.

**Population:** 406,490 residents

**Total Number of Projects in RHP:** 35

**Total DSRIP Funds:** $118,148,410\(^{16}\)

**Anchor:** Coryell County Memorial Hospital, Gatesville, TX

**Mid-Point Assessment RHP Conclusions:** Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals; however, there were projects that were underperforming due to major challenges. Regionally, some providers noted difficulties with delayed project approval.

Our assessment of 11 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 0 percent were assigned an overall ranking of 1.
- 27 percent were assigned an overall ranking of 2.
- 46 percent were assigned an overall ranking of 3.
- 27 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted of Category 1 and Category 2 projects being implemented by participating hospital entities and community mental health centers. Category 1 projects in our sample included primary care expansion projects, the implementation of technology-assisted telepsychiatry and telehealth projects, and telemedicine program implementation projects. Category 2 projects included primary care and behavioral health care integration, medication management, and expansion of chronic care management model projects.

**Higher Risk Projects:** As a result of our assessment, the following projects were identified as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Heart of Texas Region MHMR Center (084859002.2.1)
- Goodall-Witcher Healthcare Foundation (137075109.2.1)
- Goodall-Witcher Healthcare Foundation (137075109.1.5)

**Project(s) Recommended for Potential Withdrawal:** There were no projects recommended for potential withdrawal in this region.

**Project(s) Considered as Benchmarks:** There were no projects noted as benchmark projects for this region.

---

\(^{16}\) This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.

Population: 843,054 residents

Total Number of Projects in RHP: 32

Total DSRIP Funds: $66,392,053\(^{17}\)

Anchor: Texas A&M Health Science Center, College Station, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals; however, there were projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care and specialty care providers, as well as expanding clinic space and/or clinic hours.

Our assessment of 15 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 7 percent were assigned an overall ranking of 1.
- 53 percent were assigned an overall ranking of 2.
- 20 percent were assigned an overall ranking of 3.
- 20 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary and specialty care expansion projects, as well as various innovation and redesign projects implemented by the participating hospital entities, academic health science centers, and community mental health centers. A provider (Huntsville Memorial Hospital (189791001.1.100) noted difficulty finding land for sale and other providers noted challenges related to delayed approval of metric achievement.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Conroe Regional Medical Center (020841501.1.2)
- Huntsville Memorial Hospital (189791001.1.1)
- Huntsville Memorial Hospital (189791001.1.100)

Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmarks: The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and

\(^{17}\) This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Texas A&M Physicians (198523601.2.4). This project is to develop and implement a home-based palliative care program for patients with chronic conditions and has been identified as a benchmark project. This project is on track to accomplish its metrics and milestones as planned. Additionally, the project has selected appropriate menu milestones and metrics that clearly and accurately track how the project goals will be met.
RHP 18

Location: 3 counties in North Central Texas: Collin, Grayson, and Rockwall.

Population: 1,014,935 residents

Number of Projects in RHP: 23

Total DSRIP Funds: $95,408,770.03\(^{18}\)

Anchor: Collin County, McKinney, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals; however, there were projects that were underperforming due to major challenges. Regionally, providers noted difficulties with new or expanded clinic space, either with the building itself or with securing a proper location.

Our assessment of 13 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 8 percent were assigned an overall ranking of 1.
- 23 percent were assigned an overall ranking of 2.
- 38 percent were assigned an overall ranking of 3.
- 23 percent were assigned an overall ranking of 4.
- 8 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary and specialty care expansion, as well as behavioral health intervention projects, implemented by participating hospital entities and community mental health centers. The behavioral health projects reviewed in our sample include peer support specialist programs, comprehensive treatment options for populations not covered under state funding, physical health and nutrition awareness, and integration with primary care.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- LifePath Systems (084001901.2.1)
- LifePath Systems (084001901.2.3)
- Texoma Community Center (084434201.2.2)
- Children's Medical Center of Dallas (138910807.1.1)

Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmarks: The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and

\(^{18}\) This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- LifePath Systems (084001901.2.2). This project is to create intensive services for special populations, including veterans and persons with severe mental illnesses who are in the court system, individuals with intellectual disabilities, and very young children who have been abused. The provider has chosen a project option that is very broad in definition (evidence-based intervention); however, the goal of the project option is to assess some type of effectiveness using the choice of improvement milestones. For its DY4 and DY5 milestones, the provider has chosen one process and improvement milestone for each. The process milestone measures the actual number of patients served while the improvement milestone is measuring a percentage of those patients who demonstrate improved functional status. This measure is a key feature of this project option. In addition, the process milestones chosen in DY2 and DY3 assist the provider in developing and implementing the appropriate and needed interventions. Also, the narrative accurately addresses all the aspects of the program, including a clear definition of the interventions, goals, and target population. As a result, the provider is on track to complete its metrics.
RHP 19

Location: 12 counties in North Central Texas: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, and Young.

Population: 260,157 residents

Number of Projects in RHP: 37

Total DSRIP Funds: $78,695,333

Anchor: Electra Hospital District, Electra, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet the intended goals; however, there were projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care providers as well as expanding clinic space and/or clinic hours.

Our assessment of 18 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 17 percent were assigned an overall ranking of 1.
- 38 percent were assigned an overall ranking of 2.
- 28 percent were assigned an overall ranking of 3.
- 11 percent were assigned an overall ranking of 4.
- 6 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of primary/specialty care expansion projects, as well as various Category 2 innovation and redesign projects. In our sample, the Category 2 projects included hospital and ED transition care, health promotion and literacy, and performance improvement projects. DSRIP projects for two community mental health centers were included in the projects selected for review. Projects reviewed included telemedicine services for behavioral health, increasing access to behavioral health services, and care management of primary and behavioral health care services.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Hamilton Hospital (110856504.2.2)
- Wilbarger General Hospital (112707803.1.1)
- Graham Regional Medical Center (130613604.1.2)

Project(s) Recommended for Potential Withdrawal: After our project status review, our assessment is that one of the 18 projects in our sample is determined to be at risk for withdrawal from the Waiver program due to substantial lack of progress on DY2 and/or DY3 milestones.

19 This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
- Graham Regional Medical Center (130613604.1.2). The provider intended to expand primary care, but the provider had not completed any milestones as of the mid-point DY3 reporting period. To expand care, the provider’s process goals included expanding by adding an additional primary care physician and clinic space by adding exam rooms to house the additional provider. The provider then planned to increase the volume of the clinic’s visits over three demonstration years, with each year’s total increasing by 50 visits over the previous year’s total.

**Project(s) Considered as Benchmarks:** The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

- Faith Community Hospital (119874904.2.2). This project to implement a transition care program for post-discharge ED patients has been identified as a benchmark project within RHP 19. The provider included all the necessary metrics and milestones as a way to accurately measure process and improvement goals. Although the provider is including a customizable milestone in DY3-DY5 to measure the number of patients receiving transition care, we found this to be acceptable since the provider is also including two other improvement milestones in DY4 and DY5 directly from the menu. The provider developed a customizable milestone to report an absolute number instead of having to calculate a percentage. In addition, the provider’s reporting and narrative clearly identifies the target population, direct patient benefit, and the specific procedure and resource needs necessary to ensure proper implementation of the project.
RHP 20

Location: 4 counties in South Texas: Jim Hogg, Maverick, Webb, and Zapata.

Population: 330,000 residents

Total Number of Projects in RHP: 25 projects

Total DSRIP Funds: $75,409,165\textsuperscript{20}

Anchor: Webb County, Laredo, TX

Mid-Point Assessment RHP Conclusions: Based on our assessment of the region, it appears that a majority of the projects are on track to be completed and meet their intended goals; however, there were projects that were underperforming due to major challenges. Regionally, providers noted difficulties with recruiting and hiring primary care and specialty care providers as well as expanding clinic space and/or clinic hours.

Our assessment of 11 projects in the region resulted in the following overall risk rankings (see Appendix 1 for specific project rankings):

- 19 percent were assigned an overall ranking of 1.
- 27 percent were assigned an overall ranking of 2.
- 36 percent were assigned an overall ranking of 3.
- 18 percent were assigned an overall ranking of 4.
- 0 percent were assigned an overall ranking of 5.

The projects assessed for this RHP consisted mainly of specialty care expansion projects. The sample also included establishment of workforce enhancement initiatives to encourage behavioral health providers to come to underserved areas, chronic care management, health promotion programs, and improvement of patient experience programs. Many providers noted difficulties with hiring primary care and specialty care providers, and locating suitable locations and equipment needed to provide the appropriate levels of care.

Higher Risk Projects: Our assessment identified the following projects as high and very high risk due to several factors (see Appendix 2 for the detailed analysis and assessment of each project). HHSC should work with these providers to ensure that identified issues are addressed for changes or modifications that may be needed to ensure continuation of project progress.

- Border Region Behavioral Health Center (121989102.2.1)
- City of Laredo Health Department (137917402.2.1)

Project(s) Recommended for Potential Withdrawal: There were no projects recommended for potential withdrawal in this region.

Project(s) Considered as Benchmarks: The following project was assessed as a benchmark due to its success in accomplishing its project goals and objectives through deployment and utilization of what could be considered best practices in the planning, implementation and operation of its project. Our objective in identifying these Benchmark Projects was to provide other providers with examples and a resource that might assist them in improving their projects.

\textsuperscript{20} This figure represents Category 1 and 2 funds available to the region and does not represent actual payments made to providers.
The City of Laredo Health Department (137917402.2.1). This project to establish a chronic care management program for obesity and diabetes was selected as a benchmark project because of their community outreach efforts and utilization of its network used to meet their goals. The health and wellness resource center offers programs, including healthy cooking classes with portion control, Zumba classes, walking clubs, and health screenings.
HHSC Response

Based on the results of the Mid-point Assessment, Myers and Stauffer developed specific recommendations for providers as either plan modifications to address areas of potential non-compliance with RHP plans or technical changes to address corrections needed to project plans, metrics and milestones to ensure alignment with the project’s stated performance outcomes. These recommendations were shared with HHSC staff, who worked with the providers on incorporating the recommended changes in metrics for DY4 and DY5. HHSC reviewed additional information reported by the providers after the mid-point assessment review. Based on this review, if there were Myers and Stauffer recommendations that HHSC did not agree with based on this additional information, HHSC shared this information with Myers and Stauffer. HHSC feedback for each project is documented in Appendix 2.

HHSC followed the following principles during the review and implementation of the recommendations provided by Myers and Stauffer:

- **Changes to DY2 and DY3 metrics.** Even though the concentration of the review was on DY4 and DY5 metrics, Myers and Stauffer provided occasional recommendations for DY2 and DY3 metrics. For the most part, HHSC did not make changes to these metrics, because in many cases providers already reported achievement of the goals. There were a few instances when DY3 goals were updated to remove errors in the description, but only if a provider had not reported achievement of the metric.

- **Changes to DY4 metrics.** Due to the timing of the receipt of the recommendations for the projects, HHSC had limited time to update DY4 metrics and goals, since the reporting period started on April 1, 2015. HHSC prioritized changes that would clarify the goals of the metrics since this will lead to more straightforward reporting on these metrics and require less interpretation of the intended goals set by the project.

- **Changes to DY5 metrics.** HHSC worked with providers on implementing recommendations related to DY5 metrics. There were a number of instances where HHSC staff considered recommendations unnecessary because either the information was already reflected in the metric or there were other sources of information that are used by HHSC as the official record.
  
  - For example, HHSC did not update QPI baseline information for all projects where Myers and Stauffer included this recommendation. When providers report on QPI metrics, they are required to submit QPI templates. Each QPI template requires a provider to report baseline information. Through the development of QPI reporting, QPI templates became the official source of baseline and achievement information.
  
  - In addition, there were recommendations that HHSC considered already addressed though a plan modification process that was open for providers during the summer of 2014 or through the QPI clean-up process that took place after October 2014 reporting.
Changes to the narratives. HHSC staff worked with providers to update narratives to include details of the project in situations where providers deviated from the original plans, to correct errors in the narratives, or reflect additional details as recommended by Myers and Stauffer. HHSC did not update narratives when Myers and Stauffer recommended to reflect Medicaid and Low-Income Uninsured (MLIU) percentages, since HHSC is using a QPI and MLIU Summary File as the official record of this information. This summary is posted on the HHSC website. HHSC also did not update narratives when the recommendation was to update the narrative to reflect the information included in the project's milestones and metrics. Both pieces of information contributed to the full picture of what the project is doing, and if information is reflected in metrics, that is sufficient and does not necessarily need to be reflected in the narrative.

QPI goal changes. Myers and Stauffer had numerous recommendations related to resetting of QPI goals. In cases when providers reported overachievement of DY3 goals, Myers and Stauffer recommended increasing QPI goals in DY4 and DY5. When the project was considered off-track due to delays in implementing certain activities, Myers and Stauffer recommended revisiting the project's goals and adjusting them as necessary.

  a. QPI increases. Myers and Stauffer often recommended increasing QPI goals when a provider reported achievement of DY3 metrics and actual achievement was higher than the goal set for the metric. HHSC staff compared DY3 achievement to DY4 and DY5 goals and if DY3 achievement was close to the DY4 goal, HHSC staff shared the Myers and Stauffer recommendation with the provider to increase goals, and asked for an updated goal for DY5. As discussed previously, HHSC did not update DY4 goals due to the timing of Myers and Stauffers' recommendations since providers were already reporting on DY4 achievement. HHSC established a more structured process for increasing DY5 goals for projects that met or exceeded DY5 goals in DY3. HHSC requested that all projects in this category increase their DY5 goals based on a standard methodology developed by HHSC, which takes into account DY3 achievement and the increase between DY4 and DY5 as previously set in goals. Updating DY5 QPI goals is still in process and will be completed in June.

  b. QPI decreases. Myers and Stauffer often recommended revisiting QPI goals if the project was behind in reporting prior years' metrics, or communicated concerns related to hiring of staff, opening of clinics, or reported delays in other core project activities. HHSC did not initiate QPI goal reductions for all projects where such a recommendation was received. In summer of 2014, all providers had an opportunity to request plan modifications to adjust the scope of the projects or QPI goals, if necessary. Providers had to submit a thorough explanation of all of the change requests. If a provider had serious concerns related to achieving a project's goals, HHSC worked with the provider to adjust the goals, including that the project remained within the valuation ranges. HHSC did not simply approve goals reductions, but required providers to strengthen the projects by adding other milestones to compensate for the reduction.
Since all providers had the opportunity to adjust their projects, HHSC did not initiate discussions regarding project goals for all projects. HHSC understands that smaller providers may often struggle with the ability to predict recruitment trends or compete with larger providers in hiring staff. In addition, smaller providers usually operate in rural areas, which can bring additional complications due to the size of the areas covered by projects. Providers with smaller projects may have more difficulty than larger providers in adjusting their projects when major delays happen. Based on this, HHSC established a policy of considering DY5 goal reductions only for projects with valuation at or below $5 million over 4 years. All providers regardless of valuation will be able to request carryforward for DY5 metrics if providers cannot achieve the goals in DY5.

- **Project withdrawals.** Myers and Stauffer recommended withdrawal for a number of projects and explained the reasons for such recommendations. For each project with this recommendation, HHSC staff reviewed subsequent reporting to determine if the project made any progress since the April 2014 reporting period. If the project reported success in overcoming challenges and appeared to be on track, HHSC did not initiate project withdrawal with the provider.

The following section shows Myers and Stauffer’s recommended withdrawal of projects in each RHP and HHSC’s assessment.

In RHP 1, MSLC recommended considering withdrawal for five (5) projects.

- East Texas Medical Center - Tyler (020812601.1.3) - project withdrew prior to May 1, 2015
- East Texas Medical Center – Clarksville (130862905.1.1) - project withdrew prior to May 1, 2015
- Community Healthcore (137921608.1.3) - MSLC recommended to consider plan modifications since the provider was not be able to operate the ambulatory detox program. The project has potential for withdrawal if medical services cannot be provided. After project review, the provider communicated to HHSC ideas for plan modification that would allow the project to deliver necessary services. HHSC is working with the provider to make needed project changes.
- Titus Regional Medical Center (138913209.1.2) - project withdrew prior to May 1, 2015
- East Texas Medical Center – Gilmer (168447401.1.1) - project withdrew prior to May 1, 2015

In addition, there were three (3) more projects that went through the mid-point assessment and withdrew prior to the May 1 deadline: East Texas Medical Clinic - Tyler (020812601.2.1) and (020812601.2.2), and East Texas Medical Center - Crockett (137319306.1.1).

In RHP 2, MSLC recommended to consider withdrawal of one (1) project.

- Coastal Health and Wellness Center’s primary care expansion project (019053001.1.1) - HHSC contacted the provider to determine current project status. The provider stated that although there was initially a delay in hiring staff, they have seen an increase in the number of patient encounters on a consistent basis. The provider currently has all positions filled related to the DSRIP project with the exception of one position of Patient
Service Specialist and three provider vacancies. The Patient Service Specialist position is being filled by temporary staffing at this time. The provider positions are posted and Coastal Health & Wellness is actively trying to fill the positions. The provider was able to achieve the DY3 carry-forward QPI goal as of January 2015, and has started counting encounters related to the DY4 QPI goal. Based on the current project status, HHSC does not recommend that the project withdraw.

In RHP 3, MSLC recommended to consider withdrawal of one (1) project.

- Tomball Regional Hospital (131044305.1.1) - project withdrew prior to May 1, 2015

In addition, three (3) more projects withdrew prior to the May 1 deadline in RHP 3: Chambers County Public Hospital District (020993401.1.100), Rice Medical Center (212060201.1.5) and Harris County Hospital District - Ben Taub General Hospital (133355104.1.17)

In RHP 4, MSLC recommended to consider withdrawal of two (2) projects.

- Corpus Christi Medical Center – Bay Area project (020973601.1.1) - project withdrew prior to May 1, 2015
- Memorial Hospital's project (121785303.2.2) - project withdrew prior to May 1, 2015

In RHP 5, MSLC did not recommend any withdrawals.

In RHP 6, MSLC recommended to consider withdrawal of one (1) project.

- The University of Texas Health Science Center at San Antonio (085144601.1.6) - project withdrew prior to May 1, 2015

In addition, two (2) more projects withdrew prior to the May 1 deadline in RHP 6: University of Texas Health Science Center at San Antonio (085144601.1.11 and 085144601.2.1)

In RHP 7, MSLC did not recommend any withdrawals. One project withdrew prior to May 1 in RHP 7: St. Mark’s Medical Center (176692501.1.1).

In RHP 8, MSLC did not recommend any withdrawals. One project withdrew prior to May 1 in RHP 8: Central Counties Services (081771001.1.2).

In RHP 9, MSLC did not recommend any withdrawals. One project withdrew prior to May 1 in RHP 9: UT Southwestern Medical Center at Dallas (126686802.1.7).

In RHP 10, MSLC recommended to consider withdrawal of one (1) project.

- Glen Rose Medical Center’s (216719901.2.1) - MSLC recommended that the project consider withdrawal due to DY3 milestones not being met and missing details on how the project will improve patient experience with the changes in project staff. Provider responded that they will not withdraw because they have hired a new Chief Nursing Officer who has implemented new processes and an interdisciplinary team to get the project back on schedule and improve patient satisfaction.

In addition, one (1) more project withdrew prior to May 1 in RHP 10: Tarrant County Hospital District dba JPS Health Network (126675104.2.17)

In RHP 11, MSLC did not recommend any withdrawals. One project withdrew prior to May 1 in RHP 11: Anson General Hospital (094104901.1.1).
In RHP 12, MSLC did not recommend any withdrawals. One project withdrew prior to May 1 in RHP 12: Dallam-Hartley Counties Hospital District dba Coon Memorial (130826407.1.3).

In RHP 13, MSLC recommended to consider withdrawal of one (1) project.

- North Runnels Hospital (020989201.2.2) - MSLC recommended considering the project withdrawal if provider does not obtain the CT scanner. HHSC is not recommending project withdrawal, because the provider leased the CT scanner and intends to move forward with the project. Since the project was delayed, HHSC approved reduction in DY5 QPI, considering that the project is still within the valuation range.

In RHP 14, MSLC recommended to consider withdrawal of one (1) project.

- Martin County Hospital District's project (136145310.2.1) - project withdrew prior to May 1, 2015

In addition, one (1) more project withdrew prior to May 1 in RHP 14: McCamey County Hospital District (094172602.2.1)

In RHP 15, MSLC did not recommend any withdrawals.

In RHP 16, MSLC did not recommend any withdrawals. One project withdrew prior to May 1 in RHP 16: Central Counties Services (081771001.1.1).

In RHP 17, MSLC did not recommend any withdrawals. Three (3) projects withdrew prior to May 1 in RHP 17: MHMR Authority of Brazos Valley (136366507.2.3) and Montgomery County Public Health District (311035501.2.1 and 311035501.2.2).

In RHP 18, MSLC did not recommend any withdrawals.

In RHP 19, MSLC recommended to consider withdrawal of one (1) project.

- Graham Regional Medical Center (130613604.1.2) - Based on HHSC review of the information reported subsequent to April 2014, the provider is moving forward with this project. At the end of DY3, the provider received approval for one of the DY2 metrics. The provider did not report achievement of DY3 and DY4 QPI metrics, but stated that the facility is on track to accomplish the targeted goals for DY3 and DU4 by the end or the DY4 reporting period in September. The provider agreed with HHSC's assessment and stated that at this time no adjustments to DY5 goals are necessary.

In RHP 20, MSLC did not recommend any withdrawals.
Appendix 1

RHP Risk Rankings
Appendix 2

Justifications, Recommendations and Responses

Appendix 2 includes HHSC responses to recommendations made by Myers and Stauffer. HHSC’s responses were not part of our assessment and are included for informational purposes only.
Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Texas Medical Center - Quitman 01762402.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>East Texas Medical Center - Tyler 020812601.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>East Texas Medical Center - Tyler 020812601.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>East Texas Medical Center - Tyler 020812601.2.2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>East Texas Medical Center - Tyler 020812601.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Good Shepherd Medical Center 094095902.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Mother Frances Hospital 094108002.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mother Frances Hospital 094108002.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mother Frances Hospital 094108002.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>East Texas Medical Center Trinity 121817401.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>University Physician Associates 127278302.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Entity</td>
<td>Code</td>
<td>Year</td>
<td>City</td>
<td>Region</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>--------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.1.11</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.1.13</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.1.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.2.16</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.2.17</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.2.19</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.2.22</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>UTHSCT - MSRDP (University Physician Associates) 127278302.2.23</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>East Texas Medical Center - Clarksville 130862605.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Hopkins County Memorial Hospital 131037704.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Hunt Regional Medical Center Greenville 131038504.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hunt Regional Medical Center Greenville 131038504.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>East Texas Medical Center - Crockett 137319306.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Community Healthcore 137921608.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Medical Center</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>East Texas Medical Center Pittsburg</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Titus Regional Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Titus Regional Medical Center</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>East Texas Medical Center - Athens</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>East Texas Medical Center - Athens</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>East Texas Medical Center Athens</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>East Texas Medical Center - Gilmer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Red River Regional Hospital</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Red River Regional Hospital</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Andrews Center</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
RHP 2 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal Health &amp; Wellness 019053001.1.1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.1.10</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.1.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.1.3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.1.7</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.1.9</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.2.1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.2.11</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.2.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 094092602.2.8</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baptist Hospitals of Southeast Texas 094148602.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Baptist Hospitals of Southeast Texas 094148602.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Spindletop Center 096166602.1.1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Spindletop Center 096166602.1.6</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Spindletop Center 096166602.2.10</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Description</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td>Column 9</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Spindletop Center 096166602.2.11</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Spindletop Center 096166602.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Spindletop Center 096166602.2.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Physician Practice affiliated with UTMB 109372601.1.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Physician Practice affiliated with UTMB 109372601.2.2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Physician Practice affiliated with UTMB 109372601.2.3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Brazosport Regional Health System 112671602.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Angleton-Danbury Medical Center 121805903.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nacogdoches Memorial Hospital 131030203.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>The Gulf Coast Center 135222109.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>The Gulf Coast Center 135222109.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Burke Center 136367307.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Burke Center 136367307.2.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>N/A</td>
<td>4</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>Tyler County Hospital 136381405.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CHRISTUS Hospital 138296208.1.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
RHP 3 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bayshore Medical Center 020817501.1.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bayshore Medical Center 020817501.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Memorial Hermann Northwest Hospital 020834001.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Hermann Northwest Hospital 020834001.1.4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Hermann Northwest Hospital 020834001.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texana Center 081522701.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Texana Center 081522701.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Baylor College of Medicine 082006001.1.1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.1.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.1.4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Institution</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td>Column 9</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.10</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.8</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.9</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>West Houston Medical Center 094187402.2.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Spindletop Center 096166602.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Spindletop Center 096166602.2.2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.1.10</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.1.2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.1.5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.1.7</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.1.8</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.1.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Institution</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas M.D. Anderson Cancer Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas M.D. Anderson Cancer Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas M.D. Anderson Cancer Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.2.1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.2.2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.2.3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.2.4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.2.5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.2.9</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>OakBend Medical Center 127303903.1.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>OakBend Medical Center 127303903.1.3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>OakBend Medical Center 127303903.2.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Matagorda Regional Medical Center 130959304.1.1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Matagorda Regional Medical Center 130959304.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Matagorda Regional Medical Center 130959304.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tomball Regional Hospital 131044305.1.1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>El Campo Memorial Hospital 131045004.2.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.11</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.12</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.13</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.14</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.15</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.17</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.8</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.1.9</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Code</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.3</td>
<td></td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.4</td>
<td></td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.5</td>
<td></td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.8</td>
<td></td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital 133355104.2.9</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Columbus Community Hospital 135033204.1.1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Hermann Hospital 137805107.1.1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Hermann Hospital 137805107.1.2</td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Medical Center 137909111.1.1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Medical Center 137909111.2.1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Memorial Medical Center 137909111.2.2</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Medical Center 137909111.2.3</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>The Methodist Hospital 137949705.2.1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.11</td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.11</td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.12</td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.15</td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.16</td>
<td></td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.2</td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Facility Name</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>139135109.1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>139135109.1.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>139135109.1.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>139135109.1.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>139135109.1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>139135109.2.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist Willowbrook Hospital</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>140713201.2.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Joseph Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>181706601.2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>212060201.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>212060201.1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice Medical Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>212060201.1.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice Medical Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>212060201.2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice Medical Center</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>212060201.2.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Bend County Clinical Health Services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>296760601.1.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Bend County Clinical Health Services</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>296760601.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Bend County Clinical Health Services</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>296760601.2.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Bend County Clinical Health Services</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>296760601.2.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OakBend Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td>1</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>127303903.2.101</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RHP 4 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHRISTUS Spohn Hospital Beeville 020811801.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Beeville 020811801.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area 020973601.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Memorial Hospital 121785303.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Kleberg 136436606.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area 020973601.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi 121775403.1.4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 132812205.1.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>DeTar Hospital Navarro 094118902.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Beeville 020811801.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>MHMR of Nueces County 138305109.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi 121775403.2.10</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi 121775403.2.5</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Alice 094222902.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>EIN</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Gulf Bend Center</td>
<td>135254407.2.1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi</td>
<td>121775403.2.4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Kleberg</td>
<td>136436606.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>121990904.2.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Driscoll Children's Hospital</td>
<td>132812205.1.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Driscoll Children's Hospital</td>
<td>132812205.1.3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>DeTar Hospital Navarro</td>
<td>094118902.2.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Driscoll Children's Hospital</td>
<td>132812205.2.3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area</td>
<td>020973601.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Alice</td>
<td>094222902.2.3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi</td>
<td>121775403.2.11</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi</td>
<td>121775403.2.9</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Citizens Medical Center</td>
<td>137907508.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area</td>
<td>020973601.1.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Yoakum Community Hospital</td>
<td>112673204.1.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Driscoll Children's Hospital</td>
<td>132812205.1.5</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area</td>
<td>020973601.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>080366601.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>121785303.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Corpus Christi-Nueces County Public Health District</td>
<td>130958505.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td>3</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>Citizens Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td>3</td>
<td>N/A</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
## RHP 5 Risk Rankings

### Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned timelines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.**

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>UT Health Science Center San Antonio 085144601.1.1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.104</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.105</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Doctor's Hospital at Renaissance 160709501.1.4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Doctor's Hospital at Renaissance 160709501.1.101</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Doctor's Hospital at Renaissance 160709501.1.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.103</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>University of Texas Health Science Center San Antonio 085144601.1.100</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Knapp Medical Center 135035706.1.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health 138708601.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>UT Health Science Center San Antonio 085144601.1.3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Doctor's Hospital at Renaissance 160709501.1.106</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Doctor's Hospital at Renaissance 160709501.1.102</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 132812205.1.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Doctor's Hospital at Renaissance 160709501.1.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Valley Regional Medical Center 020947001.1.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Name</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>UT Health Science Center San Antonio 085144601.2.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Columbia Rio Grande Healthcare dba Rio Grande Regional</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center- Houston 111810101.2.101</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 132812205.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health 138708601.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health 138708601.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Starr County Memorial Hospital 136332705.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>UT Health Science Center San Antonio 085144601.2.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>McAllen hospitals LP dba Edinburg Regional Medical 094113001.2.100</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health 138708601.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health 138708601.2.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>UT Health Science Center San Antonio 085144601.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.1.2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>University of Texas Health Science Center- Houston 111810101.1.100</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.2.2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
### RHP 6 Risk Rankings

**Risk Assessment Methodology**

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note:** A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.23</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Hospital 020844901.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Hospital 136141205.2.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>N/A</td>
<td>2</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.20</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Peterson Regional Medical Center 127294003.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.2.5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baptist Medical Center 159156201.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.11.11</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Frio Regional Hospital 112688002.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Dimmit County Memorial Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retarditation Center dba Bluebonnet Trails Community Services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>University Hospital 136141205.1.9</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.16</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Methodist Hospital 094154402.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.15</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Medina Regional Hospital 133260309.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University Hospital 136141205.1.4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Val Verde Regional Medical Center 119877204.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University Hospital 136141205.1.11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Connally Memorial Medical Center 135151206.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Baptist Medical Center 159156201.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.9</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services, dba/ The Center For Health Care Services 137251808.1.5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>University Hospital 136141205.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Code</td>
<td>Location 1</td>
<td>Location 2</td>
<td>Location 3</td>
<td>Location 4</td>
<td>Location 5</td>
<td>Location 6</td>
<td>Location 7</td>
<td>Location 8</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>University Hospital 136141205.1.6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University Hospital 136141205.1.10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>University Hospital 136141205.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>San Antonio Metropolitan Health District 091308902.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Community Medicine Associates 092414401.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baptist Medical Center 159156201.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Dimmit County Memorial Hospital 112690603.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Hospital 020844901.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Peterson Regional Medical Center 127294003.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Texas Center for Infectious Disease 133257904.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Methodist Hospital 094154402.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Hospital 136141205.2.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Methodist Hospital 094154402.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 128844305.2.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services, db/a The Center For Health Care Services 137251808.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nix Health Care System 112676501.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Organization</td>
<td>Code</td>
<td>Group</td>
<td>Line 1</td>
<td>Line 2</td>
<td>Line 3</td>
<td>Line 4</td>
<td>Line 5</td>
<td>Line 6</td>
<td>Line 7</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------</td>
<td>-------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Nix Health Care System 112676501.2.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>San Antonio Metropolitan Health District 091308902.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Guadalupe Regional Medical Center 138411709.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services, dba/ The Center For Health Care Services 137251808.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>University Hospital 136141205.2.9</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Community Medicine Associates 092414401.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Hospital 136141205.2.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nix Health Care System 112676501.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### Risk Assessment Methodology

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note:** A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider</th>
<th>Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Texas Medical Center</td>
<td>121789503.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Dell Children's Medical Center</td>
<td>186599001.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Austin Travis County Integral Care</td>
<td>133542405.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>St. Mark's Medical Center</td>
<td>176682501.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University Medical Center at Brackenridge</td>
<td>137268506.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers)</td>
<td>133340307.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Community Care Collaborative</td>
<td>307459301.1.4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Community Care Collaborative</td>
<td>307459301.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services</td>
<td>126844305.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services</td>
<td>126844305.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers)</td>
<td>133340307.2.11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Community Care Collaborative 307459301.2.5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>University Medical Center at Brackenridge 137265806.2.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Community Care Collaborative 307459301.2.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>City of Austin - Health &amp; Human Services Department 201320302.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center at Brackenridge 137265806.2.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Austin Travis County Integral Care 133542405.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>University Medical Center at Brackenridge 137265806.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>City of Austin - Health &amp; Human Services Department 201320302.2.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University Medical Center at Brackenridge 137265806.2.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Community Care Collaborative 307459301.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Dell Children's Medical Center 186599001.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Community Care Collaborative 307459301.2.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dell Children's Medical Center 186599001.2.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Austin Travis County Integral Care 133542405.2.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Dell Children's Medical Center 186599001.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Austin Travis County Integral Care 133542405.2.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Col1</td>
<td>Col2</td>
<td>Col3</td>
<td>Col4</td>
<td>Col5</td>
<td>Col6</td>
<td>Col7</td>
<td>Col8</td>
<td>Col9</td>
<td>Col10</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>University Medical Center at Brackenridge</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Austin - Health &amp; Human Services Department</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
RHP 8 Risk Rankings

Risk Assessment Methodology

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round Rock Medical Center 020957901.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Williamson County &amp; Cities Health District 126936702.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services 126844305.1.5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Central Counties Services 081771001.1.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Central Counties Services 081771001.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Scott and White Hospital - Llano 020840701.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Williamson County &amp; Cities Health District 126936702.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bell County Public Health District 088334001.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Williamson County &amp; Cities Health District 126936702.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services 126844305.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Central Counties Services 081771001.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Seton Highland Lakes Hospital 094151004.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Scott and White Hospital - Llano 020840701.2.2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Little River Healthcare 183086102.1.1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
RHP 9 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas A&amp;M Health Science Center / Baylor College of Dentistry 009784201.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Texas A&amp;M Health Science Center / Baylor College of Dentistry 009784201.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Texas Health Presbyterian Hospital Dallas 020908201.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texas Health Presbyterian Hospital Dallas 020908201.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Medical City Dallas Hospital 020943901.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Medical City Dallas Hospital 020943901.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Medical City Dallas Hospital 020943901.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Health Presbyterian Hospital Denton 020967801.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Las Colinas Medical Center 020979301.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center of Lewisville 094192402.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center of Lewisville 094192402.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Doctor's Hospital at White Rock Lake 094194002.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Denton Regional Medical Center 111905902.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Denton Regional Medical Center 111905902.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Location</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td>Column 9</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Baylor Medical Center at Irving</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor Medical Center at Irving</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Baylor Medical Center at Irving</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baylor Medical Center at Irving</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baylor Medical Center at Irving</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Baylor Medical Center at Garland</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor Medical Center at Garland</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baylor Medical Center at Garland</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baylor Medical Center at Garland</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Lakes Regional MHMR Center</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Lakes Regional MHMR Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Plan Description</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.6</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.1.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.1.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.1.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.1.5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.11</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.10</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parkland Memorial Hospital 127295703.2.12</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td>Column 9</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Parkland Memorial Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Denton County MHMR Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Denton County MHMR Center</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Denton County MHMR Center</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Denton County Health and Human Services</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Dallas County MHMR dba Metrocare Services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dallas County MHMR dba Metrocare Services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baylor University Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor University Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor University Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Baylor University Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>UT Southwestern Medical Center --- Faculty Practice Plan</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Trinity Medical Center 195018001.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Methodist Richardson Medical Center 209345201.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
## RHP 10 Risk Rankings

### Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned timelines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note:** A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Center of Arlington 020950401.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center of Arlington 020950401.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Medical Center of Arlington 020950401.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cook Children's Medical Center 021184901.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Cook Children's Medical Center 021184901.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cook Children's Medical Center 021184901.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tarrant County/dba Tarrant County Public Health 022817305.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Tarrant County/dba Tarrant County Public Health 022817305.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Tarrant County/dba Tarrant County Public Health 022817305.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Tarrant County/dba Tarrant County Public Health 022817305.2.8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>MHMR of Tarrant County 081599501.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MHMR of Tarrant County 081599501.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>North Hills Hospital 094105602.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Plaza Medical Center of Fort Worth 094193202.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Plaza Medical Center of Fort Worth 094193202.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Huguley Memorial Medical Center 109574702.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Huguley Memorial Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Health Harris Methodist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hospital Fort Worth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hospital Fort Worth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Fort Worth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakes Regional MHMR Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Hospital Azle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen Farabee Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lakes Regional MHMR Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital JPS Health Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital JPS Health Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hospital JPS Health Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hospital JPS Health Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hospital JPS Health Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hospital JPS Health Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JPS Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Helen Farabee Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

* MYERS AND STAUFFER LC
<table>
<thead>
<tr>
<th>Wise Regional Health System 130606006.2.1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Health Arlington Memorial Hospital 130614405.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pecan Valley Centers for Behavioral and Developmental Healthcare 130724106.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Pecan Valley Centers for Behavioral and Developmental Healthcare 130724106.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor All Saints Medical Center at Fort Worth 135036506.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor All Saints Medical Center at Fort Worth 135036506.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baylor All Saints Medical Center at Fort Worth 135036506.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baylor All Saints Medical Center at Fort Worth 135036506.2.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Children's Medical Center 138910807.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center 138910807.1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center 138910807.1.4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>University of North Texas Health Science Center 138980111.1.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University of North Texas Health Science Center 138980111.1.1.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University of North Texas Health Science Center 138980111.1.8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Health System</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>University of North Texas Health Science Center 138980111.2.6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>JPS Physician Group 162334001.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Methodist Mansfield Medical Center 186221101.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Wise Clinical Care Associates 206106101.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Glen Rose Medical Center 216719901.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Glen Rose Medical Center 216719901.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**RHP 11 Risk Rankings**

**Risk Assessment Methodology**

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.**

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stonewall Memorial Hospital 020992601.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>West Texas Centers 130725806.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Comanche County Medical Center 281406301.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Helen Farabee Center 127373205.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Palo Pinto General Hospital 138950412.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Fisher County Hospital District 112692202.2.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Palo Pinto General Hospital 138950412.2.2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hendrick Medical Center 138644310.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Rolling Plains Memorial Hospital 133244705.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Knox County Hospital 121053602.2.1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Haskell Memorial Hospital 112702904.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Hendrick Medical Center 138644310.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hendrick Medical Center 138644310.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hamlin Memorial Hospital 094131202.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hamlin Memorial Hospital 094131202.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Center for Life Resources 133339505.1.1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Center for Life Resources 133339505.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Mitchell County Hospital</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hendrick Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Mitchell County Hospital</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
RHP 12 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Tech University Health Sciences Center-Lubbock 084599202.1.2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Childress Regional Medical Center 133250406.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center 137999206.1.4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medical Arts Hospital 189947801.1.2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Lynn County Hospital District 094180903.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cogdell Memorial Hospital 136330107.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Collingsworth General Hospital 126840107.2.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Parmer County Community Hospital, Inc. 137343308.2.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Covenant Medical Center 139461107.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Golden Plains Community Hospital 197063401.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Texas Tech University Health Sciences Center-Lubbock 084599202.1.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>StarCare Specialty Health System 084897001.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>StarCare Specialty Health System 084897001.1.2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Memorial Hospital 094121303.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Sunrise Canyon Hospital 136492909.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Code</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>City of Amarillo Department of Public Health</td>
<td>065100201.1.1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>094129602.1.1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center</td>
<td>137999206.1.3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Helen Farabee Center</td>
<td>127373205.1.2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pampa Regional Medical Center</td>
<td>178848102.1.1</td>
<td>2</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hereford Regional Medical Center</td>
<td>133544006.1.1</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>094129602.1.3</td>
<td>1</td>
<td></td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Coon Memorial Hospital and Home</td>
<td>130826407.1.3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Hereford Regional Medical Center</td>
<td>133544006.2.2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>City of Amarillo Department of Public Health</td>
<td>065100201.2.2</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Covenant Medical Center</td>
<td>139461107.2.3</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Childress Regional Medical Center</td>
<td>133250406.2.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texas Tech University Health Sciences Center-Lubbock</td>
<td>084599202.2.1</td>
<td>1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cogdell Memorial Hospital</td>
<td>136330107.2.1</td>
<td>2</td>
<td></td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Collingsworth General Hospital</td>
<td>126840107.2.1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Ochiltree General Hospital</td>
<td>112704504.2.1</td>
<td>2</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texas Tech University Health Sciences Center-Amarillo</td>
<td>084563802.2.1</td>
<td>2</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Texas Tech University Health Sciences Center-Lubbock</td>
<td>084599202.2.3</td>
<td>2</td>
<td></td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
RHP 13 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note:** A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Runnels Hospital 020989201.1.1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Shannon West Texas Memorial Hospital 137226005.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Center for Life Resources 133339505.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>West Texas Centers 130725806.1.1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>North Runnels Hospital 020989201.2.2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Shannon West Texas Memorial Hospital 137226005.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Heart of Texas Memorial Hospital 138715115.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 133340307.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Schleicher County Medical Center 179272301.2.2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Concho County Hospital 091770005.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lillian M. Hudspeth Memorial Hospital 121781205.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Shannon West Texas Memorial Hospital 137226005.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Reagan Memorial Hospital 121806703.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
RHP 14 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permian Regional Medical Center 127298103.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Reeves County Hospital 112684904.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Odessa Regional Medical Center 112711003.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Winkler County Memorial Hospital 094204701.1.1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center Hospital 135235306.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Permian Basin Community Centers 138364812.2.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texas Tech University Health Science Center-Permian Basin 081939301.1.1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Medical Center Hospital 135235306.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>West Texas Centers 130725806.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Midland Memorial Hospital 136143806.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Odessa Regional Medical Center 112711003.1.5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Texas Tech University Health Science Center-Permian Basin 081939301.2.1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Midland Memorial Hospital 136143806.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Martin County Hospital District 136145310.2.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Medical Center Hospital 135235306.2.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medical Center Hospital 135235306.2.4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
**Risk Assessment Methodology**

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. **Note:** A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Tech Ctr Family Med 084597603.1.5</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Texas Tech Ctr Family Med 084597603.1.6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Texas Tech Ctr Family Med 084597603.1.8</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Texas Tech Ctr Family Med 084597603.1.1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Las Palmas Medical Center 094109802.2.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University Medical Center of El Paso 138951211.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>City of El Paso Department of Public Health 065086301.1.2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>City of El Paso Department of Public Health 065086301.1.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texas Tech Ctr Family Med 084597603.1.4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Las Palmas Medical Center 094109802.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Providence Memorial Hospital 130601104.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sierra Providence East Medical Center 196829901.1.2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>City of El Paso Department of Public Health 065086301.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center of El Paso 138951211.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center of El Paso 138951211.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Las Palmas Medical Center 094109802.1.4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Medical Center</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
<td>Column 4</td>
<td>Column 5</td>
<td>Column 6</td>
<td>Column 7</td>
<td>Column 8</td>
<td>Column 9</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Las Palmas Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Providence Memorial Hospital</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Emergence Health Network</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Emergence Health Network</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University Medical Center of El Paso</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Texas Tech HS Ctr Family Med</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>City of El Paso Department of Public Health</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Las Palmas Medical Center</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Texas Tech HS Ctr Family Med</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sierra Providence East Medical Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>City of El Paso Department of Public Health</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center of El Paso</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>University Medical Center of El Paso</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>El Paso Children's Hospital</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>University Medical Center of El Paso</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Las Palmas Medical Center</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>University Medical Center of El Paso</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Emergence Health Network</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
RHP 16 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned timelines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Counties Services 081771001.1.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Central Counties Services 081771001.1.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Goodall-Witcher Healthcare Foundation 137075109.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hamilton General Hospital 121792903.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hamilton General Hospital 121792903.1.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Heart of Texas Region MHMR Center 084859002.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Coryell Memorial Hospital 134772811.2.7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Goodall-Witcher Healthcare Foundation 137075109.2.1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Limestone Medical Center 140714001.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Goodall-Witcher Healthcare Foundation 137075109.1.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Hamilton General Hospital 121792903.2.10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
RHP 17 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider</th>
<th>Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas A&amp;M Physicians 198523601.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Brazos County Health District 130982504.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Scott &amp; White Hospital 135226205.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Conroe Regional Medical Center 020841501.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Huntsville Memorial Hospital 189791001.1.1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Huntsville Memorial Hospital 189791001.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Huntsville Memorial Hospital 189791001.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Huntsville Memorial Hospital 189791001.1.100</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>St. Joseph Regional Health Center 127267603.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>MHMR Authority of Brazos Valley 13636507.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Texas A&amp;M Physicians 198523601.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Texas A&amp;M Physicians 198523601.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Texas A&amp;M Physicians 198523601.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Montgomery County Public Health District 311036501.2.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>College Station Medical Center 020860501.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Risk Assessment Methodology

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Path Systems 084001901.1.1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>LifePath Systems 084001901.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Life Path Systems 084001901.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Life Path Systems 084001901.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lakes Regional MHMR Center 121988304.2.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas 138910807.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas 138910807.1.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas 138910807.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Tenet Frisco, Ltd d/b/a Centennial Medical Center 169553801.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Texoma Medical Center 194997601.1.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
RHP 19 Risk Rankings

Risk Assessment Methodology
To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texoma Community Center 084434201.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Texoma Community Center 084434201.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hamilton Hospital 110856504.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Wilbarger General Hospital 112707803.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Faith Community Hospital 119874904.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Faith Community Hospital 119874904.2.3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>North Texas Medical Center 121777003.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nocona General Hospital 127310404.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Helen Farabee Center 127373205.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Graham Regional Medical Center 130613604.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Electra Memorial Hospital 135034009.1.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Electra Memorial Hospital 135034009.1.5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Electra Memorial Hospital 135034009.2.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>United Regional Health Care System 135237906.2.1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Facility Name</td>
<td>Value 1</td>
<td>Value 2</td>
<td>Value 3</td>
<td>Value 4</td>
<td>Value 5</td>
<td>Value 6</td>
<td>Value 7</td>
<td>Value 8</td>
<td>Value 9</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>United Regional Health Care System 135237906.2.4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Seymour Hospital 138353107.1.2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Seymour Hospital 138353107.2.3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
### Risk Assessment Methodology

To arrive at our overall risk assessment ranking, we utilized a two-step review and risk assessment process. The first step consisted of an assessment of compliance with the PFM elements. We then combined those compliance assessments with a risk assessment related to any project challenges noted by the provider and/or identified during our review. This resulted in a risk assessment ranking for Compliance and Challenges. The second step included an assessment of project status, including progress on individual metrics and the likelihood of metric accomplishment by the next reporting period. This step was finalized by assigning a risk assessment ranking based on the relative risk of a project not accomplishing its goals and objectives according to its planned time lines. A final overall risk assessment ranking was determined by averaging the two rankings. Note: A 3-point scale (1-3, 1 being the best) was used for the first six scores. A 5-point scale (1-5, 1 being the best) was used for Compliance/Challenges and Progress.

<table>
<thead>
<tr>
<th>RHP Provider Project ID</th>
<th>Compliance with Plan</th>
<th>Core Components</th>
<th>Federal Funding</th>
<th>Clarity of Metrics</th>
<th>Patient Impact</th>
<th>Lessons Learned</th>
<th>Step One: Compliance and Challenges</th>
<th>Step Two: Progress</th>
<th>Overall Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.1.1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 132812205.1.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.1.2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Maverick County Hospital District 137908303.1.1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 132812205.1.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 132812205.2.100</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Laredo Medical Center 162033801.2.1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.2.2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>City of Laredo Health Department 137917402.2.1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.1.3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Recommendations to Provider

Set forth and track all milestones.

The provider should consider including a customizable improvement milestone to measure QPI in DY 4 and DY 5 since both Milestone and Metric had the exact same language. HHSC followed up with the provider who agreed with this recommendation. Metric was updated to reflect: Number of patients positively impacted by improvements, including how the provider intends to measure the metric (i.e., based on satisfaction scores, surveys, etc.).

Set forth and track all milestones.

The QPI metric I-11.1 is only measuring the number of patients who receive the protocol and is not comparing this number to the total population eligible to receive the protocol as required by the Category 2 Menu.

No recommendations at this time.

The provider should consider including a customizable milestone to show an increase in the absolute number of patients. Metric I-11.1 requires the provider show a percentage improvement in the target population. The provider’s goal for DY 4 and DY 5 only indicates a percent increase in the number of patients from year to year. The intent of Milestone I-11 is to compare the number of patients receiving the protocol to the number of patients eligible.

No recommendations at this time.

The provider should consider using a customizable milestone to show an increase in the number of patients who receive a PCP referral. The provider is not comparing this number to the total population eligible to receive the protocol as required in the Category 2 Menu.

No recommendations at this time.

The provider should clarify its metric description for Metric I-101.1 in DY 4 and DY 5. The milestone and metric should not have the exact same language. The phrase “positively impacted by improvements” should be defined in the metric description, including how the provider intends to measure the metric (i.e., based on satisfaction scores, surveys, etc.).

No recommendations at this time.

The provider needs to show how it plans to increase visits without hiring a new provider (such as increasing space or offering extended hours).

However, the provider did not include a metric to actually measure an improvement in patient satisfaction scores.

The provider has noted that it is difficult to impact customer service for each patient in a high volume/high acuity hospital.

The project is on pace to surpass DY 4 & DY 5 goals in the DY 3 reporting period.

HHSC contacted provider to discuss the project status.

Provider withdrew the project.

Possible Project Withdrawal:

Provider should consider the possible withdrawal of this project from the waiver program as it cannot meet its objective. Without hiring a psychiatrist, the provider will not be able to accomplish the goal of the project. The provider needs to fulfill the objective of the project which is to hire a new psychiatrist. If the provider wants to maintain the project, it should submit a plan modification to show how it intends to increase visits without a new hire, such as expanded hours.

The provider should consider using another improvement milestone in DY 5 to show effectiveness of the program, such as a reduction in ED usage by frequent ED users. Currently, the only milestone is I-6.3 which is only measuring the percent of non-emergent patients without a PCP who receive a PCP referral compared to the total non-emergent patients without a PCP — although the provider did not report significant progress in DY 3 on this metric, there is concern that this measurement alone could possibly be easily accomplished. We have seen instances of other providers who referred almost 100% of non-emergent patients to a PCP.

No recommendations at this time.

The provider is on track to complete DY 3 milestones by the next reporting period. The provider has hired staff and opened its new facility. There is one metric that the provider has not hired in the employment in DY 3. Provider needs to show how it plans to increase visits without hiring a new provider (such as increasing space or offering extended hours).

Possible Plan Modification:

Provider is not able to hire a psychiatrist and therefore cannot show an increase in the number of visits due to any type of expansion.

The provider has noted that it is difficult to impact customer service for each patient in a high volume/high acuity hospital.

No recommendations at this time.

Provider withdrew the project.

Technical Change: in order to show an increased percentage between DY 4 and DY 5, provider should use the same baseline for Metrics I-11.1 in DY 4 and DY 5. By changing the denominator between DY 4 and DY 5, as is currently written, the provider is actually showing a decreasing percentage.

No recommendations at this time.

Provider is not able to hire a psychiatrist and therefore cannot show an increase in the number of visits due to any type of expansion.

The provider has noted that it is difficult to impact customer service for each patient in a high volume/high acuity hospital.

No recommendations at this time.

Provider is not able to hire a psychiatrist and therefore cannot show an increase in the number of visits due to any type of expansion.

The provider has noted that it is difficult to impact customer service for each patient in a high volume/high acuity hospital.

No recommendations at this time.

Provider is not able to hire a psychiatrist and therefore cannot show an increase in the number of visits due to any type of expansion.

The provider has noted that it is difficult to impact customer service for each patient in a high volume/high acuity hospital.

No recommendations at this time.
APPENDIX 2 - RHP 1

Provider Project ID  | Overall Risk Ranking | Narrative Describing Mid-Point Assessment Score Justification | Recommendations to Provider | HHSC Response to Recommendation for HHSC | HHSC Response to Recommendations for the Project
--- | --- | --- | --- | --- | ---
East Texas Medical Center Trinity 121817401.1.1 | 4 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider noted in its progress update on the DY 3 report that it is on track to exceed its DY 3 goals. The project option, Performance Improvement and Reporting Capacity, receives a higher ranking with regard to risk. While the provider is reporting a QPI metric, the provider is not measuring patient impact for a particular service or direct patient intervention. While the provider describes patient impact in the narrative, these benefits are indirect in that quality improvement reports will allow the provider to implement changes, which will affect patients at a later time as these changes are made to services and service delivery. | No recommendations at this time. | No recommendations at this time. | N/A
Frisco Community Center 59434201.1.4 | 2 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The project option, Performance Improvement and Reporting Capacity, receives a higher ranking with regard to risk. While the provider is reporting a QPI metric, the provider is not measuring patient impact for a particular service or direct patient intervention. While the provider describes patient impact in the narrative, these benefits are indirect in that quality improvement reports will allow the provider to implement changes, which will affect patients at a later time as these changes are made to services and service delivery. | No recommendations at this time. | No recommendations at this time. | N/A
Guthrie Medical Center 094059502.1 | 4 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. At mid-point, the provider has not yet hired or trained patient care navigators and therefore to patient encounters have occurred. The provider’s goal is to train 500 patient navigators and meet its I-12.1 metric by DY 3. Without training the patient navigators, provider may not be able to meet its QPI goals. The provider's QPI goals between DY 3 and DY 5 are using two different measurements. 0-6.1 and 0-6.2 in DY 3 and 0-6.1 and 0-6.2 in DY 5. Provider has included two additional improvement milestones in DY 5 (I-7.1 and I-8.1). Both of these measures are somewhat similar (reduction in ED visits). | No recommendations at this time. | No recommendations at this time. | N/A
Good Shepherd 094108002.2 | 2 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reported progress on DY 3 Metric P-3.2 and has provided 15 of 175 telemedicine encounters. However, provider reported in the semi-annual report that this number does not include the ECHO encounters, which will be reported in October 2014. Based on the information provided, provider is likely to remain on track to complete its DY 3 milestone. | No recommendations at this time. | No recommendations at this time. | N/A
Mother Francis Hospital 094108002.1.2 | 3 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. To show expansion of its specialty care clinic, the provider is using metric P-11.1. However, this metric requires the provider measure the number of patients served. Currently, the provider is measuring the number of physicians, mid-level staff, and other staff hired. | No recommendations at this time. | No recommendations at this time. | N/A
Mother Francis Hospital 094108002.1.3 | 2 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reported progress on DY 3 Metric P-3.2 and has provided 15 of 175 telemedicine encounters. However, provider noted in the semi-annual report that this number does not include the ECHO encounters, which will be reported in October 2014. Based on the information provided, provider is likely to remain on track to complete its DY 3 milestone. | No recommendations at this time. | No recommendations at this time. | N/A
Mother Francis Hospital 094108002.2 | 4 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has reported enrolling 124 patients out of a goal of 200 patients. | No recommendations at this time. | No recommendations at this time. | N/A
Mother Frances Hospital 094108002.2.1 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has included two additional improvement milestones in DY 5 (I-7.1 and I-8.1). Both of these measures are somewhat similar (reduction in ED visits). | No recommendations at this time. | No recommendations at this time. | N/A
Mother Frances Hospital 094108002.2.2 | 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has reported enrolling 124 patients out of a goal of 200 patients. | No recommendations at this time. | No recommendations at this time. | N/A
 Recommendations to HHSC | Recommendations to Provider | HHSC Response to Recommendation for HHSC | HHSC Response to Recommendations for the Project
--- | --- | --- | ---
No recommendations at this time. | Possible Plan Modification: Provider should consider using the services of the dentists associated with the junior college instead of trying to hire their own. This would keep the project more in line with the intent of the project option as stated on the menu. The purpose of the project option is to partner with existing resources as a way to deliver services in a cost-effective manner. | N/A | MSLC recommended that provider consider using the services of the dentists associated with the junior college instead of trying to hire their own, since provider reported delays in hiring the provider. Based on current attribution, provider may not be able to reach its target population due to technical changes it cited in its progress report, including connectivity issues in rural areas and availability of broadband services to the low-income population.

MSLC does not have any recommendations. | No recommendations at this time. | N/A | MSLC did not have any recommendations.

MSLC did not have any recommendations. | No recommendations at this time. | N/A | MSLC did not have any recommendations.

2 of 2 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | Delays in the project have occurred due to the inability to hire a supervisory dentist for the project. | Possible Plan Modification: Provider has experienced technical challenges. Technology is a primary feature of this project and such challenges may inhibit the provider's ability to complete its DY 3 metrics. Two of the DY 3 milestones include training of staff (P-2.1) and the development of referral mechanisms to address expanded specialty care additions to meet its DY 3 goal (P-5.1). Therefore, the incomplete status of these metrics at mid-point does not present a known risk at this time. Provider indicated that it intends to improve its current referral mechanisms to address expanded specialty care additions to meet its DY 3 goal of 210 encounters. | N/A | MSLC recommended that provider consider replacing Metric I-6.1 with Metric I-6.4 if the provider intends to measure the number and percentage of patients enrolled in the medical home empanelment. Provider is using Milestone I-6.1 in DY 4 and DY 5 to measure the number and percentage of patients enrolled in the navigator program who receive a scheduled appointment with a PCP. Metric I-6.1 is specific to referrals and medical home empanelment, not navigator program who receive a scheduled appointment with a PCP. | N/A | MSLC recommended that provider consider using the services of the dentists associated with the junior college instead of trying to hire their own, since provider reported delays in hiring the provider. Provider reported enrolling 345 patients out of a goal of 900 patients as of mid-point DY 3. One mobile team is operational while the other is still in development. With the second team operational, the provider should be able to meet its QPI goals. | N/A | MSLC did not have any recommendations.

2 of 2 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | Two of the DY 3 milestones include training of staff (P-2.1) and the development of referral mechanisms (P-5.1). Therefore, the incomplete status of these metrics at mid-point does not present a known risk at this time. Provider indicated that it intends to improve its current referral mechanisms to address expanded specialty care additions to meet its DY 3 goal of 210 encounters. | Possible Plan Modification: Provider reported enrolling 345 patients out of a goal of 900 patients as of mid-point DY 3. One mobile team is operational while the other is still in development. With the second team operational, the provider should be able to meet its QPI goals. | N/A | MSLC recommended that provider consider replacing Metric I-6.1 with Metric I-6.4 if the provider intends to measure the number and percentage of patients enrolled in the medical home empanelment. Provider is using Milestone I-6.1 in DY 4 and DY 5 to measure the number and percentage of patients enrolled in the navigator program who receive a scheduled appointment with a PCP. Metric I-6.1 is specific to referrals and medical home empanelment, not scheduled appointments. | N/A | MSLC recommended that provider consider replacing Metric I-6.1 with Metric I-6.4 if the provider intends to measure the number and percentage of patients enrolled in the medical home empanelment. Provider is using Milestone I-6.1 in DY 4 and DY 5 to measure the number and percentage of patients enrolled in the navigator program who receive a scheduled appointment with a PCP. Metric I-6.1 is specific to referrals and medical home empanelment, not scheduled appointments.

2 of 2 DY 2 milestones complete. | 1 of 1 DY 3 milestones complete. | The project is being executed by CHRISTUS St. Michael Health System which has partnered with the group Genesis PrimeCare to deliver the services. Provider has reported significant progress of DY 3 metric I-12.1. | No recommendations at this time. | N/A | MSLC recommended that provider shows increase in goals for I-12.1. Due to the technical changes it cited in its progress report, MSLC recommends changing I-6.1 into I-6.4 in DY4 and DY5. Goals remained the same.

2 of 2 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | The Category 2 benefit specified by the project narrative is to foster a culture of quality and safety by reaching a total of 600 CHF patients. This project received a higher ranking in terms of risk because the patient benefit is not direct. | Possible Plan Modification: Provider reported enrolling 345 patients out of a goal of 900 patients as of mid-point DY 3. One mobile team is operational while the other is still in development. With the second team operational, the provider should be able to meet its QPI goals. | N/A | MSLC recommended that provider shows increase in goals for I-12.1. Due to the technical changes it cited in its progress report, MSLC recommends changing I-6.1 into I-6.4 in DY4 and DY5. Goals remained the same.

2 of 2 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | The Category 2 benefit specified by the project narrative is to foster a culture of quality and safety by reaching a total of 600 CHF patients. This project received a higher ranking in terms of risk because the patient benefit is not direct. | Possible Plan Modification: Provider reported enrolling 345 patients out of a goal of 900 patients as of mid-point DY 3. One mobile team is operational while the other is still in development. With the second team operational, the provider should be able to meet its QPI goals. | N/A | MSLC recommended that provider shows increase in goals for I-12.1. Due to the technical changes it cited in its progress report, MSLC recommends changing I-6.1 into I-6.4 in DY4 and DY5. Goals remained the same.

2 of 2 DY 2 milestones complete. | 1 of 1 DY 3 milestones complete. | The Category 2 benefit specified by the project narrative is to foster a culture of quality and safety by reaching a total of 600 CHF patients. This project received a higher ranking in terms of risk because the patient benefit is not direct. | Possible Plan Modification: Provider should consider a reduction of QPI in I-11.1 metric in DY 5. The provider may not be able to reach its target population due to technical changes it cited in its progress report, including connectivity issues in rural areas and availability of broadband services to the low-income population. | N/A | MSLC recommended that provider consider replacing Metric I-6.1 with metric I-6.4 effective in I-12.1, which would allow provider accurately report information meeting metric’s intent. Provider agreed with the change. HHSC changed I-6.1 into I-12.1 in I-6.4 in DY4 and DY5. Goals remained the same.

2 of 2 DY 2 milestones complete. | 1 of 1 DY 3 milestones complete. | The Category 2 benefit specified by the project narrative is to foster a culture of quality and safety by reaching a total of 600 CHF patients. This project received a higher ranking in terms of risk because the patient benefit is not direct. | Possible Plan Modification: Provider should consider a reduction of QPI in I-11.1 metric in DY 5. The provider may not be able to reach its target population due to technical changes it cited in its progress report, including connectivity issues in rural areas and availability of broadband services to the low-income population. | N/A | MSLC recommended that provider consider replacing Metric I-6.1 with Metric I-6.4 if the provider intends to measure the number and percentage of patients who receive an appointment with a PCP and not medical home empanelment. Provider is using Milestone I-6.1 in DY 4 and DY 5 to measure the number and percentage of patients enrolled in the navigator program who receive a scheduled appointment with a PCP. Metric I-6.1 is specific to referrals and medical home empanelment, not scheduled appointments. | N/A | MSLC recommended that provider consider replacing Metric I-6.1 with Metric I-6.4 if the provider intends to measure the number and percentage of patients who receive an appointment with a PCP and not medical home empanelment. Provider is using Milestone I-6.1 in DY 4 and DY 5 to measure the number and percentage of patients enrolled in the navigator program who receive a scheduled appointment with a PCP. Metric I-6.1 is specific to referrals and medical home empanelment, not scheduled appointments.
Recommendations to Provider

No recommendations at this time.

Recommendations to HHSC

No recommendations at this time.

Consideration to possible impact on project valuation should be given if possible plan modification is submitted and approved.

Possible Plan Modification: Provider should consider a reduction of QPI in its P-4.1 metric in DY 5. The provider may not be able to reach its target due to the transportation issues cited in the April progress report.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program. Provider reported that the clinic closed on 12/31/14.

HHSC was aware of closure of some of the ETMC facilities and will work with the provider on withdrawal.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Modification: Provider is searching for another site, and expanding its clinic by only four hours.

Discussion for possible withdrawal as clinic has now been closed.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Provider requested a plan modification to move all milestones into the next year; however, the intervention should have an impact on cost. A cost accounting system may be able to measure the costs, but not necessarily bring about cost reductions.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider withdrew the project.

Appendix 2 - RHP 1

Provider Project ID

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

HHSC Response to Recommendation for HHSC

HHSC Response to Recommendations for the Project

Provider Requested Plan Modification to Move All Milestones into the Next Year. However, the Intervention Should Have an Impact on Cost. A Cost Accounting System May Be Able to Measure the Costs, But Not Necessarily Bring About Cost Reductions.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

Provider withdrew the project.

Consideration to possible withdrawal if medical services cannot be provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider withdrew the project.

Provider Requested Plan Modification to Move All Milestones into the Next Year. However, the Project Has Potential for Withdrawal if Medical Services Cannot be Provided.

Possible Project Withdrawal: Provider should consider official withdrawal from the waiver program.

Provider withdrew the project.
APPENDIX 2 - RHP 1

East Texas Medical Center – Pittsburg 138374715.1

4 0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has been unable to recruit the needed specialists for this project to succeed. There is a strong possibility project will not be able to achieve its goals.

No recommendations at this time.

Possible Plan Modification: Provide should consider revising the project to focus on either general or orthopedic surgery visits, but not both, in order to meet at least one of its QPI goals. As a result, this would also require a reduction in valuation.

A/A

Possible Project Withdrawal: Provider should consider possible project withdrawal. This provider should not be able to achieve its project milestones in DY 4 and DY 5. Provider is using Metric I-14.1 twice in the same DY.

A/A

East Texas Medical Center 138913209.1.2

4 0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has not been able to hire an endocrinologist and therefore cannot show an increase in the number of visits due to any type of expansion.

No recommendations at this time.

Possible Project withdrawal: Provider should consider possible withdrawal from the weaver program if the endocrinologist cannot be hired. If the provider can hire the required specialist, then a QPI reduction may be needed.

Provider confirmed project withdrawal. Provider withdrew the project.

East Texas Medical Center 138913209.2.1

3 0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Although the provider has completed its milestones, the project was given a higher ranking because implementing a cost accounting system does not appear to be a valid “intervention” according to the language in the menu. The intervention should have an impact on cost. A cost accounting system may be able to measure the costs, but not necessarily bring about cost reductions. Although the provider is required to report QPI, such a measure does not show a direct patient health benefit.

No recommendations at this time.

Possible Project Modification: Provider should consider adjusting the QPI metric to I-7 to show actual changes in cost prior to and after the specific intervention in addition to its QPI measure I-7.1. This would coincide with the actual description of Milestone I-17.

East Texas Medical Center 138913209.2.2

3 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider plans to implement Lean Process Improvement methodology in the ED in order to reduce unnecessary use of ED. Provider has not yet met project for DY 2 that was not met as of April sign off; provider cited delay in CMS approval for delay in achievement.

No recommendations at this time.

Technical Change: Provider should correct its numbering of Improvement Milestone metrics in DY 4 and DY 5. Provider is using Metric I-14.1 twice in the same DY.

A/A

Technical Change: Provider should consider revising the project development and determine that Provider has already replaced I-7 with a more descriptive metric during plan modification process, which should address MSLC recommendation. Based on this, HHSC did not initiate discussions related to I-7.

East Texas Medical Center - Athens 139173209.2.1

5 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Metric chosen (I-6.3) as written on the menu does not correspond to the activities specified by the provider. Metric I-6.3 requires the provider to report on the number of patients referred by the navigator program who are actually seen by a PCP. This provider is implementing the navigator program in the ED and may not have the ability to track patients’ PCP visits. It was also not clear how the provider intended to increase its referral performance between DY 3 and DY 5. The provider would need to rely on increase in ED visits in order for it to meet its QPI goals in DY 4 and DY 5.

Based on interviews with the provider, the current I-6.3 may not be attainable as written. The provider’s goal is to increase the percentage of patients referred to a PCP. However, the provider has created criteria for referral and stated that 100 percent of eligible cases are referred and the number of Level 4 and 5 non-emergency cases in the ED has decreased significantly.

No recommendations at this time.

Possible Project Modification: Provider should consider replacing its current milestones in DY 4 and DY 5 with milestones to measure the decrease in the number of Level 4 and 5 non-emergency cases that present initially to the ED.

A/A

Technical Change: Provider should consider updating the numbering of metric I-14.1, which was used twice in the same year. However, for this type of metric, provider had an option to define specific area that is measured by I-14.1. In both cases provider defined the area of measurement: for the first milestone it is “Decrease in patient time to provider from baseline.” In the 2nd case - “Decrease in percentage of patients who leave without being seen”. Provider used these metrics appropriately. Based on this, HHSC did not initiate discussions related to renumbering of I-14.1.

East Texas Medical Center - Athens 139173209.2.2

4 0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The QPI metric I-11.1 is only measuring the number of patients who receive the protocol and is not comparing this number to the total population eligible to receive the protocol.

No recommendations at this time.

Possible Project Modification: The provider should consider replacing Metric I-11.1 with a customizable metric if the provider does not intend to compare the number of patients who receive the transition protocol to the total number eligible. Metric I-11.1 as written on the menu requires the provider to show a percentage improvement in the target population. The provider’s goal for DY 4 and DY 5 only indicates the measure of the improvement in the number of patients from year to year.

A/A

Possible Project Withdrawal: Provider should consider possible withdrawal for DY 3 and DY 5 if the provider does not intend to measure the improvement in the number of patients who received the protocol. Provider is not able to hire an endocrinologist and therefore cannot show an increase in the number of visits due to any type of expansion.

Provider should consider adding a second metric to the project to include a more descriptive measure for this project. HHSC checked subsequent project development and determined that Provider already replaced I-7 with a more descriptive metric during plan modification process, which should address MSLC recommendation. Based on this, HHSC did not initiate discussions related to I-7.

Provider withdrew the project.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Texas Medical Center Athens 1391732003.2.3</td>
<td>3 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete.</td>
<td>Provider is using a customizable improvement metric I-101.1 to measure its QPI in DY 4 and DY 5 because the available metrics do not specifically measure patients or encounters.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC recommended to clarify metric I-101.1 because milestone and metric language need the same and metric did not have sufficient details. HHSC updated metric description: I-101.1 in DY4 and DY5 - Number of unique individuals who are positively impacted by patient experience improvements.</td>
</tr>
<tr>
<td>East Texas Medical Center - Gorman 168447401.1.1</td>
<td>2 of 1 DY 2 milestones complete. 2 of 1 DY 3 milestones complete.</td>
<td>Provider noted difficulties in hiring staff and was therefore not able to achieve any milestones. During MSLC follow-up with the provider, the provider indicated that the clinic will close in January 2015.</td>
<td>Discus possible project withdrawal due to closing of clinic.</td>
<td>N/A</td>
<td>Provider withdrew the project.</td>
</tr>
<tr>
<td>Red River Regional Hospital 177870603.2.2</td>
<td>3 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete.</td>
<td>Project uses customizable milestones to measure &quot;positively impacted individual.&quot; A higher ranking is warranted given that the project is only measuring patient satisfaction scores and there is no direct patient health benefit involved. Provider noted that patient satisfaction is a difficult measure to capture.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC recommended that provider clarify its metric description for Metric I-101.1 in DY4 and DY5, since milestones and metric have the exact same language. Even though it is allowable for customizable milestones and metrics to have similar description, HHSC clarified a custom description of the metric in DY4 and DY5. Number of unique individuals who are positively impacted by patient experience improvements.</td>
</tr>
<tr>
<td>Red River Regional Hospital 177870603.2.3</td>
<td>4 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete.</td>
<td>Provider intends to offer outpatient psychiatric care to the geriatric population. However, a renovation at the facility has put the project behind, although no mention of the need for facility renovation was mentioned in project narrative. There is risk that the provider does not have the foundation and infrastructure to offer behavioral health services.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC recommended that provider update baseline information in the narrative and re-evaluates its goals for DY4 and DY5. Pre-baseline information is included in the QPI template. HHSC is not requiring providers to include all the details in the narrative. Provider reported to HHSC that while there are delays due to change in management, they feel that that if the new management on board the project can still progress fast and meets its goals. Provider is aware of the opportunity to withdraw by May 1. As of May 4th, provider did not submit a request to withdraw which means that they still intend to meet the project goals.</td>
</tr>
<tr>
<td>Andrews Center N12841/0.2.3</td>
<td>2 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete.</td>
<td>Provider will report on its DY 3 metrics in October 2014 stating that these metrics need a full year of measurement. One therapist left the organization during the reporting year, although the provider noted that another was hired and the project was able to remain on track.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>

APPENDIX 2 - RHP 1

No recommendations at this time.

Possible Plan Modification: Provider should consider including a baseline describing its pre-DSRIP level of outpatient behavioral health services provided, including staffing levels as well as the needed space. There is risk that the provider began this project without the foundation for providing behavioral health services and therefore may not be in a position to meet its QPI goals in DY4 and DY5.

Possible Project Withdrawal: Provider should consider an official withdrawal from the waiver program. Provider reported that the clinic will close January 2015.

HHSC was aware of closure of some of the ETMC facilities and will work with the provider on withdrawal.

Provider withdrew the project.
<table>
<thead>
<tr>
<th>Project</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal Health &amp; Wellness 015053001.1</td>
<td>1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>Provider has not been able to expand its existing clinic due to the inability to hire additional staff. As a result, the provider would need to hire two Primary Care Providers in DY 3. In addition to hiring additional PCPs, the provider intends to add additional clinic hours through the use of mobile clinics, however, provider has not been able to complete the hiring of providers to staff the mobile clinics. As a result, the ability to meet the QPI metric (I-12.1) in DY 4 and DY 5 is at risk. Provider provided an update of its project to MSLC and noted that the required staff was hired at the end of DY 3, fulfilling the DY 2 carryover metric. However, the provider has experienced turnover of those positions since the October reporting period. Provider did not report the number of increased visits due to the expansion and has yet to increase hours using the mobile clinic option.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC recommended to consider a reduction in QPI if the provider is unable to meet its QPI goals (I-12.1) in DY 4 and DY 5. If the expanded clinic opens prior to DY 4, then this metric could still be met.</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 0094092602.1.10</td>
<td>1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No significant risks to future progress were noted at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 0094092602.1.2</td>
<td>3 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>Provider has had difficulty in securing a proper location for the expanded Pediatric Urgent Care clinic. Provider requested carryforward of DY 3 Milestone P-1 to DY 4. (Expansion of clinic space) due to building permitting issues and the approval process of the local jurisdiction. As long as the provider is able to open the expanded clinic, provider should be able to meet its QPI goals (I-12.1) in DY 4 and DY 5. If the expanded clinic opens prior to DY 4, then this metric could still be met.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 0094092602.1.3</td>
<td>3 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>Provider requested carryforward of DY 2 metric P-1.1 (increase number of exam rooms at the Alvin Primary Care clinic location). Provider reported hiring one of the five required staff as of mid-point DY 3. To achieve its DY 3 P-4.1 metric of expanding hours, the provider will need to complete the build-out of the clinic space first. If provider can complete construction in time and hire the remaining staff, the QPI milestones in DY 4 and DY 5 may be achievable.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital 0094092602.1.7</td>
<td>4 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>The project option, Performance Improvement and Reporting Capacity, receives a higher ranking with regard to risk. While the provider is reporting a QPI metric, the provider is not measuring patient impact for a particular service or direct patient intervention. The project proposes to generate reports on quality improvement, implement activities based on those reports, and share those activities with other providers in RHP 2. The risk ranking was increased for this project because the project option does not provide a direct patient benefit. The provider submitted additional information to MSLC to clarify how the QPI will be measured in DY 5. The provider stated that three RHP 2 sites are submitting discharge and readmission data to a third party vendor for analysis. Not all RHP 2 sites track data as needed for the project and not all sites are participating.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC recommended to consider a reduction in QPI if provider continues to have challenges in receiving data from hospitals in RHP 2. In conjunction with a reduction of QPI, the provider could change its QPI to reflect discharges solely from its facilities and therefore will not need to obtain data from other sources to meet its QPI.</td>
</tr>
</tbody>
</table>

**APPENDIX 2 - RHP 2**

**Recommendations to Provider:**
- Possible Project Withdrawal: Provider should consider possible withdrawal from the waiver program if the additional primary care providers cannot be hired. During October reporting, provider reported achievement of P-5 from DY2 and P-5 from DY 3 - hiring of additional staff/hiring of 2 providers, 2 MA, 1 patient services specialist and 1 Quality Data specialist). Since the provider wants to continue with the project and accomplished hiring, HHSC will not initiate project withdrawal.

**Recommendations to HHSC:**
- Possible Project Withdrawal: Provider should consider possible withdrawal from the waiver program if the additional primary care providers cannot be hired.
<table>
<thead>
<tr>
<th>University of Texas Medical Branch Hospital</th>
<th>Recommendations to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations to HHSC</strong></td>
<td><strong>Technical Change</strong></td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital</td>
<td>0 of 5 DY 2 milestones complete.</td>
</tr>
<tr>
<td>0 of 4 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>There was concern during the midpoint review as to how the provider would measure its I-9.1 metric in DY 4 and DY 5. Provider submitted clarification indicating that I-11.1 is not a numeric goal but instead requires the analysis of three disparity studies over the course of the project. The top three targeted health disparities will be identified and analyzed in DY 3 and DY 4 using the Race, Ethnicity, and Language data fields for patients. The improvement plan to address these disparities will be updated and modified in DY 5 as required by the Category 1 Menu.</td>
<td></td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital</td>
<td>0 of 5 DY 2 milestones complete.</td>
</tr>
<tr>
<td>0 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>There is some risk with the project as the provider has chosen to vary slightly from the QPI calculation as specified in the Category 2 Menu for I-16.1. The menu specifies that the provider measure the number of enrolled patients’ primary care visits at the medical home compared to the total number of enrolled patients’ primary care visits at all provider facilities. Although the provider is reporting an absolute number of medical home visits, the percentage reported by the provider is calculating new patients over the total number of patients seen.</td>
<td></td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital</td>
<td>0 of 2 DY 3 milestones complete.</td>
</tr>
<tr>
<td>0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>The provider has included a customizable milestone to measure QPI in DY 5. The milestone is specific to measuring an actual outcome that will directly impact patients. Specifically, this outcome is a decrease in no-show rates which will improve access to care for patients.</td>
<td></td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital</td>
<td>0 of 2 DY 3 milestones complete.</td>
</tr>
<tr>
<td>0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>The provider has included a customizable milestone to measure QPI in DY 5. The milestone is specific to measuring an actual outcome that will directly impact patients. Specifically, this outcome is a decrease in no-show rates which will improve access to care for patients.</td>
<td></td>
</tr>
<tr>
<td>University of Texas Medical Branch Hospital</td>
<td>0 of 2 DY 3 milestones complete.</td>
</tr>
<tr>
<td>0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>The provider has included I-7.1 as its QPI metric, which is measuring the number of patient encounters provided. It was not clear from the information in the narrative and in the reports how the provider would measure a patient encounter. The provider submitted further clarification and stated that participants with two specific DRGs are monitored by the cost accounting system and are included in the measurement of the QPI metric. However, the metric chosen by the provider is specific to measuring the actual improvement in costs. MSLC conducted follow-up with the provider to determine if the provider intended to measure cost containment. The provider stated that it will measure cost containment with the cost accounting system. However, this is not specifically included as an improvement metric.</td>
<td></td>
</tr>
<tr>
<td>Baptist Hospital of Southeast Texas</td>
<td>0 of 1 DY 4 milestones complete.</td>
</tr>
<tr>
<td>0 of 1 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>The project's narrative is similar to the provider's navigation project (094148602.2.2) and has a high risk of duplication. Provider did not report specific progress on its DY 3 milestone. Provider plans to submit a plan modification to add hypertension and diabetes to the set of patients being served by the program.</td>
<td></td>
</tr>
</tbody>
</table>
HHSC should consider allowing the provider to report all patients served by the navigation program, not just patients who meet a certain diagnosis in order to properly distinguish this project from the chronic care project. Many of these patients are also counted in the chronic disease management program because the provider’s navigation program will refer patients to the chronic disease management program.

Possible Plan Modification: To distinguish this project from the provider’s chronic care management project, provider should consider updating the project narrative to include aspects that are specific to the navigation project, such as the target population that extends to more than just patients with a chronic disease. Patients who benefit from navigation services are not required to have a specific diagnosis and not all patients in the navigation program are counted in the provider’s QPI. The narrative should specify that the navigation program can feed patients to the chronic disease management program, but the two programs are different.

Possible Plan Modification: Provider should consider revising Milestone P-3.1 and deleting the specific diagnosis. The intent of the navigation program according to the project option is to serve not only patients with chronic disease, but any patient who may be at-risk for fragmented and uncoordinated care.

HHSC agrees that the project may count all patients served by the navigation program.

MSL declined specific diagnosis since the project option is to serve not only patients with a chronic disease, but any patient who may be at-risk for fragmented and uncoordinated care. HHSC updated P-3.1 to the following:

- DY4: The total number of patients for September 2011 – August 2012 who are uninsured, underserved, indigent or who had Medicaid, was 285. By year four our goal is to increase the number of the targeted patients served to 1,534. Goal: Increase the number of Medicaid, Medicare, uninsured, indigent or underserved and uninsured patients, that have been diagnosed with diabetes, hypertension, heart failure, AMI, pneumonia, COPD, sepsis, or renal failure served by the patient navigation program to 896 in DY4.

- DY5: The total number of targeted patients for September 2011 – August 2012 was 285. Goal: Increase to a cumulative total of 2,659 patients served. This will include 1,075 patients served in DY5 by the patient navigation program who are uninsured, underserved, indigent, or Medicaid or Medicare and have been diagnosed with diabetes, hypertension, heart failure, AMI, pneumonia, COPD, sepsis, or renal failure. The provider also updated the narrative to address MSLC’s recommendation to include aspects that are specific to the navigation program, such as the target population that extends to more than just patients with a chronic disease to distinguish it from the chronic care management project 094148602.2.1. The updated narrative also clarified that the navigation program can feed patients to the chronic disease management program, but the two programs are different.

Provider should consider revising Milestone P-3.1 and deleting the specific diagnosis. The intent of the navigation program according to the project option is to serve not only patients with chronic disease, but any patient who may be at-risk for fragmented and uncoordinated care.

HHSC agreed that the project may count all patients served by the navigation program.

Provider should consider revising Milestone P-3.1 and deleting the specific diagnosis. The intent of the navigation program according to the project option is to serve not only patients with chronic disease, but any patient who may be at-risk for fragmented and uncoordinated care.

HHSC agreed that the project may count all patients served by the navigation program.

Provider should consider revising Milestone P-3.1 and deleting the specific diagnosis. The intent of the navigation program according to the project option is to serve not only patients with chronic disease, but any patient who may be at-risk for fragmented and uncoordinated care.

HHSC agreed that the project may count all patients served by the navigation program.

Because I-3.1 under Project Option 1.9.2 only allows in-person visits to be counted towards the QPI, MSLC recommended that a non-QPI, customizable metric be added to DYS to track phone updates and consults or other “visits” beyond the in-person encounters. Provider indicated that they no longer needed to add a metric to track phone follow-ups because they will be able to meet their in-person goals.
APPENDIX 2 - RHP 2

Provider | Project ID | Overall Risk Level | Narrative Describing Mid-Point Assessment Score Justification | Recommendations to HHSC | Recommendations to Provider | HHSC Response to Recommendations for HHSC | HHSC Response to Recommendations for the Project
---|---|---|---|---|---|---|---
Spindletop Center 906166602.2.10 | 2 | 1 of 1 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time.

Possible Plan Modification: Provider should consider including an improvement milestone for DY 4 and DY 5 that shows an impact on the target population. Other behavioral health providers/LMHAs that chose this project option included an impact milestone, such as measuring functional status or adherence to medication. Development of a customizable milestone to measure impact should also be an option since the current menu is limited and may not fit the goals of all interventions.

Technical Change: Description of Milestone I-101 and Metric I-101.1 on the Phase 4 Master Summary should describe how the activities in the milestone and the metric are different. The description of the metric should include how improvement will be achieved from year to year and how the provider will conduct its measurement (i.e. increase the number of individuals from the target population receiving X service/intervention).

IA

MSLC recommended that an improvement milestone be added to DYS to strengthen the project that measures impact and it may be a customizable milestone. Other providers that chose this project area 2.13 included an impact milestone, such as measuring functional status or adherence to medication. Provider chose not to add a DYS metric because their Category 3 requires a stretch activity in which they will be measuring impact already.

Spindletop Center 906166602.2.11 | 3 | 1 of 1 DY 3 milestones complete. | 0 of 1 DY 3 milestones complete. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time.

The provider has chosen a customizable milestone that does not adhere to the intent of the other improvement milestones for option 2.13.1. This other improvement milestone measures the impact of an intervention on individuals using various measurement options. The milestone chosen by the provider does not measure impact. It is simply a count of the number of individuals in the wellness program.

Possible Plan Modification: Provider should consider adding an improvement milestone for DY 4 and DY 5 that shows an impact on the target population. The intent of this Category 2 project option is to evaluate a research-based intervention for a target population. Development of a customizable milestone to measure impact should also be an option since the current menu is limited and may not fit the goals of all interventions.

Technical Change: Description of Milestone I-101 and Metric I-101.1 on the Phase 4 Master Summary should describe how the activities in the milestone and the metric are different. The description of the metric should include how improvement will be achieved from year to year and how the provider will conduct its measurement (i.e. increase the number of individuals from the target population receiving X service/intervention).

IA

MSLC recommended that an improvement milestone be added to DYS to strengthen the project that measures impact and it may be a customizable milestone. Other providers that chose this project area 2.13 included an impact milestone, such as measuring functional status or adherence to medication. Provider chose not to add a DYS metric because their goal of their project is improving the health of individuals participating in the wellness program which is accomplished by their Category 3 outcomes measuring diabetes care, LDL screenings, body mass index, and high blood pressure screenings and follow-up.

Spindletop Center 906166602.2.3 | 2 | 1 of 1 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time.

The provider has chosen a customizable milestone that does not adhere to the intent of the other improvement milestones for option 2.13.1. The other improvement milestones measure the impact of an intervention on individuals using various measurement options. The milestone chosen by the provider does not measure impact. It is simply a count of the number of individuals in the program.

Possible Plan Modification: Provider should consider adding an improvement milestone for DY 4 and DY 5 that shows an impact on the target population. The intent of this Category 2 project option is to evaluate a research-based intervention for a target population. Development of a customizable milestone to measure impact should also be an option since the current menu is limited and may not fit the goals of all interventions.

Technical Change: Description of Milestone I-101 and Metric I-101.1 on the Phase 4 Master Summary should describe how the activities in the milestone and the metric are different. The description of the metric should include how improvement will be achieved from year to year and how the provider will conduct its measurement (i.e. increase the number of individuals from the target population receiving X service/intervention).

IA

MSLC recommended that an improvement milestone be added to DYS to strengthen the project that measures impact and it may be a customizable milestone. Other providers that chose this project area 2.13 included an impact milestone, such as measuring functional status or adherence to medication. Provider chose not to add a DYS metric because their Category 3 requires a stretch activity in which they will be measuring impact already.

Spindletop Center 906166602.2.9 | 3 | 1 of 1 DY 2 milestones complete. | 0 of 1 DY 3 milestones complete. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time. | No recommendations at this time.

Provider has chosen to use all customizable milestones for this project option. Provider is not measuring its improvement milestones using a comparison, only an absolute number. The improvement milestones on the Category 2 require the provider use a comparison of the target population as a way to show the effectiveness of the campaign/program.

Possible Plan Modification: Provider should consider improving the number of families served on a cumulative basis, but is not increasing the goal from DY 1 to DY 3. Therefore, the provider should indicate its baseline and cumulative totals on the Phase 4 Master Summary.

Technical Change: Provider should indicate baseline for I-101 on the Phase 4 Master Summary as a way to show improvement between demonstration years.

IA

MSLC recommended that the baseline be added to I-101. The issue was already addressed through Plan Mods. MSLC recommended that the customizable milestone and metric descriptions differ. Providers were allowed to add customizable metrics especially for QPI. Customizable milestone and metric descriptions were allowed to be identical as long as the goal was clear. HHSC did not follow up with the provider regarding MSLC’s recommendations.
APPENDIX 2 - RHP 2

**Provider** | **Project ID** | **Overview** | **Risk Management** | **Narrative Describing Mid-Point Assessment Score Justification** | **Recommendations to HHSC** | **Recommendations to Provider** | **HHSC Response to Recommendations for HHSC** | **HHSC Response to Recommendations for the Project**
--- | --- | --- | --- | --- | --- | --- | --- | ---
**Physician Practice affiliated with UTMB** | 103579901.1.1 | 2 | 3 | 0 | 3 | 3 | 3 | 2 | Provider cannot begin progress on DY 3 milestones until the gap assessment from DY 2 is complete. The milestonesto provide needed to complete in DY 3 include training staff on referral guidelines, implementing specialty care programs at 25 percent of clinics, and increasing patient volume of visits (goal of 1,200 visits). Due to the limited progress reported by the provider, MSLC requested additional information from the provider. Provider reported that the DY 2 milestone has been completed as well as the DY 3 QPI metric. DY 3 metrics P-2.1 and I-2.4 have been forward to DY 4. | No recommendations at this time. | No recommendations at this time. | IA | MSLC did not have any recommendations.
**Physician Practice affiliated with UTMB** | 103579901.2.2 | 4 | 3 | 3 | 3 | 3 | 3 | 2 | Provider requested carryforward for most DY 2 metrics. The provider has included several improvement milestones between DY 2 and DY 5, but has yet to achieve its DY 2 milestones. Due to the limited progress reported by the provider at mid-point, MSLC requested additional information from the provider. Provider reported that five of the seven DY 2 Metrics have been achieved. Provider requested carryforward of all DY 3 milestones and noted that several challenges have delayed the project but did not provide specifics. | No recommendations at this time. | No recommendations at this time. | IA | MSLC recommended that the provider submit DY 4 metrics that were not directly tied to the project/patient impact because the provider requested a carryforward for multiple metrics in early years. In Plan Mods, provider requested and was approved to decrease QPI, since the project was still within acceptable valuation ranges, and add metrics to spread risk. HHSC is not checking with the provider if milestones should be deleted based on the provider's desire to increase milestones.
**Physician Practice affiliated with UTMB** | 103799901.3.3 | 1 | 3 | 3 | 3 | 3 | 3 | 2 | Provider requested carryforward for most DY 2 metrics. The provider has included several improvement milestones between DY 2 and DY 5, but has yet to achieve its DY 2 milestones. Due to the limited progress reported by the provider at mid-point, MSLC requested additional information from the provider. Provider reported that five of the seven DY 2 Metrics have been achieved. Provider requested carryforward of all DY 3 milestones and noted that several challenges have delayed the project but did not provide specifics. | No recommendations at this time. | No recommendations at this time. | IA | MSLC recommended that the provider submit DY 4 metrics that were not directly tied to the project/patient impact because the provider requested a carryforward for multiple metrics in early years. In Plan Mods, provider requested and was approved to decrease QPI, since the project was still within acceptable valuation ranges, and add metrics to spread risk. HHSC is not checking with the provider if milestones should be deleted based on the provider's desire to increase milestones.
**Brazosport Regional Health System** | 132617602.1.1 | 2 | 3 | 3 | 3 | 3 | 3 | 2 | Provider will begin measuring QPI in DY 4 by tracking primary care and urgent care visits. However, the provider has included both of these measures in the same metric. | No recommendations at this time. | No recommendations at this time. | IA | MSLC recommended that the provider submit DY 4 metrics that were not directly tied to the project/patient impact because the provider requested a carryforward for multiple metrics in early years. In Plan Mods, provider requested and was approved to decrease QPI, since the project was still within acceptable valuation ranges, and add metrics to spread risk. HHSC is not checking with the provider if milestones should be deleted based on the provider's desire to increase milestones.
**Angelina-Sanbury Medical Center** | 131805003.1.3 | 2 | 3 | 3 | 3 | 3 | 3 | 2 | Project proposes to increase primary care, specifically OB/GYN care. MSLC clinical review determined the following. OB/GYN residency training focuses on pregnancy, childbirth, and management of problems of the female reproductive system. They do not typically manage chronic diseases. The project intent states that the provider wants to expand primary care management which seems more in line with the Expand Specialty Care Services project option. | No recommendations at this time. | No recommendations at this time. | IA | MSLC recommended that 1.5 be split into two QPI metrics I-15.2 as is.
**Nacogdoches Medical Hospital** | 131030003.2.2 | 2 | 3 | 3 | 3 | 3 | 3 | 2 | The QPI metric chosen by the provider (I-20.1) requires the measurement of patient satisfaction scores compared to baseline. While the provider has included a calculation of percent improvement in scores, the provider has also included a numerical goal of patients seeking out primary care services will not necessarily benefit from the expansion of OB/GYN services. | No recommendations at this time. | No recommendations at this time. | IA | MSLC recommended that 1.5 be split into two QPI metrics I-15.2 as is.
**The Gulf Coast Center** | 135222109.1.2 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | The QPI metric chosen by the provider to measure utilization for option 1.12.2 is specific to patients receiving services from mobile clinics. This is not the intent of the project. | No recommendations at this time. | No recommendations at this time. | IA | MSLC recommended that 1.11 be updated to a customizable milestone. HHSC allowed providers to use customized numerator and denominator descriptions to address the intent of the QPI metric. HHSC is not updating the QPI metric I-11.1 to customizable because the goal language with the customized numerator and denominator descriptions addresses the intent. HHSC did not follow up with the provider regarding this recommendation.
Recommendations to HHSC

MSLC recommended that the first I-6.2 be deleted. HHSC worked with the provider to clarify QPI for the second I-6.2 metric and marked the first I-6.2 metric as non-QPI. HHSC did not follow up again regarding MSLC’s recommendation.

Possible Plan Modification:

Provider should consider reducing the percentage goal for DY 5 metric I-5.1 since 100 percent goal is not realistic for the metric due to the extremely unpredictable nature of the behavioral health population.

HHSC Response to Recommendations for the Project

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

MSLC recommended that I-12.1 be updated to reflect visits instead of patients. During Plan Mods, the provider updated the goal language to reflect visits.

Recommendations to Provider

No recommendations at this time.

HHSC Response to Recommendation for HHSC

Provider states no recommendations at this time.

Technical Change:

Baseline established by the provider in DY 2 for this milestone is measuring visits.

Provider should consider using a customizable milestone to measure QPI (the number of individuals experiencing improvement in patient satisfaction scores) and not the specific number of individuals showing improvement in scores.

HHSC Response to Recommendation for HHSC

Provider requested to update DY5 goal to 42.5%.

Page 120
### APPENDIX 2 - RHP 3

#### Recommendations to Provider

**HHSC will consider MSLC’s recommendations** regarding supporting documentation for training and hiring metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.

**Technical Change:** Remove of the percentage goals and references to "targeted patients" for QPI metrics I-13.1 for DY 4 and DY 5 for greater metric clarity.

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Tolerance</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to IHSC</th>
<th>Recommendations to Provider</th>
<th>IHSC Response to Recommendation for IHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>020817501.1.2</td>
<td>2</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider stating that metric 1-12.1 for DY 3 -DY 5 is an increase over the pre-DSRIP baseline as stated below.</td>
<td>N/A</td>
<td>MAS recommended removing the QPI metric language to add the pre-DSRIP baseline on 3 and 5, and state that the goals are an increase over the pre-DSRIP baseline. HHSC did not agree because the QPI Reporting Template that the provider submitted during October 2013 reporting shows a pre-DSRIP baseline of 7,566; the Baseline/Goal language for the DY4 and DYS metrics already includes the pre-DSRIP baseline of 7,566 as well as the number of additional encounters above pre-DSRIP baseline to be provided in the DY. Therefore HHSC did not make the recommended changes.</td>
</tr>
<tr>
<td>020817501.1.2</td>
<td>6</td>
<td>1 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
<td>MAS recommended that HHSC consider requiring that all future supporting documentation for training and hiring metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.</td>
</tr>
<tr>
<td>020834001.1.2</td>
<td>6</td>
<td>2 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
<td>MAS recommended removing the percentage goals and references to &quot;targeted patients&quot; for QPI metrics I-13.1 for DY 4 and DY 5 for greater metric clarity. HHSC agreed that the metric language for QPI metric I-13.1 in DY 4 and 5 should be clarified by removing the percentage goals and references to &quot;targeted patients.&quot; Current and revised language for this metric is provided below.</td>
</tr>
<tr>
<td>020834001.1.2</td>
<td>6</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
<td>Current DY4 Baseline/Goal - Goal: Increase use by 5% as calculated by number of targeted patients accessing the advice line out of total number of targeted patients. Patient impact of 43,000 patient encounters in DY4. Revisited DY4 Baseline/Goal - DY4 Goal: Increase the number of encounters by 43,000 over pre-DSRIP baseline. Current DYS Baseline/Goal - Goal: Increase use by 15% as calculated by number of targeted patients accessing the advice line out of total number of targeted patients. Patient impact of 61,300 patient encounters in DYS. Revisited DYS Baseline/Goal - DYS Goal: Increase the number of encounters by 61,300 over pre-DSRIP baseline. HHSC sent the revised language to the provider and the provider agreed with the revised language, so HHSC updated the milestones/ metrics accordingly.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Memorial Hermann Northwest Hospital 020834001.1.4</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. Provider attended 8 of 12 RHP meetings and the expansion of hours was 64 with a goal of 68 hours. 1 additional clinic has already been established to meet the metric P-1.1 goal. Medicaid/Uninsured impact for this project is 7 percent. QPI metrics do not align with percentage improvement goals. Patient satisfaction goals require an established baseline from which to demonstrate improvement.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should establish a baseline from which to show a percent improvement, or the improvement should be quantified in another manner. Technical Change: Update metric I-12.1 to either remove the percentage increase or update it to be in line with the encounter goal for DY 4 and DY 5. Provider reports a baseline of 5,982 visits in DY 2 so the percentage increases will not yield the intended encounter outcomes.</td>
<td>N/A M&amp;S recommends that the provider establish a baseline for I-11.1 and I-11.2 from which to show a percent improvement, or the improvement should be quantified in another manner. HHSC disagrees that I-11.1 and I-11.2 need to be revised to include the baseline. The provider can provide both the baseline and the documentation showing that they met the goal during reporting. M&amp;S also recommended updating metric I-12.1 to either remove the percentage increase or make it in line with the encounter goal for DY 4 and DY 5. Provider reports a baseline of 5,982 visits in DY 2 so the percentage increases will not yield the intended encounter outcomes. HHSC agrees to remove the percentage increase from the metric language for QPI metric I-12.1. Current and revised language for this metric is provided below. I-12.1 (QPI Metric) - Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Current DY4 Baseline/Goal: 5% increase over DY 2 baseline. Baseline/Goal is 11,900 visits. (encounters) Revised DY4 Baseline/Goal - DY 4 Goal: Increase the number of encounters by 11,000 over pre-DSRIP baseline. Current DY5 Baseline/Goal: 10% increase over DY 2 baseline. Baseline/Goal is 12,400 visits. (encounters) Revised DY5 Baseline/Goal - DY 5 Goal: Increase the number of encounters by 12,400 over pre-DSRIP baseline. HHSC sent the revised language to the provider and the provider agreed with the revised language, so HHSC updated the milestones/metrics accordingly.</td>
<td></td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Memorial Hermann Northwest Hospital 020834001.2.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. Provider has reported significant progress towards DY 3 metrics and is likely to remain on track. Medicaid/Uninsured percentage listed in the project narrative is different from the QPI Summary. Baseline for QPI metric I-21.1 is zero so percentage increases in the goals are not feasible.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the M/U percentage in the project narrative to be more in line with actual project activities and the QPI summary. Technical Change: Remove the goals relating to a percentage increase over the baseline be removed from metric I-21.1 for DY 3 to DY 5 since the baseline for this project is zero due to it being a new project.</td>
<td>N/A</td>
</tr>
<tr>
<td>Texana Center 081522701.1.1</td>
<td>2</td>
<td>2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reports 17 of 12 learning collaborative meetings but did not report for achievement of the metric in April DY 3. 10 of 34 children were enrolled in services as of April DY 3. Valuation was noted to be very high. HHSC noted a risk for this project due to the high valuation and the provider’s intent to increase Medicaid/Uninsured percentage to 100% decreasing the valuation per individual.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Texana Center 081522701.1.3</td>
<td>4</td>
<td>4 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider has established 3 of 3 new specialty care clinics and achieved 508 of 3600 encounters by April DY 3. Provider reported that their anticipated encounters for the first 2 quarters were significantly under the estimated projections due to limited ramp-up and challenges getting referrals and building public awareness. There is an approved plan modification requesting a for change on Metric I-23.1 for DY 4 &amp; 5 to modify the encounter goal of 4800 in DY 4 to 3000 and modify the encounter goal of 6000 in DY 5 to 4500. The greater reduction in DY 4 is reported to be based on the projected DY 3 carry forward for late achievement.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Provider</td>
<td>Project ID</td>
<td>Overall Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>082006001.1.1</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reports 837 of 2000 primary care encounters, 156 of 500 patients accepting contraception services, and 7 of 800 encounters for treatment for STIs. Provider notes the major challenge affecting the progress of the project is the ability to open the clinic to the community at large due to security reasons. Noted lack of baselines for several DY 4 and DY 5 metrics. Noted possible additional federal funding. Provider reports having worked collaboratively with school administration to gain access to the students to provide a variety of services, including providing clinic tours to students, Zumba Mothers program, and opening the clinic to Tejano graduates. Provider clarified that no additional federal funds were being used for this project and they stated, &quot;The clinic activities, revenues and expenses, are segregated in separate cost centers in BCM’s accounting system, which ensures that the DSRIP funds are not commingled with non-DSRIP funds and activities.&quot;</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the manner in which baselines are stated for metrics I-103.1 and I-104.1 for DY 4 and DY 5 in order to demonstrate an increase over the baselines as stated in the metric goals.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
APPENDIX 2 - RHP 3

Provider

City of Houston Department of Health and Human Services 923744008.1.1

Overall

2 of 2 DY 2 milestones complete.

Risk

2 of 2 DY 3 milestones complete.

Ranking

Technical Change:

N/A

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

HHSC Response to Recommendation for HHSC

HHSC Response to Recommendations for the Project

City of Houston Department of Health and Human Services 923744008.1.2

4 of 4 DY 2 milestones complete.

No recommendations at this time.

Technical Change: Update metric I-101.1 goals in DY 4 and DY 5 so that the term individuals is replaced with encounters for greater clarity.

N/A

City of Houston Department of Health and Human Services 923744008.1.3

4 of 4 DY 3 milestones complete.

No recommendations at this time.

Technical Change: Update metrics I-17.1 in DY 4 and DY 5 to state that the baseline will be established in DY 3 in order to demonstrate a percentage improvement.

N/A

HHSC should consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties.

HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current polices, and incorporate in future reviews if recommended steps are missing.

MRLC recommended that HHSC consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties. HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.

Technical Change: Update wording of DY 5 metrics I-14.1 goals to state that the project intends to count the number of elderly accessing dental services instead of stating "special population members" accessing services. (encounters)

HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current polices, and incorporate in future reviews if recommended steps are missing.

MRLC recommended that HHSC consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties. HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.

Technical Change: Update wording of DY 5 metrics I-14.1 goals to state that the project intends to count the number of elderly accessing dental services instead of stating "special population members" accessing services. (encounters)

HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current polices, and incorporate in future reviews if recommended steps are missing.

MRLC recommended that HHSC consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties. HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.

Technical Change: Update wording of DY 5 metrics I-14.1 goals to state that the project intends to count the number of elderly accessing dental services instead of stating "special population members" accessing services. (encounters)

HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current polices, and incorporate in future reviews if recommended steps are missing.

MRLC recommended that HHSC consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties. HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.

Technical Change: Update wording of DY 5 metrics I-14.1 goals to state that the project intends to count the number of elderly accessing dental services instead of stating "special population members" accessing services. (encounters)

HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current polices, and incorporate in future reviews if recommended steps are missing.

MRLC recommended that HHSC consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties. HHSC will consider MSLC's recommendations regarding supporting documentation for contracting metrics, review our current policies, and incorporate in future reviews if recommended steps are missing.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.1.4</td>
<td>2</td>
<td>3 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reports that the project was implemented according to plan, preliminary baseline numbers were captured, and final baseline numbers will be reported in October DY 3. However, the provider also reported that the program has not yet been completely implemented as a PDSA cycle cannot be established until October reporting. 1207 of 6000 individuals have been served as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.1</td>
<td>2</td>
<td>3 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reported that the Healthy Homes project was implemented according to plan and an execution of an evaluation process was initiated. However, HHSC marked these metrics NMI because achievement was dated April 2014 on supporting documentation. 0 of 500 individuals have been reported of April DY 3 due to project delays related to IT but the provider states that 244 seniors have been educated on Healthy Homes Fall Prevention. Noted that DY 5 metric I-8.1 goal for homes inspected is incorrectly stated as 105 instead of 110 (10% increase from 100). Possible risk of overachievement once provider is able to report on QPI metrics.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update DY 5 metric I-8.1 goal for homes inspected to state a goal of 110 (10% increase from 100).</td>
<td>N/A</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.10</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. A Care Transitions Assessment was completed but the Care Transitions policies and procedures was considered NMI by HHSC because information on the supporting documentation did not match the summary provided. 120 of 360 individuals were served as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>City of Houston Department of Health and Human Services 093774008.2.2</td>
<td>4</td>
<td>3 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Due to IT related project delays, the project was unable to establish a baseline number of patients enrolled in the program, establish a baseline for the percentage of patients that were given PCP referrals, and 0 of 960 individuals were enrolled for navigation services. Provider support for DY 2 metric P-2.1 may be insufficient to demonstrate metric achievement. DY 3 metric I-10.3 states the Baseline/Goal on the Phase 4 Master Summary as 960 individuals “served” but the provider notes in the DY 3 sign-off summary states the 960 individuals with non-emergent conditions who are “enrolled” for navigation services in the past 12 months of DY 3. Provider states that the number of persons served (referred to basic services, including PCP) will be counted towards QPI rather than number of enrolled. Enrollment requires persons to agree to participate in 12 month tracking and follow up; which, they can deny to participate.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
APPENDIX 2 - RHP 3

Recommendations to HHSC

Provider: City of Houston Department of Health and Human Services
Project ID: 33374498.2.4

Due to project delays regarding IT issues, the project reports 0 of 230 individuals served. No progress reported towards implementing the program including metric P-3.1 because they state this is a newly added metric by HHSC that they will communicate with HHSC about.

Technical Change: Update project narrative. Phase 4 Master Summary, semi-annual sign off summaries and the QPI summary to consistently state the same project area and project option.

No recommendations at this time.

Recommendations to Provider

Provider: City of Houston Department of Health and Human Services
Project ID: 33374498.2.7

Due to project delays regarding IT issues, the project reports 0 of 230 individuals served. No progress reported towards implementing the program including metric P-3.1 because they state this is a newly added metric by HHSC that they will communicate with HHSC about.

Technical Change: Update project narrative. Phase 4 Master Summary, semi-annual sign off summaries and the QPI summary to consistently state the same project area and project option.

No recommendations at this time.

Recommendations to HHSC

Provider: City of Houston Department of Health and Human Services
Project ID: 33374498.2.3

Due to project delays regarding IT and staffing issues the project reports 0 of 150 individuals enrolled. The provider clarification is that no progress was reported due to the IT issues.

Technical Change: Update project narrative. Phase 4 Master Summary, semi-annual sign off summaries and the QPI summary to consistently state the same project area and project option.

No recommendations at this time.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Houston Department of Health and Human Services 333749408.2/3</td>
<td>4</td>
<td>3 of 5 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. Due to project delays, the program was unable to implement the project within the reporting period. A detailed evaluation plan was created but the dissolution of the strategic plan was not reported for achievement. The CoCAS program has also not started the process of established evaluative processes. The project reports 27 of 300 individuals served as of April DY 3. Noted that provider's DY 3-5 metric goals are unclearly stated regarding the percent increase and what baseline would be used. Also noted that the QPI is measuring individuals enrolled rather than individuals served. Provider states that the total impact for the CoCAS Program will be 100% over five years. There will be a 20% increase over DY 3 in DY 4 and a 40% increase over DY 5 in DY 5. This corresponds to a numeric goal of 300 in DY 3, 360 in DY 4, and 420 in DY 5 for a total impact of 1,080. Provider states that all individuals enrolled into the CoCAS Program will at minimum, complete the program questionnaire, receive colorectal cancer awareness material/education, and receive a take home FIT test. Therefore, all enrolled participants will be counted towards QPI.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: The QPI metric goals are incorrectly stated in regards to their percentage increases from the baseline established in DY 3. Update as follows: DY 3: Goal: 300 individuals DY 4: Baseline: 300 individuals in DY 3; Goal: 20% increase over DY 3 baseline; total of 360 individuals in DY 4 FY 5: Baseline: 300 individuals in DY 3; Goal: 40% increase over DY 3 baseline; total of 420 individuals for DY 5.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>West Houston Medical Center MM18402.2.1</td>
<td>4</td>
<td>3 of 5 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. As of April DY 3, 234 of 730 individuals were served and baselines were in the process of being established. Noted significant discrepancies in the intended Medicaid/Uninsured percentage of 23% and the actual reported percentage of 4%. Provider noted significant challenges with tracking patients within their system. Provider also noted that they were choosing to be more selective in choosing patients for enrollment despite already lagging behind on their QPI metrics. Provider clarified that the Medicaid/Uninsured percentage reported in April was in error, as it was not counting dual eligible patients. The revised percentage is 26% as of October DY 3. Provider stated that their initial patient tracking process was a manual paper process at the beginning of the project but since April DY 3 systems have been developed to build an IT system to provide electronic patient tracking. Provider stated that patient eligibility is generally determined based on functional/cognitive status and whether the patient is from a nursing home. The provider believes that with the expansion of their project to hospital-wide eligible seniors and expansion of the target population to the ED to include all adults without a PCP they can still achieve their QPI goals.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SparkleStop Center 536186602.2.1</td>
<td>2</td>
<td>3 of 5 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. If 10 patients have been served as of March 2014 and provider expects to meet metric by September. It was noted that the project narrative mentions the purchase of a mobile clinic but this was not a part of the metrics for this project. Provider reports that the purchase of a mobile clinic was not the best method of delivery of care and the project was changed to be in line with the current metrics without the need to purchase a mobile clinic.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SparkleStop Center 536186602.2.2</td>
<td>3</td>
<td>3 of 5 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Project was not approved until December 2013. Policies and procedures have been started and training materials are pending the completion of the software design.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update metric I-11.1 for DY 5 to correctly state 6% instead of 5% to reflect the 12 participants.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**APPENDIX 2 - RHP 3**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>111810101.1.10</td>
<td>6</td>
<td>3 of 3 DY 2 milestones complete. 6 of 3 DY 3 milestones complete. As of April DY 3 provider reports hiring 1 support staff and they are finalizing the hiring of a physician. Community outreach has been started but will not be finalized until the end of DY 3. Provider reports O 550 additional specialty care encounters by April DY 3. Training of 2 providers, 2 referral coordinators and 4 front desk staff and the development of referral and workaround guidelines as required from DY 2 carryfoward metrics had not yet been completed as of April DY 3. Provider site visit demonstrated that one of the 2 clinics was open and already serving patients and the other was soon to follow. Clinic's opening seems to have garnered positive support from the community and the community engagement plans for the facilities are extensive which is likely to help this project catch up with their QPI metrics. Provider already has plans to further expand services at the current location.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;$ did not have any recommendations.</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>111810101.1.2</td>
<td>4</td>
<td>3 of 4 DY 2 milestones complete. 6 of 3 DY 3 milestones complete. Project leadership has begun strategizing for identification of appropriate clinical teaching tools for faculty/mentors. Due to the carry-forward of DY 2 milestones to April, new residents will not be served until July of 2014, when the start of the new professional growth year (PGY) begins. As of April DY 3 67 200 patient encounters have taken place. Noted possible additional federal funding. Provider noted significant challenges engaging stakeholders and dealing with changes in project leadership. Provider reports, &quot;Each approved project is given a separate account that can only accrue charges affiliated with that project. These accounts are monitored by the project owners to ensure that there is no crossing between projects or funds.&quot; Provider states that a new Project Manager and Chair of Family Medicine took over in the second half of DY 3 and was able to get the project back on track.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;$ did not have any recommendations.</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>111810101.1.5</td>
<td>3</td>
<td>3 of 3 DY 3 milestones complete. 6 of 4 DY 3 milestones complete. The UTP Nurse Line has successfully been providing urgent medical advice and scheduling appointments for patients and expects to go 24/7/365 by the end of May 2014. Of the 25% expansion of bilingual personnel goal, the provider has achieved 17% by April DY 3. Provider reports having informed and educated 3427 of the 20,000 unique patients by April DY 3. Provider reports 3427 of 10,000 patients having accessed the nurse advice line as of April DY 3. The hiring of 12 registered nurses as required for the April DY 2 carryforward metric had not been achieved by April DY 3. Lack of clarity noted in QPI metric goals. DY 3 metric I-13.1 stats an increase in utilization of the nurse advice line by 4%, the patient impact of this is 10,000 which does not demonstrate a 4% increase over the baseline of 20,500. The same issue applies to metric I-13.1 in DY 4 and DY 5. Provider stated that a plan modification was proposed to HHSC to adjust the QPI metrics but that it was not accepted.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update metric I-13.1 for DY 3 - DY 5 to more clearly state the percentage increase in utilization goal aligns with the numerical increase in patient encounters.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### APPENDIX 2 - RHP 3

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Texas Health Science Center - Houston 1118101.1.7</td>
<td>4</td>
<td>2 of 3 DY 2 milestones complete. 1 of 4 DY 3 milestones complete.</td>
<td>Provider reports having hired 3 out of 4 FTE providers and 2 support staff and tracking all new patients being seen by these providers in order to meet their goal of 4,000 new patients per quarter. A strategy for community outreach has begun being developed and will be implemented in the second part of DY 3. Provider reports 0 of 13,000 encounters as of April DY 3 and no progress has been reported regarding an increase in the Medicaid/Uninsured percentage of patients reached through the program. The training of 16 staff as required by April DY 2 carryforward metric has not yet been reported for achievement.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>M&amp;S did not have any recommendations.</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 1118101.1.8</td>
<td>4</td>
<td>2 of 3 DY 2 milestones complete. 1 of 5 DY 3 milestones complete.</td>
<td>Provider appears to be off track with their metrics. No staff have been trained as of April DY 3. Provider reports 0 of 500 unique individuals for whom the risk for hospital-acquired conditions is reduced as of April DY 3. Provider’s April DY 2 carryforward metric goal of designating district team leaders, designating/hiring 1 project manager; 2 system engineers; 1 six sigma; 2 IT personnel has not yet been reported for achievement as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update wording for DY 4 and DY 5 metric to state that individuals are identified as having a reduced risk by the usage of the VTE Advisor early detection tool. Technical Change: Remove the term “vice chairs” from metric P-6.1 goals for DY 3 since the organization does not have any positions with the title “vice chairs.”</td>
<td>M&amp;S recommended updating the wording for DY4 and DY5 QPI metric I-110.1.1 to state that individuals are identified as having a reduced risk by the usage of the VTE Advisor early detection tool. M&amp;S agreed to change the Custom Milestone Description for I-101.1 to “Number of unique individuals for whom the risk for hospital-acquired conditions is reduced” to “Number of unique individuals for whom the risk for hospital-acquired conditions is reduced through the usage of the VTE Advisor early detection tool.” HHSC sent the revised language to the provider and the provider agreed with the revised language accordingly. M&amp;S also recommended removing the term “vice chairs” from metric P-6.1 goals for DY3 since the organization does not have any positions with the title “vice chairs.” However, HHSC did not agree to make this change to P-6.1 in DY3 since DY3 is over.</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 1118101.1.9</td>
<td>4</td>
<td>2 of 3 DY 2 milestones complete. 1 of 5 DY 3 milestones complete.</td>
<td>Provider appears to be off track with their progress as of April DY 3. Provider reports hiring some primary care providers and support staff for the clinic but goals were not met by April DY 3. As of April DY 3, provider reports 0 of 11,652 increased number of visits. Provider’s DY 2 carryforward metric goal of community outreach has not yet been reported for achievement.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update DY 5 metric I-111.1 to state that the baseline being used for demonstrating the increase in patient satisfaction will be established in DY 4.</td>
<td>M&amp;S recommended updating the wording for DY5 metric I-111.1 to state that the baseline being used for demonstrating the increase in patient satisfaction will be established in DY4. HHSC did not agree that DY5 metric I-111.1 needed to be updated to state that baseline being used for demonstrating the increase in patient satisfaction will be established in DY4, as this is implied. HHSC believes it is sufficient for the provider to submit documentation of the baseline and baseline period during reporting. Any issues with the baseline or baseline period can be addressed through reporting. Therefore HHSC did not make the recommended changes.</td>
</tr>
<tr>
<td>Provider</td>
<td>Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>111810101.2.3</td>
<td>4</td>
<td>2 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider has hired and trained 5 out of 12 patient navigators and 2 social workers as of April DY 3. Provider has attended 1 of 2 learning collaborative meetings. Patient navigators have not yet begun to schedule primary care appointments so the provider is reporting 0 of 12,490 individuals receiving services as of April DY 3. Provider's April DY 2 carryforward metric of establishing a baseline for the average number of patients admitted that do not have a PCP has not yet been reported for achievement. Provider noted a large variance in the data used for the needs assessment which significantly reduced the estimated percentage of UTP patients without a PCP. This may affect ability to reach patients. Provider states that needs assessment data showed 77% of patients without a PCP while after collaborating with the data analytics team at Memorial Hermann Healthcare System they established that 23.5% was a more accurate estimation. Problem was discovered to be due to the EHR not being required to enter data into the PCP category which may have resulted in inaccurate data.</td>
<td>Consideration should be given to project valuation if plan modification to reduce QPI is submitted and approved. Possible Plan Modification: Provider should consider possible decrease in QPI based on the provider's updated needs assessment information. Technical Change: Update the project narrative to state the QPI goals as individuals instead of encounters so that it is in line with metric goals.</td>
<td>No recommendations at this time.</td>
<td>MAS recommended that the provider consider possible decreasing the QPI based on the provider's updated needs assessment information. MAS further recommended that consideration be given to the potential impact on project valuation if plan modification to reduce QPI is submitted and approved and revised valuation falls outside the range. However, the provider indicated that they are on track to meet their QPI goals, and therefore, they do not need to reduce their QPI. MAS also recommended updating the project narrative to state the QPI goals as individuals instead of encounters so that it is in line with metric goals. However, as the metric goals of record are in the Cooper system, HHSC does not plan to update the project narrative to reflect the goals.</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston</td>
<td>111810101.2.6</td>
<td>1</td>
<td>2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider has completed the creation of and final approval for the protocols and updated policies and procedures for DKA admissions, cancer surgery patients, and diabetic (type 1) adolescents graduating from pediatric care to adult care. Provider has also completed the development and implementation of a staffing plan for each of the 3 transitions processes. Provider reports 144 of 250 individuals as of April DY 3. Project was noted as a benchmark project due to significant progress towards the achievement of DY 3 metrics, excellent lessons learned regarding the value of early commitment of stakeholders, and having well documented support for the achievement of their metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>The University of Texas Health Science Center - Houston 111810101.2.8</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider has completed 3 of 4 signed agreement to integrate services at clinics. Provider has located 3 of the 5 providers needed for the integration of care and as of April DY 3 0 of 500 individuals were served. Noted that QPI metric was unclear regarding whether individuals being counted were receiving both physical and behavioral health care services as stated in the percentage goals. Provider clarified that numerical QP goal and percentage QPI goal are to be counting both primary and behavioral health care services provided to individuals.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update metric I-8 in DY 3-DY 5 to state that individuals being counted are receiving both behavioral health care services as well as primary care.</td>
<td>N/A</td>
<td>M&amp;S recommended updating metric I-8 in DY3-DY5 to state that individuals being counted are receiving both behavioral health care services as well as primary care. HHSC agreed to clarify the goal for the DY4 and DY5 metrics I-8.1 but not the DY3 metric, as DY3 is over.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>0 of 2 DY 3 milestones complete. 0 of 3 DY 3 milestones complete. Provider has completed 3 of 1 signed agreement to integrate services at clinics. Provider has located 3 of the 5 providers needed for the integration of care and as of April DY 3 0 of 500 individuals were served. Noted that QPI metric was unclear regarding whether individuals being counted were receiving both physical and behavioral health care services as stated in the percentage goals. Provider clarified that numerical QP goal and percentage QPI goal are to be counting both primary and behavioral health care services provided to individuals.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;S did not have any recommendations.</td>
</tr>
<tr>
<td></td>
<td>5 of 5 DY 2 milestones complete. 3 of 2 DY 3 milestones complete. Provider cited difficulties reaching their targeted number of patients due to missed appointments and changes in volume at Legacy clinics. Provider states that they are addressing this issue through the use of reports provided by Legacy clinics listing patients who had self-reported as smoking and had a positive HIV diagnosis. They report this significantly increasing their enrollment in the program.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2 of 5 DY 3 milestones complete. 3 of 3 DY 3 milestones complete. Provider cited difficulties reaching their targeted number of patients due to missed appointments and changes in volume at Legacy clinics. Provider states that they are addressing this issue through the use of reports provided by Legacy clinics listing patients who had self-reported as smoking and had a positive HIV diagnosis. They report this significantly increasing their enrollment in the program.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>Project ID</td>
<td>Overall Risk Tacking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>University of Texas M.D. Anderson Cancer Center 112672402.2.3</td>
<td>2</td>
<td>2 of 3 DY 2 milestones complete. 3 of 2 DY 3 milestones complete.</td>
<td>5,643 of 12,500 individuals have been enrolled into the ASPIRE program as of April DY 3 and the provider has attended 1 of 2 learning collaborative meetings. The provider is currently not tracking the number of Medicaid and uninsured patients as a percent of the total project population and does not plan on doing so. It was also noted that QPI metrics P-2.1 and I-5.1 for DY 3 - DY 5 are only counting enrollment and not services provided to the individual. Provider reports, “There is no process in place to track Medicaid/Uninsured individuals because the individuals using ASPIRE are not patients. ASPIRE is mainly being delivered at schools in the Houston area. The estimated 81% Medicaid/Uninsured number comes from the Houston Independent School District’s reported percentage of students receiving free/reduced-cost lunches.”</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider having QPI metrics P-2.1 and I-5.1 clearly count patient impact through the providing of services, rather than simply track patient enrollment. Preferably counting the number of unique individuals who have received some form of smoking cessation counseling during the demonstration year.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HHSC should consider requiring that all supporting documentation for training be signed by all parties in order to be accepted for metric achievement.

Technical Change: Update project narrative to clearly state the goal of the metric is to show that the goal is to be maintained across clinics in DY 4 and 8 clinics in DY 5. Current metric goal states “goal of two clinics demonstrating improved adherence to eligibility process” which is unclear and not in line with the provider's description of the intent of the metric.

HHSC reviewed the supporting documentation that was submitted for P-102.1 and P-103.1 and found that it demonstrated achievement of these metrics. HHSC agreed these metrics for payment and made the payments. HHSC also removed the baseline from the Baseline/Goal cell as it reflects the number of encounters provided during the previous DY rather than the pre-DSRIP baseline.

Recommendations to Provider

HHSC should consider requiring that all supporting documentation for training be signed by all parties in order to be accepted for metric achievement.

Technical Change: Update project narrative and QPI metric I-15.1 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC agreed to update QPI metric I-15.1 in DYS 4 and 5 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies.

Recommendations to HHSC

HHSC should consider requiring that clinical collaboration agreements being used for supporting documentation be signed by all parties in order to be accepted for metric achievement.

Technical Change: Update project narrative and QPI metric I-102.1 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC agreed to update QPI metric I-102.1 in DY 4 and 5 to include a listing of individuals trained as well as when and where the training took place.

Going forward, HHSC will consider requiring additional supporting documentation to demonstrate achievement of these metrics.

Technical Change: Update project narrative and QPI metric I-5.1 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC agreed to update QPI metric I-5.1 in DYS 4 and 5 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC also removed the baseline from the Baseline/Goal cell as it reflects the number of encounters provided during the previous DY rather than the pre-DSRIP baseline.

Recommendations to HHSC

HHSC should consider requiring that clinical collaboration agreements being used for supporting documentation be signed by all parties in order to be accepted for metric achievement.

Technical Change: Update project narrative and QPI metric I-15.1 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC agreed to update QPI metric I-15.1 in DYS 4 and 5 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC also removed the baseline from the Baseline/Goal cell as it reflects the number of encounters provided during the previous DY rather than the pre-DSRIP baseline.

Recommendations to HHSC

Technical Change: Update project narrative and QPI metric I-102.1 to clearly state that the goal of the metric is to show that the 65% goal is to be maintained across clinics in DY 4 and 8 clinics in DY 5. Current metric goal states “goal of two clinics each demonstrating improved adherence to eligibility process” which is unclear and not in line with the provider's description of the intent of the metric.

HHSC reviewed the supporting documentation that was submitted for P-102.1 and P-103.1 and found that it demonstrated achievement of these metrics. HHSC approved these metrics in DY 5.

HHSC will consider updating the project narrative and QPI metric I-15.1 to clearly state that encounters will not only include mammograms but also additional treatments such as breast ultra-sounds and biopsies. HHSC also removed the baseline from the Baseline/Goal cell as it reflects the number of encounters provided during the previous DY rather than the pre-DSRIP baseline.
Recommendations to Provider (continued)

Current DY4 Baseline/Goal - Baseline of six clinics/Goal of two clinics
M&S also recommended updating metric I-102.1 in DY5 to remove the term "mobile clinics" from the project goals.

Provider has achieved 1 of 3 DY3 milestones complete and reports overcrowaching QPI metric goal by seeing 494 patients when they only needed 250 patients.

Provider did not agree with this recommendation because their ability to over-serve in DY3 was due to an already established waiting list for mental health services that they were able to immediately target to provide a mental health intervention service. They hired 3 new teams to meet the needs of this waiting list of which 1 team was funded through DSRIP revenue. Their original QPI proposal was based only the number of individuals served by DSRIP-funded teams to meet the needs of this waiting list for mental health services that they were able to immediately target.

M&S also recommended updating metric I-102.1 in DY5 to remove the term "mobile clinics" from the project goals. HHSC responded that provider can increase QPI due to significant overachieving in April DY3. M&S further recommended that consideration be given to potential impact on project valuation if plan modification to increase QPI is submitted and approved. HHSC does not plan to adjust the valuation if plan modification to increase QPI is submitted and approved.

The provider agreed with the revised language, so HHSC updated the milestones’ metrics accordingly.

Possible Plan Modification: Provider should consider increasing QPI due to significant overachieving in April DY3.

Technical Change: Update metric I-102.1 in DY 5 to remove the term "mobile clinics" from the project goals.

HHSC Response to Recommendation for Provider

Current DY4 Baseline/Goal - Baseline of six clinics/Goal of two clinics
M&S recommended that the provider consider increasing QPI due to significant overachieving in April DY3. M&S further recommended that consideration be given to potential impact on project valuation if plan modification to increase QPI is submitted and approved.

The provider did not agree with this recommendation because their ability to over-serve in DY3 was due to an already established waiting list for mental health services that they were able to immediately target to provide a mental health intervention service. They hired 3 new teams to meet the needs of this waiting list of which 1 team was funded through DSRIP revenue. Their original QPI proposal was based only on the number of individuals served by DSRIP-funded teams to meet the needs of this waiting list for mental health services that they were able to immediately target.

M&S also recommended updating metric I-102.1 in DY5 to remove the term "mobile clinics" from the project goals. HHSC and the provider agreed with this recommendation and HHSC updated the milestones’ metrics accordingly.
<table>
<thead>
<tr>
<th>Project</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Final Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>3</td>
<td>1 of 3 DY 2 milestones complete. 2 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;S did not have any recommendations.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>3</td>
<td>1 of 3 DY 4 milestones complete.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>M&amp;S did not have any recommendations.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>3</td>
<td>3 of 3 DY 2 milestones complete.</td>
<td>Recommendation future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.1.5 (continued)</td>
<td>(continued)</td>
<td>(continued)</td>
<td>(continued)</td>
<td>(continued)</td>
<td>(continued)</td>
<td>(continued)</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.1.6</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete</td>
<td>Provider reports 173 of 250 individuals being served by April DY 3 and baseline data is being gathered. Significant lack of clarity in the project narrative regarding hiring goals listed and how they apply to this project. Project narrative also stated that a new clinic would be created and this was noted as a part of DY 3 metric P-6.1 goals. Support for DY 2 metric P-4.1 did not indicate the date of hire or the positions the personnel were hired for. Metric I-102.1 references the use of a mobile clinic in the denominator but no mobile clinic is mentioned in the project plans. Provider states that each clinical team will consist of &quot;1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians&quot; and that &quot;additional Clinical Team Leaders and Rehab staffs were hired to strength actual services provided to achieve the targeted outcomes.&quot; Provider states, &quot;One new clinic is defined as creating a clinical team to serve in one of the 5 clinics.&quot; Provider confirmed that the use of a mobile clinic is not a part of the project's activities.</td>
<td>Recommend future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.</td>
<td>Technical Change: Update metric I-102.1 in DY 4 and DY 5 to remove the term &quot;mobile clinic&quot; from the project's goals.</td>
<td>HHSC will take this into account in the future.</td>
<td>HHSC will consider MSLC recommendation regarding supporting documentation for documentation for hiring metrics. Review our current policies and incorporate in future reviews if recommended steps are missing.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.1.7</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete</td>
<td>Provider reports 109 of 250 individuals being served by April DY 3 and baseline data is being gathered. Significant lack of clarity in the project narrative regarding hiring goals listed and how they apply to this project. Project narrative also stated that a new clinic would be created and this was noted as a part of DY 3 metric P-6.1 goals. Support for DY 2 metric P-4.1 did not indicate the date of hire or the positions the personnel were hired for. Metric I-102.1 references the use of a mobile clinic in the denominator but no mobile clinic is mentioned in the project plans. Provider states that each clinical team will consist of &quot;1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians&quot; and that &quot;additional Clinical Team Leaders and Rehab staffs were hired to strength actual services provided to achieve the targeted outcomes.&quot; Provider states, &quot;One new clinic is defined as creating a clinical team to serve in one of the 5 clinics.&quot; Provider confirmed that the use of a mobile clinic is not a part of the project's activities.</td>
<td>Recommend future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.</td>
<td>Technical Change: Update metric I-102.1 in DY 4 and DY 5 to remove the term &quot;mobile clinic&quot; from the project's goals.</td>
<td>HHSC will take this into account in the future.</td>
<td>HHSC will consider MSLC recommendation regarding supporting documentation for documentation for hiring metrics. Review our current policies and incorporate in future reviews if recommended steps are missing.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.1.8</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete</td>
<td>Provider reports 173 of 250 individuals being served by April DY 3 and baseline data is being gathered. Significant lack of clarity in the project narrative regarding hiring goals listed and how they apply to this project. Project narrative also stated that a new clinic would be created and this was noted as a part of DY 3 metric P-6.1 goals. Support for DY 2 metric P-4.1 did not indicate the date of hire or the positions the personnel were hired for. Metric I-102.1 references the use of a mobile clinic in the denominator but no mobile clinic is mentioned in the project plans. Provider states that each clinical team will consist of &quot;1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians&quot; and that &quot;additional Clinical Team Leaders and Rehab staffs were hired to strength actual services provided to achieve the targeted outcomes.&quot; Provider states, &quot;One new clinic is defined as creating a clinical team to serve in one of the 5 clinics.&quot; Provider confirmed that the use of a mobile clinic is not a part of the project's activities.</td>
<td>Recommend future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.</td>
<td>Technical Change: Update metric I-102.1 in DY 4 and DY 5 to remove the term &quot;mobile clinic&quot; from the project's goals.</td>
<td>HHSC will take this into account in the future.</td>
<td>HHSC will consider MSLC recommendation regarding supporting documentation for documentation for hiring metrics. Review our current policies and incorporate in future reviews if recommended steps are missing.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County 113180703.1.9</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete</td>
<td>One new community based setting for behavioral health has been established. 10 of 20 individuals have been served as of April DY 3 and baselines are being established. Notable discrepancies between the metrics stated in the Phase 4 Master Summary and the Project Narrative. It appears that DY 2 metric P-4.1 support was insufficient to support the goals for hiring and training.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;S did not have any recommendations.</td>
</tr>
</tbody>
</table>
Provider | Project ID | Overall Risk | Fantasy | Narrative Describing Mid-Point Assessment Score Justification | Recommendations to HHSC | Recommendations to Provider | HHSC Response to Recommendation for HHSC | HHSC Response to Recommendations for the Project
---|---|---|---|---|---|---|---|---
Mental Health and Mental Retardation Authority of Harris County | 113180703.2.1 | 4 | 0 of 1 DY 1 milestones complete. 0 of 3 DY 2 milestones complete. | No progress on the project to date. Lack of clarity regarding metric baselines. Project reported difficulty hiring a Project Director to oversee the project and all activities would begin after that person was hired. Sites being researched but no agreements had been made as of Apr DY 3. | It was noted that several metrics descriptions stated that the goal was an increase over a baseline but the metric goals were not in line with the metric descriptions. Some metrics were also noted to have goals of an increase over a baseline but did not state when the baseline would be established. | During site visit, provider showed that space had been set aside for the first co-location of the FQHC’s used for the project. Provider reports seeing approximately 50 patients as of March 2014 towards their DY 3 goal of 800 patients. It was noted during the site visit that there may be a possibility of overlapping services between DSRIP projects through the use of the FQHC’s. Provider recommended establishing baselines by using the first 6 months of data related to the project activities. | Consideration should be given to potential impact on project valuation if plan modification to increase QPI is submitted and approved and revised valuation falls outside the range. | Provider should consider decrease in QPI due to lack of progress towards DY 3 QPI goals. | M&S recommended that the provider consider decreasing QPI due to lack of progress towards DY3 QPI goals. They further recommended that consideration be given to potential impact on project valuation if plan modification to decrease QPI is submitted and approved and revised valuation falls outside the range. In response, HHSC requested a status update from the provider, and asked the provider if they anticipated having significant difficulty reaching their QPI metric goals for the initiative increased over the baseline. (Provider recommended establishing baselines by using the first 6 months of data related to the project activities.) | Possible Plan Modification: Provider should consider decrease in QPI due to lack of progress towards DY 3 QPI goals. | Technical Change: Update metric I-9.1 in DY 4 and DY 5 to have a clearly established baseline in order to demonstrate an improvement over the baseline. (Provider recommended establishing baselines by using the first 6 months of data related to the project activities.) | Provider recommended establishing baselines by using the first 6 months of data related to the project activities. | Provider recommended establishing baselines by using the first 6 months of data related to the project activities. | Technical Change: Update all metrics I-11.1 in DY 4 and DY 5 each have a clearly established baseline and percentage increase over the baseline listed in the goals for the metrics so that they are in line with the metric descriptions. (Provider recommended establishing baselines by using the first 6 months of data related to the project activities.) | Technical Change: Update project narrative to be in line with the metric goals as stated in the Phase 4 Master Summary. | HHSC always reviews any submitted plan modification request to reduce QPI with an eye toward valuation. However, since the provider did not request to decrease QPI via plan modification, HHSC is not going to reduce initiative goals decrease since project's valuation is above $5 min. | Possible Plan Modification: HHSC recommends considering decrease in QPI due to lack of progress towards DY3 API target goal due to some delays in finalizing contractual agreements with identified collaborative partners and hiring qualified providers. However, to offset this difficulty they are planning to expand services with existing partners that contractual agreements have been finalized with and services have begun. In addition, they have taken steps to identify referral sources within the agency to stimulate and increase the number that they serve. Also, they have streamlined the referral and intake process to afford the opportunity to create an upsurge of access to services. There has been increased efforts and mechanisms in place to identify qualified providers, specifically psychiatrists and RN’s. The Human Resources department is aware of the necessity of hiring providers and has expedited procedures to ensure that applicants are processed in a timely manner. They are confident their efforts will result in their ability to achieve the DY3 QPI goal of 800 individuals. Based on the provider’s status update, HHSC disagreed with the recommendation to decrease QPI.

M&S also recommended updating metric I-9.1 to DY4 and DY5 to have a clearly established baseline in order to demonstrate an improvement over the baseline. HHSC disagreed that metric I-9.1 in DY4 and DY5 needed to be updated to include the baseline. HHSC believes it is sufficient if the provider submits documentation of the baseline and baseline period during reporting. Any issues with the baseline or baseline period can be addressed through reporting.

M&S also recommended updating all metrics I-11.1 in DY4 and DY5 to have a clearly established baseline and percentage increase over the baseline listed in the goals for the metrics so that they are in line with the metric descriptions. HHSC believes it is sufficient if the provider submits documentation of the baseline and baseline period during reporting. Any issues with the baseline or baseline period can be addressed through reporting.

M&S also recommended updating the project narrative to be in line with the metric goals as stated in the Phase 4 Master Summary. As the metric goals of record are in the Cooper system, HHSC does not believe it is necessary to update the project narrative to reflect the goals.
### Recommendations to Provider

**Current** DY4 Baseline/Goal - Enroll 800 more individuals (over DY3) in substance abuse treatment (total of 800 served at year end).

**Revised** DY4 Baseline/Goal - DY4 Goal: 1,400 individuals above pre-DSRIP baseline are receiving substance abuse treatment services.

**Current** DY5 Baseline/Goal - Enroll 800 more individuals (over DY3) in substance abuse treatment (total of 800 served at year end).

**Revised** DY5 Baseline/Goal - DY5 Goal: 1,550 individuals above pre-DSRIP baseline are receiving substance abuse treatment services.

#### Technical Change:
- Update DY4 and DY5 metrics I-104.1 and I-104.2. to clearly state what baselines will be used to demonstrate improvement.
- Update the project narrative to be in line with the metric goals as stated in the Phase 4 Master Summary.
- HHSC disagrees that metrics I-104.1 and I-104.2 in DY4 and DY5 need to be updated to include the baseline. HHSC believes it is sufficient if the provider submits documentation of the baseline and baseline period during reporting. Any issues with the baseline or baseline period can be addressed through reporting.

#### Provider Response

**HHSC**

- HHSC notes that the provider consider increasing QPI due to significant over achieving in DY3, and that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.
- HHSC does not plan to adjust the valuation for increasing the QPI metric goal in DY5 due to achievement of the DY5 goal in DY3.
- HHSC recommends that the provider consider increasing QPI due to significant over achieving in DY3, and that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.
- HHSC recommends that the provider consider increasing QPI due to significant over achieving in DY3, and that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.

**Provider**

- Provider stated that as of October reporting they had seen a total of 1,353 individuals who were 3% Medicaid and 97% Low Income Uninsured.
- Provider reported that as of October reporting they had seen a total of 1,353 individuals who were 3% Medicaid and 97% Low Income Uninsured.
- Provider stated baselines are being established.
- Noted several discrepancies in the project narrative relating to metric goals. QPI metric P-3.1 in DY 4 and DY 5 each state a goal of enrolling 800 more individuals over DY 3 which was 300 individuals. However, the total number of patients being served in DY 4 and DY 5 is listed as being only 800. Metrics I-104.1 and I-104.2 in DY 4 and DY 5 do not have clearly stated baselines.

#### Possible Action Plan

- Consideration should be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.

**Recommendations to HHSC**

- HHSC recommends that the provider consider increasing QPI due to significant over achieving in DY3, and that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.
- HHSC recommends that the provider consider increasing QPI due to significant over achieving in DY3, and that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.

**APPENDIX 2 - RHP 3**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703.2.2</td>
<td>2</td>
<td>1 of 3 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Project has served 508 individuals out of a goal of 300 individuals as of April DY 3 and baselines are being established. Noted several discrepancies in the project narrative relating to metric goals. QPI metric P-3.1 in DY 4 and DY 5 each state a goal of enrolling 800 more individuals over DY 3 which was 300 individuals. However, the total number of patients being served in DY 4 and DY 5 is listed as being only 800. Metrics I-104.1 and I-104.2 in DY 4 and DY 5 do not have clearly stated baselines.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703.2.3</td>
<td>3</td>
<td>2 of 3 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 2 clinicians were hired and 10 of 150 individuals have been served as of April DY 3. 250 of 500 warm hand-offs of individuals have been performed as of April DY 3. HHSC states that DY 2 metric P-2.7 is no longer eligible for payment due to lack of additional report in October DY 2 per Health's request. Provider states, &quot;We carried forward this QPI metric as we had not achieved the targeted 1,500. We have been working under the premise that the baseline goal for us to achieve is the 1,500 which we expect to achieve by June for reporting during DY 4 Oct. reporting.&quot; Provider stated that they have been hiring more care providers to get the QPI goals back on track for future years.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
</tr>
</tbody>
</table>
### APPENDIX 2 - RHP 3

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendations for HHSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703.2.4</td>
<td>3 of 4 DY 2 milestones complete.</td>
<td>of 3 DY 3 milestones complete.</td>
<td>Consideration should be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider QPI increase due to significant over-achieving in DY 4 and therefore does not plan to adjust valuation.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703.2.5</td>
<td>3 of 4 DY 2 milestones complete.</td>
<td>of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update QPI metric goals as XX number of unique individuals over the 1400 individual baseline noted in the project narrative for greater clarity.</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703.2.3</td>
<td>4 of 4 DY 3 milestones complete.</td>
<td>of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update metric I-38.1 in DY 4 and DY 5 to remove the patient impact of 140 individuals and the total impact listed.</td>
</tr>
</tbody>
</table>

**Technical Change:**

- **Possible Plan Modification:** Provider should consider QPI increase due to significant over-achieving in DY 4 and therefore does not plan to adjust valuation.
- **Technical Change:** Update QPI metric goals as XX number of unique individuals over the 1400 individual baseline noted in the project narrative for greater clarity.
- **Technical Change:** Update metric I-38.1 in DY 4 and DY 5 to remove the patient impact of 140 individuals and the total impact listed.
- **Technical Change:** Update the QPI metric goals to reflect the QPI metrics being metrics I-101.1 and I-101.2 in DY 4 and DY 5.
- **Technical Change:** Update the QPI summary to reflect the QPI metrics being metrics I-101.1 and I-101.2 in DY 4 and DY 5.

**Possible Plan Modification:**

- Change I-101.2 in DY 5 to I-101.1 in DY 5 and increase the goal so that it is higher than the DY4 goal.
- Make I-101.1 in DY 4 and DY 5 a QPI metric.

**Technical Change:**

- Update the QPI metric goal in DY 5 to significant over-achieving in DY3. M&S further recommended that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved. The revised QPI goals for QPI metric P-3.1 are 10 in DY3, 20 in DY4, and 30 in DY5. The provider achieved 25 in DY5, which is less than the revised DY5 goal of 30. Therefore, HHSC does not recommend increasing the QPI goal for DY5. M&S recommended that the provider consider increasing the QPI due to significant over-achieving in DY3. M&S further recommended that consideration be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved. The revised QPI goals for QPI metric P-3.1 are 10 in DY3, 20 in DY4, and 30 in DY5. The provider achieved 25 in DY5, which is less than the revised DY5 goal of 30. Therefore, HHSC does not recommend increasing the QPI goal for DY5. M&S also recommended updating the project narrative to be in line with metric goals as stated in the Phase 4 Master Summary. However, as the metric goals of record in the Cooper system, HHSC does not agree to update the project narrative to reflect the goals. Therefore, HHSC did not require that the provider update narratives.
Recommendations to Provider

2 of 2 DY 2 milestones complete.

- A Steers Functional Team to evaluate the Chronic Disease Registry Program at 56% of their overall personnel when the goal was only 25%, and implemented it at 100% of their sites when the goal was only 30%.
- Noted that support for the implementation of the Chronic Disease Registry was insufficient to demonstrate metric achievement. The provider support metric P4.1 only shows the sites in a "checklist" style format marked as "100% implemented." The support doesn't show sufficient proof of functionality or actual integration. Noted lack of clear baselines for DY 4 and DY 5 metrics 13.1.1 and this metric also measures only patients entered into the registry, not those patients who benefited from being in the registry.
- Provider submitted additional supporting documents including screenshots of the sample registry reports and sample patient visit reports from the new Chronic Disease Registry.

HHSC should consider requesting future supporting documentation for implementation of a chronic disease registry at multiple locations include sample registry reports, sample patient visit reports, and other screenshots showing implementation of the new system at the various locations.

Possible Plan Modification: Provider should consider an increase in QPI in DY 4 and DY 5 due to significant overachievement of DY 3.

HHSC does not plan to adjust evaluation as the project does not have a DY QPI metric, and therefore, the provider could not have achieved the DY5 QPI metric goal in DY3. HHSC does not change evaluation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's valuation.

HHSC will consider requesting future supporting documentation for implementation of a chronic disease registry at multiple locations include sample registry reports, sample patient visit reports, and other screenshots showing implementation of the new system at the various locations in the future.

Recommendations to HHSC

- Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved.

Technical Change: Update metrics I-16.1 for DY 4 and DY 5 to clearly state the baseline period on which a percent increase is based upon.

No recommendations at this time.

OakBend Medical Center
273230932.1

2 of 1 DY 2 milestones complete.

- Noted possible future over-achievement due to hiring additional 10 specialists when the goal was only hiring 1 OB/GYN. Provider reports being on track to train 20% of its staff by the end of DY 3.
- Provider states, "While OakBend has already met the project's DY 3 recruitment goals, OakBend plans to recruit 1 or 2 additional specialists in each year DY 4 and DY 5 that aligns with DY 4 and DY 5 recruitment goals."

HHSC Response to Recommendations for the Project

- No recommendations at this time.

M&S did not have any recommendations.

Malaga Centro Regional Medical Center
195055004.1

2 of 2 DY 2 milestones complete.

- Noted potential risk because the project failed to identify ways in which they would attempt to improve patient satisfaction. Also noted that the baseline for the percentage of improvement of patient satisfaction was not clearly stated.
- Provider stated that they are in the process of selecting a baseline period and they expect to finalize the baseline by early summer. The provider is participating in activities that will allow them to increase the patient satisfaction, such as performing roundtables with managers, expanding training and education, and implementing a zero tolerance policy when dealing with staff who are not performing up to standards set by the Steering Committee.

HHSC should strengthen supporting documentation requirements as a press release or flyer is not sufficient support to show the hiring of staff. Signed contracts, offer letters, or HR documents would suffice.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

HHSC will review its policies and adjust as necessary.

Malaga Centro Regional Medical Center
195055004.1

2 of 2 DY 2 milestones complete.

- The project is behind schedule due to delays with CMS approval. QPI metric starts in DY 4. QPI metrics I-23.1 seems to be only counting the increase in patients over the prior year goal. The baseline for this project must be zero since there was no prior clinic and all encounters during the DSRIP project should be counted towards QPI. Support for P2 metric P1.1.1 was notably weak in demonstrating achievement of the metric.
- Provider stated, "The Specialty Care Expansion project is a new service line to Malaga Centro Regional Medical Center and the timing of the project implementation to include recruitment of new providers only allowed for a baseline established in DY 3 versus a pre-DSRIP baseline. There was no Specialty Care Clinic established at MRRMC prior to DSRIP."

HHSC should strengthen supporting documentation requirements as a press release or flyer is not sufficient support to show the hiring of staff. Signed contracts, offer letters, or HR documents would suffice.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encouneters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

HHSC will review its policies and adjust as necessary.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounter seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

HHSC will review its policies and adjust as necessary.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

HHSC will review its policies and adjust as necessary.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

HHSC will review its policies and adjust as necessary.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.

Possible Plan Modification: Provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value due to the delayed start to the project.

Possible Plan Modification: Provider should consider adjusting the QPI goals for metric I-23.1 to reflect the encounters seen above the baseline of zero for DY 4 since this was not established in DY 3. Being that this is a new clinic, all encounters over the baseline of zero should be counted towards QPI, not solely the encounters over the prior year's goal.
APPENDIX 2 - RHP 3

Provider Project ID Overall Risk Factor Narrative Describing Mid-Point Assessment Score Justification Recommendations to HHSC Recommendations to Provider HHSC Response to Recommendations for HHSC HHSC Response to Recommendations for the Project

Agustina Regional Medical Center 300555004.1.3 4 0 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. The clinic has expanded to 30 out of 44 hours per week. The clinic began as of March 5, 2014 so there were 0 of 500 encounters by April DY 3. Due to the late clinic opening, the baseline of patient satisfaction scores had not yet begun. The nurse advice line has not yet been established but the provider reports that it is being partnered with the patient navigation program and will be in conjunction with that project. Noted lack of clear baselines for metrics i-13.1, i-12.1 and i-14.1. Noted that QPI is only measuring the increase over the DY 3 established baseline for after hours services which are new to the clinic for this project. Provider noted significant challenges with getting the project moving due to pending contract completion and hiring challenges. Provider stated that baseline for i-13.1 was zero, the baseline for i-12.1 was 500 visits as established in DY 3, and the baseline for i-14.1 is zero. Provider states, “MRMC & MEHOP leadership teams worked collectively to ensure contract completion, strong communication, and operational & contractual alignment with DSRIP deliverables to successfully kick-off the project and the project continues to grow and meet expectations of all involved.” No recommendations at this time. Possible Plan Modification: Provider should consider updating QPI metrics to count all after hours patient visits towards the QPI for each DY. HHSC does not believe that this plan modification is unnecessary. QPI (I-12.1) goal for DY4 is 25% over prior reporting period (DY3). Provider reported 500 in DY3, so DY4 would be 1,750. This is clear in QPI template. Technical Change: Technical change 1: Provider has already reported on this metric for FY3 and it was approved so no change/cleanup to language is necessary. Technical change 2: DY4 goal for I-14.1 is “Increase number of patients served by 25% for a total of 625 patients served in FY4.” It is unclear why M&S believe that provider has reported a zero baseline. Reviewing review would look for a total of 625 patients served. A change is not necessary. NA

Agustina Regional Medical Center 300555004.2.1 4 0 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Data has been collected but has not yet been reported on the types of patient navigator services provided. Provider has not yet stated training staff as patient navigators. Provider has not yet compiled their needs assessment for their DY 2 carryforward metric. Noted lack of clarity regarding the use of the term “new individuals” and “patients served” for metric P-3.1 in DY 4 and DY 5. Noted DY 5 metric P-3.1 states the baseline as year 3 for new patients with reported avoidable ED visits but the goal is a 15% increase in number enrolled patients. The baseline should be DY 4 metric P-3.1 180 patients enrolled so the 10% increase would be 207 enrolled patients for DY 5. Provider noted that the nurse advice line has been tasked to the Patient Navigation leadership development team and is being monitored monthly. Provider also notes, ”The terms “new individuals” and “patients served” can be interchanged as long as the specific metric & DY is considered when using the term” and “The baseline for P-3.1 is zero as the Patient Navigation program is a new service line to MRMC.” No recommendations at this time. Possible Plan Modification: Provider should consider adjusting metric goal to 207 individuals served since it appears that the patient goal expressed in i-13.3.1 in DY 5 is meant to demonstrate the 10% increase in patients as noted in P-3.1. Technical Change: Update metric I-13.1 in DY 3 for greater clarity regarding baselines. Metric states the baseline as being established in DY 3 but also states a goal of an increase in patients over DY 2. Technical Change: Remove reference to percent increase over baseline for metric i-14.1. Baseline for metric i-14.1 in DY 4 and DY 5 is zero as reported by the provider so the percentage increase over the baseline cannot be demonstrated. NA

Fortball Regional Hospital 51044305.1.1 5 0 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project has had no progress to date on any of their milestones or metrics. Milestone descriptions for i-12 for DY 4 and DY 5 is not clearly stated. Not: Provider states, “The project has not started as yet. The hospital is in discussion with other providers to for alternatives clinic operations and “the partner clinic had to withdraw from the project due to financial issues.” Provider should consider discussing of possible project withdrawal if provider initiates such a process. Provider should consider adjusting the way QPI is calculated such that it is based upon the corrective actions taken to improve patient experience based on the surveys, not on the number of patients surveyed. This would satisfy the requirement to demonstrate patient impact. NA

St. Luke's Memorial Hospital 510443004.2.1 2 0 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reports being halfway complete with all metrics including patient experience training, surveying 500 patients, and employees with patient experience objectives in their job descriptions. Noted that QPI is based upon patient surveys being administered which does not show a positive impact to the patient. Also noted lack of increase in patient surveys administered year over year. Provider states that the survey responses are used to monitor and study for areas that they can improve processes and implement corrective practices. Provider also states that since they are a small rural hospital they do not anticipate survey responses to be increase above the current rate of return. No recommendations at this time. No recommendations at this time. NA

MYERS AND STAUFFER LD Page 142
**APPENDIX 2 - RHP 3**

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Level</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.1.1</td>
<td>DEFENSE</td>
<td>Provider should update the number of individuals enrolled in DY 3 to meet the baseline goal of 12,121 to more accurately reflect the percentage goals for patient contact.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;S did not have any recommendations.</td>
</tr>
<tr>
<td>133355104.1.11</td>
<td>CRITICAL</td>
<td>Provider reported working on establishing the increase in hours at the temporary location while the new clinic site had been determined and would be established in May. Provider had 0 of 4 new positions and reported 0 of 1000 patient encounters as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>133355104.1.12</td>
<td>DANGER</td>
<td>Provider reported working on establishing the increase in hours at the temporary location while the new clinic site had been determined and would be established in May. Provider had 0 of 4 new positions and reported 0 of 1000 patient encounters as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>133355104.1.13</td>
<td>LOW RISK</td>
<td>Provider stated that after the baseline of 250 employees in DY 3 they will not be doing any additional hiring therefore the hiring goals should be removed from the DY 4 and DY 5 metric goals and the training of the 250 employees be the focus of the goals as well as the maintaining of the 250 person baseline.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>M&amp;S recommended updating the goals for metrics P-6.1 in DY 3 to be more in line with the actual project activities and state clear goals and baselines. The provider stated that after the baseline of 250 employees in DY 3 they will not be doing any additional hiring therefore the hiring goals should be removed from the DY 4 and DY 5 metric goals and the training of the 250 employees be the focus of the goals as well as the maintaining of the 250 person baseline.</td>
</tr>
</tbody>
</table>

*Note: Recommendations to Provider and HHSC Response to Recommendation for HHSC are based on specific project details and are subject to change based on new information and feedback from providers.*
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris County</td>
<td>133355104.1.14</td>
<td>3</td>
<td>0 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 0 of 1 new primary care clinic established but hours for the temporary site have been determined. 0 of 3 new providers and staff were hired by Apr DY 3. Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.2 projects used the same Medicaid/Uninsured percentage despite the clinics being in different locations. Provider noted significant challenges with hiring and getting temporary space established. Provider states, “We did not meet the DY 3 goal of 1,000 visits and had to Carry Forward this metric. One of the principal challenges in meeting volume for this project is the time it takes to inform the community of the new services that are available. We plan to report on this QPI metric in Apr DY 4 and continue our marketing efforts to meet the 10,000 visits goal in DY 4 by October 2015.”</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the QPI Summary to represent more accurate Medicaid/Uninsured percentages based upon the actual populations being served in each location.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County</td>
<td>133355104.1.15</td>
<td>3</td>
<td>0 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Prep work for the expansion of 5 health centers has reported to have begun. 0 of 1 new FTE dentists have been hired and 0 of 1,100 encounters have been completed as of Apr DY 3. Note that DY 3 metric P-103.1 establishes a baseline but this project is an extension of services so the baseline should be a pre-DSRIP baseline. Provider states that this concern was addressed during the most recent Change Request process. It was determined that the baseline period for this project’s QPI metric (individuals) is actually pre-DSRIP in DY1 (10/1/2011 – 9/30/2012). The QPI metric baseline is 30,223 with goals to increase by 478 in DY 5, 3,784 in DY 4 and 7,068 in DY 5. The changes will be reflected in the narrative and in the October DY 3 QPI reporting template.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update metric P-103.1 to simply state a patient impact, not the establishment of a baseline and to refer all other references to baselines to the pre-DSRIP baseline as stated by the provider.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County</td>
<td>133355104.1.17</td>
<td>3</td>
<td>0 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Hours for the temporary site have been determined but not yet completed and 0 of 1 new clinics have been completed. 0 of 4 new FTEs have been hired and 0 of 1000 encounters have been reported as of Apr DY 3. Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.2 projects used the same Medicaid/Uninsured percentage despite the clinics being in different locations. Provider noted significant challenges with hiring and getting temporary space established. Provider reports, “The marketing plan and smooth transition to the permanent site successfully allowed us to report on our DY 3 volume goal of 1,000 completed visits in time. As of DY 4, the permanent site is now open and seeing patients at expected rates.”</td>
<td>No recommendations at this time.</td>
<td>Technicial Change: Update the QPI Summary to represent more accurate Medicaid/Uninsured percentages based upon the actual populations being served in each location.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County</td>
<td>133355104.1.2</td>
<td>4</td>
<td>0 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Hours for the temporary site have been determined but not yet completed and 0 of 1 new clinics have been completed. 0 of 4 new FTEs have been hired and 0 of 1000 encounters have been reported as of Apr DY 3. Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.2 projects used the same Medicaid/Uninsured percentage despite the clinics being in different locations. Provider noted significant challenges with hiring and getting temporary space established. Provider reports, “The marketing plan and smooth transition to the permanent site successfully allowed us to report on our DY 3 volume goal of 1,000 completed visits in time. As of DY 4, the permanent site is now open and seeing patients at expected rates.”</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the QPI Summary to represent more accurate Medicaid/Uninsured percentages based upon the actual populations being served in each location.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Recommendations to Provider

Technical Change:
1 of 1 DY 2 milestones complete.

MSLC recommended updating baseline information in I-12.1. QPI template clearly states pre-DSRIP baseline and was approved in DY3. Change is not necessary.

Technical change: Update QPI summary to more clearly state that the MILU percentages are based upon the actual populations being served in each location.

Possible Plan Modification:
Provider should consider an increase in QPI based on DY 3 QPI overachievement.

HHSC Response to Recommendations for the Project

HHSC would consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review current policies, and incorporate in future reviews if recommended steps are missing. Information reported by providers for the number of patients served or services provided will also be included in the compliance monitoring work providing additional verification of the reported information.

HHSC Response to Recommendations for the Project

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's valuation.

Recommended for Project

Provider should consider an increase in QPI based on DY 3 QPI overachievement.

HHSC will consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review current policies, and incorporate in future reviews if recommended steps are missing. Information reported by providers for the number of patients served or services provided will also be included in the compliance monitoring work providing additional verification of the reported information.

Provider should consider an increase in QPI based on DY 3 QPI overachievement.

Provider should consider an increase in QPI based on DY 3 QPI overachievement.

HHSC will consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review current policies, and incorporate in future reviews if recommended steps are missing. Information reported by providers for the number of patients served or services provided will also be included in the compliance monitoring work providing additional verification of the reported information.

HHSC will consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review current policies, and incorporate in future reviews if recommended steps are missing. Information reported by providers for the number of patients served or services provided will also be included in the compliance monitoring work providing additional verification of the reported information.

HHSC will consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review current policies, and incorporate in future reviews if recommended steps are missing. Information reported by providers for the number of patients served or services provided will also be included in the compliance monitoring work providing additional verification of the reported information.

Recommended for Project

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.
### Recommendations to HHSC

**Recommendation to Provider:**

Consideration should be given to the potential impact on project valuation if plan modification to decrease QPI is submitted and approved.

**Possible Plan Modification:**

Provider should consider reduction in QPI and comparable reduction in valuation for this project.

**HHSC Response to Recommendation for HHSC**

Yes

**Recommendation to Provider:**

N/A

**HHSC Response to Recommendations for the Project**

N/A

### Provider Recommendations

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital</td>
<td>133355104.1.8</td>
<td>1 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete.</td>
<td>As of April DY 3, the project is slightly off-track reporting only 1707 of 5500 completed patient visits through the referral program. Provider states that only 1 of the core components from their referral project is being worked on at this time and the FQHCs that will be providing patient visits will be fulfilling the core components as needed. Lack of clarity in continuity of reporting between the FQHCs and the provider and additional federal funding was noted. Provider stated that additional federal funding is added to their general fund and not tracked but only patients that have not received additional federal funds are being counted towards QPI for all their projects. Provider stated that they are highly unlikely to meet the QPI goals due to a decrease in the need for referrals due to their expansion of new clinics through other DSRIP projects. Provider reported having only 4695 completed visits to date which is still below the DY 2 QPI goal. For DY 3 thus far they reported only 687 additional encounters over their DY 2 volume. Provider suggested that an expansion of types of services the referrals are provided for, such as specialty care, could offer them the possibility to increase volume.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital</td>
<td>133355104.1.9</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>Provider states that the goal of hiring 2.2 FTE’s Psychiatrist and 3.2 FTE’s Behavioral Therapist has been partially completed and 1 of 1 new site has been established. Provider reports that the goal of 1,837 encounters has been partially completed.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital</td>
<td>133355104.2.1</td>
<td>4 of 4 DY 3 milestones complete. The central fill facility built out is in progress and the go live date is scheduled for June 2024. The 40 percent increase in prescriptions filled at the central fill facility has not yet been started. 6 of the 12 required monthly RHP meetings have been attended. 0 of 31,916 individuals have been served by April DY 3.</td>
<td>Provider states that the goal of hiring 2.2 FTE’s Psychiatrist and 3.2 FTE’s Behavioral Therapist has been partially completed and 1 of 1 new site has been established. Provider reports that the goal of 1,837 encounters has been partially completed.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital</td>
<td>133355104.2.2</td>
<td>3 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete.</td>
<td>The central fill facility built out is in progress and the go live date is scheduled for June 2024. The 40 percent increase in prescriptions filled at the central fill facility has not yet been started. 6 of the 12 required monthly RHP meetings have been attended. 0 of 31,916 individuals have been served by April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris County Hospital District Ben Taub General Hospital</td>
<td>133355104.2.3</td>
<td>3 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete.</td>
<td>Provider states that the goal of hiring 2.2 FTE’s Psychiatrist and 3.2 FTE’s Behavioral Therapist has been partially completed and 1 of 1 new site has been established. Provider reports that the goal of 1,837 encounters has been partially completed.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Technical Change

**Technical Change 1:** Update metric I-101.1 in DY 5 to state “pediatric patients receiving BH services” instead of “pediatric patients seeking BH services” in order to demonstrate actual/patient impact.

**Technical Change 2:** Update metric I-11.1 in DY 5 to state a percentage of the patients getting prescriptions filled through the automation out of the total number of patients getting prescriptions. Stating a percentage increase over a baseline of zero is not feasible so expressing the goal in this manner would be more accurate.

**Technical Change 3:** Remove the references to monthly goals from the DY 4-5 QPI metric I-101.1 goals since the goals are meant to be measured on an annual basis, not a monthly basis.

**Technical Change 4:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 5:** Unclear why this change would be needed since provider is measuring monthly volume and percentage of prescriptions filled at central fill, and that was how it was reported during DYS 2.

**Technical Change 6:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 7:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 8:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 9:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 10:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 11:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 12:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 13:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 14:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.

**Technical Change 15:** Metric is to increase the number of prescriptions filled at central fill. Their goal for DY 4 is to have 50% of their monthly prescriptions to be filled at new central fill, up from 0% of their monthly prescriptions filled there prior to DSRIP implementation. Provider reported on this metric in DY 3 and it was approved.
Recommendations to Provider

HHSC Response to Recommendations for the Project

No recommendations at this time.

Possible Plan Modification: Provider should consider decreasing QPI goals as the baseline was established in DY 2. Technical Change: For DY 4 and DY 5 metric I-101.1, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

Recommendations to HHSC

HHSC Response to Recommendation for HHSC

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

APPENDIX 2 - RHP 3

Harris County
Hospital District
Ben Taub General
Hospital
33355104.2.4

There are no significant risks that appear to be preventing the provider from meeting that FY 3 metrics. QPI metric I-10.3 reports 24 out of 20 individuals. Provider stated in April DY 3 reporting they will continue working towards their goal. For FY 3:

QPI metric I-10.3 states, "Documentation of increased number of unique patients served;" however, the Baseline/Goal section states the goal is to enroll patients. Based on the metric wording, it is unclear if the provider is achieving the metric's intent by enrolling patients vs serving them.

Provider stated, "The purpose of this project is to serve pregnant women. The reason why the metric reads as "unique number of patients served" is because that is how the metric was stated in the Protocol/memo. We further defined our goal in the actual go-to-verbatim, which was allowed." Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved.

Recommendations to HHSC

HHSC Response to Recommendations for the Project

Possible Plan Modification: Provider should consider decreasing QPI goal as the baseline was established in FY 3. To a more achievable value should the provider feel future QPI goal is unattainable.

HHSC recommends decreasing project's QPI due to delayed project's progress. Since this provider had an opportunity to address this issue by requesting the change during plan modification, and since the valuation of the project is over $5 mn, HHSC is not issuing goals change.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

No recommendations at this time.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

No recommendations at this time.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

No recommendations at this time.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

No recommendations at this time.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

No recommendations at this time.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.

No recommendations at this time.

Technical Change: Update FY 4 and FY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in FY 2.

No recommendations at this time.

Technical Change: For DY 4 and FY 5 metric I-121.2, provider should clearly list the goals in a more specific manner rather than "individuals served." Recommend use of more specific terminology such as individuals with completed appointments or receiving anticoagulation services.
Recommendations to Provider

1. Consider revising the I-12.1 metric. The metric requires the provider to report on the utilization of alternative settings compared to other settings. However, this provider is simply going forward since it is significantly lower than most projects.

2. Metric I-12.1 should be revised to include a numeric goal. The current goal is a percent increase yet it is not clear if a baseline will be established from which the provider can measure the percent increase in DY 4. The provider prefers to keep its percent increase goal, a baseline should be clearly established.

Recommendations to HHSC

1. MSLC recommended to increase the goal for I-12.1 in DY 4. HHSC agrees that I-12.1 should be revised to include a numeric goal. Metric I-12.1 is a "Number of telemedicine visits" but goal is 17.02% increase. Project providers are planning to provide 150 telemedicine visits in DY 4. (DY5 already contains a numeric goal of 200 visits). It is true that baseline is unclear so it is difficult to tell what the percentage increase is based on. After contacting provider, HHSC updated reporting system for I-12.1 in DY4.

Lack of clarity noted in QPI metrics due to percentage goals listed. 5% expected Medicaid/Uninsured impact. Provider is noted as being a benchmark project due to the substantial lessons learned they reported in April DY 3, including the value of using "Performance logic" for communication among team members, the detection of errors in baselines, early engagement of stakeholders, and the need of a patient navigator for the project.

HHSC Response to Recommendations for the Project

1. NA

HHSC Response to Recommendations for the Project

1. MSLC did not have recommendations for this project.
APPENDIX 2 - RHP 3

Technical Change:
MSLC did not have recommendations for this project.

2 of 3 DY 2 milestones complete.

Provider has hired 6 staff and the OBS/SN provider is scheduled to start seeing patients in May 2014. Baseline hours of operation has not yet begun as of April DY 3. In DY 2 provider noted delays in construction of the new clinic including possible soil contamination.

Technical Change:
Provider should consider removing DY 4 metric I-102.1 since 100 percent of employees with patient and/or employee experience objectives in their employee job descriptions was already demonstrated in DY 3 metric P-6.1.

Recommendation to Provider:
Update the DY 4 and DY 5 metric I-102.1 goals to remove this metric. HHSC agrees with this recommendation.

Recommendation to HHSC:
Recommend considering the potential impact on project valuation if metric is removed from plan.

Agree that I-102.1 should be changed to individuals. Phase 4 change would not be impacted, because the funding for OBGYN services was already achieved. No plan modification is necessary.

Recommendation to HHSC:
Recommend that future support regarding implementation plans should show concrete steps to be used in the implementation of the project and appropriate timelines for completion. Also recommend that since the metric goals specifically state, “completion of implementation plan for each workgroup formed in DY 2” it is important to ensure that each workgroup for this project be mentioned specifically in the implementation plan in order to prove metric achievement.

Recommendations to Provider:
Provider has completed the implementation plan and the cost analysis as of April DY 3. Provider has attended 1 of 2 learning collaborative.

The provider's support for the implementation plan appears to be insufficient to meet the metric as their role is not an executive level. Metric is not approved and is no longer eligible for payment.

Provider has completed the implementation plan and cost analysis as of April DY 3. Provider has attended 1 of 2 learning collaborative.

Provider notes that their estimated number of patient encounters for DY 5 metric I-101.1 was an error and should be stated to be 7600.

Recommendation to Provider:
Refurbish the equipment and stated the baseline for the metric and notify the provider.

HHSC denied the request from provider was to change QPI measure to customizable metric I-102.1 with the goal of 600 individuals. HHSC made the change to the metric and notified the provider.

HHSC made the change to the metric and notified the provider.

HHSC recommended removing P-6.1 in DY 4 because they believe the metric is already achieved. Provider DY3 goal was that 90% of new PT and PT employees will receive patient experience training, and they “overachieved” this by training 100% of new employees. DY4 goal is that 100% of employees will have with patient experience in their job descriptions, which is a different goal, and although it may have been achieved already it has not been reported. No plan modification is necessary.

Provider notes that the estimated number of patient encounters for DY 5 metric I-101.1 was an error and should be stated to be 7600.

Technical Change:
Provider should consider removing DY 4 metric P-6.1 since 100 percent of employees with patient and/or employee experience objectives in their employee job descriptions and work plans were already demonstrated in DY 3 metric P-6.1.

Provider should recalculate its percentage increase in metric I-102.1. The percent increase calculation using the DY 4 and DY 5 numerical goals is 211 percent.

Possible Plan Modification:
Prove that the impact of 1492 encounters.

Even if a metric were to be removed, valuation would not be impacted, because the funding spread among remaining milestones/metrics within that demonstration year.

HHSC recommended removing P-6.1 in DY 4 because they believe the metric is already achieved. Provider DY3 goal was that 90% of new PT and PT employees will receive patient experience training, and they “overachieved” this by training 100% of new employees. DY4 goal is that 100% of employees will have with patient experience in their job descriptions, which is a different goal, and although it may have been achieved already it has not been reported. No plan modification is necessary.

Provider has hired 6 staff and the OBS/SN provider is scheduled to start seeing patients in May 2014. Baseline hours of operation has not yet begun as of April DY 3. In DY 2 provider noted delays in construction of the new clinic including possible soil contamination.

Technical Change:
Provider should recalculate its percentage increase in metric I-102.1. The percent increase calculation using the DY 4 and DY 5 numerical goals is 211 percent.

Recommendation to Provider:
Provider has completed the implementation plan and the cost analysis as of April DY 3. Provider has attended 1 of 2 learning collaborative.

The provider's support for the implementation plan appears to be insufficient to meet the metric requirement, “completion of implementation plan for each workgroup formed in DY 2” although HHSC approved the metric for achievement in Apr DY 3. Lack of clarity noted in DY 3 and DY 5 metric I-102.1 in regards to whether the goal is stated as counting individuals or encounters.

Demanding 100% of employees having specific patient experience objectives in their job descriptions in DY 3 and then demonstrating 100% again in DY 4 with the same metric.

Technical Change:
Provider should recalculate its percentage increase in metric I-102.1. The percent increase calculation using the DY 4 and DY 5 numerical goals is 211 percent.

Recommendation to Provider:
Provider should consider removing DY 4 metric P-6.1 since 100 percent of employees with patient and/or employee experience objectives in their employee job descriptions and work plans were already demonstrated in DY 3 metric P-6.1.

Provider states that the term “develop staff” refers to hiring and training staff.

No recommendations at this time.
### APPENDIX 2 - RHP 3

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Methodist Hospital 139135109.1.2</td>
<td>3 of 7 DY 2 milestones complete.</td>
<td>0 of 7 DY 3 milestones complete.</td>
<td>Consideration should be given to project evaluation if plan modification to reduce QPI is submitted and approved.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.11</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>0 of 2 DY 3 milestones complete.</td>
<td>Recommend reaching out to provider to clarify that the core components for this project should be: a) Increase service availability with extended hours. b) Increase number of specialty clinic locations c) Implement transparent, standardized referrals across the system. d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying &quot;lessons learned,&quot; opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>Texas Children's Hospital 139135109.1.12</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Technical Change:

- **Update metric I-43.1 in DY 4 and DY 5 goals to state a decrease in preventable all-cause admissions and readmissions as per the metric description.**
- Current goal states an increase of 10% from the average of DY 2 and DY 3 which would give the opposite result.

**Recommendations to Provider:**

- **Recommend reaching out to provider to clarify that the core components for this project should be:**
  - a) Increase service availability with extended hours.
  - b) Increase number of specialty clinic locations.
  - c) Implement transparent, standardized referrals across the system.
  - d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**HHSC Response to Recommendations for the Project:**

- **MSLC recommended updating I-43.1 to include a percent decrease in all-cause admissions and readmissions. Goal for I-43.1 in DY4 and DY5 is for a percentage above baseline. HHSC clarified with provider that the goal is for a % improvement over baseline, or a % decrease in PPIAs and PPRAs. Contacted provider and updated reporting system.**
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for this Project</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children's Hospital</td>
<td>139135109.1.15</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 16,001 specialty care visits of the baseline of 21,467 of which their goal is to have 644 additional encounters. Provider has participated in 1 of 2 learning collaborative. Noted unclear baseline for DY 3 - DY 5 metric I-23.1 which states clinic volume increase across all locations of care. Noted discrepancy in core components as noted in project 139135109.1.1. Provider states, &quot;The baseline used for metric I-23.1 in DY 3-DY 5 is 21,467 encounters. This baseline was established using volume in FY12 (October 1, 2011-September 30, 2012).&quot;</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>139135109.1.16</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The referral and workup guidelines are in development but not yet completed. 1 of 2 learning collaboratives have been attended. Provider has had 1,122 mental health visits of the baseline of 700 of which their goal is to have 50 additional encounters but the provider did not report the metric for completion. Noted discrepancy in core components as noted in project 139135109.1.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have recommendations for this project.</td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>139135109.1.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Goal was to decrease average referral process time and time to appointment scheduled by 25% from baseline of 33.1 calendar days and the progress is reported as being 4 days. Provider attended 1 of 2 learning collaboratives. Provider has had 5,562 specialty care visits of the baseline of 4,000 of which their goal is to have 157 additional encounters but the metric was not reported for achievement. Noted discrepancy in core components as noted in project 139135109.1.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have recommendations for this project.</td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>139135109.1.3</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 2,149 specialty care visits of the baseline of 2,091 of which their goal is to have 150 additional encounters. Provider attended 1 of 2 learning collaboratives. Noted discrepancy in core components as noted in project 139135109.1.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have recommendations for this project.</td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>139135109.1.4</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 12,884 specialty care visits of the baseline of 23,950 of which their goal is to have 719 additional encounters. Provider attended 1 of 2 learning collaboratives. Noted discrepancy in core components as noted in project 139135109.1.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have recommendations for this project.</td>
</tr>
<tr>
<td>Texas Children's Hospital</td>
<td>139135109.1.7</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 13,550 specialty care visits of the baseline of 21,222 of which their goal is to have 2,122 additional encounters. Provider attended 1 of 2 learning collaboratives. Noted lack of clear baselines for metric I-23.1 considering the percent increase in patients served as well as the encounter goals in DY 3-DY 5. Noted discrepancy in core components as noted in project 139135109.1.1. Provider states, &quot;The baseline used for metric I-23.1 in DY 3-DY 5 is 21,222 encounters. This baseline was established using volume in FY12 (October 1, 2011-September 30, 2012).&quot;</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Texas Children’s Hospital 139135109.1.8</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSQC did not have recommendations for this project.</td>
<td></td>
</tr>
<tr>
<td>Texas Children’s Hospital 139135109.1.9</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: For metric I-23.1 in DY 4 and DY 5, the provider should provide information for the number of unique patients during that time so that the provider will be able to demonstrate the increase in the percentage of patients served as stated in the metric goal.</td>
<td>NA</td>
<td>MSQC recommended updates to I-23.1. Submitted and approved QPI template clearly states number of patients to be served each DY so change is unnecessary.</td>
<td></td>
</tr>
<tr>
<td>Texas Children’s Hospital 139135109.2.1</td>
<td>1</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSQC did not have recommendations for this project.</td>
<td></td>
</tr>
<tr>
<td>Methodist Rehabilitation Hospital 140713201.2.1</td>
<td>3</td>
<td>8 of 7 DY 2 milestones complete. 0 of 6 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSQC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>2. Joseph Medical Center 181706601.2.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSQC did not have any recommendations.</td>
<td></td>
</tr>
</tbody>
</table>
Recommendations to Provider

No recommendations at this time.

Technical Change: Update metrics I-12.1 in DY 4 and DY 5 to state the total patient impact including the patients seen in DY 3 for metric P-4.1.

Technical Change: Update the QPI Summary to include the patient impact from metric D-3 metrics P-4.1.

Recommendations to HHSC

Update the QPI Summary to show the DY 5 QPI as a measurable goal.

Update the DY 5 metric I-6.1 goal to clearly state that the DY 5 patient impact is 1065, which would be 320 individuals above the DY 4 patient impact.

Update the QPI Summary to show the DY 5 QPI as being 1065 individuals.

HHSC Response to Recommendations for the Project

MSLC recommended updating the DY 5 metric I-17.1, so it is unnecessary to update the QPI metric in DY 4 and DYS with data from a different metric.

MSLC did not have recommendations for this project.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
</table>
| Fort Bend County Clinical Health Services  | 296760601.1.1       | 2                    | - 2 of 2 DV 3 milestones complete.  
- Provider is still in the process of hiring and training dispatch workforce. A training manual has been established. Guidelines for crisis services and operational protocols have not yet been completed as of April DY 3.  
- 0 of 2 DV 3 milestones complete.  
- Provider claims to have achieved the hiring of 1 provider and 6 staff but HHSC found documentation to only show 1 physician and 5 staff being hired and trained so metric was marked NMI. Provider has achieved 1644 of 3000 primary care visits as of April DY 3.  
- No recommendations at this time.  
- No recommendations at this time.  
- N/A  
- MSLC did not have recommendations for this project. | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have recommendations for this project. |
| Fort Bend County Clinical Health Services  | 296760601.1.2       | 2                    | - 1 of 1 DV 2 milestones complete.  
- 1 of 3 DV 3 milestones complete.  
- 20 of 20 additional clinic hours have been established. Provider claims to have achieved the hiring of 1 provider and 6 staff but HHSC found documentation to only show 1 physician and 5 staff being hired and trained so metric was marked NMI. Provider has achieved 1644 of 3000 primary care visits as of April DY 3.  
- No recommendations at this time.  
- No recommendations at this time.  
- N/A  
- MSLC did not have recommendations for this project. | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have recommendations for this project. |
| Fort Bend County Clinical Health Services  | 296760601.2.3       | 4                    | - 1 of 1 DV 2 milestones complete.  
- 0 of 3 DV 3 milestones complete.  
- The Paramedic Coordinator position will post by the middle of May 2014, after which patients will begin being referred into the community paramedic program for the provider to start towards their goal of 50 patients using the program. Since the Paramedic Coordinator has not been hired, the data collection process for patients encountered by community paramedic has not yet begun. Provider has attended 1 of 2 learning collaborative.  
- Note DV 3 metric P-103.1: baseline states TBD by DV 3 baseline data. DV 3 metric I-104.1 states the baseline to be TBD in DY 3 but there is no corresponding metric in DY 3.  
- Provider confirms that baselines are not applicable for metrics P-103.1 and I-104.1 and should be removed or restated. Provider stated that they were able to find temporary housing for the paramedic team and as of March 2015 the team has moved to a permanent location.  
- No recommendations at this time.  
- No recommendations at this time.  
- NA  
- MSLC did not have any recommendations. | No recommendations at this time. | No recommendations at this time. | NA | MSLC did not have any recommendations. |
| Fort Bend County Clinical Health Services  | 296760601.2.4       | 2                    | - 1 of 1 DV 2 milestones complete.  
- 0 of 3 DV 3 milestones complete.  
- 0 of 50 patients have been referred for colonoscopy screening as of April DY 3. Provider as attended 1 of 2 learning collaboratives.  
- Note DV 5 Metric I-101.1 does not state baseline from which to measure the 100% increase in target population reached.  
- Provider stated that they are collaborating with a local non-profit agency for community outreach and education in DY 3 and the data from this start-up year will be the baseline for improvement.  
- No recommendations at this time.  
- Technical Change: Update the DV 5 metric I-101.1 to clearly state that the baseline for the metric will be the data collected from the community outreach and education in DY 3.  
- N/A  
- Based on MSLC recommendation, baseline information should be added to baseline/goal for I-101.1 in DY5. HHSC updated the reporting system to reflect the baseline information provided by provider (212 individuals in DY5). | No recommendations at this time. | No recommendations at this time. | N/A | Based on MSLC recommendation, baseline information should be added to baseline/goal for I-101.1 in DY5. HHSC updated the reporting system to reflect the baseline information provided by provider (212 individuals in DY5). |
| OakBend Medical Center                    | 127305903.2.101     | 1                    | - No DV 2 milestones. This is a 3 year project.  
- 0 of 2 DV 3 milestones complete.  
- One behavioral health patient navigator has been hired and trained. Plan for identifying and linking patients to behavioral health services has been established and a multidisciplinary team has been created.  
- No recommendations at this time.  
- No recommendations at this time.  
- NA  
- NA | No recommendations at this time. | No recommendations at this time. | NA | NA |
### APPENDIX 2 - RHP 4

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendation for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHRISTUS Spohn Hospital Beeville 026818801.1</td>
<td>1</td>
<td>0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>Tasking has begun on the disease management registry and should be fully implemented by the end of the reporting period. Provider planned to hire staff in July 2014 which will allow DY 3 milestones to be completed. Although the milestones are not completed for DY 3, the project appears to be on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Beeville 026818801.1</td>
<td>3</td>
<td>0 of 1 of DY 2 milestones complete. 0 of 2 of DY 3 milestones complete.</td>
<td>MSLC is concerned about the benefit of the project to the population based on the location of where the project decided to put this clinic (in an existing clinic), we do not see this as a high-risk project based on the provider's narrative. The provider has not achieved their DY 3 milestones, but it appears that the project will meet its milestones and metrics prior to DY 4. We rank this project as a low/moderate risk.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area 026979001.1</td>
<td>5</td>
<td>0 of 1 of DY 2 milestone complete. 0 of 3 of DY 3 milestones complete.</td>
<td>Close monitoring of this project especially because DY 2 milestones were approved for a carry forward but as of DY 3 had not been completed. Consideration should be given to withdrawal due to the delay in hiring key personnel.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Memorial Hospital 1178582</td>
<td>2</td>
<td>0 of 1 of DY 2 milestones complete. 0 of 2 of DY 3 milestones complete.</td>
<td>The patients seen thus far, have not had Medicaid as the primary payer. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Killeen 139436001.2</td>
<td>2</td>
<td>0 of 1 of DY 2 milestones complete. 0 of 2 of DY 3 milestones complete.</td>
<td>Although patients have not been seen, their QPI is too low that it could be met before the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area 026979001.1</td>
<td>4</td>
<td>0 of 1 of DY 2 milestone complete. 0 of 2 of DY 3 milestone complete.</td>
<td>Milestone 1-101 is not clear and needs to be changed to be measurable. With significant improvement the project could get back on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi 1211775463.1</td>
<td>1</td>
<td>0 of 2 of DY 2 milestones complete. 0 of 2 of DY 3 milestones complete.</td>
<td>Provider has assigned 384 of the 480 Medicaid patients to an intensivist. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Driscoll Children's Hospital 133812055.1</td>
<td>2</td>
<td>0 of 4 of DY 2 milestones complete. 0 of 3 of DY 3 milestones complete.</td>
<td>Provider has seen 15,569 primary care clinic visits of the 27,675 and should meet their goal by the end of the reporting year. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
Recommendations to Provider
No recommendations at this time.

MSLC did not have any recommendations.

HHSC Response to Recommendations for the Project
MSLC suggested revising DY5 goals, since the provider had delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring additional staff in August. It appears there are no track and don’t need to revisit DY5 goals.

APPENDIX 2 - RHP 4

1 Gulf Bend Center 1 1 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Project delayed due to hiring and training of faculty. Provider also indicated that there was a high rate of "no shows" and therefore having difficulty meeting metrics. Potential that milestone(s) might not be met in a timely manner. Recommended that consideration be given to the potential impact on project valuation if plan modification is approved. Possible Plan Modification: Provider should consider lowering QPI due to the delay in hiring key staff. The lowered QPI would allow provider to better accomplish project goal given the delay. HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation. MSLC suggested revising DY5 goals, since the provider had delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring additional staff in August. It appears there are no track and don’t need to revisit DY5 goals.

2 Bluebonnet Trails Community Mental Health and Mental Retardation Center 2 0 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider is overseeing their QPI milestone. A plan modification exists to fix this. Provider should remain on track. Recommended that consideration be given to the potential impact on project valuation if plan modification is approved. Possible Plan Modification: Milestone 1-101 uses P-3 as the baseline. Provider should clarify that the baseline includes frequent utilizers of the ED. HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation. MSLC suggested revising DY5 goals, since the provider had delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring additional staff in August. It appears there are no track and don’t need to revisit DY5 goals.

3 DeTar Hospital Corpus Christi 3 0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has started seeing patients and is working with the implementation team to continue to improve the project. Although the milestones are not completed, the project appears to remain on track. Recommended that consideration be given to the potential impact on project valuation if plan modification is approved. Possible Plan Modification: Provider should consider lowering QPI due to the delay in hiring key staff. The lowered QPI would allow provider to better accomplish project goal given the delay. HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation. MSLC suggested revising DY5 goals, since the provider had delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring additional staff in August. It appears there are no track and don’t need to revisit DY5 goals.

4 Christus Spohn Healthcare System 4 0 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The provider has an established primary care residency, but still needs to hire a program director. Although the milestones are not completed, the project appears to remain on track. Recommended that consideration be given to the potential impact on project valuation if plan modification is approved. Possible Plan Modification: Possible Plan Modification: Clarification of QPI metric I-122.1 for DY 4 & 5 as there are multiple measurements within the same metric. It is unclear what the actual goal should be. All the sites visit the provider mentioned that they wanted to separate the individuals being screened from those being referred. This would be a significant help to the clarity of the metric. HHSC was able to find the documents for QPI P-4.1 that were submitted during the NMI review, the issue was that it was not sufficient information to support an analysis of patients with co-diagnoses of CHF &/or Diabetes with MH/Depression. The issue was discussed with waiver management. MSLC suggested revising DY5 goals, since the provider had delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring additional staff in August. It appears there are no track and don’t need to revisit DY5 goals.

5 Avita Behavioral Health 5 0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The provider has not reported on seeing patients, but states they will meet their target QPI prior to the end of the reporting period. Although the milestones are not completed, the project appears to remain on track. Recommended that consideration be given to the potential impact on project valuation if plan modification is approved. Possible Plan Modification: Possible Plan Modification: The provider has expanded the primary care residency, but still needs to hire a program director. Although the milestones are not completed, the project appears to remain on track. Recommended that consideration be given to the potential impact on project valuation if plan modification is approved. Possible Plan Modification: Provider should consider lowering QPI due to the delay in hiring key staff. The lowered QPI would allow provider to better accomplish project goal given the delay. HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation. MSLC suggested revising DY5 goals, since the provider had delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring additional staff in August. It appears there are no track and don’t need to revisit DY5 goals.

Provider Project ID Overall Risk Rating Narrative Describing Mid-Point Assessment Score Justification Recommendations to HHSC Recommendations to Provider HHSC Response to Recommendations for the Project HHSC Response to Recommendations for the Project

201705003.1 NA NA NA NA

201705004.1 NA NA NA NA

201705005.1 NA NA NA NA

201705006.1 NA NA NA NA

201705007.1 NA NA NA NA

201705008.1 NA NA NA NA
**APPENDIX 2 - RHP 4**

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>J241SUS Sports</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hospital Corpus Christi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>221775463.2.4</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHHSC Response to Recommendations for the Project</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>J241SUS Sports</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hospital Kleberg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>136436606.2.3</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Camino Real</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Community Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>121990904.2.1</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Driscoll Children's Hospital</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>132812205.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driscoll Children's Hospital</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>132812205.1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHRISTUS Sports</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hospital Corpus Christi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corpus Christi</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>132812205.2.3</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td>No suggestions.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider</td>
<td>Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area 020973601.2.2</td>
<td>1</td>
<td>3 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Provider has reallocated their focus and states they will start tracking the patients prior to the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Alice 094222902.2.3</td>
<td>2</td>
<td>3 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Provider is tracking their data now and states they will report on completion at the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi 121775403.2.11</td>
<td>3</td>
<td>3 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. MSLC is concerned about the QI-4.5 valuation for this project. The project QPI is measuring the reduction in the number of patients impacted by a Serious Safety Event. Although small in number, these events can be life threatening and/or debilitating and come with an extreme cost. Therefore, although the QPI values are small in number the overall qualitative impact is exponentially higher. The Spohn facilities are training over 3,000 associates and 400 providers in safety/efficiency protocols. This training will impact nearly 400,000 patient encounters. The training will impact nearly 3,000,000 patient encounters. MSLC state that results include &quot;significant reduction in event rate, number of suits or claims, and professional liability expenses. Clients have also received national recognition for their achievement in quality and safety.&quot; These improvement will have a positive impact on patients, providers, and associates. Although the milestones are not completed, the project appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi 121775403.2.9</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Training staff has been delayed, but in progress. Provider states they are working on the training and will complete prior to the end of DY 3 and will report in October. This should not affect QPI since they will be trained prior to the end of DY 3 and they do not start seeing QPI until DY 4.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Citizens Medical Center 137907508.2.1</td>
<td>3</td>
<td>3 of 3 DY 2 milestones complete. 3 of 8 DY 3 milestones complete. Training staff has been delayed and provider still needs to create a manual for value-added and non-value-added procedures. The procedures will be completed prior to the end of DY 3. There is no explanation of when the training will be completed. No patients have been seen at this time. Potential that milestones might not be met in a timely manner.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>The Corpus Christi Medical Center - Bay Area 020973601.1.5</td>
<td>3</td>
<td>3 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Initial planning for this project has yet to be completed. Provider stated it took much longer than they expected to decide on the appropriate option for a disease registry. Provider stated once they got it implemented they would catch up quickly. Provider states in April DY 3 sign-off summary that they expect the disease registry to be complete prior to the end of the DY 3 reporting period and will report on completion of the two DY 3 milestones in October.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
Recommendations to Provider

NA

Recommendations to HHSC

No recommendations at this time.

HHSC Response to Recommendations for the Project

MSLC recommended revisiting goals for milestone I-12 since the new clinic is not yet opened. In October reporting, provider requested QPI achievement of 1334 encounters in less than 4 months that exceeded their DT5 goal of 1110. Based on this, HHSC will consider discussing decrease of QPI goals for this project.

APPENDIX 2 - RHP 4

Provider

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to Provider

Recommendation that consideration be given to the potential impact on project valuation if plan modification is approved.

Possible Plan Modification: Recommend a plan modification to decrease the QPI goal for milestone I-23 since the provider has concerns of meeting their QPI for DY 4 & DY 5.

Recommendations to HHSC

No recommendations at this time.

HHSC Response to Recommendation for HHSC

(1) Confirmed that HHSC did not approve deletion of I-23.1
(2) HHSC approved the Plan Mod to use program hours in DY4.5 but flagged for compliance monitoring of scope changes.
(3) HHSC does not change valuation based on QPI changes.

Possible Plan Modification: Recommend a plan modification to decrease the QPI goal for milestone I-10 since the new clinic is not yet opened.

Potential to decrease QPI which would be driven by a decrease in patients attending new clinic.

HHSC Response to Recommendations for the Project

MSLC recommended revisiting goals for project since the provider has concerns of meeting their QPI for DY4 & DT5. HHSC is not recommending decrease in QPI for this project, since provider did not request it via plan modification and because the project has a valuation of more than $5 mln.

Possible Plan Modification: Milestone I-102 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-23 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC recommends increasing goals for I-102 since the provider has concerns of meeting their QPI for DT4 & DT5. HHSC can decrease project’s valuation if a plan modification is approved.

Possible Plan Modification: Milestone I-12 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Provider

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to Provider

Recommendation that consideration be given to the potential impact on project valuation if plan modification is approved.

Possible Plan Modification: Recommend a plan modification to decrease the QPI goal for milestone I-23 since the provider has concerns of meeting their QPI for DY 4 & DY 5.

Recommendations to HHSC

No recommendations at this time.

HHSC Response to Recommendation for HHSC

(1) Confirmed that HHSC did not approve deletion of I-23.1
(2) HHSC approved the Plan Mod to use program hours in DY4.5 but flagged for compliance monitoring of scope changes.
(3) HHSC does not change valuation based on QPI changes.

Possible Plan Modification: Milestone I-102 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-12 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-23 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC recommends increasing goals for I-102 since the provider has concerns of meeting their QPI for DT4 & DT5. HHSC can decrease project’s valuation if a plan modification is approved.

Provider

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to Provider

Recommendation that consideration be given to the potential impact on project valuation if plan modification is approved.

Possible Plan Modification: Recommend a plan modification to decrease the QPI goal for milestone I-23 since the provider has concerns of meeting their QPI for DY 4 & DY 5.

Recommendations to HHSC

No recommendations at this time.

HHSC Response to Recommendation for HHSC

(1) Confirmed that HHSC did not approve deletion of I-23.1
(2) HHSC approved the Plan Mod to use program hours in DY4.5 but flagged for compliance monitoring of scope changes.
(3) HHSC does not change valuation based on QPI changes.

Possible Plan Modification: Milestone I-102 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-12 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-23 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC recommends increasing goals for I-102 since the provider has concerns of meeting their QPI for DT4 & DT5. HHSC can decrease project’s valuation if a plan modification is approved.

Provider

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to Provider

Recommendation that consideration be given to the potential impact on project valuation if plan modification is approved.

Possible Plan Modification: Recommend a plan modification to decrease the QPI goal for milestone I-23 since the provider has concerns of meeting their QPI for DY 4 & DY 5.

Recommendations to HHSC

No recommendations at this time.

HHSC Response to Recommendation for HHSC

(1) Confirmed that HHSC did not approve deletion of I-23.1
(2) HHSC approved the Plan Mod to use program hours in DY4.5 but flagged for compliance monitoring of scope changes.
(3) HHSC does not change valuation based on QPI changes.

Possible Plan Modification: Milestone I-102 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-12 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Possible Plan Modification: Milestone I-23 is overachieving and the goal should be raised since 288 of 125 patients have received preventative health services. Provider should determine a more reasonable goal based on their historical progress.

HHSC recommends increasing goals for I-102 since the provider has concerns of meeting their QPI for DT4 & DT5. HHSC can decrease project’s valuation if a plan modification is approved.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Hospital</td>
<td>121785303.2.1</td>
<td>3</td>
<td>0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider did not start the project as of DY 2 reporting. Although progress is extremely slow and no milestones have been achieved, the provider is reporting in DY 3. Potential that milestones might not be met in a timely manner.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>Provider noted that they have not begun project as of October reporting but will begin in two months.</td>
<td>Provider withdrew the project.</td>
</tr>
<tr>
<td>Corpus Christi- Nueces County Public Health District</td>
<td>130958505.2.3</td>
<td>3</td>
<td>DY 2 Not included in sign-off summary, project awaits approval. 0 of 2 DY 3 milestones met. The original project has been pulled and is being replaced by this project. This project is not progressing because the provider is waiting for the project replacement to be approved.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MS/LC did not have any recommendations.</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>121785303.2.2</td>
<td>5</td>
<td>0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider did not start project as of DY 2 reporting. Provider states they were initially interested in the project, but the school system has no interest in proceeding further. On January 29th the provider notified MSLC that they withdrew from DSRIP in the summer of 2014.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>Confirmed that this project was withdrawn.</td>
<td>Provider withdrew the project.</td>
</tr>
<tr>
<td>Citizens Medical Center</td>
<td>137907508.1.100</td>
<td>3</td>
<td>Has a 3-year project therefore it does not have any DY 2 milestones. 0 of 5 DY 3 milestones complete. Project does not specify how the new BIH observational unit will be staffed. The project narrative states Citizen will provide one licensed nurse but not other mention if new staff will be hired to implement project. HHSC stated concern regarding strong overlap with Gulf Bend Centers (a stated partner on this 3 year project) 5-year project 135254407.1.1. The projects seem to be providing different interventions. Gulf Bend Centers project states it will expand behavioral crisis services by implementing a Crisis Assessment Center with Medical clearance to provide crisis stabilization services. The services that will be included in this project are crisis residential services and crisis respite services that offer varying degrees of support based upon the needs of the client. The Citizen's Medical Center is an extended observation unit &quot;EOU&quot; located within CMC and operated by GBC. It is not a crisis center; the criteria for an observation stay are that the patient is not exhibiting homicidal or suicidal tendencies and does not initially require Acute IP psychiatric level of care. Potential that milestone(s) might not be met in a timely manner.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
**APPENDIX 2 - RHP 5**

### Provider Project ID | Overall Risk Rating | Narrative Describing Mid-Point Assessment Score Justification | Recommendations to HHSC | Recommendations to Provider | HHSC Response to Recommendation for HHSC | HHSC Response to Recommendations for the Project
--- | --- | --- | --- | --- | --- | ---
F) Health Science Center San Antonio 05144801.1.1 | 2 | 1 of 2 DY 2 milestones complete. 3 of 4 DY 3 milestones complete. | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.

**HHSC Response to Recommendations for the Project**

N/A

**Possible Plan Modification:** Recommend reducing the QPI for I-23, since the provider has only seen 2,263 of 6,068.

- **Recommendation:** No change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

- **Potential:** HHSC will not initiate a discussion of QPI goal reductions prior to the initiation of the 3-year project change request process. If a provider feels that the DYS QPI goal is not achievable, they can submit a request to adjust the DYS QPI goal. The change request process in June 2015. HHSC has notified the provider of the upcoming opportunity to request changes to this project for DYS. HHSC has recommended to the provider that they review the status of the project and request adjustments for DYS if needed. For any requested adjustments, they should provide a thorough explanation of the reason for the requested adjustment and submitted requests will go through a standard HHSC review of plan modifications.

- **HHSC does not change valuation:** QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

- **HHSC Response to Recommendation for the Project**

HHSC did not have any recommendations.

---

**HHSC Response to Recommendations for the Project**

N/A

**Possible Plan Modification:** Recommend reducing the QPI for I-23, since the provider has only seen 2,263 of 6,068.

- **Recommendation:** No change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

- **Potential:** HHSC will not initiate a discussion of QPI goal reductions prior to the initiation of the 3-year project change request process. If a provider feels that the DYS QPI goal is not achievable, they can submit a request to adjust the DYS QPI goal. The change request process in June 2015. HHSC has notified the provider of the upcoming opportunity to request changes to this project for DYS. HHSC has recommended to the provider that they review the status of the project and request adjustments for DYS if needed. For any requested adjustments, they should provide a thorough explanation of the reason for the requested adjustment and submitted requests will go through a standard HHSC review of plan modifications.

- **HHSC does not change valuation:** QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

- **HHSC Response to Recommendation for the Project**

HHSC did not have any recommendations.

---

**HHSC Response to Recommendations for the Project**

N/A

**Possible Plan Modification:** Recommend reducing the QPI for I-23, since the provider has only seen 2,263 of 6,068.

- **Recommendation:** No change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

- **Potential:** HHSC will not initiate a discussion of QPI goal reductions prior to the initiation of the 3-year project change request process. If a provider feels that the DYS QPI goal is not achievable, they can submit a request to adjust the DYS QPI goal. The change request process in June 2015. HHSC has notified the provider of the upcoming opportunity to request changes to this project for DYS. HHSC has recommended to the provider that they review the status of the project and request adjustments for DYS if needed. For any requested adjustments, they should provide a thorough explanation of the reason for the requested adjustment and submitted requests will go through a standard HHSC review of plan modifications.

- **HHSC does not change valuation:** QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.

- **HHSC Response to Recommendation for the Project**

HHSC did not have any recommendations.
Recommendations to Provider

This is a 3-year project therefore it does not have DY 2 milestones.
2 of 4 DY 3 milestones complete.
Provider has seen 80 of 137 patients. Provider appears to remain on track.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

Possible Plan Modification:
Recommend that provider should change milestone P-3 to have goals across DY 3-DY 5, instead of only DY 3.

No recommendations at this time.

No recommendations at this time.

N/A

MSL recommended including P-3 in subsequent years, since the goal of P-3 was to train staff by the end of DFS. Provider agreed with this recommendation. Based on that, HHSC added P-3 in DY 4 with the goal of 63 staff and P-3 in DY 5 with the goal of 125 staff to be trained.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

Recommendations to HHSC

This is a 3-year project therefore it does not have DY 2 milestones.
2 of 4 DY 3 milestones complete.
Provider has seen 80 of 137 patients. Provider appears to remain on track.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

Possible Plan Modification: Recommend that provider should change milestone P-3 to have goals across DY 3-DY 5, instead of only DY 3.

No recommendations at this time.

No recommendations at this time.

N/A

MSL recommended including P-3 in subsequent years, since the goal of P-3 was to train staff by the end of DFS. Provider agreed with this recommendation. Based on that, HHSC added P-3 in DY 4 with the goal of 63 staff and P-3 in DY 5 with the goal of 125 staff to be trained.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.

No recommendations at this time.

No recommendations at this time.

N/A

MSL did not have any recommendations.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Hacking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>138708601.2.4</td>
<td>3 of 3 DY 2 milestones complete. 0 of 4 of DY 3 milestones complete.</td>
<td>Provider has increased 896 of 1,120 participants for the Cadena Healthplan. Provider needs to attend two learning collaboratives, has increased the prenatal education sessions for 147 of 180 patients, and provided prenatal education consults. Provider appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>121989102.2.1</td>
<td>0 of 4 of DY 3 milestones complete.</td>
<td>Provider did not develop a set of standards for integrated services (P-3), identify existing clinics where services could be supported (P-2), weekly tests to provide ideas or solutions (P-9), or participate in a learning collaborative (P-10) in DY 2. Both P-9 and P-10 are milestones in DY 3 and have not been met yet either. Provider needs to hire staff in order to see 20 patients (P-5) and this has not yet been accomplished.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>138708601.2.101</td>
<td>0 of 4 of DY 3 milestones complete.</td>
<td>Provider has seen 269 of 325 patients. Provider still needs to record preventable readmissions for data analysis purposes (231 of 1,000 completed), and reduce this number by a percentage. Provider appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>

Possible Plan Modification:

Recommend increasing the QPI metric goal to 100 in DY5 (from 50).

Possible Plan Modification:

Provider needs to clarify P-5 is achieving a level 4, since this is used as the baseline for milestone P-6 which uses the language level 4.

Recommendation to Provider:

Provider was open to an increase in QPI goals - HHSC Changed P-6 QPI metric goal to 100 in DY5 (from 50).
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ticking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia</td>
<td>2</td>
<td>1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider is in the process of implementing a program to improve efficiencies, which is their DY 2 milestone. Although the milestones are not completed, the project appears to remain on track.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the project narrative it states the baselines will be taken from FY11 for comparisons in DY 4 and DY 5. However, DY 4 QPI Metric I-14.2 states FY11 and DY 5 QPI Metric I-16.1 states DY 2. The QPI baseline must be the same for each DY. It is unclear if the QPI Metrics in DY 4 &amp; DY 5 are being determined from the same baseline. DY 4 Metric I-14.1 is measuring increase in patient volume in the ED with a 10% improvement from FY11. DY 5 Metric I-16.1 is measuring a 10% improvement over DY 2 baseline.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 of 2 DY 2 milestones complete.</td>
<td>0 of 1 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should clarify the baseline for DY 4 and DY 5 for I-101 to state how the baseline was determined. DY 4 baseline is 400, which is the total to be seen in DY 3; and DY 5 baseline is 650 which is the total to be seen in DY 4.</td>
<td>N/A</td>
<td>MSLC recommended clarifying selection of QPI metrics to keep consistency across the years, since project has I-14 as a QPI in DY4 and I-16 as QPI in DY5. Provider agreed with the recommendation. HHSC updated system to reflect that I-14 is a QPI metric in DY5, I-16 replaced I-16. QPI goals did not change.</td>
</tr>
<tr>
<td>1 of 2 DY 3 milestones complete. Provider has seen 204 of 400 patients. Provider has started training staff and applying the chronic care model to 409 of 1,500 patients. Provider appears to remain on track.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project delayed due to hiring and turnover of those hired, but with significant improvements the project could get back on track. Upon meeting with the provider, we do not have any recommendations at this time. Provider hired a new key leadership to get the program started and they resigned. This has led to a delay, but with the key leadership was on staff, a lot of planning was accomplished. Once the accreditation is approved, the project should get back on track in a timely manner since this was their major setback.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 of 2 DY 2 milestones complete.</td>
<td>0 of 1 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider has started enrolling the primary care settings into the remote behavioral health consultation services and will complete by 6/1/14. They are completing a needs assessment, are working on agreements between parties for the virtual psychiatric consultations so they can provide those services to patients, and will provide ideas and solutions every week after 6/1/14 when they expect to complete the implementation of the project. Although the milestones are not completed, the project appears to remain on track.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 of 5 DY 3 milestones complete.</td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider is in the process of implementing a program to improve efficiencies, which is their DY 2 milestone. Although the milestones are not completed, the project appears to remain on track.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider has started enrolling the primary care settings into the remote behavioral health consultation services and will complete by 6/1/14. They are completing a needs assessment, are working on agreements between parties for the virtual psychiatric consultations so they can provide those services to patients, and will provide ideas and solutions every week after 6/1/14 when they expect to complete the implementation of the project. Although the milestones are not completed, the project appears to remain on track.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 of 2 DY 2 milestones complete.</td>
<td>0 of 1 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 of 2 DY 3 milestones complete.</td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider has started enrolling the primary care settings into the remote behavioral health consultation services and will complete by 6/1/14. They are completing a needs assessment, are working on agreements between parties for the virtual psychiatric consultations so they can provide those services to patients, and will provide ideas and solutions every week after 6/1/14 when they expect to complete the implementation of the project. Although the milestones are not completed, the project appears to remain on track.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 of 2 DY 2 milestones complete.</td>
<td>0 of 1 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 of 2 DY 3 milestones complete.</td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

APPENDIX 2 - RHP 5
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border Region Behavioral Health Center 121989102.1.2</td>
<td>5</td>
<td>1 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. In DY 2, the provider did not complete their gap analysis or participate in a learning collaborative. In DY 3, the provider has not started their plan, do, study, act (PDSA), and still has not attended a learning collaborative. The provider states in the April sign-off summary that the project is having issues finding providers to relocate for a job in their region. Project does not appear to be progressing and completing their goals. Provider stated that all DY 2 and DY 3 milestones have been met.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of Texas Health Science Center - Houston 111810101.1.100</td>
<td>3</td>
<td>This is a 3-year project therefore it does not have DY 2 milestones. 0 of 4 DY 3 milestones complete. Provider has identified the target population diagnosed with selected chronic diseases or multiple chronic conditions to be managed with the registry, but will not show completion of this milestone until the October DY 3 reporting period. Since the registry will not be finalized until July, the provider is unable to show the 500 patients enrolled and hopes to show the 500 enrolled by the October DY 3 reporting. The provider has established 4 of the 5 personnel involved in the cross-functional team to evaluate the registry and are working on the documentation of the various roles of this team. Potential that milestone(s) might not be met in a timely manner.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121989102.2.2</td>
<td>3</td>
<td>1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is working on designing community-based specialized interventions for target populations, but stated they are still in the process of planning. Additionally, they stated they will not have staff hired until August 2014 and will need to be trained. They are unable to see their targeted individuals served in the project until the planning is complete, staff is hired/trained. Potential that milestone(s) might not be met in a timely manner, since this will not be complete until August 2014 at the earliest.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendations for the Project</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 885144801.1.2</td>
<td>3</td>
<td>Mid of 4 DY 2 milestones complete.</td>
<td>o of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the narrative to reflect the goals listed on the Phase 4 Master Summary.</td>
<td>NA</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 885144801.1.23</td>
<td>3</td>
<td>Mid of 4 DY 2 milestones complete.</td>
<td>o of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary and the semi-annual reports to state that the baseline/goal were not applicable or that they were at zero for the following metrics: DY 2 Metric P-1.1, DY 2 Metric P-3.1, DY 4 Metric I-17.1 and DY 4 Metric I-17.2.</td>
<td>MSLC recommended that the provider update the narrative to reflect the goals listed on the Phase 4 Master Summary and the semi-annual reports to state that the baseline/goal were not applicable or that they were at zero for the following metrics: DY 2 Metric P-1.1, DY 2 Metric P-3.1, DY 4 Metric I-17.1 and DY 4 Metric I-17.2.</td>
</tr>
<tr>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services &amp; The Center For Health Care Services: 137251908.2.5</td>
<td>3</td>
<td>Mid of 4 DY 2 milestones complete.</td>
<td>o of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the narrative to reflect the goals listed on the Phase 4 Master Summary and the semi-annual reports to state that the baseline/goal were not applicable or that they were at zero for the following metrics: DY 2 Metric P-1.1, DY 2 Metric P-3.1, DY 4 Metric I-17.1 and DY 4 Metric I-17.2.</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University Hospitals: 138142853.2.100</td>
<td>3</td>
<td>Mid of 4 DY 2 milestones complete.</td>
<td>o of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Swtich the baseline listed in the 3-Year Projects Workbook for DY 4 and DY 5 metric I-11.2 to read a baseline of 0, as intended by the provider.</td>
<td>NA</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 885144801.1.1</td>
<td>2</td>
<td>Mid of 4 DY 2 milestones complete.</td>
<td>o of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider decreasing the QPI goal for metric I-101.1 to a more achievable value if they are not able to demonstrate that 20,000 out of the 106,405 individuals were positively impacted by the quality improvements via surveys.</td>
<td>MSLC recommended that the baseline listed in the 3-Year Projects Workbook for DY 4 and DY 5 metric I-11.2 be revised to read a baseline of 0, as intended by the provider. The most current version of the 3-year projects workbook did reflect the intended baseline so no additional changes were needed.</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 885144801.1.20</td>
<td>2</td>
<td>Mid of 4 DY 2 milestones complete.</td>
<td>o of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider decreasing the QPI goal for metric I-101.1 to a more achievable value if they are not able to demonstrate that 20,000 out of the 106,405 individuals were positively impacted by the quality improvements via surveys.</td>
<td>MSLC recommended that the provider should consider decreasing QPI goal for metric I-101.1 to a more achievable value if they are not able to demonstrate that 20,000 out of the 106,405 individuals were positively impacted by the quality improvements via surveys. The provider surpassed their goal of 20,000 in DY3 so HHSC did not contact the provider regarding a possible decrease.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Houston Regional Medical Center 127294003.3.1</td>
<td>4</td>
<td>3 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>technical change: Update the phase 4 master summary to reflect the target population as being diabetic patients, as intended to be reached by QPI metric I-101.1 in DY 4 and DY 5.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. QPI metric P-3.1 reports 62 out of 180 individuals enrolled as of April DY 3.</td>
<td></td>
<td>NA</td>
<td>MSLC recommended changes I-101.1 to reflect the target population as being diabetic patients. HHSC updated the reporting system to reflect the updates to I-101.1 in DYs 4 and 5.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider had discrepancies between the goals stated in the project narrative and the Master 4 Master Summary. In the project narrative the provider sets goals for seeing unique patients as 120/360/540 for DY 3, DY 4, and DY 5, respectively. However, the Master summary states the goals as 180/450/720. The provider also had unclear baselines. For example in for Metric P-3.1 the provider sets a goal of 180 Unique Patients. However, For the same metric in DY 4 the provider sets the baseline at 120.</td>
<td></td>
<td>NA</td>
<td>MSLC recommended that the provider update QPI Summary and the Phase 4 Master Summary to reflect the provider's intended baseline/goals for QPI metric P-3.1. The baseline is intended to be 0 for both DY 4 and DY 5 and the goal is intended to be 360 for both DY 4 and DY 5.</td>
<td></td>
</tr>
<tr>
<td>Affinity of Texas Health Science Center at San Antonio 855144001.2.5</td>
<td>3</td>
<td>3 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>no recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. QPI metric P-3.1 reports 82 out of 180 individuals enrolled as of April DY 3.</td>
<td></td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Baptist Medical Center 159156201.2.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>no recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider appears to be on track to meet their DY 3 metrics. Provider states in April DY 3 reporting for QPI metric I-101.1 that if the progress is annualized they are on track.</td>
<td></td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 855144001.1.11</td>
<td>3</td>
<td>3 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider decreasing the QPI goal for metric I-12.1 to a more achievable value due to difficulty in hiring.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>As of April DY 3, DY 2 metric P-5.1 has not been completed. Provider stated during April DY 3 carry forward reporting that they are in the final stages of recruiting the last hire. QPI metric I-12.1 had not started as of April DY 3. The provider stated that the metric will be achieved at a later time based on increasing the number of clinical providers and the pending date of the clinic.</td>
<td></td>
<td>Technical Change: Update the project narrative to align with the expected number of patient seen in DY 3, as stated in the Phase 4 Master Summary. The narrative currently does not include the 12,000 patients referenced in metric I-12.1.</td>
<td>MSLC recommended that the provider update QPI Summary and the Phase 4 Master Summary to reflect the provider's intended baseline/goals for QPI metric P-3.1. The baseline is intended to be 0 for both DY 4 and DY 5 and the goal is intended to be 360 for both DY 4 and DY 5.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The project narrative states the DY 3 patient benefit to be 4,000 unique patients for clinic 1 but does not include the 12,000 visit goal of metric I-12.1 as stated in the Master Summary. There is lack of clarity with I-12.1 in DY 3 relating to increased unique patients visiting the clinic.</td>
<td></td>
<td>Technical Change: Update the Phase 4 Master Summary to be reflective of it's intended goals for QPI metric I-12.1.</td>
<td>HHSC confirmed the baseline and goals with the provider and updated the reporting system to reflect the correct goals for DY4 and DY5.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The master summary is referencing an increase of 5% for clinic 2 bringing the total to 12,000 whereas the total for DY 4 was only 1,000.</td>
<td></td>
<td>Technical Change: Separate the goals for clinic #1 and clinic #2 into different metrics. The achievement of QPI metric I-12.1 in DY 4 and DY 5 could be threatened if one of the two clinics does not meet its stated goal.</td>
<td>HHSC confirmed the baseline and goals with the provider and updated the reporting system to reflect the correct goals for DY4 and DY5.</td>
<td></td>
</tr>
<tr>
<td>Park Regional Hospital 113088602.1.1</td>
<td>4</td>
<td>3 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider decreasing the QPI goal for metric I-12.1 to a more achievable value due to delay in hiring and training staff.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>None of the milestones for DY 2 or DY 3 had been met as of April DY 3 reporting, due to difficulties in hiring.</td>
<td></td>
<td>Technical Change: Update the project narrative to align with the expected number of patient seen in DY 3, as stated in the Phase 4 Master Summary. The narrative currently does not include the 12,000 patients referenced in metric I-12.1.</td>
<td>MSLC recommended that the provider update QPI Summary and the Phase 4 Master Summary to reflect the provider's intended baseline/goals for QPI metric P-3.1. The baseline is intended to be 0 for both DY 4 and DY 5 and the goal is intended to be 360 for both DY 4 and DY 5.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider stated that they are located in a rural area that has a severe shortage of qualified personnel. These positions were filled towards the end of the last reporting period, although they have not been fully trained. In August of 2014, the hospital hired an HR / Marketing Director to spearhead training for all employees.</td>
<td></td>
<td>Technical Change: Update the project narrative to align with the expected number of patient seen in DY 3, as stated in the Phase 4 Master Summary. The narrative currently does not include the 12,000 patients referenced in metric I-12.1.</td>
<td>MSLC confirmed the baseline and goals with the provider and updated the reporting system to reflect the correct goals for DY4 and DY5.</td>
<td></td>
</tr>
</tbody>
</table>

HNRS AND STAUFFER LD
Page 167
<table>
<thead>
<tr>
<th>Provider</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastview Memorial Hospital 12928903.1.2</td>
<td>4</td>
<td>2 of 4 DY 2 milestones complete. 3 of 4 DY 3 milestones complete. 0 of 3 DY 4 milestones complete.</td>
<td>Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider decreasing the QPI goal for metric I-101.1 to a more achievable value due to delays with the ED Fast Track and the nurse advice line.</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 136844305.1.1</td>
<td>3</td>
<td>0 of 2 DY 2 milestones were met. 0 of 2 DY 3 milestones were met. As of April DY 3, the provider had not found a home/family for this project and could potentially fall behind on their QPI metrics unless significant progress is made. Provider reports difficulty establishing partnerships with child placing agencies and difficulties recruiting foster families. As of April DY 3, 0 of 2 youths had been served for QPI metric I-101.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University Hospital 13614205.1.9</td>
<td>2</td>
<td>0 of 3 DY 3 milestones complete. 3 of 3 DY 4 milestones complete. 1 of 2 DY 5 milestones complete.</td>
<td>Provider has achieved all their DY 3 metrics, as of April DY 3. QPI metrics start in DY 4. Core components are not specifically stated in the project narrative but project activities reported in the semi-annual reports show some progress towards core components including: CQI: DY 5 baselines for both metrics are unclear because they state that the DY 4 activity is the baseline but the goal for DY 5 does not appear to be an increase over the amount from the prior year but rather the goals appear to be just the total goal amount for the current year. There is potential for overlap with QPI metric I-101.1 (metric #2) in DY 4 and DY 5. The metric language does not specify the individuals have to be related to Psychiatric Emergency Services (PES) in order to distinguish themselves from the QPI in 13614205.1.10, which is related to the Crisis Intervention Unit (CIU). There are 2 separate metrics labeled I-101.1 in the Phase 4 Master Summary for DY 4 and DY 5.</td>
<td>No recommendations at this time.</td>
<td>MSLC recommended that the project narrative be updated to reflect the provider's intended baselines for metric P-5.1 in DY 4 - DY 5.</td>
</tr>
<tr>
<td>Christus Santa Rosa Hospital 320644001.1</td>
<td>2</td>
<td>0 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric I-121 states in April DY 3 reporting they are on target for achieving goal by 09/30/2014. The baselines and goals are unclear for metric P-6.1 in DY 3 - DY 5. The provider stated that Santa Rosa's baseline for its Downtown Clinic was 13 primary care providers and its baseline for the new Westover Clinic was 6 providers. As DY 2 and DY 3 increased, Santa Rosa's Downtown Clinic's baseline was 10 and DY 2 baseline was 0 and going forward, Santa Rosa's Downtown Clinic's baseline was 3. The provider also stated Santa Rosa's DY 3 baseline for metric I-101.1 as being zero. 2. Specify the individuals for QPI metric I-101.1 (metric #2) to have to be related to Psychiatric Emergency Services (PES) in order to distinguish themselves from the QPI in 13614205.1.10, which is related to the Crisis Intervention Unit (CIU). 3. Reflect only one metric labeled I-101.1 in DY 4 and DY 5 (currently two metrics labeled I-101.1).</td>
<td>No recommendations at this time.</td>
<td>MSLC recommended that the project narrative be updated to include the core components as mentioned in the Category 1 Menu. Technical Change: Update the project narrative to include the core components as mentioned in the Category 1 Menu. Technical Change: Update the Phase 4 Master summary to: 1. Reflect the intended baselines of zero for DY5 metrics P-6.1 and I-101.1 as being zero. 2. Specify the individuals for QPI metric I-101.1 (metric #2) to have to be related to Psychiatric Emergency Services (PES) in order to distinguish themselves from the QPI in 13614205.1.10, which is related to the Crisis Intervention Unit (CIU). 3. Reflect only one metric labeled I-101.1 in DY 4 and DY 5 (currently two metrics labeled I-101.1).</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendations</td>
<td>Project Phase 4 Master Summary Update</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 385144601.1.16</td>
<td>2</td>
<td>1 of 2 DY 2 milestones complete. 1 of 1 DY 3 milestone complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 385144601.1.13</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master summary to reflect the provider's intended baselines being zero for metric P-101.1 in DY 3-DY 5. This is a training metric and the curriculum was developed in DY 2.</td>
<td>NA</td>
</tr>
<tr>
<td>Methodist Hospital: 393154602.1.1</td>
<td>3</td>
<td>1 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master summary to: 1. Reflect the intended baselines for both QPI metrics labeled I-12.1 i in DY 4 and DY 5. The baseline for stroke consults is 31 and the baseline for behavioral health consults is 0. 2. Reflect only one metric labeled I-12.1 in DY 4 and DY 5 (currently two metrics labeled I-12.1).</td>
<td>NA</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio: 385144601.1.15</td>
<td>3</td>
<td>1 of 2 DY 2 milestones complete. 1 of 1 DY 3 milestone complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the project narrative to align with the: 1. Goals in the Phase 4 Master Summary for metric I-18.1 in DY 3-DY 5. 2. QPI measurement as being encounters, as stated in the Phase 4 Master Summary.</td>
<td>NA</td>
</tr>
<tr>
<td>Metro Regional Hospital: 532602003.1.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>Provider</td>
<td>Project ID</td>
<td>Overall Risk</td>
<td>Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>355144601.1.9</td>
<td>3 of 6 DY 2 milestones complete. 2 of 6 DY 3 milestones complete.</td>
<td>0 of 4 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. The provider did not report numerical progress towards QPI metric I-12.1, but states they anticipate reporting 144 visits by October DY 3 reporting.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>355144601.1.6</td>
<td>3 of 6 DY 2 milestones complete. 2 of 6 DY 3 milestones complete.</td>
<td>0 of 5 DY 3 milestones complete.</td>
<td>There is no significant risk that appears to be preventing the provider from meeting their DY 3 metrics. The provider submitted metrics P-1.1 and I-12.2 as complete in April DY 3; however, HHSC did not accept these metrics as complete. The provider submitted a response during the NMI period.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>Provider withdrew the project.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>Provider stated on 02/27/15 that they are submitting a withdrawal form for this project as of April of 2014. There have been no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. The provider submitted metrics P-1.1 and I-12.2 as complete in April DY 3; however, HHSC did not accept these metrics as complete. The provider submitted a response during the NMI period.</td>
<td>No recommendations at this time.</td>
<td>0 of 1 DY 3 milestone complete.</td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
</tr>
</tbody>
</table>
APPENDIX 2 - RHP 6

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital 136141205.1.3</td>
<td>2</td>
<td>0 of 4 DY 3 milestones complete. 0 of 4 DY 3 milestones complete. 0 of 4 DY 3 milestones complete. 0 of 4 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 229 out of 225 individuals as of April DY 3. The baseline used in metric I-101.1 is zero in DY 3, but it is based on prior years in DY 4 and DY 5.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the intended baseline of zero to be used for QPI metric I-101.1 in DY 4 &amp; DY 5.</td>
<td>MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baseline of zero to be used for QPI metric I-101.1 in DY 4 &amp; DY 5. HHSC determined that the most recent workbook already reflected the intended baselines so no additional action was needed. HHSC did not contact the provider with this recommendation.</td>
</tr>
<tr>
<td>University Hospital 136141205.1.6</td>
<td>2</td>
<td>0 of 4 DY 3 milestones complete. 0 of 4 DY 3 milestones complete. 0 of 4 DY 3 milestones complete. 0 of 4 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. The provider does not report numerical progress towards QPI metric I-12.1, but states they are on track to meet their goal by October DY 3 reporting.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the intended baseline of zero to be used for QPI metric I-12.1 in DY 4 &amp; DY 5.</td>
<td>MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baseline of zero to be used for QPI metric I-12.1 in DY 4 &amp; DY 5. HHSC determined that the most recent workbook already reflected the intended baselines so no additional action was needed. HHSC did not contact the provider with this recommendation.</td>
</tr>
<tr>
<td>University Hospital 136141205.1.10</td>
<td>2</td>
<td>0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>Provider achieved all their DY 3 metrics, as of April DY 3. QPI metrics start in DY 4.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>Technical Change: Update the Phase 4 Master Summary to: 1. Reflect the intended baseline of zero for DY 5 metrics P-6.1 and I-101.1 as being zero. 2. Specify the individuals for QPI metric I-101.1 (metric #2) have to be related to the Crisis Intervention Unit (CIU) in order to distinguish themselves from the QPI in 136141205.1.9, which is related to Psychiatric Emergency Services (PES). 3. Reflect only one metric labeled I-101.1 in DY 4 &amp; DY 5 (currently there are two metrics labeled I-101.1).</td>
<td>MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baselines for DY5 metrics P-6.1 and I-101.1. HHSC specified that the individuals for QPI metric I-101.1 (metric #2) have to be related to the Crisis Intervention Unit (CIU) in order to distinguish themselves from the QPI in 136141205.1.9, which is related to Psychiatric Emergency Services (PES). HHSC recommended the project narrative be updated to reflect the intended goals for metric I-101.1 in DY 4 &amp; DY 5. HHSC determined that the most recent workbook already reflected the intended baselines so no additional action was needed. HHSC did not contact the provider with the recommendations.</td>
</tr>
</tbody>
</table>

HHSC should consider strengthening supporting documentation requirements as the Manual of Operations submitted for metric P-3.1 in DY 2 did not clearly pertain to this project. The Manual of Operations or documentation submitted along with the manual should be specific to the project or should clarify that the project will be adhering to the policies, procedures, and protocols already in place.

Technical Change: Update the project narrative to align with the intended QPI goals for metric I-101.1 in DY 4 & DY 5 of 64 & 87 patients served, as stated in the Phase 4 Master Summary. HHSC will take this into consideration and will review our policies for reporting reviews.

MSLC recommended the project narrative be updated to align with the intended QPI goals for metric I-101.1 in DY 4 & DY 5 of 64 & 87 patients served, as stated in the Phase 4 Master Summary. The most recent project narrative reflected the intended goal so no additional changes were needed. HHSC did not contact the provider with the recommendations.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital</td>
<td>136142635.1.2</td>
<td>2</td>
<td>1 of 3 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. The provider does not report numerical progress towards QPI metric I-12.1, but states they are on track to meet their goal by October DY 3 reporting.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>311305960.1.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider is likely to meet or exceed all their DY 3 metric goals by the end of DY 3. Overachievement is likely for QPI metric I-14.1 in DY 3. The provider reported 7,462 out of the 8,126 individuals as of April DY 3 reporting. DY 5 QPI goal for this metric is 3,540; therefore, overachievement of DY 5 goal based on April DY 3 progress is not evident. This project is being assessed as a benchmark project because its lessons learned mentioned in October DY 2 and April DY 3 Sign-off Summaries may be of benefit to other school based programs. Some of the lessons learned include: In order to overcome the challenge of developing detailed services plans with each school district during the summer months when school administration staff was not available, the providers states &quot;Detailed service plans should be solidified prior to the end of the previous school year, in advance of summer break.&quot; Obtaining consent forms during the enrollment process may yield improved participation rates and improved efficiency in distribution of consent forms. Teachers, school nurses and administrative would benefit greatly from training sessions prior to clinic sessions. Through these sessions, district staff will gain a better understanding the impact of oral disease on students' ability to learn and will become strong advocates for student participation in the program. The opportunity to review program forms and materials, receive facility requirements and pre-post clinic activities will improve overall project efficiency.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Community Medicine Associates</td>
<td>322414401.1.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 3 of 4 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Baptist Medical Center</td>
<td>159152601.1.3</td>
<td>2</td>
<td>3 of 3 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. The provider does not report numerical progress towards QPI metric I-101.1, but states they are on track if they annualize their progress as of April DY 3 reporting.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>355144601.1.5</td>
<td>3</td>
<td>3 of 2 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Neither of the DY 3 metrics were started as of April DY 3; however, the provider stated they anticipate they will be achieved by October DY 3 reporting. The provider reported challenges with establishing the registry due to delays caused by legal and technical issues. The provider stated that the initial barriers that led to a delay in the project have all been overcome and they anticipate that they will successfully catch up on DY 3 metrics and not fall behind on future metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider/Project ID</td>
<td>Overall Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendations for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| University of Texas Health Science Center at San Antonio 085144601.1.7 | 3 | 2 of 3 DY 2 milestones complete. 0 of 1 DY 3 milestone complete.  
Provider has only seen 23 of the 540 patients required to meet their metric goal for DY 3.  
Provider reports delay due to the hiring and training of new staff.  
It was noticed there was potential for overlap between this project and 085144601.1.23. The patients seen for this project are general neurology patients and the patients seen for 085144601.1.23 deal with a subset of neurology (epilepsy/seizures). The baseline used for QPI metric I-23.1 should be clarified since it currently states "patients seen"; however, the QPI measurement is encounters. The baseline number used for this metric should also be added for more clarity. The project narrative states that location would be changed due to a lack of space at the downtown location (UHS).  
During the site visit, the provider reported surpassing the goal for I-23.1 by having 746 encounters in DY 3. The 23 encounters in April DY 3 was a result of the hiring challenge the provider faced. The provider stated that location has been overcome. Provider stated that project 085144601.1.23 is dealing with epilepsy/seizures is different from the project 085144601.1.7 which is general neurology. They have different doctors working on the programs and they are seeing different patients, the QPI for each project should be distinguishable. Provider stated that the baseline was 150 and that it was dealing with encounters. Provider stated their goal was easily able to meet the target population. Provider moved the downtown patients to MARC (current location). This was made possible by the close proximity between UHS and MARC and a very reliable bus system between the two places. | No recommendations at this time. | Technical Change: Update the Phase 4 Master Summary to reflect the baseline intended to be used by the provider for QPI metric I-23.1 in DY 3 - DY 5 of 150 patient visits per month. The baseline currently references patients seen which it is based on individuals and not encounters. | | |
| Dimmit County Memorial Hospital 112690603.1.1 | 2 | 2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.  
Provider appears to be on track to meet their DY 3 metric. QPI metric I-23.1 reports 418 out of 500 visits as of April DY 3.  
It is unclear what will allow them to increase their QPI goal from 500 in DY 3 to 2500 in DY 4.  
The provider stated that 2500 encounters for DY 4 may be unrealistic.  
Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved. | No recommendations at this time. | Possible Plan Modification: Provider should consider decreasing the QPI goal for metric I-23.1 to a more achievable value since the provider stated the current goals appear to be unrealistic. | MSLC recommended that the provider should consider decreasing QPI goal for metric I-23.1 to a more achievable value since the provider stated the current goals appear to be unrealistic. Since the provider reported achievement of their QPI metric in DY 3 and did not submit a plan modification request, HHSC did not contact the provider regarding this recommendation. |
| CHRISTUS Santa Rosa Hospital 020844901.2.1 | 2 | 2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.  
There are no significant risks that appear to be preventing the provider from meeting their DY 3 metric. The provider did not report numerical progress towards QPI metric I-12.1 during April DY 3 reporting.  
Unclear if the baselines for QPI metric I-12.1 is the original/baseline used in DY 3 or the total from the prior year. | No recommendations at this time. | Technical Change: Update the Phase 4 Master Summary to reflect the baseline intended to be used by the provider for QPI metric I-12.1 in DY 3 - DY 5.  
The provider stated the baselines are the totals from the prior year. | MSLC recommended that the provider should consider decreasing QPI goal for metric I-12.1 to a more achievable value since the provider stated the current goals appear to be unrealistic. Since the provider reported achievement of their QPI metric in DY 3 and did not submit a plan modification request, HHSC did not contact the provider regarding this recommendation. |
APPENDIX 2 - RHP 6

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peterson Regional Medical Center 37294003.2.1</td>
<td>2</td>
<td>1 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider achieved all their DY 3 metrics, as of April DY 3. QPI metrics start in DY 4. DY 4 and DY 5 Metric I-12.1 states a goal of reduction of high users of ambulatory sensitive conditions identified for care transitions program but does not state any specific percentage goal for either year.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
</tr>
<tr>
<td>unlikely to meet project goals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Center for Infectious Disease 13325704.2.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist Hospital 094154402.2.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. The provider does not report numerical progress towards QPI metric P-3.2, but states they are on track to complete the goal.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist Hospital 094154402.2.2</td>
<td>2</td>
<td>1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexar County Board of Trustees for Mental Health Mental Retardation Services, dba The Center For Healthcare Services 137251808.2.2</td>
<td>2</td>
<td>1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba Bluebonnet Trails Community Services 13864305.2.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric P-3.1 reports 6 out of 8 individuals as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2 - RHP 6

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Tracking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation of HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>2</td>
<td>3 of 4 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the intended baselines for QPI metric I-13.1 in DY 5.</td>
<td>NA</td>
<td>MSAC recommended updating the Phase 4 Master Summary to reflect the intended baselines for QPI metric I-13.1 in DY 5 - DY 7. The most updated baseline information should be included in the QPI template submitted by the provider. Since HHSC has a record established for this project, HHSC did not update the system with baseline information.</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>4</td>
<td>3 of 4 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the intended baselines for both QPI metrics labeled I-6.1 and P-101.1.</td>
<td>NA</td>
<td>MSAC recommended the Phase 4 Master Summary be updated to reflect the intended baselines of zero for both QPI metrics labeled I-6.1 and P-101.1. The provider stated in April DY 3 reporting that beginning in May the project aims to schedule and successfully hold 15 workshops with at least 12 participants each in order to enroll at least 180 individuals each six weeks from May 19th through the end of DY 3. The baselines for I-6.1 in DY 3 - DY 5 are not listed on the Phase 4 Master Summary. There are also two metrics labeled I-6.1 in DY 3 - DY 5.</td>
</tr>
<tr>
<td>Myer Medical Center</td>
<td>2</td>
<td>3 of 4 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to include the intended baseline for QPI metric I-101.1 to be 0.</td>
<td>NA</td>
<td>Provider withdrew the project.</td>
</tr>
</tbody>
</table>

#### Notes

- **Technical Change**: Update the Phase 4 Master Summary to reflect the intended baselines for QPI metric I-13.1 in DY 5.
- **Possible Plan Modification**: Provider should consider decreasing the QPI goal for metric P-3.2 to a more achievable value, due to the delayed start of the project potentially threatening the achievement of the QPI metric.
- **Provider Welcome to the project**: HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.
- **HHSC Response to Recommendations for the Project**: Provider withdrew the project.
## Recommendations to HHSC

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Tiers</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Beckery County District Health Mental Health System</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>The Beckery County District Health Mental Health System</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>The Beckery County District Health Mental Health System</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Technical Change

- **Update the Phase 4 Master Summary to include the intended baseline for metric I-15.1 in DY5.** The provider stated, the DY 4 QPI (metrics P-3.1) is the baseline for DY 5 metrics I-5.1.
- NA

### Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Tiers</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital 13414325.3</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>University Hospital 13414325.3</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>University Hospital 13414325.3</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Technical Change

- **Update the Phase 4 Master Summary to reflect the intended baseline of zero to be used for QPI metric I-101.1 in DY 4 and DY 5.**
- NA

### Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Tiers</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Medicine Associates 0224144001.2</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio 085144601.2</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>University Hospital 13414325.2</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Technical Change

- **Update the Phase 4 Master Summary to reflect the intended baseline of zero to be used for QPI metric I-16.1.**
- NA

### Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Tiers</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIP Health Care System 132676501.2</td>
<td>Disease</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Technical Change

- **Update the Project Narrative so that the QPI goals listed on the Phase 4 Master Summary align with the goals listed in the project narrative. Currently, the project narrative states, "We are expecting around 1,900 patients by the end of DY 2, with a 10% increase annually over the next 3 years: 2,090 by end DY 3, 2,299 by end DY 4 and 2,529 by end DY 5; but the goals for metric I-12.1 for DY 3 - DY 5 are 500/1000/2500.**
- NA

### Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Tiers</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHSC</td>
<td>HHS</td>
<td>Excellent</td>
<td>Excellent</td>
<td>NA</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Technical Change

- **Update the Phase 4 Master Summary to reflect the intended baselines and goals listed for I-15.1 and I-17.1. For example, I-17.1 currently states in the Baseline/goal section in DY 4, “Goal 75%.”**
- NA
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 132540307.2.1</td>
<td>2</td>
<td>1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete. Provider exceeded their DY 3 metric. QPI metric I-101.1 reports 300 out of 30 individuals as of April DY 3. The provider submitted a plan modification to HHSC, increasing DY 4 and DY 5 QPI based on overachievement. This project is being assessed as a benchmark project because they exceeded their QPI goal in DY 3 and requested a plan modification to increase future goals. The project also served over 10% more Medicaid/Uninsured patients than originally expected (98%). No significant risks were identified during the review of this project.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center (dba Bluebonnet Trails Community Services) 135844305.2.1</td>
<td>2</td>
<td>1 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete. Provider has completed both DY 3 metrics as of April DY 3. Provider exceeded their DY 3 QPI goal. QPI metric P-3.1 reports 51 of 15 individuals as of April DY 3. The provider submitted a plan modification to HHSC, increasing DY 4 and DY 5 QPI based on overachievement.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
Recommendations to Provider

Technical Change:

MSLC recommended a technical change for DY4 QPI. DY4 I-23.1 goal.

No recommendations at this time.

MSLC did not have any recommendations.

2 of 3 DY 2 milestones complete.

No recommendations at this time.

NA

HHSC Response to Recommendations for the Project

HHSC Response to Recommendation for HHSC

Recommendations to Provider

HHSC Response to Recommendations for the Project

Recommendations to HHSC

No recommendations at this time.

NA

MSLC did not have any recommendations.

1 of 1 DY 2 milestone complete.

0 of 1 DY 2 milestone complete.

No recommendations at this time.

0 of 1 DY 2 milestone complete.

No recommendations at this time.

MSLC did not have any recommendations.

No recommendations at this time.

MSLC did not have any recommendations.

2 of 2 DY 2 milestones complete.

0 of 2 DY 2 milestones complete.

No recommendations at this time.

0 of 2 DY 2 milestones complete.

No recommendations at this time.

MSLC did not have any recommendations.

1 of 1 DY 2 milestone complete.

0 of 1 DY 2 milestone complete.

No recommendations at this time.

0 of 1 DY 2 milestone complete.

No recommendations at this time.

MSLC did not have any recommendations.

1 of 1 DY 2 milestone complete.

0 of 1 DY 2 milestone complete.

No recommendations at this time.

0 of 1 DY 2 milestone complete.

No recommendations at this time.

MSLC did not have any recommendations.

1 of 2 DY 3 milestones complete.

0 of 2 DY 3 milestones complete.

No recommendations at this time.

No recommendations at this time.

NA

HHSC recommended a technical change for DY4 QPI. DY4 I-23.1 goal was addressed through the QPI cleanup process with HHSC.

1 of 2 DY 3 milestones complete.

0 of 1 DY 3 milestone complete.

No recommendations at this time.

No recommendations at this time.

NA

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's valuation.

MSLC recommended clarification of DY5 metrics. Provider withdrew project during mid-point assessment window so no project changes were made.

3 of 2 DY 3 milestones complete.

0 of 2 DY 3 milestones complete.

Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.

Possible Plan Modification:

Provider should consider increasing the QPI goals because provider reports 935 out of 1,500 encounters for QPI metric I-23.1 as of April DY 3.

Technical Change:

Update the Phase 4 Master Summary to reflect the DY 4 QPI goal for metric I-23.1 as listed in the QPI Summary.

Technical Change:

Update the Phase 4 Master Summary to reflect:

1. Removal of the second metric labeled I-21.1 in DY 5, as it is not the provider's intent to include it.
2. The inclusion of baselines for QPI metric I-23.1 in DY 3 - DY 5.

University Medical Center at Brackenridge 13725805.1.4

2 of 2 DY 3 milestones complete.

0 of 4 DY 3 milestones complete.

No recommendations at this time.

No recommendations at this time.

NA

MSLC recommended clarification of DY5 metrics. Provider withdrew project during mid-point assessment window so no project changes were made.

St. David’s Medical Center 17692501.1.1

3 of 2 DY 2 milestones complete.

0 of 2 DY 2 milestones complete.

The provider may exceed QPI metric I-23.1 as they report seeing 305 of the 1,500 encounters as of April DY 3. The goal for DY 5 is 1,500 encounters. In April DY 3 reporting, the provider stated, that the Medical Office Building renovations for Cardiovascular are scheduled to be completed in Aug-Sep 2014. This may cause the goal of 400 individuals to be carried forward for metric P-11.1 in DY 3. This metric only appears in DY 3.

Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.

Possible Plan Modification:

Provider should consider increasing the QPI goals because provider reports 935 out of 1,500 encounters for QPI metric I-23.1 as of April DY 3.

Technical Change:

Update the Phase 4 Master Summary to reflect:

1. Removal of the second metric labeled I-21.1 in DY 5, as it is not the provider's intent to include it.
2. The inclusion of baselines for QPI metric I-23.1 in DY 3 - DY 5.

MSLC recommended clarification of DY5 metrics. Provider withdrew project during mid-point assessment window so no project changes were made.

University Medical Center of San Antonio 133542405.1.2

2 of 2 DY 3 milestones complete.

0 of 2 DY 3 milestones complete.

There are no significant risks that appear to be preventing the provider from meeting their DY 3 metric. As of April DY 3, numerical progress was not reported on QPI metric I-101.1; however, the provider states the project is currently on track to meet the metric.

Possible Plan Modification:

Provider should consider increasing the QPI goals because provider reports 935 out of 1,500 encounters for QPI metric I-23.1 as of April DY 3.

Technical Change:

Update the Phase 4 Master Summary to reflect:

1. Removal of the second metric labeled I-21.1 in DY 5, as it is not the provider's intent to include it.
2. The inclusion of baselines for QPI metric I-23.1 in DY 3 - DY 5.

MSLC recommended clarification of DY5 metrics. Provider withdrew project during mid-point assessment window so no project changes were made.

Hill Country MHMR Center (dba Hill Country MHMR) 133540307.1.1

2 of 2 DY 2 milestones complete.

0 of 1 DY 3 milestone complete.

No recommendations at this time.

No recommendations at this time.

NA

Recommendations to PPIS

Recommendations to HHSC

Recommendations to Provider

HHSC Response to Recommendation for HHSC

MSLC did not have any recommendations.
Recommendations to Provider

MSLC did not have any recommendations.

Technical Change:

NA

3 of 3 DY 2 milestones complete.

MSLC recommended to add baseline information to the QPI metrics

MSLC did not have any recommendations.

MSLC recommended that the narrative be updated to reflect the most

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC Response to Recommendations for

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.

HHSC

Technical Change:

NA

1 of 1 DY 2 milestone complete.

No recommendations at this time.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Medical Center at Brackenridge 137265806.2.7</td>
<td>2</td>
<td>All 4 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>As of April DY 3, numerical progress was not reported on QPI metric I-101.1. During April DY 3, the provider reported, “Following change in guidance around QPI metrics, provider is in communication with RHP 7 and HHSC and has identified a plan to carry forward this metric into DY 4. Provider anticipates meeting this goal in DY 4.” Provider stated that metric I-101.1 was reported as complete in October 2014.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Care Collaborative 307450001.2.7</td>
<td>3</td>
<td>All 1 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. As of April DY 3, QPI metric P-2.2 had not started. Provider stated that they were able to meet all metrics related to this project in DY 3 and on track in DY 4. The provider states the baseline is 0 for QPI metric P-2.2; therefore, it appears as though the goals should be 500, 750, and 1,000.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Austin - Health &amp; Human Services Department 201300302.2</td>
<td>2</td>
<td>All 1 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are no significant risks that appear to be preventing the provider from meeting their DY 3 metric. As of April DY 3, QPI metric I-101.1 had not started. Provider mentioned in April DY 2 reporting they plan to meet this metric by 9/30/14.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers) 335540007.2.7</td>
<td>2</td>
<td>All 1 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All 1 DY 3 milestone complete.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are no significant risks that appear to be preventing the provider from meeting their DY 3 metric. As of April DY 3, QPI metric I-101.1 had not started. Provider mentioned in April DY 2 reporting they plan to meet this metric by 9/30/14.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Austin - Health &amp; Human Services Department 201300302.2</td>
<td>2</td>
<td>All 1 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. As of April DY 3, numerical progress was not reported on QPI metric I-101.1; however, the provider stated they anticipate meeting this metric in October 2014. There is the risk of possible overlap with project 137265806.2.5 and 137265806.2.6. The narrative for 137265806.2.5 states, “Patients requiring a lower-level of intervention or have a lower hospital/ED utilization history will be referred to our Care Transitions projects” (137265806.2.5). The narrative for 137265806.2.6 states, “Patients requiring a higher-level of intervention or have a higher hospital/ED utilization history will be referred to Performing Provider’s Chronic Care Management” (137265806.2.6). During the site visit to discuss 137265806.2.5, the provider stated they use a stratification tool to distinguish between patient attributes. Project 2.6 is for patients with more advanced illnesses. Provider stated that this DSRIP project and DSRIP project (137265806.2.5) each provide distinct services at different points along the continuum of care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austin Travis County Integral Care 313542003.2.4</td>
<td>2</td>
<td>All 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
Recommendations to Provider

University Medical Center at Brackenridge
137258582.2

2 of 3 DY 2 milestones complete.
No recommendations at this time.

City of Austin - Health & Human Services Department
301230392.2

3 of 3 DY 2 milestones complete.
No recommendations at this time.

University Medical Center at Brackenridge
137258582.2

2 of 3 DY 2 milestones complete.
No recommendations at this time.

Community Care Collaborative
307435901.2

3 of 3 DY 2 milestones complete.
No recommendations at this time.

NARRATIVE DESCRIBING MID-POINT ASSESSMENT SCORE JUSTIFICATION

University Medical Center at Brackenridge
137258582.2

2 of 3 DY 2 milestones complete.
No recommendations at this time.

City of Austin - Health & Human Services Department
301230392.2

3 of 3 DY 2 milestones complete.
No recommendations at this time.

University Medical Center at Brackenridge
137258582.2

2 of 3 DY 2 milestones complete.
No recommendations at this time.

Community Care Collaborative
307435901.2

3 of 3 DY 2 milestones complete.
No recommendations at this time.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dell Children’s Medical Center</td>
<td>186599001.2.2</td>
<td>2</td>
<td>All 3 DY 3 milestones complete. No significant risks that appear to be preventing the provider from meeting their DY 3 metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers)</td>
<td>133594937.2.5</td>
<td>3</td>
<td>All 3 DY 3 milestones complete. No significant risks that appear to be preventing the provider from meeting their DY 3 metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Austin Travis County Integral Care</td>
<td>133542405.2.6</td>
<td>2</td>
<td>All 3 DY 3 milestones complete. No significant risks that appear to be preventing the provider from meeting their DY 3 metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hill Country MHMR Center (dba Hill Country MHDD Centers)</td>
<td>133519078.2.9</td>
<td>2</td>
<td>All 3 DY 3 milestones complete. No significant risks that appear to be preventing the provider from meeting their DY 3 metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University Medical Center at Brackenridge</td>
<td>137025856.1.2</td>
<td>2</td>
<td>All 3 DY 3 milestones complete. No significant risks that appear to be preventing the provider from meeting their DY 3 metrics.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
University Medical Center at Brackenridge 137265806.1.5

2 of 4 DY 2 milestones complete.
6 of 3 DY 3 milestones complete.

As of April DY 3, numerical progress was not reported on QPI metric I-101.1; however, the provider stated they anticipate meeting this metric in October 2014.

During the site visit, the provider stated they exceeded the goal for QPI metric I-101.1. The provider submitted a plan modification to increase the goal for QPI metric I-101.1 from 80,000 to 2.1 million patient encounters in DY 4 and from 100,200 to 4.3 million patient encounters in DY 5.

During the site visit, the provider stated they chose to measure QPI based on encounter because this was the recommended QPI measurement for the project option. The provider said only patient encounters with physicians and nurses trained in cultural competency will be counted towards QPI. An encounter will be one patient encounter with a trained physician/nurse per day. The provider is able to conduct audits of this metric internally by reviewing the physician/nurse progress reports to determine if an adequate encounter took place.

The provider stated they plan to report the QPI based on encounters in the EMR system for trained staff members. Patient level data and FIN# specific to the patient will also be provided. The provider is very confident that increased QPI goals can be met based upon analytics run internally and stated they are on track to exceed DY 4 QPI goal. The provider stated they do not wish to reduce QPI goals for DY 4 and DY 5.

Recommendations to HHSC: No recommendations at this time.

Recommendations to Provider: No recommendations at this time.

HHSC Response to Recommendations for the Project: NA

MSLC did not have any recommendations.

University Medical Center at Brackenridge 137265806.2.5

3 of 4 DY 2 milestones complete.
6 of 3 DY 3 milestones complete.

There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. As of April DY 3, numerical progress was not reported on QPI metric I-101.1; however, the provider stated they anticipate meeting this metric in October 2014.

During the site visit, the provider stated DY 3 QPI metric I-101.1 was met as well as DY 2 metric I-11.1.

There is the risk of possible overlap with project 137265806.2.5 and 137265806.2.6. The narrative for 137265806.2.5 states, "Patients requiring a higher-level of intervention or have a higher hospital/ED utilization history will be referred to Perforning Provider's Chronic Care Management" (137265806.2.5). The narrative for 137265806.2.6 states, "Patients requiring a lower-level of intervention or have a lower hospital/ED utilization history will be referred to our Care Transitions projects" (137265806.2.5). During the site visit, the provider stated they use a stratification tool to distinguish between patient attributes. Project 2.5 is for patients with less advanced illnesses.

Provider stated that the DSRIP project and DSRIP project (137265806.2.6) each provide distinct services at different points along the continuum of care.

Recommendations to HHSC: No recommendations at this time.

Recommendations to Provider: No recommendations at this time.

HHSC Response to Recommendations for the Project: NA

MSLC did not have any recommendations.

University Medical Center at Brackenridge 137265806.2.8

3 of 4 DY 2 milestones complete.
6 of 3 DY 3 milestones complete.

As of April DY 3, numerical progress was not reported on QPI metric P-3.1; however, the provider stated they anticipate meeting this metric in DY 5. The provider had not reported on DY 2 metric I-101.1 as of April DY 3.

The provider stated DY 2 metric I-101.1 was not completed during the carry forward period and metric P-3.1 was reported as complete in October 2014.

Recommendations to HHSC: No recommendations at this time.

Recommendations to Provider: No recommendations at this time.

HHSC Response to Recommendations for the Project: NA

MSLC did not have any recommendations.

City of Austin - Health Services Department 201320302.2.1

2 of 4 DY 2 milestones complete.
6 of 3 DY 3 milestones complete.

Provider appears to be on track to meet their DY 3 metrics. Provider overachieved QPI metric P-3.1 in DY 3 as they reported 15 out of 8 individuals as of April DY 3.

Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.

Possible Plan Modification: Provider should consider increasing the QPI goals because the provider reports an overachievement for metric P-3.1 as of April DY 3 (achieved 15 of the 8 individuals).

HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's valuation.

MSLC recommended that the QPI goals be increased based on DY3 April achievement. HHSC will be conducting a separate process to increase DY5 QPI goals for all projects that overachieved DY3 QPI goals.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Austin - Health &amp; Human Services Department 2013303032.2.3</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. There are no significant risks preventing the provider from meeting their DY 3 metrics. As of April DY 3, the provider did not report numerical progress or state if they anticipate achieving QPI metric I-5.1 by Oct DY 3. Unclear baseline for QPI metric I-5.1. It is also unclear what the 50% reference is to in DY 5 QPI metric I-5.1.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to: 1. Reflect the intended baseline of 9 for QPI metric I-5.1. 2. Remove the percentage reference “by 50%” from DY 5 QPI metric I-5.1.</td>
<td>NA</td>
<td>MSLC recommended that the goal of 50% be removed from DY5 I-5.1 and only the numeric QPI goal be maintained. MSLC also recommended to add the baseline to the QPI goals. HHSC removed the percentage goal. HHSC is not adding baselines to QPI metrics because this will be captured in the QPI Template during reporting.</td>
</tr>
<tr>
<td>Community Care Collaborative 3074550801.2.1</td>
<td>2</td>
<td>0 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. As of April DY 3, QPI metric I-101.2 had not started. Upon review of the July DY 3 NMI provider response, the provider stated they had not seen any patients as of April DY 3, but have seen over 10,000 patients as of July 2014 because the providers had since adopted the new model.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Recommendations to Provider: No recommendations at this time.

Recommendations to HHSC: No recommendations at this time.

HHSC Response to Recommendations for HHSC: NA

MSLC did not have any recommendations.

**Recommendations to Provider**

**Recommendations to HHSC**

**HHSC Response to Recommendations for HHSC**

**MSLC did not have any recommendations.**
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bell County Public Health District 086334601.2.1</td>
<td>4</td>
<td>all 1 DY 2 milestones complete, all 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Williamson County &amp; Cities Health District 730938702.1.1</td>
<td>3</td>
<td>all 2 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center Inc/Bluebonnet Trails Community Services 736844305.2.1</td>
<td>3</td>
<td>all 2 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Central Counties Services 381771001.1.2</td>
<td>4</td>
<td>all 2 DY 2 milestones complete.</td>
<td>Consideration should be given to possible impact on project valuation if plan modification to reduce QPI is approved.</td>
<td>Possible Plan Modification: Recommend a reduction in QPI since the project received late approval.</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.</td>
<td>MSLC recommended a reduction in QPI. HHSC clarified the DY4-5 QPI goals with the provider through the plan modification process which resulted in a DY5 decrease. No further actions were taken and HHSC did not contact the provider on this recommendation.</td>
</tr>
<tr>
<td>Scott and White Hospital - Llano 320840701.2.2</td>
<td>1</td>
<td>all 2 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider</td>
<td>Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Little River Healthcare</td>
<td>183086102.1.1</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. There appears to be some variation in project narrative, approved matrix, and sign-off summaries regarding Primary Care Clinic Patients, Fast Track Patients, and School Clinics. April sign-off is referencing 5 school clinics which are not mentioned in Matrix Summary. Provider reported in DY 3 milestone 3.25. It is not clear if this percent of their goal or just the number of patients to be seen. Provider needs to clarify and if patients seen needs to state what percentage are Medicaid. It was noted during the site visit that many DY 3 milestones have far exceeded their milestone goals. They have opened clinics in five schools. Averaged 24-32 hours/week whereas exceeding their goal of 5 hours/week. It doesn’t appear that project has not seen Medicaid clients. However, our risk assessment of 4 is accurate with respect to reflecting risk as of April reported status and data. This project was selected for a benchmark because of the project option and how they implemented the project. This project was also very active in the outreach efforts which allowed the project to over-achieve project goals.</td>
<td>Consideration should be given to project valuation if plan modification to increase QPI is approved.</td>
<td>Technical Change: Provider should discuss the activities mentioned in the narrative within the sign-off summary, since they are doing so much more than they are actually reporting on. During the site visit it was stated by the provider that they are now offering flu shots, home visits, and sports physicals. Possible Plan Modification: Recommend the provider adjust their QPI milestone I-12, since they are overachieving.</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project’s valuation.</td>
</tr>
<tr>
<td>MYERS AND STAUFFER LC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MSLC recommended the provider should discuss the activities mentioned in the narrative within the sign-off summary, since they are doing so much more than they are actually reporting on. During the site visit it was stated by the provider that they are now offering flu shots, home visits, and sports physicals. HHSC notified the provider that they should include additional information in their reporting. MSLC recommended the provider adjust their QPI milestone I-12, since they are overachieving. HHSC contacted the provider regarding this recommendation and the provider stated they did not feel they could increase their QPI. HHSC notified the provider that we would contact them during May 2015 with recommended QPI increases.</td>
<td></td>
</tr>
</tbody>
</table>

APPENDIX 2 - RHP 8
No recommendations at this time.

Possible Plan Modification: Provider should consider adding Metric I-14.2 to specifically measure the number of children receiving sealants. The current metric used to measure the improvement of this project, Metric I-14.1, is not specific to sealant treatment and includes children who only receive a screening but not treatment.

Technical Change: Delete the language for the populations not included in the measurement for the I-14.1 metric, baseline, and goal description to accurately reflect how the provider will measure the milestone. This project is aimed specifically at school-age children. The other populations included in the metric language are special needs patients, pregnant women, and/or the elderly, which are not part of this project's target population.

No recommendations at this time.

Possible Plan Modification: Provider should consider adding Metric I-15.2 to more accurately reflect what provider is reporting on. Metric I-15.1 is not specific to sealant treatment and includes children who only receive a screening but not treatment.

Technical Change: Provider should consider changing Metric I-15.1 to Metric I-15.2. The provider is currently measuring additional encounters using I-15.1. However, according to the Category 1 Menu, metric I-15.1 requires a measure of individuals in the target population, not encounters. Metric I-15.2 measures the increased number of primary care visits. Alternatively, the provider may retain I-15.1 but should report a percentage to show an increase in the target population reached.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical City Dallas Hospital</td>
<td>020943901.1.2</td>
<td>4</td>
<td>3 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. Provider noted in its April DY 3 report challenges with recruiting and hiring a psychiatrist; therefore, the number of consults have been limited to 18 consults out of a goal of 1,000. However, provider also indicated that contracts with additional providers are being finalized and additional consults may start in July 2014.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Medical City Dallas Hospital</td>
<td>020943901.2.3</td>
<td>2</td>
<td>3 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Texas Health Presbyterian Hospital Denton</td>
<td>020967801.2.1</td>
<td>3</td>
<td>4 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. Provider reported a slight decline in DY 3 in sepsis treatment rates; however, provider stated that a sepsis coordinator was hired which may improve these results.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>All Children Medical Center</td>
<td>020979301.2.1</td>
<td>4</td>
<td>4 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. Provider reported progress on DY 3 milestones, serving 45 of 100 patients for metric P-2.2 and 84 of a goal of 300 encounters for metric P-2.3. The provider also mentions that they are in the planning stages of opening their own chronic care clinic due to a lack of resources of their local FQHC in dealing with certain patients with complex needs. Provider also noted lack of resources to which to refer patients. Without referral resources, provider may not be able to meet its I-10.2 QPI goals in DY 4 and DY 5.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Medical Center of Lewisville</td>
<td>094192402.2.1</td>
<td>4</td>
<td>0 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider reports as of mid-point DY 3 that they have completed 3416 of 5279 calls (for metric I-101.1). The targeted number of calls in DY 4 is 10,998 and in DY 5 the goal is 20,237 calls. There is risk that the provider may not be able to achieve such a high volume of calls.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Medical Center of Lewisville</td>
<td>094192402.2.2</td>
<td>2</td>
<td>3 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. Provider reported progress on DY 3 metrics for milestone I-13: For Sepsis Bundle Compliance metric, provider reported 50 cases out of a goal of 123 cases. For correct diagnosis of sepsis, provider reported 29 patients out of a goal of 107 patients. Provider reported that a sepsis coordinator will be hired to manage the project with the goal of increasing the project’s QPI.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Doctors Hospital at White Rock Lake</td>
<td>094194002.2.1</td>
<td>3</td>
<td>3 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. For its DY 3 QPI milestone, provider reported that it had assigned 75 patients to medical homes as of mid-point DY 3, out of a targeted goal of 250 patients by the end of DY 3. The project proposes a partnership with Mission East Dallas where Drs. Hospital refers high-risk and chronic care patients to Mission East Dallas. The feasibility presents somewhat of a risk, considering that Mission East was already having trouble servicing their established patients and now Doctor’s Hospital will be sending them additional patients who are high-risk and chronic care patients.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Denton Regional Medical Center 111905902.2.1</td>
<td>2</td>
<td>8 of 4 DY 2 milestones complete. 8 of 2 DY 3 milestones complete. 0 of 2 DY 2 milestones complete. Provider reported progress on DY 2 metrics for milestone I-13: For Sepsis Bundle Compliance metric, provider reported 69 cases out of a goal of 143 cases. For correct diagnosis of sepsis, provider reported 94 patients out of a goal of 178 patients. The provider also reported hiring a Sepsis Coordinator to manage the program.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Denton Regional Medical Center 111905902.2.2</td>
<td>4</td>
<td>8 of 2 DY 2 milestones complete. 8 of 4 DY 3 milestones complete. Provider requested carryforward of all two DY 2 Milestones which were not yet complete as of mid-point DY 3 (establish steering committee and develop a family strategic plan). However, it appears that the provider's other metrics can progress while the DY 2 metrics are in progress. Provider reported progress on QPI metric I-101.1 at DY 3 mid-point of 765 calls out of a goal of 6,282 calls.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Baylor Medical Center at Irving 121778204.1.1</td>
<td>3</td>
<td>8 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete. The project's target population is indigent, non-Baylor patients who need primary care services. The provider is in the process of developing a system to track the non-Baylor patients for this process. Provider noted that once a new patient is in the current system, it is difficult to track a patient specifically for the project. Provider noted in its progress update that increasing clinic volume has been challenging because of staff and physician turnover at this location. The provider discussed how it intends to add to its number of encounters over DY 4 and DY 5 and stated that the other DSRIP projects, such as patient navigation and transition care, will feed patients into the primary care system.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Baylor Medical Center at Irving 121778204.1.2</td>
<td>4</td>
<td>8 of 2 DY 2 milestones complete. 8 of 3 DY 3 milestones complete. Challenges noted by the provider include late approval, availability of needed specialists willing to accept indigent patients, and issues collecting data from out-of-network specialists. It is also noted in the DY 3 sign-off summary that one of their challenges is recruiting specialists to take on DSRIP patients, volunteer physicians are only willing to take 1-2 patients making it difficult to determine which patients have priority. If the provider is unable to contract with these specialists, this poses a risk in meeting CAT3 outcomes which require GYN and pulmonology specialists for cervical cancer and asthma screenings.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Baylor Medical Center at Irving 121778204.2.2</td>
<td>2</td>
<td>8 of 3 DY 2 milestones complete. 8 of 4 DY 3 milestones complete. Provider states it has completed the hiring of all behavioral health staff for the Baylor Clinic; however, training still needs to be completed. The project's QPI (I-101.1) is dependent upon the number of patients seeking primary care who are also in need of behavioral health services.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Baylor Medical Center at Irving 121778204.2.3</td>
<td>2</td>
<td>8 of 3 DY 2 milestones complete. 8 of 2 DY 3 milestones complete. Provider reported serving 455 individuals out of a goal of 720 individuals for metric I-10.3. This project presents slight risk as the provider must rely on patients to present to the Emergency Department in order to meet its QPI.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
</tbody>
</table>
Recommendations to HHSC

Provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to Provider

Provider recommends changing the metric to report a percentage for I-17.1 as required. HHSC's assessment is that the provider is reporting in line with the menu and did not contact the provider on this recommendation.

HHSC Response to Recommendations for the Project

NA

No recommendations at this time.

MSLC did not have any recommendations.

Provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to HHSC

Provider recommends changing the metric to report a percentage for I-17.1 as required. The only percentage reported is the increase over baseline and there is no indication that the provider will be reporting percentage using the calculation on the menu. The provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to Provider

Provider recommends changing the metric to report a percentage for I-17.1 as required. HHSC's assessment is that the provider is reporting in line with the menu and did not contact the provider on this recommendation.

HHSC Response to Recommendations for the Project

NA

No recommendations at this time.

MSLC did not have any recommendations.

Provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to HHSC

Provider recommends changing the metric to report a percentage for I-17.1 as required. The only percentage reported is the increase over baseline and there is no indication that the provider will be reporting percentage using the calculation on the menu. The provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to Provider

Provider recommends changing the metric to report a percentage for I-17.1 as required. HHSC's assessment is that the provider is reporting in line with the menu and did not contact the provider on this recommendation.

HHSC Response to Recommendations for the Project

NA

No recommendations at this time.

MSLC did not have any recommendations.

Provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to HHSC

Provider recommends changing the metric to report a percentage for I-17.1 as required. The only percentage reported is the increase over baseline and there is no indication that the provider will be reporting percentage using the calculation on the menu. The provider states they have had challenges developing the overall program due to software and IT infrastructure issues as well as electronic health record connectivity issues. They were not able to hire a manager for the program until December 2013. The provider engaged pharmacy residents to help develop the program and serve patients. This delay poses a risk in meeting the DY 3 goals (to serve 350 individuals) which are tied to their DY 4-5 DSRIP goals. There is also risk in meeting DY 4-5 Metric I-9.1 due the percentage increase each year in the number of patients consistently receiving medication management counseling at the point of care/patient population. Patients who drop out of the program could pose a risk to meet the QPI numbers.

Recommendations to Provider

Provider recommends changing the metric to report a percentage for I-17.1 as required. HHSC's assessment is that the provider is reporting in line with the menu and did not contact the provider on this recommendation.

HHSC Response to Recommendations for the Project

NA

No recommendations at this time.

MSLC did not have any recommendations.
Recommendations to Provider

[2] Technical Change: Provider should change the language of Metric I-101.1 in DY 4 to match the language for DY 5. DY 4 currently states that the number of individuals will be measured, while DY 5 states the percentage of individuals will be measured.

Recommendations to MSLC

- MSLC recommended the provider delete its goal of 100 percent technical change for metric I-11.1 in DY 4 that describes "number of individuals" while the goal is measured in terms of the number of individuals served.
- MSLC did not have any recommendations.
- MSLC recommended the language of Metric I-5.1 in DY4 be changed to match the number of individuals positively impacted by improvements. The provider's narrative states that the patient benefit is to provide health care delivery re-engineering and data reporting capabilities and to improve quality of care by decreasing hospitalizations, readmissions, and complications. However, it is not clear how this project will have a direct benefit to patients.
- MSLC did not have any recommendations.
- MSLC recommended the provider should specify either in the narrative or on the Phase 4 Master Summary how patient impact will be measured for Metric I-101.1. The current language states "number of individuals positively impacted by the improvements." This is a very general measure.
- MSLC recommended the provider should specify either in the narrative or on the Phase 4 Master Summary how patient impact will be measured for Metric I-101.1. The current language states "number of individuals positively impacted by the improvements." This is a very general measure.
- MSLC recommended the provider should specify either in the narrative or on the Phase 4 Master Summary how patient impact will be measured for Metric I-101.1. The current language states "number of individuals positively impacted by the improvements." This is a very general measure.
- MSLC did not have any recommendations.
<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Delete the calculation in the goal description for Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Recommendations to Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>MSLC did not have any recommendations.</strong></td>
<td></td>
<td></td>
<td></td>
<td>No recommendations at this time.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Technical Change:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Metric I-12.1. The provider is measuring the percent change and not a percentage using the numerator and denominator as specified in the Category 1 Menu.</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
</tbody>
</table>

*APPENDIX 2 - RHP 9*

**Note:** The percent increase measure is not a specific goal that can be calculated previously. The specific unit of measurement is included.

Currently, the provider only indicates a percent increase. However, no previous calculation with which to compare this percent increase is included. The percent increase measure is not a specific goal that can be calculated using the specified numerator and denominator.
### Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>127295703.1.1</td>
<td>2</td>
<td>The implementation of the project has been delayed due to the time it took to hire a vendor and sign contracts. There were issues with the measurement of several DY 4 and DY 5 milestones as they relate to the Category 2 menu (see recommendations). There is also an issue with metric I-16.1 in DY 4 and DY 5, as it does not seem to be related to this project. Provider has included several improvement milestones in DY 4 and DY 5 (so total in each DY). This could pose a risk for the provider in terms of ability to measure every milestone while still focusing on the patient impact of the project.</td>
<td>HHSC should revise the calculation on the Category 2 menu for I-8.1. Currently, the metric states &quot;X percent increase&quot; yet a percent calculation is included. These are two different measures. Metric I-9.1 description requires provider to &quot;increase the number of patients&quot; yet also includes a percentage calculation. If the calculation is required, then the metric language needs to change to state &quot;increase the percentage of patients.&quot; Revise the language for metric I-8.1.</td>
<td>No recommendations at this time.</td>
<td>MSLC recommended the provider should specify the percent increase goal as required by the metric since the current percentage calculation actually shows a decrease between DY 3 and DY 4. HHSC agreed with this and suggested the provider replace their QPI metric I-16.1 with a customizable metric in DY 5. The provider requested that the metric be changed for both DY 4 and DY 5, so HHSC updated the reporting system with these changes. MSLC recommended the provider include either a number or percentage be included in Metrics I-8.1, I-11.1, and I-18.1. HHSC did not think the provider needs to include this information and did not contact the provider on these recommendations.</td>
</tr>
<tr>
<td>127295703.1.6</td>
<td>2</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>175287501.2.3</td>
<td>3</td>
<td>There are slight discrepancies between the provider's intended measurement of I-14.1 and the measurement as indicated on the Category 2 Menu. Provider has only included percent increase calculation for I-14.1 and not a percentage goal.</td>
<td>Metric I-18.1: Revise the language of the metric. The states &quot;increase the number of order entries,&quot; not &quot;increase the number of order entries per person.&quot; Provider is reporting three goals: a percent increase, number of patients, and a percent calculation from the menu.</td>
<td>No recommendations at this time.</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>126686802.2.5</td>
<td>4</td>
<td>No recommendations at this time.</td>
<td>Metric I-9.1: The metric is not asking for a percent increase over baseline. While the provider can include this measurement, the specific goal, either a number or percentage, needs to be included. Metric I-18.1: Revise the language of the metric. The states &quot;increase the number of order entries,&quot; not &quot;increase the number of order entries per person.&quot; Provider is reporting three goals: a percent increase, number of patients, and a percent calculation from the menu. Metric I-11.1: While the provider can include a percent increase calculation, the metric requires a percentage calculation using a specified numerator and denominator. The provider needs to include a percentage goal as well as a number from which a percentage can be calculated.</td>
<td>Technical Change: Provider needs to include a percentage goal for I-14.1. Currently, the provider only indicates a percent increase from the baseline. While this can be included, it is not a specific goal that can be calculated using the specified numerator and denominator.</td>
<td>MSLC recommended the provider include a percentage goal for I-14.1 (currently, the provider only indicates a percent increase from the baseline). HHSC determined this was an acceptable deviation from the menu and did not contact the provider with this recommendation.</td>
</tr>
<tr>
<td>127295703.2.3</td>
<td>4</td>
<td>No recommendations at this time.</td>
<td>Metric I-9.1: The metric is not asking for a percent increase over baseline. While the provider can include this measurement, the specific goal, either a number or percentage, needs to be included. Metric I-18.1: Revise the language of the metric. The states &quot;increase the number of order entries,&quot; not &quot;increase the number of order entries per person.&quot; Provider is reporting three goals: a percent increase, number of patients, and a percent calculation from the menu. Metric I-11.1: While the provider can include a percent increase calculation, the metric requires a percentage calculation using a specified numerator and denominator. The provider needs to include a percentage goal as well as a number from which a percentage can be calculated.</td>
<td>Technical Change: Provider needs to include a percentage goal for I-14.1. Currently, the provider only indicates a percent increase from the baseline. While this can be included, it is not a specific goal that can be calculated using the specified numerator and denominator.</td>
<td>MSLC recommended the provider include a percentage goal for I-14.1 (currently, the provider only indicates a percent increase from the baseline). HHSC determined this was an acceptable deviation from the menu and did not contact the provider with this recommendation.</td>
</tr>
<tr>
<td>127295703.2.6</td>
<td>4</td>
<td>No recommendations at this time.</td>
<td>Metric I-9.1: The metric is not asking for a percent increase over baseline. While the provider can include this measurement, the specific goal, either a number or percentage, needs to be included. Metric I-18.1: Revise the language of the metric. The states &quot;increase the number of order entries,&quot; not &quot;increase the number of order entries per person.&quot; Provider is reporting three goals: a percent increase, number of patients, and a percent calculation from the menu. Metric I-11.1: While the provider can include a percent increase calculation, the metric requires a percentage calculation using a specified numerator and denominator. The provider needs to include a percentage goal as well as a number from which a percentage can be calculated.</td>
<td>Technical Change: Provider needs to include a percentage goal for I-14.1. Currently, the provider only indicates a percent increase from the baseline. While this can be included, it is not a specific goal that can be calculated using the specified numerator and denominator.</td>
<td>MSLC recommended the provider include a percentage goal for I-14.1 (currently, the provider only indicates a percent increase from the baseline). HHSC determined this was an acceptable deviation from the menu and did not contact the provider with this recommendation.</td>
</tr>
<tr>
<td>127295703.1.6</td>
<td>2</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>127295703.1.1</td>
<td>2</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>

### APPENDIX 2 - RHP 9

*MYERS AND STAUFFER LC*
Recommendations to Provider

2 of 2 DY 2 milestones have been met.

MSLC recommended the provider consider revising its DY 5 goal for 2 of 2 DY 2 milestones complete.

NA

No recommendations at this time.

MSLC did not have any recommendations.

Technical Change:

3 of 3 DY 2 milestones complete.

MSLC recommended the provider should also report a percent increase figure between DY 4 and DY 5 as a way to show an increase for metric I-15.1 over DY 4 and DY 5.

NA

No recommendations at this time.

MSLC did not have any recommendations.

2 of 2 DY 3 milestones complete.

Provider reported partial completion of its DY 3 milestones complete.

Provider reported that its DY 3 milestones were not complete as of mid-point DY 3 but did note that all mid-level providers were hired (for metric P-101.1). As of mid-point, provider indicated that the clinic had been launched but that patient visits had not yet been recorded.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.

2 of 2 DY 3 milestones complete.

Provider reported completion of milestone P-6: Establish criteria for medical home assignment. However, in its progress update, provider noted that the criteria is not specific, only that a patient previously without a medical home is eligible to enroll.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.

0 of 3 DY 3 milestones complete.

Provider reported that its DY 3 milestones were not complete as of mid-point DY 3 but did note that all mid-level providers were hired (for metric P-101.1). As of mid-point, provider indicated that the clinic had been launched but that patient visits had not yet been recorded.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.

0 of 2 DY 3 milestones complete.

Provider reported completion of milestone P-6: Establish criteria for medical home assignment. However, in its progress update, provider noted that the criteria is not specific, only that a patient previously without a medical home is eligible to enroll.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.

2 of 2 DY 3 milestones complete.

Provider reported that its DY 3 milestones were not complete as of mid-point DY 3 but did note that all mid-level providers were hired (for metric P-101.1). As of mid-point, provider indicated that the clinic had been launched but that patient visits had not yet been recorded.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.

2 of 2 DY 3 milestones complete.

Provider reported completion of milestone P-6: Establish criteria for medical home assignment. However, in its progress update, provider noted that the criteria is not specific, only that a patient previously without a medical home is eligible to enroll.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.
### APPENDIX 2 - RHP 9

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>130032405.2.1</td>
<td>3</td>
<td>2 of 4 DY 2 milestones complete. 2 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>130032405.2.6</td>
<td>2</td>
<td>2 of 4 DY 2 milestones complete. 1 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>127295703.2.4</td>
<td>3</td>
<td>2 of 4 DY 2 milestones complete. 2 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>127295703.2.6</td>
<td>2</td>
<td>2 of 4 DY 2 milestones complete. 1 of 4 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>127295703.2.10</td>
<td>1</td>
<td>2 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Parkland Memorial Hospital</td>
<td>127295703.2.4</td>
<td>2</td>
<td>2 of 4 DY 2 milestones complete. 2 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Parkland Memorial Hospital</td>
<td>127295703.2.5</td>
<td>2</td>
<td>3 of 4 DY 2 milestones complete. 2 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Parkland Memorial Hospital</td>
<td>127295703.2.12</td>
<td>2</td>
<td>2 of 4 DY 2 milestones complete. 2 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Parkland Memorial Hospital</td>
<td>127295703.2.10</td>
<td>3</td>
<td>3 of 4 DY 2 milestones complete. 2 of 4 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Parkland Memorial Hospital</td>
<td>127295703.2.5</td>
<td>3</td>
<td>3 of 4 DY 2 milestones complete. 2 of 5 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Challenges**

- Challenges indicated by the provider include a limited labor market and limited cooperation from patients after discharge. The metric used by the provider to measure quantifiable patient impact is I-17.1: the number of patients receiving care under the chronic care management model. Inherent risks associated with this project option, as noted by the provider, include reaching patients after discharge and encouraging patients to complete the primary care appointment and other follow-up visits as required by the model.

**Technical Change**

- Provider should provide a description of milestones I-104 in DY 4 and DY 5 that differs from the language of the metric. Also, provider should define how it intends to measure impacted patients.

**Possible Plan Modification**

- Provider should consider separating the two measures in its I-13.1 metric in DY 4 and DY 5. The measure of efficiency in I-13.1 should be included in a separate milestone, such as I-14 because the provider found that the provider was only measuring the number of OPAT patients served and did not contact the provider on this recommendation.

- Technical Change: Provider should provide a description of milestones I-104 in DY 4 and DY 5 that differs from the language of the metric and define how it intends to measure impacted patients. HHSC requested this information from the provider and updated the reporting system accordingly.

- Provider’s goals for DY 3 include implementing a cost-accounting methodology, establishing a baseline for cost, and conducting a cost analysis. Once these are completed, the provider should be able to measure its DY 4 and DY 5 costs. Due to an earlier plan modification, the project option changed from 2.5.2 to 2.5.1; the project narrative and the Phase 4 Master Summary were not changed to reflect the change in the target population which ultimately affects the QPI calculation.

- Potential risks originally noted for this project included the provider’s ability to obtain the needed space to conduct the OPAT clinic. Provider discussed the program with Myers and Stauffer during the RHP 2 site visit and noted that the expanded clinic is open and serving patients. The provider noted that this project not only reallocates bed days to indigent patients with more complex conditions, but also should provide a cost savings to the facility. However, while the intervention is innovative, it does not directly correspond to the intent of the project option (applying a process improvement methodology).

- Provider reported difficulty with the primary care referral process. There is limited availability of physicians willing to accept indigent and/or Medicaid patients. In other cases, appointments with physicians willing to accept a patient are not available for up to four weeks. This could affect the provider’s ability to meet its I-14.3 goals in DY 4 and DY 5.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Dallas Medical Center</td>
<td>135032405.2.3</td>
<td>4</td>
<td>2 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider requested carryforward of all DY 2 milestones. The provider reported significant challenges with collecting data in order to be able to report on the metrics. There is a slight discrepancy between how the provider is reporting I-12.1 and the measurement as required by the Category 2 menu. The Category 2 menu specifies a percentage calculation (comparing the number of patients assigned to a medical home to the total number of patients eligible for assignment). Provider's goal only indicates a numeric goal of patients assigned to a medical home. Provider requested a plan modification to remove DY 4 and DY 5 metric I-13.1 and replace with metric I-15.1. This milestone will require the provider to inquire with the patient in order to gather data for this milestone. There is a risk that the information gathered may not be accurate if the provider does not already have a process in place to survey patients.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: To remain consistent with the Category 2 menu, provider should consider submitting the total number of individuals eligible for assignment when reporting on its numerical goal for I-12.1.</td>
<td>NA</td>
<td>MSLC recommended to remain consistent with the Category 2 menu. Provider should also consider submitting the total number of individuals eligible for assignment when reporting on its numerical goal for I-12.1. HHSC did not agree with this recommendation and did not contact the provider on this recommendation.</td>
</tr>
<tr>
<td>Denton County MHMR Center</td>
<td>135234606.2.1</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider did not submit any project updates during the DY 3 April reporting period. Provider did submit an update in July that indicates progress on Milestone #5 (30 cases out of a goal of 100) as of April 2014. The provider does not mention in its narrative that additional resources will be needed, such as staffing and coordination with EDs or law enforcement, but yet later describes these as challenges. One other area of concern is that the goal of this project is to reduce ED usage and reduce cost per patient in area hospitals; however, the provider is a Local Mental Health Authority and would not necessarily have real-time access to this information. Also, the project option selected by the provider does not fit the category selected. Project area 2.8 requires the implementation of a process improvement methodology. The interventions described by the provider align more with a Category 1 project or a Category 2 behavioral health intervention.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider deleting the second goal in DY 5 (14.1 measure (20% increase in productivity) and including it in a separate measure. Metric I-16.1 is an option.</td>
<td>NA</td>
<td>MSLC recommended the provider should consider deleting the second goal in DY 5 (14.1 measure (20% increase in productivity) and including it in a separate measure. HHSC found that the additional information was not needed to determine achievement and did not contact the provider on this recommendation.</td>
</tr>
<tr>
<td>Denton County MHMR Center</td>
<td>135234606.2.2</td>
<td>4</td>
<td>1 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider did not submit a progress update during the April DY 3 reporting period. Provider did report progress during the July 2014 NMI reporting period, but this information was as of July and could therefore not be used in our assessment of project progress.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Denton County MHMR Center</td>
<td>135234606.2.3</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider did not submit a progress update during the April DY 3 reporting period. Provider did report progress during the July 2014 NMI reporting period and noted that two of the three DY 3 milestones (I-101 and I-5) did not have progress because the project has not yet started serving patients. There is also some risk with how the provider intends to measure metric I-11.1 in DY 5 (decrease in criminal justice admissions and readmissions). Provider stated that it intends to review discharges at three, six, and nine months to see if its interventions impacted potentially preventable readmissions to the criminal justice system.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Denton County Health and Human Services</td>
<td>3.6350583.2.2</td>
<td>MSLC did not have any recommendations.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>HHSC will take this into consideration.</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Dallas County MHMR</td>
<td>3.7525807.1.2</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Dallas County MHMR</td>
<td>3.7525807.2.4</td>
<td>1 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Children’s Medical Center of Dallas</td>
<td>3.7651080.1.2</td>
<td>3 of 2 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
</tbody>
</table>

APPENDIX 2 - RHP 9

**Recommendations to HHSC**
- HHSC should consider strengthening the supporting document to show completion of metric P-101.1. HHSC should at least require copies of purchase orders, although packing slips and/or invoices from the supplier to the provider are preferable.

**Recommendations to Provider**
- Providers should consider separating the primary care visits and the nurse advice line encounters into different metrics. These are different measures and the Category 1 menu for I-12.1 only includes a measure for primary care visits and not Nurse Advice line encounters. Measuring nurse advice line encounters is similar to the calculation for I-14.1, although the provider is measuring patients with I-14.1. Since none of the nurse advice line metrics accurately reflect what the provider intends to measure, the provider could use I-15.2 (increase primary care capacity using innovative project option).

**Technical Change:** In its response to MSLC request for additional information, the provider reported that it intends to measure the number of patients who place calls to the nurse advice line for I-14.1. The DY 5 goal for this metric indicates “calls” and includes a calculation for the percentage of unique records created from calls received to the nurse advice line. Provider should change the language of its goal in DY 5 to patients.
### Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Medical Center of Dallas 138910807.1.1.4</td>
<td>2 of 3 DY 2 milestones complete.</td>
<td>0 of 3 DY 3 milestones complete. The purpose of this project is to bring behavioral health services into the primary care setting. However, the project option chosen by the provider is not the integrated care option, but instead an expansion of community-based behavioral health services. The metrics for this project option are limited and as a result, the DY 4 and DY 5 QPI metric chosen require the provider to revise the metric measurement and language. The metric as described on the Category 1 Menu requires the provider to measure the number of patients using mobile clinics compared to the number of patients using expanded behavioral health services. The provider is reporting both a numeric value of patients served and a percentage goal which the provider described as being calculated by the denominator being the patients who present with a behavioral health concern and patients who screen positive for a behavioral health issue and numerator being the eligible patients (subset of the denominator) who receive additional behavioral health services.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider replacing Metric I-11.1 with a customizable milestone using the same measurement since the calculation used by the provider does not correspond to the language of the metric on the Category 1 Menu.</td>
<td>NA</td>
</tr>
<tr>
<td>Children's Medical Center of Dallas 138910807.2.2</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>0 of 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center of Dallas 138910807.2.4</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>0 of 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baylor University Medical Center 139485012.1.1</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>0 of 3 DY 3 milestones complete.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baylor University Medical Center 139485012.1.2</td>
<td>3 of 3 DY 2 milestones complete.</td>
<td>The target population is indigent, non-Baylor patients who need primary care services. The provider described how it will measure the percentage for this milestone. Milestone I-12.1 includes all clinic visits while I-15.1 is measuring indigent patients as a way to show increase in access. The provider is in the process of developing a system to track the non-Baylor patients for this process. Once a new patient is in the current system, it is difficult to track them specifically for the project. The provider discussed how it intends to add to its number of encounters over DY 4 and DY 5 and stated that the other DSRIP projects, such as patient navigation and transition care, will feed patients into the primary care system.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
</tr>
</tbody>
</table>

**APPENDIX 2 - RHP 9**

**Recommendations to HHSC**

- Provider should consider replacing Metric I-11.1 with a customizable milestone using the same measurement since the calculation used by the provider does not correspond to the language of the metric on the Category 1 Menu. HHSC confirmed with the provider that they would be willing to replacing I-11.1 with a customizable metric (I-101.1) and updated the system accordingly.

**Recommendations to Provider**

- Provider indicated that they would be willing to replacing I-11.1 with a customizable milestone using the same measurement since the calculation used by the provider does not correspond to the language of the metric on the Category 1 Menu.

**HHSC Response to Recommendations for the Project**

- MSLC recommended the provider consider replacing Metric I-11.1 with a customizable milestone using the same measurement since the calculation used by the provider does not correspond to the language of the metric on the Category 1 Menu. HHSC confirmed with the provider that they would be willing to replacing I-11.1 with a customizable metric (I-101.1) and updated the system accordingly.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendations for HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendations for Provider</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor University Medical Center 139450612.2.1</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>The provider noted that this type of project presents many challenges, including physician referral of patients to the program, which could affect the provider’s progress on Metric I-2.1.2, and issues relating to the nature of the indigent population, which could affect metric I-21.4. Many patients are transient and may not stay in the program long enough for staff to gauge progress on goals.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Baylor University Medical Center 139450612.2.5</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>The provider noted challenges in tracking the QPI metric I-101.1. The provider’s project narrative states that patient impact will be measured by what practitioners learn during and apply after the quality improvement training. Provider’s QPI goals are high (20,000 individuals in both DY 4 and DY 5). There is risk that this may be a difficult metric to measure as written, as well as provide evidence that patients will be uniquely impacted. The project option requires a provider apply a process improvement methodology, This provider is simply expanding a training program in quality improvement.</td>
<td>When requesting supporting documentation for QPI, HHSC should require the provider show which specific quality improvement initiative was used for that specific patient.</td>
<td>Possible Plan Modification: To effectively show patient impact, the provider should consider reporting how each patient directly benefited from the courses taught to the practitioners.</td>
<td>HHSC will take this into consideration.</td>
<td>MSLC recommended that to effectively show patient impact, the provider should show how each patient directly benefited from the courses taught to the practitioners. HHSC will continue working with the provider and providing technical assistance to help the provider report measurement of this metric.</td>
</tr>
<tr>
<td>27 Southwestern Medical Center -- Faculty Practice Plan 126686802.2.2</td>
<td>4</td>
<td>2 of 4 DY 2 milestones complete. 0 of 5 DY 3 milestones complete.</td>
<td>Provider noted challenges in tracking the QPI metric I-101.1. The provider’s project narrative states that patient impact will be measured by what practitioners learn during and apply after the quality improvement training. Provider’s QPI goals are high (20,000 individuals in both DY 4 and DY 5). There is risk that this may be a difficult metric to measure as written, as well as provide evidence that patients will be uniquely impacted. The project option requires a provider apply a process improvement methodology, This provider is simply expanding a training program in quality improvement.</td>
<td>When requesting supporting documentation for QPI, HHSC should require the provider show which specific quality improvement initiative was used for that specific patient.</td>
<td>Possible Plan Modification: To effectively show patient impact, the provider should consider reporting how each patient directly benefited from the courses taught to the practitioners.</td>
<td>HHSC will take this into consideration.</td>
<td>MSLC recommended that to effectively show patient impact, the provider should show how each patient directly benefited from the courses taught to the practitioners. HHSC will continue working with the provider and providing technical assistance to help the provider report measurement of this metric.</td>
</tr>
<tr>
<td>27 Southwestern Medical Center -- Faculty Practice Plan 126686802.2.4</td>
<td>3</td>
<td>2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>Provider requested carryforward of two of the three DY 2 milestones and reported completion of one these milestones as of mid-point DY 3. Provider reported partial completion of its DY 3 milestones but has not reported specific progress on its impact milestones. Provider noted that patients still need to be identified for the program. The provider is not measuring I-7.1 in accordance with the Cat 2 Menu. The intent of the metric is to measure the actual ED/hospitalizations of patients in the program and then show a reduction over the DYs. The provider is instead measuring an increase in ED/hospitalizations avoided but not measuring the reduction in utilization of the ED/Inpatient hospital system.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: The provider is not measuring I-7.1 in accordance with the Cat 2 Menu. The intent is to measure the actual ED/hospitalizations of patients in the program and then show a reduction over the DYs. The provider is measuring an increase in ED/hospitalizations avoided but not measuring the reduction in utilization of the ED/Inpatient hospital system. Metric measurement description should be revised to better reflect how the provider is measuring the metric.</td>
<td>Technical Change: Provider should delete the percent increase calculation for I-6.1, I-6.2, and I-6.5 in DY 4 and DY 5. The metric requires the provider measure the number of new patients receiving the specified service compared to the total number of patients eligible or in the program. These metric goals cannot be larger than 100 percent as the numerator is a subset of the denominator. When reporting on this metric, provider will need to show a percentage based on the calculation as indicated by the menu.</td>
<td>MSLC recommended the metric measurement description for I-7.1 should be revised to better reflect how the provider is measuring the metric. HHSC worked with the provider and MSLC to ensure the language was acceptable and updated the reporting system accordingly. MSLC recommended the provider delete the percent increase calculation for I-6.1, I-6.2, and I-6.5 in DY 4 and DY 5. HHSC confirmed with the provider that they were in agreement with the deletions and updated the reporting system by deleting the percent increase calculation for I-6.1, I-6.2 and I-6.5 in DY 4 and DY 5.</td>
</tr>
<tr>
<td>27 Southwestern Medical Center - St. Paul University Hospital 175287501.2.1</td>
<td>2</td>
<td>0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete.</td>
<td>Provider’s DY 3 milestone is comprised of three metrics. Provider reports progress on the outstanding milestone and expects full completion by end of DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for the Project</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Trinity Medical Center 195018001.2.1</td>
<td>4</td>
<td>2 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The provider noted that this type of project presents many challenges, including physician referral of patients to the program, which could affect the provider's progress on Metric I-21.3. and issues relating to the nature of the indigent population, which could affect metric I-21.4. Many patients are transient and may not stay in the program long enough for staff to gauge progress on goals.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Methodist Richardson Medical Center 203045201.2.1</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported difficulty with the primary care referral process. There is limited availability of physicians willing to accept indigent and/or Medicaid patients. In other cases, appointments with physicians willing to accept a patient are not available for up to four weeks. This could affect the provider's ability to meet its I-6.3 goals in DY 4 and DY 5. Provider also reported challenges coordinating navigation services with Emergency Department staff.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Methodist Richardson Medical Center 203045201.2.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. There was slight risk that the project was too limited in scope (Diabetic ED users) and that QPI goals may not be met. Provider submitted additional information to M&amp;S and noted that the target population has increased by expanding the scope of the patient navigator to include inpatients that have entered the hospitals through the ED. The provider has defined the target population as diabetic patients with at least one ED visit in the last 12 months that have received intervention from the CCM-based Chronic Care program. An intervention is defined as a patient navigator contact in person, by phone or by mail.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for Provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Center of Arlington 320950401.2</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. Provider had not completed any milestones as of the DY 3 April sign off. Provider has cited a delay in approval of the project as the reason. Provider reported completing 570 out of a goal of 8,962 calls for metric I-101.1 in DY 3. There is a risk that the provider will not be able to complete the volume of calls needed to complete the metrics in DY 4 and DY 5.</td>
<td>Consideration should be given to the potential impact on project valuation if plan modification to decrease QPI is submitted and approved and new QPI puts project valuation outside the range. Potential Plan Modification: Provider should consider a reduction in QPI for I-101.1 for DY 4 and DY 5 due to significant delays in DY 3. Possible Plan Modification: Provider requested to update I-12.2 to I-12.1 to match the stated goals with the goals in the Cat 1 menu.</td>
<td>HHSC did not have any recommendations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Center of Arlington 320950401.2.2</td>
<td>2</td>
<td>2 of 4 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider has administered the sepsis treatment bundle for 13 patients out of a goal of 129 for DY 3 metric I-13.1. Provider has hired a full time sepsis coordinator to manage the project as a way to improve progress. A plan modification was submitted to delete one metric for Milestone I-13 (Sepsis Bundle Completion) in DY 4 and DY 5 due to overlap with Category 3 outcomes. As a replacement for this metric, provider requested the addition of three metrics to measure the following: target population reached, ICU length of stay, and improvement in treatment rates for patients with sepsis. Provider replaced their QPI Milestone (I-13) to customizable option I-101, target population reached.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Center of Arlington 320950401.2.3</td>
<td>2</td>
<td>2 of 4 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider reported serving 225 out of the 250 patients needed for milestone I-11.1 in DY 3.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cook Children’s Medical Center 321184901.1</td>
<td>4</td>
<td>2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider had not completed construction of the new clinic as of the April DY 3 sign off. DY 3 milestone I-12.2 is dependent upon the opening of the clinic. Provider has delayed the hiring of new staff, DY 2 milestone P-5.1, until clinic construction is closer to completion. Provider has completed 0 of the needed 8,000 visits needed for milestone I-12.2. Provider has selected a goal of visits for metric I-12.2, which is the goal of metric I-12.1 in the Cat 1 menu. Metric I-12.2 goal in the Cat 1 menu is patients and not visits.</td>
<td>Consideration should be given to the potential impact on project valuation if plan modification to decrease QPI is submitted and approved and new QPI puts project valuation outside the range. Technical Change: Change milestone to I-12.1 to match the stated goals with the goals in the Cat 1 menu. Possible Plan Modification: Provider should consider a reduction in QPI for I-12.2 to a more achievable range due to the significant delays in construction of the clinic.</td>
<td>HHSC recommended to update I-12.2 to I-12.1 and decrease QPI goals. HHSC updated DY4.5-12.2 to I-12.1 to align with the intended QPI grouping of visits and informed the provider. The provider opened their clinic in September and appears to be able to meet the DY3 QPI goal by February 2015 according to the carryforward responses during October reporting. Based on the current amount of encounters, the provider would also be able to meet the DY4 QPI goal by September 2015. HHSC did not follow up with the provider to decrease QPI goals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cook Children’s Medical Center 321184901.1.2</td>
<td>4</td>
<td>1 of 1 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider's goal for metric P-1.1 on the Phase 4 Summary about adding additional clinics was not clear. Provider's Narrative and sign off summary state only one new clinic would be opened. Provider has selected a goal of visits for metric I-12.2, which is the goal of metric I-12.1 in the Cat 1 menu. Metric I-12.2 goal in the Cat 1 menu is patients.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

APPENDIX 2 - RHP 10

HHSC Response to Recommendations for the Project

MSLC recommended that QPI goals be decreased due to project delays. Provider exceeded DY3 QPI goal as reported in October. HHSC did not follow up with the provider to decrease QPI goals based on DY3 achievement.
Provider Project ID

North Hills Hospital 021184901.1.3

Recommendations to HHSC

2 of 2 DY 2 milestones complete.

No recommendations at this time.

Possible Plan Modification: Provider should consider updating milestones to reflect project's intent of opening only one new clinic.

Technical Change: Change metric I-14.1 to a customizable milestone so provider can report visits as goal.

HHSC Response to Recommendation for HHSC

NA

MSLC recommended to update DY3 P-4.1 to reflect addition of one clinic and update I-14.1 to a customizable milestone. HHSC approved the reporting of DY3 P-4.1 and will remove DY3 P-4.1 even though the provider had not started identifying pertussis cases for the DY3 project. The Health Information Exchange was not operational as of the DY3 April Sign off and construction have been cited for the reason.

Recommendations to HHSC

NA

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.
APPENDIX 2 - RHP 10

Provider Project ID | Overall Risk Ranking | Narrative Describing Mid-Point Assessment Score Justification | Recommendations to HHSC | Recommendations to Provider | HHSC Response to Recommendation for HHSC | HHSC Response to Recommendations for the Project
--- | --- | --- | --- | --- | --- | ---

Plaza Medical Center of Fort Worth 03419302.2.1

2 of 2 DY 2 milestones complete.  
Use of 4 DY 3 milestones complete.  
Provider reported completing 1,819 of the 3,855 phone calls needed to complete DY 3 metric I-101.1.  
Provider has stated difficulties in coordinating schedules as well as having enough staff to complete the required number of phone calls.

No recommendations at this time.  
No recommendations at this time.  
NA  
MSLC did not have any recommendations.

Plaza Medical Center of Fort Worth 03419302.2.2

2 of 4 DY 2 milestones complete.  
Use of 3 DY 3 milestones complete.  
Provider has administered the sepsis treatment bundle for 13 out of the 95 patients needed to complete DY 3 metric I-13.1.  
Provider has stated they have hired a full-time sepsis coordinator to assist in increasing treatment rates.

No recommendations at this time.  
No recommendations at this time.  
NA  
MSLC did not have any recommendations.

Huguley Memorial Medical Center 105674702.2.1

2 of 6 DY 2 milestones complete.  
Use of 4 DY 3 milestones complete.  
The goal of provider I-15.1 metric DV 3, DY 4, and DY 5 is not specified in the phase four summary, narrative, or sign-off summaries.  
The phase four summary only states the goal is a 2% improvement over baseline for each of the years.

No recommendations at this time.  
No recommendations at this time.  
Technical Change: Provider should update the described goal of milestone I-13.1 to specify what criteria they are using to determine a patient has met the target goal.  
NA  
MSLC recommended that I-13.1 goals be clarified to specify a patient had met the goal.  
HHSC updated the baseline/goal to specify CHF patients received hospital care, discharge education and post discharge follow-up and informed the provider.

Huguley Memorial Medical Center 105674702.2.2

2 of 5 of DY 2 milestones complete.  
Use of 4 of DY 3 milestones complete.  
Project appears to be on target to meet intended goals.

No recommendations at this time.  
No recommendations at this time.  
NA  
MSLC did not have any recommendations.

Texas Heart Institute Methodist Hospital Fort Worth 113673902.2.1

2 of 2 DY 2 milestones complete.  
Use of 3 DY 3 milestones complete.  
The overall target population needed to determine the percentage goal for metric I-16.1 needs to be clearly defined.  
The narrative states the target population could come from patients presenting in the ED, inpatient population, and patients identified in community outreach.  
The total overall patient population needs to be determined to fulfill this milestone.

Provider's QPI metric I-21.2 has a goal to "serve" patients.  
The intervention that constitutes "serving" a patient is not clearly defined.

No recommendations at this time.  
Possible Plan Modification: Provider should consider clearly defining the target population for which the percentage goal for milestone I-16.1 will be measured.  
Possible Plan Modification: Provider should consider identifying what interventions will be needed in order for a patient to be served by the diabetes CARE team for milestone I-21.2.  
NA  
MSLC recommended to update I-16.1 to specify the target population and update I-21.2 to specify the intervention.  
HHSC updated I-16.1 to specify the target population as diabetes patients and informed the provider.  
HHSC assumes the intervention for I-21.2 is as stated in the narrative of serving patients to a medical home and diabetes management resources for ongoing coaching and education rather than requiring reference to the intervention in the metric.  
HHSC did not follow up with the provider regarding I-21.2.

Texas Heart Institute Methodist Hospital Fort Worth 113673902.2.2  
Use of 3 DY 2 milestones complete.  
Provider reported screening 14 out of the needed 40 CHF patients needed for DY 3 metric P-11.1.

No recommendations at this time.  
No recommendations at this time.  
NA  
MSLC did not have any recommendations.

Texas Heart Institute Methodist Hospital Fort Worth 113673902.2.4

1 of 5 DY 2 milestones complete.  
Use of 3 DY 3 milestones complete.  
The only risk with the project is ensuring that the minimum number of sepsis patients required to fulfill metric I-13.1 in DY 4 and DY 5 present to the Emergency Department.

No recommendations at this time.  
No recommendations at this time.  
NA  
MSLC did not have any recommendations.

Texas Heart Institute Methodist Hospital Fort Worth 113673902.2.5

3 of 4 DY 2 milestones complete.  
Use of 3 DY 3 milestones complete.  
This project is expanding the operation of a mobile clinic that was in use prior to the waiver program.  
It was unclear if patients counted in the QPI metric I-5.1 are in addition to the pre DSRIP baseline.

Provider had mechanical problems with one of the mobile units, resulting in the provider being behind schedule for completion of DY 3 metric I-5.1.  
Provider reported seeing 417 out of the needed 4,763 patients for DY 3.  
Consideration should be given to the potential impact on project valuation if data modified to decrease QPI is submitted and approved and new QPI puts project valuation outside the range.

Potential Plan Modification: Provider should consider a reduction in QPI for milestone I-5.1, due to delays in DY 3 since mobile clinic had mechanical problems.  
Technical Change: Update goals of milestone I-5.1 to reflect additional patients seen over pre DSRIP baseline.  
NA  
MSLC recommended a decrease in QPI goals and to update I-5.1 goals to specify baseline.  
Through the separate Plan Mod process, HHSC approved provider's requests to decrease QPI that was within allowable range and include baseline.  
HHSC did not follow up with the provider since the QPI goals had already been updated.
Recommendations to Provider

Provider: Texas Health Harris Methodist Hospital
Southwest Fort Worth 12072004.2.1

No recommendations at this time.

Provider: Texas Health Harris Methodist Hospital
Southwest Fort Worth 12072004.2.2

No recommendations at this time.

Provider: Texas Health Harris Methodist Hospital
Southwest Fort Worth 12072004.2.3

No recommendations at this time.

Provider: Texas Health Harris Methodist Hospital
Southwest Fort Worth 12072004.2.4

No recommendations at this time.

Provider: Lakes Regional MHMR Center 121988304.1.1

No recommendations at this time.

Provider: Lakes Regional MHMR Center 121988304.1.3

No recommendations at this time.

Provider: JPS Health Network 126675104.2.1

No recommendations at this time.

Provider: JPS Health Network 126675104.2.2

No recommendations at this time.
Recommendations to Provider

MSLC did not have any recommendations.

Recommendations to HHSC

There is no direct patient impact with this project. The project activities described in the narrative and sign off summaries consist of managing the provider’s other DSRIP projects.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

Technical Change: Update QPI summary table to reflect accurate QPI goals for metric I-401.1.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

MSLC did not have any recommendations.

MSLC did not have any recommendations.

MSLC did not have any recommendations.

MSLC did not have any recommendations.

MSLC recommended to update the QPI summary to reflect the correct QPI goals for DY4 12,200 and DY5 18,000. HHSC updated the QPI summary to reflect that goal. Recommendation is addressed. HHSC did not follow up with the provider.

Possible Plan Modification:

HHSC recommended to update the QPI goals for metric I-401.1 to reflect the correct goals for DY4 12,200 and DY5 18,000. HHSC updated the QPI summary to reflect that goal. Recommendation is addressed. HHSC did not follow up with the provider.

HHSC Response to Recommendation for

Technical Change: Update QPI summary table to reflect accurate QPI goals for metric I-401.1.

Possible Plan Modification: Provider should consider updating QPI goals for metric I-401.1 to reflect the correct goals for DY4 and DY5.

HHSC did not follow up with the provider.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.

No recommendations at this time.
## APPENDIX 2 - RHP 10

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>130265006.2.1</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>Provider has reported treating 35 of the needed 70 patients for DY 3 metric I-103.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>130265006.2.2</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>Provider reported enrolling 26 of the needed 25 patients into the chronic care model program for metric P-5.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>130274106.1.1</td>
<td>4 of 3 DY 2 milestones complete.</td>
<td>Provider has cited difficulty in obtaining cooperation from other providers. Provider had not started seeing patients for DY 3 metric I-23.1.</td>
<td>Possible Plan Modification: Provider should consider reduction in QPI for metric I-23.1 to a more achievable range due to significant project delays.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC recommended that the provider decrease QPI due to project delays. HHSC worked with the provider through the separate QPI cleanup process to correct their QPI goals. Provider has misunderstood pre-DSRIP baseline and QPI goals were adjusted accordingly.</td>
</tr>
<tr>
<td>130265006.2.1</td>
<td>3 of 3 DY 2 milestones complete.</td>
<td>Provider had not started making referrals for DY 3 metric P-3.1 as of the DY 3 April reporting. Provider has stated they are working with directors of indigent clinics and have hired a project manager to help with the project.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>130265006.1.1</td>
<td>3 of 2 DY 2 milestones complete.</td>
<td>The target population is indigent, non-Baylor patients who need primary care services. The provider is in the process of developing a system to track non-Baylor patients for this process. Provider noted that once a new patient is in the current system, it is difficult to track a patient specifically for the project. The provider has discussed how it intends to add to its number of encounters over DY 4 and DY 5 and stated that the other DSRIP projects, such as patient navigation and transition care, will feed patients into the primary care system.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>130265006.1.2</td>
<td>3 of 2 DY 2 milestones complete.</td>
<td>The provider reported that it had not yet contracted with any specialists for metric I-22.1 out of a goal of three specialists. The provider is working to increase the number of providers in their network which will increase volume of encounters. The target population is the indigent patients who use Baylor’s community care clinics. Provider noted that it intends to increase the number specialty care visits by increasing its primary care volume through ED navigation programs and inpatient transition care projects. Challenges noted by the provider include late approval, availability of needed specialists willing to accept indigent patients, and issues collecting data from out-of-network specialists.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>130265006.2.4</td>
<td>1 of 2 DY 3 milestones complete.</td>
<td>Provider states it has completed the hiring of all behavioral health staff for the Baylor Clinic; however, training still needs to be completed. For DY 3, Metric I-101.1 the provider has seen 130 unduplicated patients out of a goal of 173 unduplicated patients. The project’s QPI measure (I-101.1) is dependent upon the number of patients seeking primary care who are also in need of behavioral health services.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>130265006.2.5</td>
<td>2 of 2 DY 3 milestones complete.</td>
<td>Provider has reported enrolling 695 patients out of the 1,000 patients needed to complete DY 3 metric I-103.3. There is slight risk with this project as the provider must rely on patients to present to the emergency department in order to meet the increasing QPI goal.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations to Provider</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center 1380/10867.1.2</td>
<td>2 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete.</td>
<td>The purpose of this project is to bring behavioral health services into the primary care setting. However, the project option chosen by the provider is not the integrated care option, but instead the expansion of community-based behavioral health services. The metrics for this project option are flexible and as a result, the DY 4 and DY 5 QPI metrics chosen require the provider to measure the number of patients using mobile clinics compared to the number of patients using expanded behavioral health services. The provider is reporting both a numeric value of patients served and a percentage goal which the provider described as being calculated by the denominator being the patients who present with a behavioral health concern and patients who screen positive for a behavioral health issue and numerator being the eligible patients (subset of the denominator) who receive additional behavioral health services.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center 1380/10867.1.3</td>
<td>3 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete.</td>
<td>The purpose of this project is to bring behavioral health services into the primary care setting. However, the project option chosen by the provider is not the integrated care option, but instead an expansion of community-based behavioral health services. The metrics for this project option are flexible and as a result, the DY 4 and DY 5 QPI metrics chosen require the provider to measure the number of patients using mobile clinics compared to the number of patients using expanded behavioral health services. The provider is reporting both a numeric value of patients served and a percentage goal which the provider described as being calculated by the denominator being the patients who present with a behavioral health concern and patients who screen positive for a behavioral health issue and numerator being the eligible patients (subset of the denominator) who receive additional behavioral health services.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center 1380/10867.2.1</td>
<td>2 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete.</td>
<td>Provider's QPI metric I-12.1 is not clear as to how the provider is determining which patients are eligible for medical home assignment. Metric I-13.1 is to contact patients between 60 and 120 days of being assigned to a medical home. Four months may be too long to wait to contact a patient.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Children's Medical Center 1380/10867.2.2</td>
<td>3 of 2 DY 2 milestones complete. 5 of 3 DY 3 milestones complete.</td>
<td>Provider has reported difficulties with the patient population remaining compliant with the program and difficulty in finding enough patients for the program. Both of these difficulties affect the provider's ability to meet QPI metric P-9.1 to increase referrals and metric I-17.1 to provide care to individuals using the chronic care model. Provider reported seeing eight out of the needed 40 patients for DY 3 metric I-17.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 353260608.2.1</td>
<td>2 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete.</td>
<td>Provider recommends adding a percentage goal to I-15.1 and No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 353260608.2.3</td>
<td>1 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete.</td>
<td>Provider intends to use the same individuals for metric I-11.1 to DY 4 and DY 5 but gives a cumulative goal of treating a total number of individuals. Provider reported making 154 out of the needed 258 referrals for metric P-3.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 353260608.2.4</td>
<td>2 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete.</td>
<td>Provider reported placing 223 out of 540 patients into the registry for DY 3 metric I-15.1. There is some ambiguity in the wording in the Cat 1 menu. Provider has chosen a number of patients as their goal for this milestone. Provider reported placing 223 out of 540 patients into the registry for DY 3 metric I-15.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Hurst-Euless-Bedford Methodist Hospital Texas Health Harris Methodist Hospital</td>
<td>353260608.2.3</td>
<td>Provider does not have any recommendations.</td>
<td>MSLC did not have any recommendations.</td>
<td>MSLC did not have any recommendations.</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
<tr>
<td>Hurst-Euless-Bedford Methodist Hospital Texas Health Harris Methodist Hospital</td>
<td>353260608.2.4</td>
<td>Provider does not have any recommendations.</td>
<td>MSLC did not have any recommendations.</td>
<td>MSLC did not have any recommendations.</td>
<td>MSLC did not have any recommendations.</td>
<td></td>
</tr>
</tbody>
</table>
## Recommendations to HHSC

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Project Risk</th>
<th>Overall Risk</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of North Texas Health Science Center 138980111.1.4</td>
<td>2</td>
<td>3</td>
<td>0 of 3 DY 2 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of North Texas Health Science Center 138980111.1.7</td>
<td>2</td>
<td>3</td>
<td>0 of 3 DY 2 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>University of North Texas Health Science Center 138980111.1.8</td>
<td>2</td>
<td>3</td>
<td>0 of 3 DY 3 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>JPS Physician Group 162334001.1.1</td>
<td>3</td>
<td>3</td>
<td>0 of 3 DY 2 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Kaufholtz Medical Center 162221013.1</td>
<td>3</td>
<td>3</td>
<td>0 of 3 DY 3 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Wise Clinical Care Associates 206106101.2.1</td>
<td>3</td>
<td>3</td>
<td>0 of 3 DY 3 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hall Medical Center 216719901.1.1</td>
<td>4</td>
<td>4</td>
<td>0 of 2 DY 2 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Hall Medical Center 216719901.2.1</td>
<td>5</td>
<td>5</td>
<td>0 of 3 DY 2 milestones complete. null</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
Recommendations to HHSC

Technical Change: Update Phase 4 Master Summary to reflect accurate percentage increase of 15% (not 10%) over baseline in metric I-11.1 in DY 5.  
MSLC recommended clarification and accuracy of data submitted to reflect metric I-11.1 in DY 5 and to state QPI measurement as being individuals, not encounters as it is currently stated.

Possible Plan Modification: The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

Possible Plan Modification: The provider requested a decrease in DY4 and DY5 QPI. HHSC let the provider request a decrease in DY3 as the provider is including the patients from a pre-existing clinic in their April DY3 progress update. White inclusion of the pre-DSRIP baseline is appropriate since this is an expansion project, HHSC did communicate the MSLC recommendation to the provider and suggested the provider include a statement on why patients from a pre-existing clinic are included in the reporting.

Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

Consideration should be given to the potential impact on project valuation if this plan modification is submitted and approved.

Consider strengthening supporting documentation requirements for proof of hire, i.e. the hiring of the counselor (Supporting Doc 5: Spack M Proof of Hire) for metric P-4.1 in DY 2.

HHSC should follow up with provider for a possible plan modification for QPI metrics P-3.2 as they do not match what was stated in the Master Summary.

Recommended Describing Mid-Point Assessment Score Justification

APPENDIX 2 - RHP 11

Provider: General Hospital of Fisher County 123456789.1.1

Recommendations to HHSC


due to the difficulties in hiring a physician. Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

Consideration should be given to the potential impact on project valuation if this plan modification is submitted and approved.

Consider strengthening supporting documentation requirements for proof of hire, i.e. the hiring of the counselor (Supporting Doc 5: Spack M Proof of Hire) for metric P-4.1 in DY 2.

HHSC should follow up with provider for a possible plan modification for QPI metrics P-3.2 as they do not match what was stated in the Master Summary.

Recommended Describing Mid-Point Assessment Score Justification

APPENDIX 2 - RHP 11

Provider: General Hospital of Fisher County 123456789.1.1

Recommendations to HHSC


due to the difficulties in hiring a physician. Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

Consideration should be given to the potential impact on project valuation if this plan modification is submitted and approved.

Consider strengthening supporting documentation requirements for proof of hire, i.e. the hiring of the counselor (Supporting Doc 5: Spack M Proof of Hire) for metric P-4.1 in DY 2.

HHSC should follow up with provider for a possible plan modification for QPI metrics P-3.2 as they do not match what was stated in the Master Summary.

Recommended Describing Mid-Point Assessment Score Justification

APPENDIX 2 - RHP 11

Provider: General Hospital of Fisher County 123456789.1.1

Recommendations to HHSC


due to the difficulties in hiring a physician. Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

Consideration should be given to the potential impact on project valuation if this plan modification is submitted and approved.

Consider strengthening supporting documentation requirements for proof of hire, i.e. the hiring of the counselor (Supporting Doc 5: Spack M Proof of Hire) for metric P-4.1 in DY 2.

HHSC should follow up with provider for a possible plan modification for QPI metrics P-3.2 as they do not match what was stated in the Master Summary.

Recommended Describing Mid-Point Assessment Score Justification

APPENDIX 2 - RHP 11

Provider: General Hospital of Fisher County 123456789.1.1

Recommendations to HHSC


due to the difficulties in hiring a physician. Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

Consideration should be given to the potential impact on project valuation if this plan modification is submitted and approved.

Consider strengthening supporting documentation requirements for proof of hire, i.e. the hiring of the counselor (Supporting Doc 5: Spack M Proof of Hire) for metric P-4.1 in DY 2.

HHSC should follow up with provider for a possible plan modification for QPI metrics P-3.2 as they do not match what was stated in the Master Summary.

Recommended Describing Mid-Point Assessment Score Justification

APPENDIX 2 - RHP 11

Provider: General Hospital of Fisher County 123456789.1.1

Recommendations to HHSC


due to the difficulties in hiring a physician. Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

The provider is expanding the clinic through a relocation of the pre-existing clinic to a larger space so inclusion of previous QPI is appropriate to demonstrate that additional patients are served.

Provider reported making progress on increasing the number of patients seen despite the new clinic not being open which may pose a possible risk if provider is trying to include patients not seen in the new clinic towards this metric.
No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.

No recommendations at this time. No recommendations at this time. NA

MSLC did not have any recommendations.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk</th>
<th>Narrative Describing Mid-Point Assessment Score</th>
<th>Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for Bid Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamlin Memorial</td>
<td>094131202.1.1</td>
<td>2</td>
<td>0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete.</td>
<td>Project appears to be on track and reports that the community need was greater than originally anticipated; thus, overachieving as of April DY 3 (688 out of 860 encounters). The project evaluation appears high and there is a risk to COQ noted due to the semi-annual meeting notes being very similar. Note: Provider was advised during site visit to strengthen submission of documentation (namely the semi-annual meeting notes). The provider was advised to ensure the notes were more independent from each other and to contain a roster of attendees.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the narrative to reflect the expected Medicaid/Uninsured population.</td>
<td>HHSC recommended the project narrative be updated to reflect the expected MU population and the Phase 4 Master Summary be updated to reflect the QPI from the QPI summary for Metric I-7.2. HHSC worked with the provider and updated the narrative to reflect the expected MU population. HHSC did not contact the provider regarding the recommendation to update the QPI as this was addressed through the plan modification process.</td>
</tr>
<tr>
<td>Hamlin Memorial</td>
<td>094131202.1.2</td>
<td>2</td>
<td>0 of 1 DY 2 milestone was n/a. 0 of 2 DY 3 milestones complete.</td>
<td>Project narrative does not state what impact they expect to have on the Medicaid/Uninsured population and the first page appears to be incomplete.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the QPI from the QPI summary for Metric I-7.2.</td>
<td>HHSC recommended the project narrative be updated to reflect the expected MU population and the Phase 4 Master Summary be updated to reflect the QPI from the QPI summary for Metric I-7.2. HHSC worked with the provider and updated the narrative to reflect the expected MU population. HHSC did not contact the provider regarding the recommendation to update the QPI as this was addressed through the plan modification process.</td>
</tr>
<tr>
<td>Hamlin Memorial</td>
<td>094131202.1.3</td>
<td>4</td>
<td>0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete.</td>
<td>Project has shown no significant progress as of April DY 3 due to having to appoint an interim CEO after the previous one left in DY 2. Project narrative is unclear as to the expected % of Medicaid/Uninsured patients this project intends to reach. Note: Plan modification been requested to significantly reduce DY 4 and DY 5 baselines and goals. Myers and Stauffer agrees with HHSC’s approval of this plan modification.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Medicaid/Uninsured percentage listed in the project narrative (QPI Summary says 14% Medicaid/24% uninsured).</td>
<td>HHSC recommended an update to the Medicaid/Uninsured percentage listed in the project narrative. HHSC did not require project to include RUL in the narrative because the QPI summary will contain the most current information. HHSC did not contact the provider with this recommendation.</td>
</tr>
<tr>
<td>Center for Life Resources</td>
<td>133395805.1.1</td>
<td>2</td>
<td>0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete.</td>
<td>This project appears to be crossing over with several other projects from this provider, including 133395805.1.2 in RHP 11. Provider used the same support to claim DY 2 metric achievement for 4 different projects.</td>
<td>Close review all the telemedicine projects for this provider to ensure that the provider is not getting paid multiple times for the same metric achievements.</td>
<td>Technical Change: Update project narrative as it states the provider intends to provide 20 telemedicine encounters in DY 3 but the QPI Summary states that the goal is to provide 10 telemedicine encounters. When submitting the same documentation to show achievement of metrics for multiple projects, the provider should submit an explanation of the relationships between the metrics/projects, justifying the same support documentation.</td>
<td>HHSC agreed that provider can explain that they’re implementing the same project but in different regions and why documentation is the same. HHSC is open to MSLC including similar projects performed by the same provider in multiple regions on the compliance monitoring list. HHSC recommended the project narrative be updated to reflect the expected MU population and the Phase 4 Master Summary be updated to reflect the QPI from the QPI summary for Metric I-7.2. HHSC worked with the provider and updated the narrative to reflect the expected MU population. HHSC did not contact the provider regarding the recommendation to update the QPI as this was addressed through the plan modification process.</td>
</tr>
<tr>
<td>Center for Life Resources</td>
<td>133395805.1.2</td>
<td>2</td>
<td>0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete.</td>
<td>This project appears to be crossing over with several other projects from this provider, including 133395805.1.1 in RHP 11. Provider used the same support to claim DY 2 metric achievement for 4 different projects.</td>
<td>Close review all the telemedicine projects for this provider to ensure that the provider is not getting paid multiple times for the same metric achievements.</td>
<td>Technical Change: Update project narrative as it states the provider intends to provide 20 telemedicine encounters in DY 3 but the QPI Summary states that the goal is to provide 10 telemedicine encounters. When submitting the same documentation to show achievement of metrics for multiple projects, the provider should submit an explanation of the relationships between the metrics/projects, justifying the same support documentation.</td>
<td>HHSC agreed that provider can explain that they’re implementing the same project but in different regions and why documentation is the same. HHSC is open to MSLC including similar projects performed by the same provider in multiple regions on the compliance monitoring list. HHSC recommended the project narrative be updated to reflect the expected MU population and the Phase 4 Master Summary be updated to reflect the QPI from the QPI summary for Metric I-7.2. HHSC worked with the provider and updated the narrative to reflect the expected MU population. HHSC did not contact the provider regarding the recommendation to update the QPI as this was addressed through the plan modification process.</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Rating</td>
<td>Narrative Describing Mid-Point Assessment Score</td>
<td>Justification</td>
<td>Recommendations to HRSC</td>
<td>HRSC Response to Recommendation for HRSC</td>
<td>HRSC Response to Recommendations for Bid Project</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>-------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Mitchell County Hospital 136325111.1.2</td>
<td>4</td>
<td>1 of 1 FY 2 milestones complete. 0 of 2 FY 3 milestones complete.</td>
<td>Provider reports completion of FY 3 metric P-5.1 by hiring 1 provider; however, the provider also stated that they were going to be losing a provider in Dec 2012. Metric goal for P-5.1 clearly states that the total for completion of the metric is 4 PCPs. There is a risk that the metric may not be achieved as the provider may not hire an additional provider in time to meet the metric (totalling 4 PCPs). The provider stated that they do plan on hiring an additional PCP; however, they are in the middle of a construction project which is about 8 months behind schedule. The provider also stated by the end of this waiver, they hope to have two PCPs hired.</td>
<td>Follow up with provider and clarify the goals in metric I-12.1 for FY 4 and FY 5. Clearly with provider the expectation in achieving metric P-5.1 in FY 3. The goal states the hiring of the additional providers will give them a total of 4 PCPs; however, the provider reported achievement of this metric in April FY 3 by hiring only 1 PCP and because 1 PCP was replaced, the total will only be 3 PCPs. Note: The provider has utilized a national recruiter to assist in hiring efforts. It is recommended that other providers facing recruiting challenges consider adopting this method.</td>
<td>Possible Plan Modification: Provider should consider clarifying FY 4 and DY 5 goals for metric I-12.1 because a 5% increase over 1600 encounters would be 1680 encounters and FY 4 and FY 5 goals are currently 1632 and 1665 encounters, respectively.</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
<tr>
<td>Hendrick Medical Center 136644310.1.2</td>
<td>3</td>
<td>1 of 1 FY 3 milestones complete. 0 of 2 FY 3 milestones complete.</td>
<td>Project is moderately off track due to problems hiring a psychiatrist for the region. Provider has the ability to catch up in FY 3 but baselines being established during that period will be affected. The 2 semi-annual meeting notes are very similar. Note: Provider was advised during the site visit for 136644310.2.3 to strengthen submission of documentation (namely the semi-annual meeting notes). The provider was advised to ensure the notes were more independent from each other and to contain a roster of attendees.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Include the Medicaid/Uninsured percentage in the project narrative (QPI Summary says 10% Medicaid/6% uninsured).</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
<tr>
<td>Mitchell County Hospital 136325111.2.1</td>
<td>4</td>
<td>0 of 1 FY 2 milestones complete. 0 of 3 FY 3 milestones complete.</td>
<td>Project has had no progress to date on any of their milestones or metrics. Provider reports, “This project was probably not the right fit for the facility at this time. We will be submitting a plan modification before the July deadline.” Note: Provider has submitted plan modifications, stating, “Narrative to reflect where a physical space was expected, but how we are modifying to do a mobile care team to meet the needs of our chronic patients” and to update their FY 3 Milestone P-3 to reflect an annual, not cumulative amount.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Medicaid/Uninsured percentage listed in the project narrative (QPI Summary says 10% Medicaid/6% Uninsured).</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2 - RHP 12

Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Technical Change:</th>
<th>HHSC Response to Recommendations for Provider</th>
<th>Recommendation to HHSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Tech University Health Sciences Center- Lubbock</td>
<td>2</td>
<td>3 of 3 DY 2 milestones complete.</td>
<td>1 of 2 DY 3 milestones complete.</td>
<td>The provider appears to be on track in meeting DY 3 metrics. QPI metric starts in DY 4.</td>
<td>QPI Summary states DY 3 does not have a QPI metric; however, the April DY 3 Sign Off Summary lists P-101.3 as a QPI metric.</td>
<td>QA</td>
</tr>
<tr>
<td>Children's Medical Center</td>
<td>2</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>1 of 2 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric I-13.1 reports 272 out of 200 encounters as of April DY 3. The provider indicated it was. There was no change to the MLIU goal.</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
<tr>
<td>University Medical Center</td>
<td>2</td>
<td>1 of 2 DY 2 milestones complete.</td>
<td>0 of 2 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric I-12.1 reports 322 out of 400 encounters as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
<tr>
<td>Medical Arts of Lubbock</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>0 of 2 DY 3 milestones complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 645 out of 352 encounters as of April DY 3, but did not report for metric achievement due to not knowing the necessary Medicaid/Uninsured percentage due to all patients being Medicare. The project narrative states expanding this will be reported in the future.</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
<tr>
<td>Lynn County Hospital District</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete.</td>
<td>0 of 1 DY 3 milestone complete.</td>
<td>Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 35 out of 35 patients enrolled as of April DY 3; however, HHSC requested more information to show metric achievement. The provider has submitted a plan modification to increase QPI goals.</td>
<td>No recommendations at this time.</td>
<td></td>
</tr>
</tbody>
</table>

P-101.3: Provider requested an increase of their QPI goal for metric P-101.3 because provider reports overachievement of April DY 3. The provider requested an increase of their QPI goal for metric P-101.3 because provider reports overachievement of April DY 3. Has the language in the workbook accurately reflected the intended QPI measurement as being by encounters, as stated in the QPI Summary and the Phase 4 Master Summary. HHSC can decrease project’s valuation. | QA | Update April DY 3 Sign Off Summary to reflect the intended QPI measurement of encounters. HHSC found that the language in the workbook accurately reflected the intended QPI measurement as being by encounters and did not contact the provider on this recommendation. |
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for this Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cogdell Memorial Hospital 363530107.1.3</td>
<td>1</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-7.2 reports 491 of 750 individuals as of April DY 3, DY 4 and DY 5 goals increase to 1,000 and 1,250, respectively. No significant risks were identified. This project is being assessed as a benchmark project because it is on pace in its accomplishment of metrics and milestones as planned. Additionally, the project appears to have selected appropriate menu milestone metrics that clearly accurately track how the project goal will be met.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Collingsworth General Hospital 36840107.2.3</td>
<td>3</td>
<td>0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. QPI metric P-10.1 reports 25 out of 27 patients surveyed as of April DY 3. DY 4 and DY 5 goals increase to 58 and 116, respectively. As of April DY 3, DY 2 metric P-1.1 has not been accepted by HHSC as being achieved. Provider submitted NR support but no information is available from HHSC to determine if the support was approved. The provider stated they would like guidance on addressing the similarities between metrics P-8.1 and P-10.1 in DY 4 as well as P-1.1 and P-10.1 in DY 5. The provider notified these questions were asked to Parmer County Community Hospital, Inc. - 137343308.2.3 and they would apply to them as well. The provider is currently not tracking the number of Medicaid and Uninsured patients as a percent of the total project population and stated they do not plan on doing so.</td>
<td>No recommendations at this time.</td>
<td>Plan Modification: Provider should consider removing metric I-101.1 in DY 5 from the Phase 4 Master Summary, as the provider intended for the addition of metric P-10.1 to replace it. Note: It is recommended the provider investigate ways to be able to track the percentage of Medicaid/Uninsured patients this project serves. Technical Change: Update the goal for metric P-8.1 in DY 4 and DY 5 to more clearly reflect the provider’s intention “to develop at least 1 new survey tool”.</td>
<td>NA</td>
<td>MSLC recommended the goal for metric P-8.1 in DY4 and DY5 be updated to more clearly reflect the provider’s intention “to develop at least 1 new survey tool”. HHSC worked with the provider and updated the reporting system to reflect the intended goal for P-8.1 in DY5 (this is not a DY4 metric). MSLC recommended the provider consider removing metric I-101.1 in DY5 from the Phase 4 Master Summary, as the provider intended for the addition of metric P-10.1 to replace it. HHSC worked with the provider and updated the reporting system by removing metric I-101 in DY5.</td>
</tr>
<tr>
<td>Parmer County Community Hospital, Inc. 51745308.2.3</td>
<td>2</td>
<td>1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric P-10.1 reports 24 out of 50 patients included in an inquiry as of April DY 3. Some lack of clarity with the metrics makes it difficult to tell if there may be some overlap between metric goals.</td>
<td>No recommendations at this time.</td>
<td>Plan Modification: Provider should consider removing metric I-101.1 in DY 5 from the Phase 4 Master Summary, as the provider intended for the addition of metric P-10.1 to replace it. Technical Change: Update the goal for metric P-8.1 in DY 4 and DY 5 to more clearly reflect the provider's intention to &quot;to develop at least 1 new survey tool&quot;.</td>
<td>NA</td>
<td>MSLC recommended the goal for metric P-8.1 in DY4 and DY5 be updated to more clearly reflect the provider's intention to &quot;to develop at least 1 new survey tool&quot;. HHSC worked with the provider and updated the reporting system to reflect the intended goal for P-8.1 in DY5. MSLC recommended metric I-101.1 in DY5 be removed from the Phase 4 Master Summary, as the provider intended for the addition of metric P-10.1 to replace it. HHSC worked with the provider and updated the reporting system by removing metric I-101 in DY5.</td>
</tr>
<tr>
<td>Covenant Medical Center 136641107.2.1</td>
<td>1</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

MYERS AND STAUFFER LC Page 215
## APPENDIX 2 - RHP 12

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for this Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golden Plains Community Health System</td>
<td>2</td>
<td>1 of 1 DY 2 milestones complete. 1 of 1 DY 3 milestones complete.</td>
<td>Consideration should be given to the potential impact on project valuation 1 plan modification is submitted and approved. Possible Plan Modification: Provider should consider adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY 3 (achieved 865 of the 3000 encounters).</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's validation.</td>
<td>MSLC recommended the provider consider an adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY 3. HHSC contacted the provider regarding this recommendation and they requested that the DY5 goal not be increased. HHSC let them know this was a MSLC recommendation and that HHSC would contact them in May with proposed goals for DY5.</td>
</tr>
<tr>
<td>MYERS AND STAUFFER LC</td>
<td>1</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC recommended the provider update the Phase 4 Master Summary as metric I-101.1 in DY 4 and Metric I-103.1 in DY 5 appear to be the same metrics; however, they are numbered differently.</td>
</tr>
<tr>
<td>Project ID</td>
<td>Rank</td>
<td>Overall Risk</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>MHS</td>
<td>216</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Phase 1

**The Phase I University Health Sciences Center**

| KeyCare Specialty Health System | 3 | 2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider stated that all staff were hired, trained and began delivering services as planned in DY 4. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 15% increase in DY 5. | No recommendations at this time. Possible Plan Modification: Provider should consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 15% increase in DY 5. | MSLC recommended the provider consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. HHSC worked with the provider and replaced I-12.1 with customizable milestones I-101.1 and I-103.1 and updated the reporting system accordingly. | MSLC recommended the provider update the Phase 4 Master Summary as metric I-101.1 in DY5 states the increase will be compared to DY4 in the metric description; however, the Baseline/Goal section says the increase will be compared to DY3. HHSC found the workbook accurately reflected the goal of increased visits and did not contact the provider on this recommendation. |

### Phase 2

**University Health Sciences Center**

| Phase 2 | University Health Sciences Center- Lubbock | 1 | 2 of 2 DY 2 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. No significant risks were identified. | No recommendations at this time. | No recommendations at this time. | MSLC recommended the provider the Phase 4 Master Summary to clarify the provider's intended QPI measurement is encounters. HHSC found the workbook accurately reflected the goal of increased visits and did not contact the provider on this recommendation. |

## APPENDIX 2 - RHP 12

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for this Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golden Plains Community Health System</td>
<td>2</td>
<td>1 of 1 DY 2 milestones complete. 1 of 1 DY 3 milestones complete.</td>
<td>Consideration should be given to the potential impact on project valuation 1 plan modification is submitted and approved. Possible Plan Modification: Provider should consider adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY 3 (achieved 865 of the 3000 encounters).</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's validation.</td>
<td>MSLC recommended the provider consider an adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY 3. HHSC contacted the provider regarding this recommendation and they requested that the DY5 goal not be increased. HHSC let them know this was a MSLC recommendation and that HHSC would contact them in May with proposed goals for DY5.</td>
</tr>
<tr>
<td>MYERS AND STAUFFER LC</td>
<td>1</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC recommended the provider update the Phase 4 Master Summary as metric I-101.1 in DY 4 and Metric I-103.1 in DY 5 appear to be the same metrics; however, they are numbered differently.</td>
</tr>
<tr>
<td>Project ID</td>
<td>Rank</td>
<td>Overall Risk</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>MHS</td>
<td>216</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Phase 1

**The Phase I University Health Sciences Center**

| KeyCare Specialty Health System | 3 | 2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider stated that all staff were hired, trained and began delivering services as planned in DY 4. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 15% increase in DY 5. | No recommendations at this time. Possible Plan Modification: Provider should consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 15% increase in DY 5. | MSLC recommended the provider consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. HHSC worked with the provider and replaced I-12.1 with customizable milestones I-101.1 and I-103.1 and updated the reporting system accordingly. | MSLC recommended the provider update the Phase 4 Master Summary as metric I-101.1 in DY5 states the increase will be compared to DY4 in the metric description; however, the Baseline/Goal section says the increase will be compared to DY3. HHSC found the workbook accurately reflected the goal of increased visits and did not contact the provider on this recommendation. |

## APPENDIX 2 - RHP 12

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for this Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golden Plains Community Health System</td>
<td>2</td>
<td>1 of 1 DY 2 milestones complete. 1 of 1 DY 3 milestones complete.</td>
<td>Consideration should be given to the potential impact on project valuation 1 plan modification is submitted and approved. Possible Plan Modification: Provider should consider adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY 3 (achieved 865 of the 3000 encounters).</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's validation.</td>
<td>MSLC recommended the provider consider an adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY 3. HHSC contacted the provider regarding this recommendation and they requested that the DY5 goal not be increased. HHSC let them know this was a MSLC recommendation and that HHSC would contact them in May with proposed goals for DY5.</td>
</tr>
<tr>
<td>MYERS AND STAUFFER LC</td>
<td>1</td>
<td>2 of 2 DY 2 milestones complete. 8 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>MSLC recommended the provider update the Phase 4 Master Summary as metric I-101.1 in DY 4 and Metric I-103.1 in DY 5 appear to be the same metrics; however, they are numbered differently.</td>
</tr>
<tr>
<td>Project ID</td>
<td>Rank</td>
<td>Overall Risk</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to Provider</td>
<td>HHSC Response to Recommendation for HHSC</td>
</tr>
<tr>
<td>MHS</td>
<td>216</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Phase 1

**The Phase I University Health Sciences Center**

<p>| KeyCare Specialty Health System | 3 | 2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider stated that all staff were hired, trained and began delivering services as planned in DY 4. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 15% increase in DY 5. | No recommendations at this time. Possible Plan Modification: Provider should consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 15% increase in DY 5. | MSLC recommended the provider consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. HHSC worked with the provider and replaced I-12.1 with customizable milestones I-101.1 and I-103.1 and updated the reporting system accordingly. | MSLC recommended the provider update the Phase 4 Master Summary as metric I-101.1 in DY5 states the increase will be compared to DY4 in the metric description; however, the Baseline/Goal section says the increase will be compared to DY3. HHSC found the workbook accurately reflected the goal of increased visits and did not contact the provider on this recommendation. |</p>
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to: Recommendations for All Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete.</td>
<td>3</td>
<td>The provider appears to be on track to meet their DY 3 metric; however, the provider reports not having trained or hired any of the 3 staff required to meet DY 3 metric P-4.1. This could cause the project to fall behind if they do not complete this by the end of DY 3. However, the provider has until October DY 3 to hire and train 3 staff. QPI metric starts in DY 4. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 10% increase in DY 5. Project narrative lists the metrics used for this project but DY 3 metric P-9.1 is not listed. (Note: also variations found in DY 4 and DY 5 metrics listed). Narrative states, &quot;During DY 4 and DY 5, at least 60 adolescents per year will receive crisis respite services, with a 10% increase over baseline in utilization of this appropriate crisis alternative in DY 4 and 15% over baseline in DY 5.&quot; However, the goal for I-12.1 states 55 individuals in DY 4 and 95 individuals in DY 5. There is potential for overlap between the individuals served for this project and for 048670801.1.1. This project is intended to serve adolescents and 048670801.1.1 is intended to serve adults.</td>
<td>No recommendations at this time.</td>
<td>Possible Plan Modification: Provider should consider replacing metric I-12.1 with a customizable milestone allowing for the provider to express the intended numerical increase in QPI. Metric I-12.1 in DY 4 and DY 5 requires a percentage increase; however, this cannot be expressed with a Pre-DSRIP baseline of zero. This results in confusion when the metric description in the Phase 4 Master Summary states a 10% increase in DY 4 and a 10% increase in DY 5. Technical Change: Update the project narrative to reflect the milestones and metrics stated in the Phase 4 Master Summary. Also, update the narrative to reflect the goals for the metrics stated in the Phase 4 Master Summary. For example, the narrative states, &quot;During DY 4 and DY 5, at least 60 adolescents per year will receive crisis respite services, with a 10% increase over baseline in utilization of this appropriate crisis alternative in DY 4 and 15% over baseline in DY 5.&quot; However, the goal for I-12.1 states 55 individuals in DY 4 and 95 individuals in DY 5.</td>
<td>NA</td>
</tr>
<tr>
<td>4 0 of 2 DY 2 milestone complete. 0 of 1 DY 3 milestone complete.</td>
<td>1</td>
<td>Provider has not reported progress as of April DY3. Provider cited significant problems with implementing this project due to activities outside the DSRIP program. Provider reports their staff has been involved in the EHR implementation which has substantially delayed their progress. Provider stated they have since caught up on this particular project and are on track to meet the remaining goals.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>1 0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestone complete.</td>
<td>1</td>
<td>Provider achieved DY 3 metric as of April DY 3 reporting. QPI metric starts in DY 4. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>4 0 of 2 DY 2 milestone complete. 0 of 2 DY 3 milestone complete.</td>
<td>3</td>
<td>No significant progress reported as of April DY 3. Provider stated in April DY 3 reporting, &quot;Receipt of the mobile clinic, along with its full implementation, is schedule for August 2014.&quot; QPI metric is to provide 4,400 immunizations. If carried forward DY 3 QPI metric is to provide 4,400 immunizations. If carried forward to DY 4, this could threaten the provider’s ability to achieve DY 4 QPI metric of 4,700 immunizations. Note: Provider stated during site visit on 01/07/2015 they provided over 2,100 vaccines since October 2014 at various locations including low income apartments, homeless shelters, shell locations in the area, and at the City Health Department. They intend to reach goals by the end of the next period including catching up. They expect to exceed their numbers once they hire an additional nurse which will allow them to work around their regular clinic schedule and reach out to more patients. The provider was very excited and optimistic about the success of the project moving forward. The project narrative states 30% Medicaid/Uninsured percentage, but the QPI summary states 80%.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the project narrative to reflect the intended Medicaid/Uninsured percentage. The QPI Summary currently states 80% Medicaid/Uninsured; however, the project narrative states 30% Medicaid/Uninsured.</td>
<td>NA</td>
</tr>
<tr>
<td>2 1 of 2 DY 2 milestone complete. 1 of 1 DY 3 milestone complete.</td>
<td>1</td>
<td>Provider met DY 3 metric as of April DY 3 reporting. Provider overachieved QPI metric I-12.1 as of April DY 3 as they reported 2,131 visits over the DY 2 baseline when the goal was only 125 visits over the DY 2 baseline. Consideration should be given to the potential impact on project valuation if plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider increasing QPI goals because provider reports overachievement for metric I-12.1 as of April DY 3 (achieved 2,131 of the 125 visits).</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project’s valuation.</td>
<td>NA</td>
</tr>
</tbody>
</table>
Recommendations to Provider

2 of 2 DY 2 milestones complete.

MSLC recommended the provider update the QPI goal for metric I-12.1.

No recommendations at this time.

3 of 3 DY 2 milestones complete.

MSLC did not have any recommendations.

1 of 1 DY 2 milestone complete.

Technical Change: My provider has started a dental initiative and is working on the project goal which will be met.

Recommendations to HHSC

HHSC Response to Recommendations for HHSC

HHSC did not have any recommendations.

Technical Change: HHSC contacted the provider to check status of the project and the provider notified us they were in the process of withdrawing the project because they have not been able to find a dental provider.

HHSC Response to Recommendations for the Project

Provider is significantly behind on their QPI metric for DY 3. Provider cites lower than expected growth rate from one of their physicians as the root cause and they will attempt to address this issue in the remainder of DY 3.

Provider stated 3 staff have been hired, making it possible to meet the demands of the growing practice and will be a positive outcome in all future reporting periods.

Provider stated the baseline number will soon be revised based on actual DY 1 visits.

No recommendations at this time.

HHSC did not have any recommendations.

Provider is significantly behind on their QPI metric for DY 3. Provider cites lower than expected growth rate from one of their physicians as the root cause and they will attempt to address this issue in the remainder of DY 3.

Provider stated 3 staff have been hired, making it possible to meet the demands of the growing practice and will be a positive outcome in all future reporting periods.

Provider stated the baseline number will soon be revised based on actual DY 1 visits.

No recommendations at this time.

NA

Provider is significantly behind on their QPI metric for DY 3. Provider cites lower than expected growth rate from one of their physicians as the root cause and they will attempt to address this issue in the remainder of DY 3.

Provider stated 3 staff have been hired, making it possible to meet the demands of the growing practice and will be a positive outcome in all future reporting periods.

Provider stated the baseline number will soon be revised based on actual DY 1 visits.

No recommendations at this time.

NA

Provider is significantly behind on their QPI metric for DY 3. Provider cites lower than expected growth rate from one of their physicians as the root cause and they will attempt to address this issue in the remainder of DY 3.

Provider stated 3 staff have been hired, making it possible to meet the demands of the growing practice and will be a positive outcome in all future reporting periods.

Provider stated the baseline number will soon be revised based on actual DY 1 visits.

No recommendations at this time.

NA

Provider is significantly behind on their QPI metric for DY 3. Provider cites lower than expected growth rate from one of their physicians as the root cause and they will attempt to address this issue in the remainder of DY 3.

Provider stated 3 staff have been hired, making it possible to meet the demands of the growing practice and will be a positive outcome in all future reporting periods.

Provider stated the baseline number will soon be revised based on actual DY 1 visits.

No recommendations at this time.

NA

-value-
### APPENDIX 2 - RHP 12

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>EHSC Response to Recommendations for HHSC</th>
<th>EHSC Response to Recommendations for Bid Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-139461107.2.3</td>
<td>2</td>
<td>0 of 2 DY 3 milestones complete. No of DY 4 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. Project has potential to overachieve the following metrics: QPI metric P-3.1 as the provider reported 84 out of 125 individuals enrolled as of April DY 3 (DY 4 and 5 goals are also 125). Metric I-101.1 as the provider reported 63% of the enrollees completed the ARAD program when the goal was only 20% (DY 4 and 5 goals are 30% and 30%, respectively). Provider appears to be on track to meet their DY 3 metrics. QPI metric I-31.1 reports 151 out of 418 individuals as of April DY 3. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>139451107.2.3</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. No of DY 3 milestones complete. Although none of the DY 3 metrics are reported as partially completed, the provider does not express concerns with achieving these metrics. The goal for QPI metric I-31.1 in DY 3 is 151 patients. No significant risks were identified.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>3-139451107.2.3</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete. No of DY 3 milestones complete. Provider cites some difficulties with getting patients to adapt to the medical home model which is causing them to fall behind on their QPI metric. QPI metric I-12.1 reports 27 out of 100 patients were assigned to a medical home as of April DY 2. Provider stated that they remain hopeful they can overcome utilization challenges with the target population. The provider also stated that they are trying to overcome this obstacle by committing significant clinic resources (clerical, nursing and physician) to these patients. Project narrative states the DY 3 estimated patient impact is 300 but the Phase 4 Master Summary states the goal to be 100. The narrative also states, &quot;make medical/home assignments for as many as 5,000 area patients over the life of the project.&quot; The patient impact reflected in I-12.1 shows a total impact of 1,850 patients.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>3-139451107.2.3</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. No of DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 63% of the enrollees completed the ARAD program when the goal was only 20%. Provider cites some difficulties with getting patients to adapt to the medical home model which is causing them to fall behind on their QPI metric. QPI metric I-12.1 reports 27 out of 100 patients were assigned to a medical home as of April DY 2. Provider stated that they remain hopeful they can overcome utilization challenges with the target population. The provider also stated that they are trying to overcome this obstacle by committing significant clinic resources (clerical, nursing and physician) to these patients. Project narrative states the DY 3 estimated patient impact is 300 but the Phase 4 Master Summary states the goal to be 100. The narrative also states, &quot;make medical/home assignments for as many as 5,000 area patients over the life of the project.&quot; The patient impact reflected in I-12.1 shows a total impact of 1,850 patients.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>3-139451107.2.3</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. No of DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 63% of the enrollees completed the ARAD program when the goal was only 20%. Provider cites some difficulties with getting patients to adapt to the medical home model which is causing them to fall behind on their QPI metric. QPI metric I-12.1 reports 27 out of 100 patients were assigned to a medical home as of April DY 2. Provider stated that they remain hopeful they can overcome utilization challenges with the target population. The provider also stated that they are trying to overcome this obstacle by committing significant clinic resources (clerical, nursing and physician) to these patients. Project narrative states the DY 3 estimated patient impact is 300 but the Phase 4 Master Summary states the goal to be 100. The narrative also states, &quot;make medical/home assignments for as many as 5,000 area patients over the life of the project.&quot; The patient impact reflected in I-12.1 shows a total impact of 1,850 patients.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
</tr>
<tr>
<td>Provider Project ID</td>
<td>Overall Risk Ranking</td>
<td>Narrative Describing Mid-Point Assessment Score Justification</td>
<td>Recommendations to HHSC</td>
<td>HHSC Response to Recommendation for HHSC</td>
<td>HHSC Response to Recommendations for All Project</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Ochiltree General Hospital 112704504.2.1</td>
<td>3</td>
<td>1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 0 of 2 DY 4 milestones complete. 0 of 3 DY 5 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>HHSC did not have any recommendations.</td>
</tr>
<tr>
<td>- Although DY 3 metric P-15.1 was not considered by HHSC as being achieved as of April DY 3, the provider submitted NMI support during the July NMI period. Although, no numerical progress has been made towards achievement of QPI metric P-10.1 in DY 3, the provider does not express concern with achieving it. Provider narrative states that provider also serves patients from several counties in Oklahoma.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No of 2 DY 3 milestones complete. 0 of 2 DY 4 milestones complete. 0 of 3 DY 5 milestones complete. 0 of 4 DY 6 milestones complete. Provider reports that the dashboard is almost done but until complete no training can begin for fulfillment of metrics P-8.1 and P-8.2 in DY 3. The provider reported in April DY 3 anticipation that these metrics will be reported on in October DY 3. No numerical progress has been made towards achievement of QPI metric I-13.1 as of April DY 3, because progress towards this metric is dependent on achievement of the dashboard (P-10.1). Project narrative does not mention influenza immunizations which is the subject of the project's QPI metric I-13.1. Metric I-16.2 in both DY 3 and DY 4 have a goal of increasing 10% above the baseline set in DY 2, according to the Phase 4 Master Summary. Provider stated that the roll-out of their provider dashboard has been delayed due to various technical, programming, and infrastructure problems. It is currently slated to be released in February 2015. Since metrics DY 3 I-16.2 and I-13.1 are dependent on the dashboard, they also have been carried forward in DY 4 and will be reported in October 2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Tech University Health Sciences Center- Amarillo 884599202.2.1</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. Although QPI metric I-12.1 reports only 115 out of 2,400 patients have been assigned to a medical home as of April DY 3, the provider does not express concern with achieving this metric. Provider stated that of the 6256 patients seen in the prior 12 month period, 96.34%, or 6071, have been pre-assigned to a medical home. The assignment is not finalized until the pre-assigned patient has a visit and is introduced to their new medical home.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Tech University Health Sciences Center- Lubbock 884599202.2.3</td>
<td>3</td>
<td>2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reports that the dashboard is almost done but until complete no training can begin for fulfillment of metrics P-8.1 and P-8.2 in DY 3. The provider reported in April DY 3 anticipation that these metrics will be reported on in October DY 3. No numerical progress has been made towards achievement of QPI metric I-13.1 as of April DY 3, because progress towards this metric is dependent on achievement of the dashboard (P-10.1). Project narrative does not mention influenza immunizations which is the subject of the project's QPI metric I-13.1. Metric I-16.2 in both DY 3 and DY 4 have a goal of increasing 10% above the baseline set in DY 2, according to the Phase 4 Master Summary. Provider stated that the roll-out of their provider dashboard has been delayed due to various technical, programming, and infrastructure problems. It is currently slated to be released in February 2015. Since metrics DY 3 I-16.2 and I-13.1 are dependent on the dashboard, they also have been carried forward in DY 4 and will be reported in October 2015.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Consideration should be given to the potential impact on project valuation if plan modification is submitted and approved.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Possible Plan Modification: Provider should consider decreasing QPI goal in metric I-13.1 to a more achievable value due to the delay in releasing the dashboard.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Technical Change: Update the project narrative to include mention of influenza immunizations which is the subject of QPI metric I-13.1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HHSC does not change valuation based on QPI changes, unless the project becomes outside of range compare to other projects, and HHSC can decrease project's valuation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MSLC recommended the provider consider decreasing QPI goal in metric I-13.1 to a more achievable value due to the delay in releasing the dashboard.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HHSC contacted the provider to check status of the project and the provider indicated they felt they were on track to meet their goal and no changes were needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MSLC recommended the provider update the project narrative to include mention of influenza immunizations which is the subject of QPI metric I-13.1. HHSC found that the most recent narrative included information related to influenza vaccinations and did not contact the provider on this recommendation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HHSC did not have any recommendations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Recommendations to HHSC

MSLC recommended updating Phase 4 Master Summary Workbook to state the patient visits should only include patients seen by the additional provider hired in DY 3.

HHSC should follow up with the provider to clarify the wording of DY 4 and DY 5 metrics to state the patient visits should only include patients seen by the additional provider hired in DY 3.

Possible Plan Modification: Provider should consider clearly establishing a baseline of patient visits in order to assess improvement and project impact.

HHSC followed up with the provider to confirm that the patient visits in DY 4 and 5 will be attributable to the additional provider.

Recommendations to Provider

MSLC did not have any recommendations.

HHSC followed up with the provider to confirm that the patient visits in DY 3 and 5 will be attributable to the additional provider.

APPENDIX 2 - RHP 13

Provider
North Runnels Hospital
Shannon West Texas Memorial Hospital
Center for Life Services
West Texas Centers
North Runnels Hospital
Shannon West Texas Memorial Hospital
Heart of Texas Memorial Hospital
Project ID
0205829001.1
132726005.1.4
333336005.1.1
130726005.1.1
020989201.1.1
317226005.1.4
138715155.2.1
Narrative Describing Mid-Point Assessment Score Justification
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
In the most current version of the workbook (post Plan mod), this issue is already addressed. In DY4 the goal states: Goal: Increase the total number of telemedicine visits by 74 encounters in DY4. Goal is updated in DYS as well.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
No recommendations at this time.
APPENDIX 2 - RHP 13

Recommendations to Provider

Recommendations to HHSC

MSLC Response to Recommendation for HHSC

MSLC Response to Recommendations for this Project

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for this Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill Country Community MMR Center (aka HI Country HPHD Centers)</td>
<td>3</td>
<td>0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project experienced problems meeting their DY 2 metric and had not achieved it as of Apr DY 3. Provider expressed difficulties retaining peer specialists which may cause problems in achieving DY 4 and 5 metrics if not addressed. Project still has the ability to catch up in DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Schleicher County Medical Center</td>
<td>4</td>
<td>0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>Project has not demonstrated any significant progress towards achieving their milestones and reported difficulties regarding project funding and their ability to complete the project. This project is not likely to succeed under the current plan and may require significant plan modifications in order to achieve their goals. The provider stated that it was determined that the PCMH designation was economically unfeasible; however, have been working on the other metrics.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Zunino County Hospital</td>
<td>1</td>
<td>0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project appears to be inline with its goals. Project milestones and metrics appear to be on track for DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Jillian M Hudspeth Memorial Hospital</td>
<td>1</td>
<td>0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. In DY 3 reporting, provider states they have seen 17 of the 20 required patients for DY 3 metrics. Provider has proposed plan modifications to change the quantities identified in the project narrative to match HHSC approved QPI.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Shannon West Texas Memorial Hospital</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. This project appears to be on track as of April DY 3 reporting. Potential risk was noted regarding the overachieving of metric 1-14.1. Provider has proposed a plan modification to revise the goal for 1-14.1 to only include discharge time and add a milestone to split 1-14.1 into 2 metrics.</td>
<td>Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider increasing the goal for metric 1-15.1 due to overachieving in DY 3 (23 staff members were designated as quality champions in DY 3, the goal was 3).</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pelago Memorial Hospital</td>
<td>3</td>
<td>0 of 1 DY 3 milestone complete. Project has been significantly delayed due to problems with the approval of their application for the new clinic. This may cause difficulties in achieving DY 3 metrics. Provider has proposed a plan modification to modify the baselines and goals for metric P-5:1 and add a metric to capture QPI in 1-12.1.</td>
<td>Consideration should be given to the potential impact on project valuation if the plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider reducing QPI goals to a potentially more achievable goal.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Technical Change: Update QPI metrics 1-10.1 for DY 5 in the QPI Summary to read 221 individuals, not 171. | N/A | N/A |

Technical Change: Update project narrative as it states this is project option 2.1.3 and the Phase 4 Master Summary and QPI Summary state the project option is 2.1.4. | N/A | N/A |

Technical Change: Update project narrative as it states this is project option 2.1.3 and the Phase 4 Master Summary and QPI Summary state the project option is 2.1.4. | N/A | N/A |

Note: The Cat 2 Menu states the following for project option 2.1.4: "PCMH models include investments in projects that are the foundation of delivery system change and a complete package of change. Therefore, it is preferable to pursue a full continuum of projects (PCMH readiness preparations, the establishment or expansion of medical homes which may include gap analyses and eventual application for PCMH recognition to a nationally recognized organization such as NCQA, as well as educating various constituent groups within hospitals and primary care practices about the essential elements of the NCQA medical home standard.)" | N/A | N/A |

Note: Project does not appear on the April DY 3 Sign-off Summary. Myers and Stauffer used actual provider response for reference. Provider should include all projects in Sign-Off Summary. | N/A | N/A |

Note: Project does not appear on the April DY 3 Sign-off Summary. Myers and Stauffer used actual provider response for reference. Provider should include all projects in Sign-Off Summary. | N/A | N/A |

MSLC, stated that the project was not included in the reporting line. HHSC followed up on this and determined that the project was included in the RHP 13-14 AMI Summary (State of Texas HHSC - DY3 April DSRRP Reporting). The issue is addressed. | N/A | N/A |

MSLC, stated that the project was not included in the reporting line. HHSC followed up on this and determined that the project was included in the RHP 13-14 AMI Summary (State of Texas HHSC - DY3 April DSRRP Reporting). The issue is addressed. | N/A | N/A |

MSLC, recommended increasing QPI goals to meet the state's CFS. Provider responded with this recommendation and HHSC reflected an increase in goal from 3 champions to 20 champions for DY4. HHSC does not change valuation based on goals changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project's valuation. | N/A | N/A |

MSLC, recommended increasing QPI goals to a more achievable goals. HHSC contacted the provider to determine if QPI goals are still achievable. Provider indicated that yes, QPI goals can remain unchanged. DY3 - 300 visits DY4 - 1000 visits DY5 - 1000 visits | N/A | N/A |
Provider Project ID
Permian Regional Medical Center 272796103.1
2 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete.
Recommendations to Provider
HHSC should consider potential impact on project valuation If plan modification to increase QPI is submitted and approved.

HHSC Response to Recommendations for MSCL
HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

Technical Change:
Update the labeling of milestones I-104 and I-105 in DY 4, to avoid confusion.

Possible Plan Modification:
Provider should consider increasing QPI goals for metric I-12.1, because provider reports overachievement as of April DY 3 (achieved 3679 of the 1800 encounters) and a 11.95% reduction of non-emergent ED visits when the goal was a 4% reduction.

Possible Plan Modification:
Provider should consider separating the percentage decrease in non-emergent ED visits’ aspect (which appears to be a former Category 3 outcome measure) from the goal in metric I-12.1. The intent of metric I-12.1 is to increase the number of visits to the clinic. The achievement of this metric may be threatened by multiple goals.

HHSC Response to Recommendations for MSCL
HHSC recommended increasing QPI goals since the provider overachieved in DY3. Provider agreed with this recommendation. Increase in DY5 goals will be finalized in May, when HHSC completes its work related to DY5 goal increases.

[...]

Technical Change:
Update the Phase 4 Master Summary to reflect the percentage reference in the goal for metric I-104.1 in DY 4, as the provider states it was not their intent.

Technical Change:
Update the Phase 4 Master Summary to remove the baseline year being DY 3 for metric I-105.1 in DY 4.

Technical Change:
Update the Phase 4 Master Summary to reflect the baseline year as DY 2 for metric I-105.1 in DY 4 when the baseline was established in DY 3.

Provider appears to be on track to meet their DY 3 metrics. The description of milestones/metrics for I-104 and I-105 in DY 4 and DY 5 do not align with the descriptions for P-104 and P-105 in DY 3.

Metric I-12.1 in DY 3 and DY 4 contains multiple goals such as a percentage decrease in non-emergent ED visits and an increase in the visits to the clinics. The intent of the metric is to document an increase in number of visits.

Possible Plan Modification:
Provider should consider overachievement as of April DY 3 (achieved 3679 of the 1800 encounters) and a 11.95% reduction of non-emergent ED visits when the goal was a 4% reduction.

Possible Plan Modification:
Provider should consider separating the percentage decrease in non-emergent ED visits’ aspect (which appears to be a former Category 3 outcome measure) from the goal in metric I-12.1. The intent of metric I-12.1 is to increase the number of visits to the clinic. The achievement of this metric may be threatened by multiple goals.

HHSC Response to Recommendations for MSCL
HHSC recommended increasing QPI goals since the provider overachieved in DY3. Provider agreed with this recommendation. Increase in DY5 goals will be finalized in May, when HHSC completes its work related to DY5 goal increases.

HHSC recommended increasing QPI goals since the provider overachieved in DY5. Provider reported achievement of its QPI goal, and DY5 achievement of 829 exceeds the goals for each of DY4 and DY5 (400). Provider agreed with this recommendation and agreed to increase DY5 goal to 800. Increase in DY5 goals will be finalized in May, when HHSC completes its work related to DY5 goal increases.

Recommendations to Provider
HHSC should consider potential impact on project valuation If plan modification to increase QPI is submitted and approved.

Recommendations to Provider
HHSC should consider potential impact on project valuation If plan modification to increase QPI is submitted and approved.

Technical Change:
Update the labeling of milestones I-104 and I-105 in DY 4 and DY 5 to better align with the descriptions of milestones P-104 and P-105 in DY 3.

Technical Change:
Update the Phase 4 Master Summary to reflect the baseline year being DY 3 for metric I-105.1 in DY 4.

Technical Change:
Update the Phase 4 Master Summary to remove the baseline reference in the goal for metric I-104.1 in DY 4 and DY 5, as the provider states it was not their intent.

Technical Change:
Update the Phase 4 Master Summary to reflect the baseline year as DY 2 for metric I-105.1 in DY 4, when the baseline was established in DY 3.

Technical Change:
Update the Phase 4 Master Summary to remove the baseline year as DY 2 for metric I-105.1 in DY 4, when the baseline was established in DY 3.

Provider appears to be on track to meet their DY 3 metrics. The description of milestones/metrics for I-104 and I-105 in DY 4 and DY 5 do not align with the descriptions for P-104 and P-105 in DY 3.

Phase 4 Master Summary lists the baseline year as DY 2 for metric I-105.1 in DY 4, when the baseline was established in DY 3.

Metric I-12.1 in DY 4 and DY 5 contains multiple goals such as a percentage decrease in non-emergent ED visits and an increase in the visits to the clinics. The intent of the metric is to document an increase in number of visits.

Provider appears to be on track to meet their DY 3 metrics. The description of milestones/metrics for I-104 and I-105 in DY 4 and DY 5 do not align with the descriptions for P-104 and P-105 in DY 3.

Phase 4 Master Summary lists the baseline year as DY 2 for metric I-105.1 in DY 4, when the baseline was established in DY 3.

Metric I-12.1 in DY 4 and DY 5 contains multiple goals such as a percentage decrease in non-emergent ED visits and an increase in the visits to the clinics. The intent of the metric is to document an increase in number of visits.

Provider appears to be on track to meet their DY 3 metrics. The description of milestones/metrics for I-104 and I-105 in DY 4 and DY 5 do not align with the descriptions for P-104 and P-105 in DY 3.

Phase 4 Master Summary lists the baseline year as DY 2 for metric I-105.1 in DY 4, when the baseline was established in DY 3.
### APPENDIX 2 - RHP 14

<table>
<thead>
<tr>
<th>Provider</th>
<th>Overall Risk</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendations for HHSC</th>
<th>HHSC Response to Recommendations for Bid Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arable Center Hospital</strong> 135235306.1.1</td>
<td>4</td>
<td>Of 1 of DY 2 milestones complete. 0 of 3 DY 3 milestones complete. New clinic is 50-50% complete as of Apr DY 3 and has only signed one contract with new physician out of the 4 required in DY 3. Provider reported that they were unlikely to meet metric I-15.2 in DY 3 due to problems recruiting providers. During the site visit on 01/06/2015, the clinic was complete and operational. The provider stated they have hired a physician recruiter, are utilizing a recruiting agency, are offering tuition reimbursement, as well as partnering with Texas Tech to assist in recruiting efforts to overcome their recruiting challenges. The provider stated they had approximately 300 patient visits in September 2014. The DY 3 QPI goal for metric I-15.2 is 3,700 visits; however, the DY 4 and DY 5 goals are 8,000 and 11,000 visits respectively. The provider stated they intend on carrying forward QPI metrics every year until they accomplish their goals, and do not intend on reducing QPI goals for DY 4 and DY 5 because they want to accomplish what they said they would.</td>
<td>HHSC should consider potential impact on project valuation if plan modification to decrease QPI is submitted and approved.</td>
<td>HHSC does not change valuation based on QPI changes.</td>
<td>ASLC-recommended decreasing QPI goals due to difficulties in recruiting staff. Based on our policy, HHSC does not initiate decrease in QPI goals for projects with valuation above $5m. Provider had an opportunity to request adjustment to goals during plan modification.</td>
</tr>
<tr>
<td><strong>Permian Basin Community Center</strong> 138364812.2.1</td>
<td>3</td>
<td>Of 2 of DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Providers have not been hired for this project and patients have not been seen as of April DY 3. The provider reported in April DY 3 to have contracted recruiters for physician staff. While the provider may have to carry forward QPI goal for DY 3 metric I-8.1, seeing 30 patients seems reasonably achievable during the carry forward period, should providers be secured.</td>
<td>HHSC should consider potential impact on project valuation if plan modification to decrease QPI is submitted and approved.</td>
<td>HHSC does not change valuation based on QPI changes.</td>
<td>ASLC-recommended revising goals for the project due to delay in hiring providers. HHSC checked on subsequent reporting done by provider to determine project status. During the Oct. DY3 reporting period, the provider reported achievement of I-8.1. In fact, they surpassed their DY3 goal of 30 individuals by 46 (76 total individuals). Since the status of the project changed and because the project is over $5 million, HHSC did not initiate discussions regarding changing goals.</td>
</tr>
<tr>
<td><strong>Texas Tech University Health Science Center-Permian Basin</strong> 38193350.1.1</td>
<td>3</td>
<td>Of 4 of DY 2 milestones complete. 2 of 4 DY 3 milestones complete. QPI metric P-104.1 reports 1,475 out of 2,089 individuals as of April DY 3. The provider reported in Oct DY 2 the baseline established during September 2011 - August 2012 was 2,698. The goal for QPI metric I-12.1 in DY 3 is 2,089, which is the previously published baseline. The goal for DY 3 should be higher than the baseline. Additionally, the Phase 4 Master Summary states the DY 4 goal is a 5% increase over the baseline of 2,089, which should be 2,193 not 2,611 as listed in the Phase 4 Master Summary.</td>
<td>HHSC should consider potential impact on project valuation if plan modification to decrease QPI is submitted and approved.</td>
<td>HHSC does not change valuation based on QPI changes.</td>
<td>ASLC-recommended decreasing QPI goals to a more achievable goals to update the metric goals to reflect accurate percent increases. HHSC contacted the provider, and provider communicated that there were errors in QPI goals. HHSC will need further work with the provider to determine when this error took place and whether QPI goals need to be updated. This work will be completed in May-June.</td>
</tr>
<tr>
<td><strong>Arable Center Hospital</strong> 135235306.1.3</td>
<td>2</td>
<td>Of 2 of DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider appears to be on their way to meeting their metric goals for DY 3. QPI metric I-12.1 reports 2,116 out of 2,611 visits as of April DY 3. This is not considered significant overachievement because the QPI goal for this metric increases to 4,480 in DY 4. The project narrative states the QPI goal for metric I-12.1 will increase in DY 4 and DY 5 by 10% and 15% over the baseline, respectively. The Phase 4 Master Summary shows the increases in QPI goals in DY 4 and DY 5 as being much higher. Provider stated that the goals of 4,480 in DY 4 and 8,920 in DY 5 are their targets.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the project narrative to reflect the intended QPI increases for metric I-12.1.</td>
<td>ASLC-recommended updating project narrative to reflect the intended QPI increases for metric I-12.1. HHSC is not making updates to the narrative at this time to reflect updated QPI percentages since this information is reflected in DSIRP system on metric level.</td>
</tr>
<tr>
<td><strong>Abbot Texas Centers</strong> 130725806.1.1</td>
<td>2</td>
<td>Of 2 of DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider appears to be on their way to meeting their metric goals for DY 3. Provider reports to anticipate meeting their QPI goal for metric I-101.1 by Oct DY 3 reporting; however, does not report a numerical goal. Note: The provider has this project in RHP 11, RHP 12, RHP 13, and RHP 14. The QPI goals are different for each project and the counties stated to be served in each project narrative are different.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>ASLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
**APPENDIX 2 - RHP 14**

**Provider Project ID** | **Overall Risk Rating** | **Narrative Describing Mid-Point Assessment Score Justification** | **Recommendations to HHSC** | **HHSC Response to Recommendation for Provider** | **HHSC Response to: Recommendations for No Project**
--- | --- | --- | --- | --- | ---

**Adams County Hospital**

356143806.1.4

2 of 4 DY 2 milestones complete.

- 0 of 2 DY 3 milestones complete.

The provider appears to be on track in meeting DY 3 metrics. Possible overachievement of QPI metric P-13 in DY 3. The provider reported 1,165 out of the 1,260 encounters were completed as of April DY 3 reporting.

- HHSC should consider potential impact on project valuation if plan modification to increase QPI is submitted and approved.

- Possible Plan Modification: Provider should consider increasing QPI goals for metric P-13.1 because provider values they have reached 1,165 of the 1,260 required encounters as of April DY 3.

- HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

- AMLC recommended increasing project’s goal based on DY3 achievement. Provider agreed with this recommendation. HHSC updated DY5 QPI goals to reflect a new goal: 2,601 additional encounters over the pre-DSRIP baseline in DY5 of a total of 3,710.

**Odessa Regional Medical Center**

132710933.1, 1.5

4 of 2 DY 2 milestones complete.

- 0 of 2 DY 3 milestones complete.

Provider has yet to meet their DY 2 metric P-11.1 as of April DY 3. Their ability to meet their DY 3 QPI metric may be significantly impaired due to DY 2 metric P-11.1 carrying over. The provider does not report any numerical progress for their DY 3 QPI goal of 2,932 visits for metric I-23.1.

- HHSC should consider potential impact on project valuation if plan modification to decrease QPI is submitted and approved.

- Possible Plan Modification: Provider should consider decreasing QPI goals in metric I-23.1 to a more achievable value due to DY 2 metric P-11.1 carrying over.

- HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.

- AMLC recommended decreasing project’s goals based on the presence of carryforward metrics. HHSC contacted the provider, and the provider stated that they adjusted their process in relation to this project and feel that they will be able to meet the project goals. Provider will be reporting during the October 2015 reporting period with the current project success.

**Texas Tech University Health Science Center- Permian Basin**

3819339001.2, 1.1

2 of 2 DY 2 milestones complete.

- 0 of 4 DY 3 milestones complete.

Provider appears to be on track in meeting DY 3 metrics. Provider submitted 3 of the 4 metrics for DY 3 as completed during April DY 3 reporting, but HHSC said that the support was not sufficient to justify metric achievement. Provider submitted NIH support but no information is available from HHSC to determine if this support was approved.

- No recommendations at this time.

- No recommendations at this time.

- VA

- AMLC did not have any recommendations.

**Adams County Hospital**

136143806.2.4

3 of 1 DY 2 milestone complete.

- 0 of 1 DY 3 milestone complete.

Provider is behind on the achievement of DY 3 QPI metric I-8.1 (24 of 300) but they do not express concern in achieving this metric. The provider reports lower than expected event turnouts. The provider has the second half of DY 3 to meet this metric.

- HHSC should consider potential impact on project valuation if plan modification to decrease QPI is submitted and approved.

- Possible Plan Modification: Provider should consider decreasing QPI goal in metric I-8.1 to a more achievable value due to the lower than expected event turnouts that threaten the achievement of this metric.

- Technical Change: Update the Phase 4 Master Summary to reflect the numerical baseline used in DY 3 metric I-8.1.

- Technical Change: Update the Phase 4 Master Summary to reflect the intended QPI goals in DY 4 and DY 5 to metric I-8.1. DY 4 goal is to increase by 20% over DY 3 goal of 300, which would be 360; however, the goal for DY 4 is 450 individuals. DY 5 goal is to increase by 50% over DY 4 goal of 450, which is accurately calculated as 675 individuals; however, the intended goal for DY 4 may only be 360, not 450 according to the percentages.

- Provider should consider decreasing QPI goals in metric I-8.1 to a more achievable value due to the lower than expected event turnouts that threaten the achievement of this metric.

- HHSC recommended decreasing QPI goals for this project to a more achievable goal. HHSC checked subsequent reporting for this project - the provider reported above goal achievement during the Oct. DY5 reporting period. Based on this, HHSC did not initiate revision of the goals. AMLC also recommended updating percent increase in the QPI metric to 50% instead of 30%. Provider agreed with this recommendation and HHSC updated the system to reflect 50% increase in DY4 over DY3 levels. DY3 already showed 50% therefore, no additional changes needed in DY5.

**Arapahoe County Hospital District**

136143806.2.3

2 of 1 DY 2 milestone complete.

- 0 of 2 DY 3 milestone complete.

Provider has met DY 3 metrics as of April DY 3 reporting. QPI metrics start in DY 4. No significant risks were identified.

- No recommendations at this time.

- No recommendations at this time.

- VA

- AMLC did not have any recommendations.
<table>
<thead>
<tr>
<th>Medical Center Hospital</th>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved.</th>
<th>Possible Plan Modification: Provider should consider increasing QPI goals for metric I-101.1 because provider reports an overachievement of QPI as of April DY 3 (achieved 333 of the 268 required individuals).</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>135253586.2.4</td>
<td>2</td>
<td>1</td>
<td>The provider has met DY 3 metrics as of April DY 3 reporting. Overachievement occurred in QPI metric I-101.1 in DY 3. The provider reported 333 out of the 268 individuals were completed as of April DY 3 reporting.</td>
<td>Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider increasing QPI goals for metric I-101.1 because provider reports an overachievement of QPI as of April DY 3 (achieved 333 of the 268 required individuals).</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.</td>
<td>MSLC recommended increasing QPI goals since the provider overachieved in DY3. Provider agreed with this recommendation. HHSC updated the goal for I-101 in DY5 to 420 from 350, based on the provider’s response.</td>
</tr>
<tr>
<td>Midland Memorial Hospital</td>
<td>136143865.2.3</td>
<td>2</td>
<td>1</td>
<td>The provider appears to be on track in meeting DY 3 metric. Possible overachievement of QPI metric P-6.1 in DY 3. The provider reported 183 out of the 264 encounters were completed as of April DY 3 reporting. The DY 4 and DY 5 goals for this metric are 277 and 281 encounters, respectively. The project narrative states DY 3 goal is 20-30% of patients will be screened for palliative care, and the Phase 4 Master Summary states 10% of the patients will be screened for palliative care, in metric P-6.1 in DY 3.</td>
<td>Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider increasing QPI goals for metric P-6.1 because provider reports an overachievement as of April DY 3 (183 of the 264 required encounters). Technical Change: Update the project narrative to reflect the provider’s intention to screen 100% of patients with serious, life-limiting diseases for the possibility of a palliative care consult, not 20%-30%.</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.</td>
<td>MSLC recommended increasing QPI goals since the provider overachieved in DY5. Provider agreed with this recommendation. Provider proposed to increase the DY5 goal to 376, which will be reflected in the system. Work related to DY5 goal increases is conducted in May. MSLC also recommended that provider reflects in the narrative provider’s intention to screen 100% of patients with serious, life-limiting diseases for the possibility of a palliative care consult, not 20%-30%. Provider is monitoring to see if patients have serious chronic illnesses and if the Palliative Care Screening Tool is being used appropriately on admission. Even though this is the protocol, provider is only at an average of 61.6%. Since the provider is reflecting in the narrative the current status and not the goal, these changes are acceptable to HHSC.</td>
</tr>
</tbody>
</table>
No recommendations at this time.

Technical Change: Update the project narrative to ensure the target population described in the project narrative aligns with the patients and encounters used for QPI measurement for milestone I-23. For example, the narrative states the target population will be patients from new surgical providers (estimated to be 375 in DY 3 per the narrative and the Phase 4 Master Summary); however, the provider states all patients and encounters from the surgeon group will be measured for milestone I-23.

VA

MSLC recommended updating project narrative to align target population description with the description included in the QPI metric. HHSC did not require the provider to update project narrative, because all metrics and milestones included in the Summary Table still make a complete picture of project activities. In addition, target population maybe a little larger than what is measured in the QPI.

No recommendations at this time.

Provider should incorporate the operational procedures necessary to improve overall efficiencies and care management, as defined for metric P-4.1 in DY 3, into metric I-16.3 for DY 4 and DY 5.

VA

MSLC recommended updating metrics to align target population description with the description included in the QPI metric. HHSC did not require the provider to update project narrative, because all metrics and milestones included in the Summary Table still make a complete picture of project activities. In addition, target population maybe a little larger than what is measured in the QPI.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

Provider had an opportunity to report on this metric and HHSC to review it. If there were any deviation in the reported information from the metric goal, provider had to explain this during reporting.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

Provider stated they were not able to achieve metric DY 2 metric I-22.1 (increase number of oculist providers by two) during the carry-forward period. However, the provider stated they are very optimistic they will meet metric I-22 since those specialists for the project are now being hired.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.

No recommendations at this time.

HHSC did not have any recommendations.
Provider Site
City of El Paso Department of Public Health 300086801.1.2

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

Provider: Providence Medical Center 30061104.1.2

HHSC Response to Recommendations for HHSC

HHSC Response to  Recommendations for the Project

Milestones:
0 of 2 DY 2 milestones complete. 0 of 2 DYZ 3 milestones complete.

Recommendation:

Recommendation:

Recommendation:

Provider: Texas Tech HS for Family Med 084597603.1.4

Provider: City of El Paso Department of Public Health 300086801.1.5

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

Provider: JCA Parnassus Medical Center 094109802.1.1

HHSC Response to Recommendations for HHSC

HHSC Response to  Recommendations for the Project

Milestones:
0 of 2 DYZ 3 milestones complete.

Recommendation:

Recommendation:

Recommendation:

Provider: Providence Medical Center 30061104.1.2

Provider: JCA Parnassus Medical Center 094109802.1.1

Provider: City of El Paso Department of Public Health 300086801.1.5

Provider: Texas Tech HS for Family Med 084597603.1.4

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

Provider: Providence Medical Center 30061104.1.2

HHSC Response to Recommendations for HHSC

HHSC Response to  Recommendations for the Project

Milestones:
0 of 2 DYZ 3 milestones complete.

Recommendation:

Recommendation:

Recommendation:

Provider: Texas Tech HS for Family Med 084597603.1.4

Provider: JCA Parnassus Medical Center 094109802.1.1

Provider: City of El Paso Department of Public Health 300086801.1.5

Provider: Providence Medical Center 30061104.1.2

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

Provider: Providence Medical Center 30061104.1.2

HHSC Response to Recommendations for HHSC

HHSC Response to  Recommendations for the Project

Milestones:
0 of 2 DYZ 3 milestones complete.

Recommendation:

Recommendation:

Recommendation:

Provider: Texas Tech HS for Family Med 084597603.1.4

Provider: JCA Parnassus Medical Center 094109802.1.1

Provider: City of El Paso Department of Public Health 300086801.1.5

Provider: Providence Medical Center 30061104.1.2

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Recommendations to Provider

Provider: Providence Medical Center 30061104.1.2

HHSC Response to Recommendations for HHSC

HHSC Response to  Recommendations for the Project

Milestones:
0 of 2 DYZ 3 milestones complete.

Recommendation:

Recommendation:

Recommendation:
**Recommendations to Provider**

- **Recommendations to Provider**
  - MSLC recommended provider update the baseline/goal for metric I-22.1 in DY 4 and DY 5 to reflect the provider's intent to increase clinic hours worked by 1,300 hours in DY 4 and 1,560 hours in DY 5. Provider is going to increase clinic hours worked by 2,600 hours over a Pre-DSRIP baseline through the recruitment of specialty care physicians.
  - MSLC recommended updating narrative to remove the mention of P-101.1 in DY 3-DY 5 to delete reference to other metrics and goals set in other narrative sections. HHSC made changes to P-101.1 in DY 4 and DY 5, to delete reference to other metrics and goals set in other narrative sections (i-1) and informed the provider.
  - MSLC recommended updating narrative to remove the mention of P-101.1 in DY 3-DY 5 to delete reference to other metrics and goals set in other narrative sections.
  - MSLC recommended updating the Phase 4 Master Summary to delete metrics at this time, because providers either reported or provided status update on these metrics. HHSC checked DY4 and DY5 and noted that the goal/baseline statement specify that these are metrics, not goals.

**Technical Change**

- Update the project narrative to reflect the QPI measurement to be encountered. For example, P-101.1 in DY 3-DY 5 to reflect the provider's intent to increase clinic hours worked by 1,300 hours in DY 4 and 1,560 hours in DY 5. The goals for QPI metrics in DY 3-DY 5 currently show QPI measurement to be individual patients for DY 3, visits for DY 4, and patients in DY 5.

**APPENDIX 2 - RHP 15**

- **APPENDIX 2 - RHP 15**
  - **APPENDIX 2 - RHP 15**
  - **APPENDIX 2 - RHP 15**
  - **APPENDIX 2 - RHP 15**
  - **APPENDIX 2 - RHP 15**

**Narrative Describing Mid-Point Assessment Score Justification**

- **Narrative Describing Mid-Point Assessment Score Justification**
  - **Narrative Describing Mid-Point Assessment Score Justification**
  - **Narrative Describing Mid-Point Assessment Score Justification**
  - **Narrative Describing Mid-Point Assessment Score Justification**
  - **Narrative Describing Mid-Point Assessment Score Justification**

**Recommendations to HHSC**

- **Recommendations to HHSC**
  - **Recommendations to HHSC**
  - **Recommendations to HHSC**
  - **Recommendations to HHSC**
  - **Recommendations to HHSC**

**Provider**

- **Provider**
  - **Provider**
  - **Provider**
  - **Provider**
  - **Provider**
**Recommending to Provider**

**No recommendations at this time.**

**Technical Change:** Update the baseline and goals for metric I-10.1 as follows, as intended by the provider:

- The baseline should be 4,562, starting with a 4.38% reduction beginning in DY 3 and decreasing by 2.19% or 100 individuals thereafter.
- DY 5: Decrease by 4.38% or by 200
- DY 4: Decrease by 6.57% or by 300
- DY 5: Decrease by 8.76% or by 400

**Technical Change:** Update the baseline for metric I-12.1 to reflect 5.25 full-time providers, as intended by the provider.

**Technical Change:** Update the goal for metric I-101.1 to state "Patients served will be above Emergence normal patient load", as intended by the provider.

**Technical Change:** Update the appropriate reports to reflect the intended project option (I-13.1).

**Technical Change:** Update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the following goals intended by the provider for QPI metric I-123.1:

- Each year the agency would increase services by 9%.
- Provider is falling behind on their DY 3 metrics and may have difficulty catching up without significant changes. Provider's newly hired psych liaison quit shortly after being hired in DY 3 and may cause them to fall behind on the QPI metric.
- The provider stated during the site visit on 01/05/2015 that all three of DY 3 metrics were met in DY 3, including exceeding the goal for QPI metric I-101.1. Provider accomplished this by hiring/training of appropriate crisis alternatives from the baseline of 1,111 individuals.
- The baseline should be 4,562, starting with a 4.38% reduction beginning in DY 3 and decreasing by 2.19% or 100 individuals thereafter.

**Technical Change:** Update the baseline goal for I-12.1 in DY4 and DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 3).

**Technical Change:** Update the baseline for I-12.1 in DY5: Decrease by 8.76% or by 400. HHSC also updated QPI metric I-101.1 in DY5 only as intended by the provider. The provider stated, "Patients served will be above Emergence normal patient load". MSLC also recommended updating baseline for I-12.1. HHSC updated the baseline for I-12.1 in DY4 and DY5 to reflect the baseline at 5.25 full-time providers.

**No recommendations at this time.**

**Technical Change:** Update the baseline goal for I-12.1 in DY4:

- 1,111 IDD population x .09 percent = 100 individuals
- 200 from DY 4= 200
- 1,111 IDD population x .09 percent = 100 individuals
- 100 from DY 3= 100
- 1,111 IDD population x .09 percent = 100 individuals
- 200 from DY 4= 200

**Technical Change:** Update the appropriate reports to reflect the intended documentation requirements.

**Technical Change:** Update the baseline and goals for metric I-10.1 as follows, as intended by the provider:

- The baseline should be 4,562, starting with a 4.38% reduction beginning in DY 3 and decreasing by 2.19% or 100 individuals thereafter.
- DY 5: Decrease by 4.38% or by 200
- DY 4: Decrease by 6.57% or by 300
- DY 5: Decrease by 8.76% or by 400

**Technical Change:** Update the baseline for metric I-12.1 to reflect 5.25 full-time providers, as intended by the provider.

**Technical Change:** Update the goal for metric I-101.1 to state "Patients served will be above Emergence normal patient load", as intended by the provider.

**Technical Change:** Update the appropriate reports to reflect the intended documentation requirements.

**Technical Change:** Update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the following goals intended by the provider for QPI metric I-123.1:

- Each year the agency would increase services by 9%

**Technical Change:** Update the baseline goal for I-12.1 in DY4 and DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 3).

**Technical Change:** Update the baseline for I-12.1 in DY5: Decrease by 8.76% or by 400. HHSC also updated QPI metric I-101.1 in DY5 only as intended by the provider. The provider stated, "Patients served will be above Emergence normal patient load". MSLC also recommended updating baseline for I-12.1. HHSC updated the baseline for I-12.1 in DY4 and DY5 to reflect the baseline at 5.25 full-time providers.

**No recommendations at this time.**

**Technical Change:** Update the appropriate reports to reflect the intended documentation requirements.

**Technical Change:** Update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the following goals intended by the provider for QPI metric I-123.1:

- Each year the agency would increase services by 9%

**Technical Change:** Update the baseline goal for I-12.1 in DY4 and DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 3).

**Technical Change:** Update the baseline for I-12.1 in DY5: Decrease by 8.76% or by 400. HHSC also updated QPI metric I-101.1 in DY5 only as intended by the provider. The provider stated, "Patients served will be above Emergence normal patient load". MSLC also recommended updating baseline for I-12.1. HHSC updated the baseline for I-12.1 in DY4 and DY5 to reflect the baseline at 5.25 full-time providers.

**No recommendations at this time.**

**Technical Change:** Update the baseline and goals for metric I-10.1 as follows, as intended by the provider:

- The baseline should be 4,562, starting with a 4.38% reduction beginning in DY 3 and decreasing by 2.19% or 100 individuals thereafter.
- DY 5: Decrease by 4.38% or by 200
- DY 4: Decrease by 6.57% or by 300
- DY 5: Decrease by 8.76% or by 400

**Technical Change:** Update the baseline for metric I-12.1 to reflect 5.25 full-time providers, as intended by the provider.

**Technical Change:** Update the goal for metric I-101.1 to state "Patients served will be above Emergence normal patient load", as intended by the provider.

**Technical Change:** Update the appropriate reports to reflect the intended documentation requirements.

**Technical Change:** Update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the following goals intended by the provider for QPI metric I-123.1:

- Each year the agency would increase services by 9%

**Technical Change:** Update the baseline goal for I-12.1 in DY4 and DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 3).

**Technical Change:** Update the baseline for I-12.1 in DY5: Decrease by 8.76% or by 400. HHSC also updated QPI metric I-101.1 in DY5 only as intended by the provider. The provider stated, "Patients served will be above Emergence normal patient load". MSLC also recommended updating baseline for I-12.1. HHSC updated the baseline for I-12.1 in DY4 and DY5 to reflect the baseline at 5.25 full-time providers.

**No recommendations at this time.**

**Technical Change:** Update the baseline and goals for metric I-10.1 as follows, as intended by the provider:

- The baseline should be 4,562, starting with a 4.38% reduction beginning in DY 3 and decreasing by 2.19% or 100 individuals thereafter.
- DY 5: Decrease by 4.38% or by 200
- DY 4: Decrease by 6.57% or by 300
- DY 5: Decrease by 8.76% or by 400

**Technical Change:** Update the baseline for metric I-12.1 to reflect 5.25 full-time providers, as intended by the provider.

**Technical Change:** Update the goal for metric I-101.1 to state "Patients served will be above Emergence normal patient load", as intended by the provider.

**Technical Change:** Update the appropriate reports to reflect the intended documentation requirements.

**Technical Change:** Update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the following goals intended by the provider for QPI metric I-123.1:

- Each year the agency would increase services by 9%

**Technical Change:** Update the baseline goal for I-12.1 in DY4 and DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 3).

**Technical Change:** Update the baseline for I-12.1 in DY5: Decrease by 8.76% or by 400. HHSC also updated QPI metric I-101.1 in DY5 only as intended by the provider. The provider stated, "Patients served will be above Emergence normal patient load". MSLC also recommended updating baseline for I-12.1. HHSC updated the baseline for I-12.1 in DY4 and DY5 to reflect the baseline at 5.25 full-time providers.

**No recommendations at this time.**

**Technical Change:** Update the baseline and goals for metric I-10.1 as follows, as intended by the provider:

- The baseline should be 4,562, starting with a 4.38% reduction beginning in DY 3 and decreasing by 2.19% or 100 individuals thereafter.
- DY 5: Decrease by 4.38% or by 200
- DY 4: Decrease by 6.57% or by 300
- DY 5: Decrease by 8.76% or by 400

**Technical Change:** Update the baseline for metric I-12.1 to reflect 5.25 full-time providers, as intended by the provider.

**Technical Change:** Update the goal for metric I-101.1 to state "Patients served will be above Emergence normal patient load", as intended by the provider.

**Technical Change:** Update the appropriate reports to reflect the intended documentation requirements.

**Technical Change:** Update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the following goals intended by the provider for QPI metric I-123.1:

- Each year the agency would increase services by 9%

**Technical Change:** Update the baseline goal for I-12.1 in DY4 and DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 3).

**Technical Change:** Update the baseline for I-12.1 in DY5: Decrease by 8.76% or by 400. HHSC also updated QPI metric I-101.1 in DY5 only as intended by the provider. The provider stated, "Patients served will be above Emergence normal patient load". MSLC also recommended updating baseline for I-12.1. HHSC updated the baseline for I-12.1 in DY4 and DY5 to reflect the baseline at 5.25 full-time providers.
Recommendations to HMSC

Recommendations to Provider

HMSC Response to Recommendation for

HMSC Response to Recommendations for Not Project

Provider Project ID

Overall Risk Rating

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Technical Change: Update the goal in metric I-13.1 in DY 5 to clarify the provider's intent to increase the number of trainees by one and not two. The provider reported partial achievement of this metric during the April DY3 reporting period and achievement in the October DY3 reporting period. The documentation submitted shows attendance at events held on 4/25/2014 and 8/28/2014.

Technical Change: Update the project narrative to reflect baseline/Uninsured percentage listed in QPI Summary (25%M, 20%U). MSLC also recommended to update project narrative to reflect MLIU percent. HMSC is not requesting all projects to include MLIU because QPI Excel file summary will reflect the correct most updated info.

Technical Change: Update the Phase 4 Master Summary to clarify the goal in metric I-23.1 in DY 5 to clarify the provider's intent to increase the QPI goals for DY 4 and DY 5.

Technical Change: Update the Phase 4 Master Summary to clarify the metric description. Since provider indicated in DY 3 that they only intended to take on 1 additional trainee, despite metric I-13.1 goal stating that the goal was to increase by 100% from DY 2 (2 trainees). The project submitted a plan modification to HMSC to increase the QPI goals for DY 4 and DY 5.

Technical Change: Update the Phase 4 Master Summary to clarify the metric description. MSLC did not have any recommendations.

Technical Change: Update the Phase 4 Master Summary to clarify the goal in metric I-31.1 in DY 3 to clarify the provider's intent to increase by 100% from DY 2 (2 trainees). The provider submitted the required template during the NMI period. The provider submitted a plan modification to HMSC to increase the QPI goals for DY 4 and DY 5.

Technical Change: Update the Phase 4 Master Summary to clarify the goal in metric I-31.1 in DY 3 to clarify the provider's intent to increase by 100% from DY 2 (2 trainees). The project submitted a plan modification to HMSC to increase the QPI goals for DY 4 and DY 5.

Recommendations to HHSC

Recommendations to Provider

HMSC Response to Recommendation for

HMSC Response to Recommendations for Not Project

Provider Project ID

Overall Risk Rating

Narrative Describing Mid-Point Assessment Score Justification

Recommendations to HHSC

Technical Change: Update the goal in metric I-13.1 in DY 5 to clarify the provider's intent to increase the number of trainees by one and not two. The provider reported partial achievement of this metric during the April DY3 reporting period and achievement in the October DY3 reporting period. The documentation submitted shows attendance at events held on 4/25/2014 and 8/28/2014.

Technical Change: Update the project narrative to reflect baseline/Uninsured percentage listed in QPI Summary (25%M, 20%U). MSLC also recommended to update project narrative to reflect MLIU percent. HMSC is not requesting all projects to include MLIU because QPI Excel file summary will reflect the correct most updated info.

Technical Change: Update the Phase 4 Master Summary to clarify the goal in metric I-23.1 in DY 5 to clarify the provider's intent to increase the QPI goals for DY 4 and DY 5.

Technical Change: Update the Phase 4 Master Summary to clarify the metric description. Since provider indicated in DY 3 that they only intended to take on 1 additional trainee, despite metric I-13.1 goal stating that the goal was to increase by 100% from DY 2 (2 trainees). The project submitted a plan modification to HMSC to increase the QPI goals for DY 4 and DY 5.

Technical Change: Update the Phase 4 Master Summary to clarify the metric description. MSLC did not have any recommendations.

Technical Change: Update the Phase 4 Master Summary to clarify the goal in metric I-31.1 in DY 3 to clarify the provider's intent to increase by 100% from DY 2 (2 trainees). The provider submitted the required template during the NMI period. The provider submitted a plan modification to HMSC to increase the QPI goals for DY 4 and DY 5.

APPENDIX 2 - RHP 15
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Medical Center of El Paso 1389512112.2.3</td>
<td>2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete.</td>
<td>Provider reports to be on track to meet their DY 3 metrics. QPI metric I-13.1 reports 5,000 out of 10,000 encounters as of April DY 3. Unclear baselines for DY 4 and DY 5 metrics. DY 4 references an initial baseline while DY 5 states that it should be 10,000 over DY 4. However, for DY 5 the goal is only 10,000 additional encounters.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the provider’s intended baseline and goal for metric I-13.1 in DY 4. The goal states 10,000 encounters over DY 4, which could mean the DY 5 goal is 20,000 and not 10,000.</td>
<td>N/A</td>
<td>AISC recommended updating Provider should update the Phase 4 Master Summary to reflect the provider’s intended baseline and goal for metric I-13.1 in DY 4. The goal states 10,000 encounters over DY 4, which could mean the DY 5 goal is 20,000 and not 10,000 as the provider intended. HHSC followed up with the provider and provider confirmed existing goals. We expect approximately 10,000 admissions from ED visits per year, every year. In addition, the provider confirmed that they will report on multiple goals of the metric.</td>
</tr>
<tr>
<td>El Paso Children’s Hospital 291854201.2.1</td>
<td>1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete.</td>
<td>Support for DY 2 metric P-2.1 shows that 1,941 patients were managed by the Hospitalist Team, which is 77% (out of 2519) of the total patients. However, the goal for this metric states 80% of the total patients will be managed by the Hospitalist Team. DY 4 metric states the same amount of additional patients seen in the clinic as the DY 4 metric which is inconsistent with the project narrative.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the provider’s intended potential additional patients seen (16,006) for metric I-13.1 in DY 5.</td>
<td>N/A</td>
<td>AISC recommended updating the Phase 4 Master Summary to reflect the provider’s intended baseline and goal for metric I-13.1 in DY 5. The goal states 10,000 encounters over DY 5. Although the provider reports only 67 patients out of 180 for their DY 3 QPI metric I-101.1, the provider states the metric is on track for achievement by the end of DY 3. Although the provider reports only 1 of 3 DY 3 milestones complete.</td>
</tr>
<tr>
<td>University Medical Center of El Paso 1389512112.2.3</td>
<td>2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete.</td>
<td>Provider reports to be on track to meet their DY 3 metrics. Although the provider reports only reaching 37 patients out of 350 for their DY 3 QPI metric I-111.1, the provider states the metric is on track for achievement by the end of DY 3.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the provider’s intended baseline and goal for metric I-13.1 in DY 5. The goal states 10,000 encounters over DY 4, which could mean the DY 5 goal is 20,000 and not 10,000.</td>
<td>N/A</td>
<td>AISC did not have any recommendations.</td>
</tr>
<tr>
<td>Las Palmas Medical Center 1389512112.2.1</td>
<td>1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete.</td>
<td>Provider has already achieved their DY 3 metric goals of hiring 2 case managers so it is clear that this project will remain on track for the rest of DY 3. QPI metric starts in DY 4. No potential risks noted. This was assessed as a benchmark project because of the substantial lessons learned from identifying and overcoming the challenge of hiring case managers.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the provider’s intended potential additional patients seen (16,006) for metric I-13.1 in DY 5.</td>
<td>N/A</td>
<td>AISC did not have any recommendations.</td>
</tr>
<tr>
<td>University Medical Center of El Paso 1389512112.2.7</td>
<td>2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete.</td>
<td>Provider reports to be on track to meet their DY 3 metrics. Although the provider reports only reaching 67 patients out of 180 for their DY 3 QPI metric I-101.1, the provider states the metric is on track for achievement by the end of DY 3. Support for DY 2 metric P-9.1 shows 17 separate meetings took place; however, the goal for this metric is 2 per month (24).</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update the Phase 4 Master Summary to reflect the provider’s intended baseline and goal for metric I-13.1 in DY 4. The goal states 10,000 encounters over DY 4, which could mean the DY 5 goal is 20,000 and not 10,000. If the goal states 2 meetings per month, the supporting documentation should clearly show 2 meetings per month during the DY took place, such as meeting notes from the two different dated meetings.</td>
<td>N/A</td>
<td>AISC did not have any recommendations for the project.</td>
</tr>
</tbody>
</table>

APPENDIX 2 - RHP 15

NOTES AND STATUTORY LC
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for Bid Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergence Health Network</td>
<td>127376505.2.2</td>
<td>4</td>
<td>1 of 1 DY 2 milestones complete, 0 of 3 DY 3 milestones complete. Provider reports, “Emergence Health Network expects to serve 15 individuals during DY 3. Emergence Health Network does not expect to meet stated target of 40 individuals” for QPI metric in DY 3 because the goal did not account for start-up and implementation of the project. This poses a risk of hindering DY 4 and DY 5 QPI metrics. The provider states that in order to meet metrics, they are considering two options: 1) Carry forward metrics each year and meet them at the end of the DSRIP program. 2) Begin conversations with the local Juvenile Probation Department (JPD) to fund an additional therapist, since the majority of the referrals come from JPD.</td>
<td>Consideration should be given to the potential impact on project valuation if plan modification to decrease QPI is submitted and approved.</td>
<td>Feasible Plan Modification: Provider should consider decreasing QPI goal in metrics I-101.1 to a more achievable value because the carry forward of this metric may threaten the achievement of QPI goals for I-101.1 in subsequent years.</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project’s valuation.</td>
<td>HHSC recommended consideration for decreasing QPI goal in metric I-101.1 to a more achievable value because of the carry forward metric that may threaten the achievement of QPI goals for I-101.1 in subsequent years. HHSC reviewed subsequent project reporting. Provider reported achievement of DY3 QPI goal, and is working on achieving DY4 goal by September of 2015. According to the provider’s reporting, program has been very successful since its launch, with reportedly no turnover. HHSC does not believe that adjustments to DY5 goals are necessary. HHSC is awaiting a confirmation from the provider regarding HHSC assessment.</td>
</tr>
</tbody>
</table>
**Recommendations to Provider**

- **Central Counties Services**
  - **Project ID:** 381779001.1.1
  - **Provider:** Region MHMR Heart of Texas
  - **Overall Risk Ranking:** 1
  - **Narrative Describing Mid-Point Assessment Score Justification:**
    - 2 of 3 DY 2 milestones complete, 0 of 2 DY 3 milestones complete.
    - Although the achievement of the DY 2 milestones and metrics are behind schedule, it doesn’t appear the project needs a significant change to get back on track.
    - Note: MSLC noted measurement of metric for I-101 milestone was unclear as to whether the provider was counting individuals or encounters, however, a plan modification had already been submitted and approved by HHSC to clarify the baseline and QPI metric.
    - **Possible Plan Modification:** 2 of 3 DY 2 milestones complete.
    - No major risks/shortcomings identified that would impede the progress of the project.
    - **Recommendations to Provider:** No recommendations at this time.

- **Central Counties Services**
  - **Project ID:** 381779001.1.3
  - **Provider:** Hamilton General Hospital
  - **Overall Risk Ranking:** 1
  - **Narrative Describing Mid-Point Assessment Score Justification:**
    - 0 of 1 DY 2 milestone complete, 0 of 2 DY 3 milestones complete.
    - MSLC identified this project as a risk because provider submitted a plan modification reducing amount of new providers to be hired from 3 to 2. HHSC wants to make sure the project is still on track to meet DY 4-5 goals. It appears the project is still on track to see the increased amount of encounters despite hiring only 2 providers instead of 3.
    - **Possible Plan Modification:** 0 of 2 DY 3 milestones complete.
    - No major risks/shortcomings identified that would impede the progress of the project.
    - **Recommendations to Provider:** No recommendations at this time.

- **Goodall-Witcher Healthcare Foundation**
  - **Project ID:** 5770152.1.4
  - **Provider:** Goodall-Witcher Healthcare Foundation
  - **Overall Risk Ranking:** 1
  - **Narrative Describing Mid-Point Assessment Score Justification:**
    - 1 of 2 DY 2 milestone complete, 0 of 1 DY 3 milestone complete.
    - No major risks/shortcomings identified that would impede the progress of the project.
    - **Recommendations to Provider:** No recommendations at this time.

- **Hamilton General Hospital**
  - **Project ID:** 521792903.1.4
  - **Provider:** Hamilton General Hospital
  - **Overall Risk Ranking:** 1
  - **Narrative Describing Mid-Point Assessment Score Justification:**
    - 0 of 1 DY 2 milestone complete, 0 of 2 DY 3 milestones complete.
    - The project is behind, due to late approval. The provider reported in April DY 3 that they intend to start using teledermatology in June 2019. With full implementation of teledermatology, it is possible the project may get back on track. Metric I-17.3 does not clearly depict the intent of the Cat 1 Menu.
    - The provider stated they never intended to add metric I-17.3 to the project.
    - **Recommendations to Provider:** No recommendations at this time.

- **Heart of Texas Region MHMR Center**
  - **Project ID:** 584055902.2.1
  - **Provider:** Heart of Texas Region MHMR Center
  - **Overall Risk Ranking:** 1
  - **Narrative Describing Mid-Point Assessment Score Justification:**
    - 3 of 3 DY 2 milestones complete, 0 of 2 DY 3 milestones complete.
    - Outlays with opening of the clinic have caused this project to be behind schedule. As of April DY 3, this project is at risk of not achieving its milestones/metrics in a timely manner.
    - Note: During site visit, the provider stated it took longer to get the FQHC scope change approved then anticipated, but since then the project has been very successful. The provider stated they have met all of their DY 2 and DY 3 milestones. The provider would consider increasing QPI for DY 4 and DY 5, as it appears they will be able to achieve them sooner than expected.
    - **Consideration should be given to possible impact on project valuation if plan modification to increase QPI is approved.**
    - **Possible Plan Modification:** Provider should consider increasing goals for QPI metrics I-12.1 to DY 4 and DY 5. The provider stated they were able to enroll and serve 254 individuals from 7/1/14 - 9/30/14. The QPI goal for I-8.1 in DY 3 was 250.
    - **Recommendations to Provider:** No recommendations at this time.

**HHSC Response to Recommendation for the Project**

- **Central Counties Services**
  - **Project ID:** 381779001.1.1
  - **Provider:** Region MHMR Heart of Texas
  - **Overall Risk Ranking:** 1
  - **Recommendations to HHSC:** No recommendations at this time.
  - **MSLC Response to Recommendations for the Project:** No recommendations at this time.

- **Central Counties Services**
  - **Project ID:** 381779001.1.3
  - **Provider:** Hamilton General Hospital
  - **Overall Risk Ranking:** 1
  - **Recommendations to HHSC:** No recommendations at this time.
  - **MSLC Response to Recommendations for the Project:** No recommendations at this time.

- **Goodall-Witcher Healthcare Foundation**
  - **Project ID:** 5770152.1.4
  - **Provider:** Goodall-Witcher Healthcare Foundation
  - **Overall Risk Ranking:** 1
  - **Recommendations to HHSC:** No recommendations at this time.
  - **MSLC Response to Recommendations for the Project:** No recommendations at this time.

- **Hamilton General Hospital**
  - **Project ID:** 521792903.1.4
  - **Provider:** Hamilton General Hospital
  - **Overall Risk Ranking:** 1
  - **Recommendations to HHSC:** No recommendations at this time.
  - **MSLC Response to Recommendations for the Project:** No recommendations at this time.

- **Heart of Texas Region MHMR Center**
  - **Project ID:** 584055902.2.1
  - **Provider:** Heart of Texas Region MHMR Center
  - **Overall Risk Ranking:** 1
  - **Recommendations to HHSC:** No recommendations at this time.
  - **MSLC Response to Recommendations for the Project:** No recommendations at this time.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for All Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corpus Christi Memorial Hospital ALC 34772472.1</td>
<td>2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>-</td>
<td>No recommendations at this time.</td>
<td>Recommended plan modification to increase QPI goals. MSLC recommended the provider establish the baseline for measurement of QPI metrics. HHSC did not follow-up with the provider on this recommendation.</td>
</tr>
<tr>
<td>Joanne Wolfson Hall ALC 33705103.2</td>
<td>0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>-</td>
<td>No recommendations at this time.</td>
<td>Recommended plan modification to increase QPI goals. MSLC recommended the project narrative be updated to reflect intended QPI goals for DY 4 and DY 5 because the provider states they have seen 50 patients as of April DY 3 and the QPI goal for I-3.2 in DY 3 is intended to be 40. HHSC did not contact the provider to clarify the QPI goals and updated the project narrative to reflect intended DY3 QPI for goal of P-3.2 of 40, not 75.</td>
</tr>
<tr>
<td>Limestone Medical Center ALC 46774401.2</td>
<td>1 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete.</td>
<td>-</td>
<td>No recommendations at this time.</td>
<td>Recommended plan modification to increase QPI goals. MSLC recommended the Phase 4 Master Summary be updated to reflect the QPI measurement to be individuals for metric I-17.2. HHSC worked with the provider and replaced I-17.2 with I-10.1 and changed the language from encounters to unique patients that receive telehealth services and the denominator is the number of residents in HPSA. This isn't reflected in metric I-17.2 in the Phase 4 Master Summary.</td>
</tr>
<tr>
<td>Joanne Wolfson Hall Healthcare Foundation ALC 33705103.1</td>
<td>0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.</td>
<td>-</td>
<td>No recommendations at this time.</td>
<td>Recommended plan modification to increase QPI goals. MSLC recommended the provider consider decreasing QPI goal for I-9.1 to a more achievable value due to late approval of the project. HHSC contacted the provider to see if provider feels that the QPI goals are still achievable. HHSC did not contact the provider on this recommendation.</td>
</tr>
</tbody>
</table>

**Technical Change:**
- **Establish the baseline for measurement of QPI metrics.**
- **Update QPI Summary and semi-annual report to reflect intended DY4 QPI for goal of P-3.2 of 40, not 75.**
- **MSLC recommended the QPI Summary and semi-annual report be updated to reflect intended DY3 QPI for metric P-3.2 of 40, not 75. HHSC felt the QPI of 75 should remain because baseline was reported as 0.**
- **MSLC recommended a possible adjustment to increase QPI goals for DY4 and DY5 because the provider states they have seen 50 patients as of April DY3 and the QPI goal for I-3.2 in DY4 is intended to be 40. HHSC contacted the provider to clarify the QPI goals and updated the project narrative to reflect a DY4 goal of 120 and a DY5 goal of 170 for QPI metric P-3.2.**
- **MSLC recommended the Phase 4 Master Summary be updated to reflect the QPI measurement to be individuals for metric I-17.2 in DY4 and that metric I-17.2 be replaced with I-10.1 to more accurately reflect the intent of the project. HHSC worked with the provider and replaced I-17.2 with I-10.1 and changed the language from encounters to unique individuals in DY4.**
- **MSLC recommended the provider establish the baseline for measurement of QPI metrics. HHSC found that the pre-USPAP baseline for was 0. HHSC did not follow-up with the provider on this recommendation.**
- **MSLC recommended the provider consider decreasing QPI goal for a more achievable value due to the delayed implementation of the telemedicine equipment. HHSC did not agree with this recommendation given that with 40% MLIU, DY4 18 individuals to stay within range. HHSC does not change valuation based on QPI changes unless the project is outside of valuation ranges.**

**Provider should consider increasing QPI goals in Metric I-9.1 to a more achievable value due to late approval of the project.**

**Provider should consider decreasing QPI goals for Metric I-9.1 to a more achievable value due to late approval of the project.**

**Providers should consider aligning metric I-17.2 to a more achievable value due to the delayed implementation of the telemedicine equipment.**

**Consideration should be given to possible impact on project valuation if plan modification to decrease QPI goals is approved.**

**Consideration should be given to possible impact on project valuation if plan modification to increase QPI goals is approved.**

**Possible Plan Modification:**
- **Provider should consider decreasing QPI goal in Metric I-9.1 to a more achievable value due to late approval of the project.**
- **Provider should consider increasing QPI goals for DY 4 and DY 5 because the provider states they have seen 50 patients as of April DY3 and the QPI goal for I-3.2 in DY 3 is intended to be 40.**
- **Technical Change:** Update project narrative to reflect the removal of metric I-21 in DY 5.
- **Technical Change:** Update QPI Summary and semi-annual report to reflect intended DY 3 QPI goal for metric P-3.2 of 40, not 75.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for this Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamilton General Hospital</td>
<td>211792003.2.10</td>
<td>3</td>
<td>3 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. The milestones and metrics reported on the semi-annual report appear to be behind schedule; however, with carry forward for DY 3 it is possible the project can get on track. Metric goals for I-18.1 are unclear. The provider stated their goal for metric I-18.1 is for 25% of enrolled patients to have a documented self-management goal and in DY 5 for 50% of enrolled patients to have a documented self-management goal.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Update wording in goal for metric I-18.1 in DY 4 and DY 5. Technical Change: Update narrative to reflect Medicaid/Uninsured percentages listed in the QPI Summary (Medicaid = 10%, Uninsured = 22%).</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

MSLC recommended the provider update the wording in goal for metric I-18.1 in DY 4 and DY 5 to clarify the goal as stated by the provider.

HHSC worked with the provider and updated the reporting system to correct goals.

MSLC recommended the narrative be updated to reflect the Medicaid/Uninsured percentages listed in the QPI Summary. HHSC did not feel these changes were needed since the QPI summary would be updated and is the primary source for this information. HHSC did not contact the provider with this recommendation.
Recommendations to Provider

1 of 1 DY 2 milestone complete.
2 of 2 DY 2 milestones complete.
No recommendations at this time.
N/A

East Texas Health District

1 of 1 DY 2 milestone complete.
3 of 3 DY 3 milestones complete.
N/A

Jeff & White

2 of 2 DY 2 milestones complete.
0 of 2 DY 3 milestones complete.
Provider should consider recalculating the baseline for QPI metrics as individuals were counted multiple times if multiple services were received. Provider should also consider if measuring QPI metrics by encounter is more appropriate.

Conroe Regional Medical Center

2 of 2 DY 2 milestones complete.
0 of 2 DY 3 milestones complete.
Technical Change: Update narrative to include Medicaid/Uninsured percentage.

Portneuf Memorial Hospital

2 of 2 DY 2 milestones complete.
0 of 2 DY 3 milestones complete.
No recommendations at this time.
N/A

Portneuf Memorial Hospital

2 of 2 DY 2 milestones complete.
0 of 2 DY 3 milestones complete.
Technical Change: The provider should update the project narrative to reflect the measurement of QPI metric I-101.1 being specialty Cardiac Services. The target population in the narrative currently states, “Residents needing Cardiac Catheterization Laboratory services; and those needing a referral for cath. lab services or a referral for follow-up care after receiving Cath. Lab services.”

APPENDIX 2 - RHP 17
Provider Project ID
Provider Name
Narrative Describing Mid-Point Assessment Score Justification
Recommendations to HHSC
Recommendations to Provider
HHSC Response to Recommendations for the Project
HHSC Response to Recommendation for HHSC

MSLC did not have any recommendations.

No recommendations at this time.

Technical Change:
Update the goal in metric P-5.1 in DY 4 to include the provider's intent to hire more staff.

Technical Change:
Update the Phase 4 Master Summary to clarify the provider's intent to measure the QPI by encounters. The goal still states patients.

Technical Change:
Update the project narrative and Phase 4 Master Summary to reflect the clinic location change. Metric P-1.1 still referenced the DY 3 clinic being in Bedias.

Possible Plan Modification:
Provider should consider updating the project narrative and Phase 4 Master Summary to account for plan modification.

Possible Plan Modification:
Provider should consider reducing QPI goals should there be a continued delay in establishing a clinic in DY 4.

Provider should consider updating the project narrative and Phase 4 Master Summary to reflect the clinic location change. Metric P-1.1 in DY 4 states that the clinic is going to be open in Riverside.

More recommendations updating the project narrative and Phase 4 Master Summary to reflect the clinic location change. MSLC did not feel that this update is necessary since narrative states a clinic would be opened in either Riverside or Bedias and the provider has opened a clinic in Riverside, which is consistent with the narrative. Metic P-1.1 in DY 4 states that the clinic is going to be open in Riverside.

MSLC also recommended to revisit goals for the project due to difficulty in finding clinic space. MSLC will not initiate a discussion of QPI goal reductions prior to the initiation of the 3-year project change request process. If a provider feels that the DYS QPI goal is not achievable, they can submit a request to adjust the DYS QPI goal through the change request process in June 2015. HHSC has notified the provider of the upcoming opportunity to request changes to this project for DYS. HHSC has recommended to the provider that they review the status of the project and request adjustments for DYS if needed. For any requested adjustments, they should provide a thorough explanation of the reason for the requested adjustment.

Provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.

Provider stated in April DY 3 reporting that they are making progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.

No recommendations at this time.

Technical Change:
Update the goal in metric I-7.1 in DY 5 to show the provider's intent to create a reduction of ED visits. The provider should also add the baseline to this goal once it is established.

Technical Change:
Update the goal in metric I-7.1 in DY 5 to show the provider's intent to create a reduction of ED visits. The provider should also add the baseline to this goal once it is established.

Provider stated in April DY 3 reporting that the goal for metric I-7.1 in DY 5 needs some clarification.

No recommendations at this time.

Provider stated in April DY 3 reporting that the 2 staff required in DY 3 metric will be trained by September 2014. DY 3 metric appears to be on track as of April DY 3 reporting.

The measurement and baseline of the goal for metric I-7.1 in DY 5 needs some clarification.

No recommendations at this time.

Provider stated in April DY 3 reporting that the 2 staff required in DY 3 metric will be trained by September 2014. DY 3 metric appears to be on track as of April DY 3 reporting.

The measurement and baseline of the goal for metric I-7.1 in DY 5 needs some clarification.

No recommendations at this time.

Provider stated in April DY 3 reporting that the baseline has been updated to 621 for provider's intent to measure a reduction of ED visits. The provider should also add the baseline to this goal once it is established.

Technical Change:
Update the project narrative and Phase 4 Master Summary to reflect the change in baseline mentioned during April DY 3 reporting for metric P-3.1.

Technical Change:
Update the project narrative and Phase 4 Master Summary to reflect the change in baseline mentioned during April DY 3 reporting for metric P-3.1.

No recommendations at this time.

Provider stated in April DY 3 reporting that the baseline has been updated to 621 for provider's intent to measure a reduction of ED visits. The provider should also add the baseline to this goal once it is established.

Technical Change:
Update the project narrative and Phase 4 Master Summary to reflect the change in baseline mentioned during April DY 3 reporting for metric P-3.1.

MSLC recommended updating the goal in Metric P-5.1 in DY4 to show the provider's intent to hire more staff. The provider should also clarify the baseline and numerical goal for this metric.

MSLC approved this metric as Yes/No. Even though it is always better to have a defined goal, Yes/No was also an acceptable option for this type of metric. Taking that we are already in DY4 HHSC will not be requesting to change goals for DY4. Provider will need to include baseline and show increase in staff during reporting process.

More recommendations updating the project narrative and Phase 4 Master Summary to reflect the clinic location change. MSLC did not feel that this update is necessary since narrative states a clinic would be opened in either Riverises or Bedias and the provider has opened a clinic in Riverside, which is consistent with the narrative. Metic P-1.1 in DY 4 states that the clinic is going to be open in Riverside.

MSLC also recommended to revisit goals for the project due to difficulty in finding clinic space. MSLC will not initiate a discussion of QPI goal reductions prior to the initiation of the 3-year project change request process. If a provider feels that the DYS QPI goal is not achievable, they can submit a request to adjust the DYS QPI goal through the change request process in June 2015. HHSC has notified the provider of the upcoming opportunity to request changes to this project for DYS. HHSC has recommended to the provider that they review the status of the project and request adjustments for DYS if needed. For any requested adjustments, they should provide a thorough explanation of the reason for the requested adjustment.

Provider stated in April DY 3 reporting they had difficulty finding location and didn't realize the population size was not large enough to meet their goals. In order for them to meet their goals, the provider submitted a location change in which HHSC approved. With this significant change of location, it is possible the project can get back on track. The project needs to update Project Narrative and Phase 4 Master Summary to account for plan modification.

During the site visit in the Riverside Clinic, which was open and operational, the provider stated they have made progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.

Provider stated in April DY 3 reporting that they are making progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The measurement and baseline of the goal for metric I-7.1 in DY 5 needs some clarification.

No recommendations at this time.

Technical Change:
Update the goal in metric I-7.1 in DY 4 to include the provider's intent to hire more staff. The provider should also clarify the baseline and numerical goal for this metric.

Technical Change:
Update the Phase 4 Master Summary to clarify the provider's intent to measure the QPI by encounters. The goal still states patients.

Provider stated in April DY 3 reporting that the baseline has been updated to 621 for provider's intent to measure a reduction of ED visits. The provider should also add the baseline to this goal once it is established.

Technical Change:
Update the project narrative and Phase 4 Master Summary to reflect the change in baseline mentioned during April DY 3 reporting for metric P-3.1. Since all of the baseline information is included in QPI templates when provider reports on the metric, HHSC considers QPI templates the most updated record of baseline. Based on this, HHSC will not be updating QPI baselines in the system.

Provider stated in April DY 3 reporting that they are making progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The measurement and baseline of the goal for metric I-7.1 in DY 5 needs some clarification.

No recommendations at this time.

Provider stated in April DY 3 reporting the 2 staff required in DY 3 metric will be trained by September 2014. DY 3 metric appears to be on track as of April DY 3 reporting.

The measurement and baseline of the goal for metric I-7.1 in DY 5 needs some clarification.

No recommendations at this time.

Provider stated in April DY 3 reporting they had difficulty finding location and didn't realize the population size was not large enough to meet their goals. In order for them to meet their goals, the provider submitted a location change in which HHSC approved. With this significant change of location, it is possible the project can get back on track. The project needs to update Project Narrative and Phase 4 Master Summary to account for plan modification.

During the site visit in the Riverside Clinic, which was open and operational, the provider stated they have made progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.

Provider stated in April DY 3 reporting they had difficulty finding location and didn't realize the population size was not large enough to meet their goals. In order for them to meet their goals, the provider submitted a location change in which HHSC approved. With this significant change of location, it is possible the project can get back on track. The project needs to update Project Narrative and Phase 4 Master Summary to account for plan modification.

During the site visit in the Riverside Clinic, which was open and operational, the provider stated they have made progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.

Provider stated in April DY 3 reporting they had difficulty finding location and didn't realize the population size was not large enough to meet their goals. In order for them to meet their goals, the provider submitted a location change in which HHSC approved. With this significant change of location, it is possible the project can get back on track. The project needs to update Project Narrative and Phase 4 Master Summary to account for plan modification.

During the site visit in the Riverside Clinic, which was open and operational, the provider stated they have made progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.

Provider stated in April DY 3 reporting they had difficulty finding location and didn't realize the population size was not large enough to meet their goals. In order for them to meet their goals, the provider submitted a location change in which HHSC approved. With this significant change of location, it is possible the project can get back on track. The project needs to update Project Narrative and Phase 4 Master Summary to account for plan modification.

During the site visit in the Riverside Clinic, which was open and operational, the provider stated they have made progress on their DY 3 QPI metric and intend on achieving it during the carryforward period.

The provider also mentioned to Myers and Stauffer that finding land for sale in the qualification needed was a challenge for the new clinic in DY 4. They hope to have made a decision and have the new clinic open by mid-spring of 2015.
<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas A&amp;M Physicians</td>
<td>198523801.2.2</td>
<td>2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Overachievement is possible for metric I-6.1 in DY 3. The provider has reached 116 of the 125 individuals as of April DY 3 reporting.</td>
<td>Consideration should be given to possible impact on project valuation if plan modification is submitted and approved.</td>
<td>Possible Plan Modification: Provider should consider increasing the QPI goals for DY 4 and DY 5 because provider states they have reached 116 of the 125 required individuals as of April DY 3.</td>
<td>HHSC does not change valuation based on QPI changes, unless the project becomes outside of ranges compare to other projects, and HHSC can decrease project’s valuation.</td>
<td>MSLC recommended increasing QPI goals based on DY3 project achievement. HHSC checked with the provider and updated the goal for I-6.1, which is a QPI metric to be 219, based on the provider information.</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>311023501.2.100</td>
<td>This is a 3-year project therefore it does not have DY 2 milestones. 1 of 3 DY 3 milestones complete. QPI metric P-4.1 has enrolled 10 of the 25 patients required in DY 3. The provider reported this metric is on track for completion in the October reporting period. DY 3 milestones and metrics appear to be on track as of April DY 3.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>College Station Medical Center</td>
<td>32060501.2.1</td>
<td>2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. The provider reported 2 metrics as being complete in April DY 3; however, HHSC required more information to show metric achievement. Myers and Stauffer is not considering this as high risk because the provider was submitting information related to metric that was intended to be met at a later period.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
## Provider Project ID | Overall Risk Ranking | Narrative Describing Mid-Point Assessment Score Justification | Recommendations to HHSC | Recommendations to Provider | HHSC Response to Recommendation for HHSC | HHSC Response to Recommendations for the Project
--- | --- | --- | --- | --- | --- | ---
LifePath Systems 084001901.1.1 | 2 of 2 DY 2 milestones complete | 2 of 2 DY 3 milestones complete | No recommendations at this time. | Potential Plan Modification: Provider should consider updating the narrative to reflect the change in the location of the new clinic. | N/A | MSLC recommended updating the narrative to include the new clinic location. Provider updated the narrative and submitted to HHSC. Recommendation is addressed.
LifePath Systems 084001901.2.1 | 2 of 2 DY 2 milestones complete | 2 of 2 DY 3 milestones complete | No recommendations at this time. | Possible Plan Modification: Provider should consider decreasing the QPI goal. However, if QPI is decreased, the project needs a valuation review for DY 4 and DY 5. The provider will still be able to keep the project going while meeting its goals. | N/A | MSLC recommended decreasing QPI due to difficulties in managing population served by this project. BH population often experiences high no-show rates and longer than average appointment times which would result in a lower QPI. HHSC requested an update on the status from the provider. Provider stated that while this project has proven to be the most difficult project to implement, they believe that the DY5 QPI goal remains achievable. No changes were made to the project.
LifePath Systems 084001901.2.2 | 1 of 2 DY 2 milestones complete | 2 of 2 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
LifePath Systems 084001901.2.3 | 2 of 2 DY 2 milestones complete | 2 of 2 DY 3 milestones complete | No recommendations at this time. | Possible Plan Modification: Provider should consider replacement of milestone I-17 with a customizable milestone. The provider is an LMHA and does not provide preventative health services. | N/A | MSLC recommended updating project metrics and considering substituting a QPI metric with a customizable milestone. The provider is an LMHA and does not provide preventative health services. In addition, provider's understanding of the metric's language was different than MSLC interpretation. HHSC contacted provider, who requested to replace current I-17 QPI measure with two measures: P-8 and I-19.1, a new QPI measure. HHSC reviewed this request and determined that this would address the concerns raised by MSLC. HHSC made updates in the system.
Arias Center 08434201.1.4 | 1 of 1 DY 2 milestones complete | 0 of 1 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
Forsa Community Center 08434201.2.2 | 0 of 1 DY 2 milestones complete | 0 of 1 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
Forsa Community Center 08434201.2.3 | 0 of 1 DY 2 milestones complete | 0 of 1 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
Forsa Community Center 08434201.3.4 | 0 of 1 DY 2 milestones complete | 0 of 1 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
Forsa Community Center 08434201.4.5 | 0 of 1 DY 2 milestones complete | 0 of 1 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
Forsa Community Center 08434201.5.6 | 0 of 1 DY 2 milestones complete | 0 of 1 DY 3 milestones complete | No recommendations at this time. | No recommendations at this time. | N/A | MSLC did not have any recommendations.
**APPENDIX 2 - RHP 18**

### Provider Project ID

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Overall Risk Tolerance</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Frisco, Ltd. Centennial Medical Center</em> 1656563001.1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Harbor Regional MHMR Center</em> 121998304.2.1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Harris County</em> 09497801.1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Jacksonville Community Center</em> 0943439021.2.3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Lakes Regional MHMR Center</em> 121998304.2.1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Lebanon Medical Center</em> 138910807.1.1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Monroe Medical Center</em> 138910807.1.3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Recommendations to Provider

**Recommendation 1:**
- **Possible Plan Modification:** Provider should consider deleting the number of patients stated in the I-18.3 goal or include the number of patients served in a new metric, such as I-18.4.
- **Technical Change:** MSLC recommended deleting some language from DY5 Metric I-15.2.

**Recommendation 2:**
- **Possible Plan Modification:** Provider should consider deleting the unique number of individuals for DY4 and DY5 and only report a percentage based on the number of individuals enrolled. The unique number currently reported is the number of patients served by the intervention but does not necessarily explain adherence to medication. This should be a separate milestone, such as I-3.
- **Technical Change:** MSLC recommended considering deleting the goal for I-12 metric in DY4 and DY5, as it was measuring increased unique number of individuals, while provider appears to be measuring visits. Provider agreed with this recommendation. MSLC changed I-12.2 from the project’s metrics, leaving I-12.1 as the QPI metric for the project. Goals did not change.

**Recommendation 3:**
- **Possible Plan Modification:** Provider should consider adjusting its baseline for metric I-12.1 and reduce QPI goals in DY4 and DY5.
- **Technical Change:** MSLC recommended changing this metric into a customizable one and HHSC recommended deleting I-12.2 from the project's metrics.

**Recommendation 4:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 5:**
- **Possible Plan Modification:** Provider should consider adjusting its baseline for metric I-15.1 in DY4 and DY5.
- **Technical Change:** MSLC recommended changing this metric into a customizable one and HHSC recommended changing this metric from a 3 year project menu to a 1 year project menu.

**Recommendation 6:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 7:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 8:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 9:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 10:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 11:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 12:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 13:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 14:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.

**Recommendation 15:**
- **Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY4 and DY5. The menu does not require the provider to report on "number of unique individuals receiving care under a PCMH." If the provider would like to keep this measure, it should consider measuring it using a customizable milestone.
- **Technical Change:** MSLC recommended considering deleting I-12 metric in DY4 and DY5, as it was measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the percent before and the calculation. Provider agreed with this recommendation. MSLC changed I-12.1 and I-12.2 from the project's menu, and will only measure the number of individuals and not the percent.
Recommendations to Provider

N/A

Technical Change: The P-11.1 percent increase on the Phase 4 Master Summary should be corrected. The percent increase from DY 4 to DY 5 is 140 percent, not 240 percent. (Inc increase: +240 - 100/100)

Possible Plan Modification: The provider should consider modifying metric I-18.2 and using a milestone from the menu specific to reporting encounters. The metric also requires the provider to show a comparison of a subset of patients to the patient population, not simply a percent increase from DY 4 to DY 5. If the provider intends to show only the absolute number of patients and encounters, the provider should consider including a separate customizable metric. This modification could potentially affect valuation as initial project valuation was based on encounters as stated in the metric.

Recommendations to HHSC

N/A

Technical Change: Milestone I-25.1: Recalculate the percent increase on the Phase 4 Master Summary using "number of additional patients who receive instruction " as the numerator. The current calculation is incorrectly using the total number of patients in the numerator. In a percent increase calculation, the numerator is calculated as "Total units-Baseline units=Additional units."

Possible Plan Modification: Provider should consider updating its narrative to show how the wellness center and health education classes together make up a self-management program and how the project impacts the Medicaid/Low-income uninsured population.

Possible Plan Modification: Provider should consider options for increasing its QPI numbers, such as excluding enrollees in the wellness center and/or health education classes, not just those who complete a pre-assessment survey at the wellness center. Attendees at the health education classes are also not currently included in QPI.

Possible Plan Modification: Provider should consider adding a metric to measure the number of clients referred to the wellness center or health classes by physicians in either primary or specialty care or recent hospital discharges as way of showing impact.

Recommendations to HHSC Responses to Recommendations for the Project

N/A

MSLC recommended a technical change to metric P-11.1, since percent increases on the Phase 4 Master Summary should be corrected. The percent increase from DY 4 to DY 5 is 140 percent, not 240 percent. Provider agreed with this recommendation. HHSC updated DSRIP system to reflect 140%.

MSLC also recommended updates to I-18.2 (DY4 and DY5) because the provider should report individuals instead of encounters. The provider is currently reporting encounters. We made a change for QPI metrics from I-18.2 to I-101.1 in DY4 and DY5 and cleaned the language to eliminate individuals and 40 patients using telemedicine services. Goals (in encounters) stayed the same.

Provider Project ID Overall Risk Level Projecting Narrative Describing Mid-Point Assessment Score Justification Recommendations to HHSC

Texas Community Center 384434201.1.1

2

Milestones I-25.1 milestones complete.

0 of 1 DY 2 milestones complete.

of 1 DY 3 milestones complete.

The provider’s QPI measurement (I-18.2) is currently measured in encounters. The metric chosen by the provider requires the QPI be measured in patients.

Based on the information in the Phase 4 Master Summary, the numbers reported on the QPI summary for I-1.1 are incorrect. Total for 0 of 1 of DY 5 should be 140 encounters, not 240. The 240 figure is the total for DY 4 and DY 5.

Technical Change: The I-11.1 percent increase on the Phase 4 Master Summary should be corrected. The percent increase from DY 4 to DY 5 is 140 percent, not 240 percent. (Inc increase +240 - 100/100)

Possible Plan Modification: The provider should consider deleting Metric I-18.2 and using a milestone from the menu specific to reporting encounters. The metric also requires the provider show a comparison of a subset of patients to the patient population, not simply a percent increase from DY 4 to DY 5. If the provider intends to show only the absolute number of patients and encounters, the provider should consider including a separate customizable metric. This modification could potentially affect valuation as initial project valuation was based on encounters as stated in the metric.

HHSC Response to Recommendation for

No recommendations at this time.

N/A

HHSC Response to Recommendations for the Project

N/A

MSLC did not have any recommendations.

Texas Community Center 384434201.1.4

3

Milestones I-25.1 milestones complete.

0 of 1 DY 2 milestones complete.

of 1 DY 3 milestones complete.

The project option, Performance Improvement and Reporting Capacity, receives a higher rating with regard to risk. While the provider is reporting a QPI metric, the provider is not measuring patient impact for a specific service or direct patient intervention. While the provider describes patient impact in the narrative, these benefits are indirect in that quality improvement reports will allow the provider to implement changes, which will affect patients at a later time, such as improving performance to enhance service availability at a lower cost.

The incorrect metric is used on the Phase 4 Master Summary in DY 4 and DY 5.

Provider did not submit the appropriate provider contracts as requested by HHSC for DY 2.

Provider did not update the appropriate provider contracts as requested by HHSC for DY 4.

The provider’s QPI measurement (I-18.2) is currently measured in encounters. The metric chosen by the provider requires the QPI be measured in patients.

No recommendations at this time.

N/A

HHSC Response to  Recommendations for the Project

N/A

MSLC did not have any recommendations.

Permian Hospital 1108586504.2.2

4

Milestones I-25.1 milestones complete.

0 of 1 DY 2 milestones complete.

of 1 DY 3 milestones complete.

The project, based on the information reported, does not currently fit the clinical definition of a self-management program. While the project mentions the development of a fitness center and health education classes, it is unclear if these two pieces of the project are connected. It is also unclear how a patient’s self-management goals are determined and how patients are selected for the project (i.e. from primary care, etc.). The provider’s target population is unclear and the QPI numbers are extremely low.

Provider has incorrectly calculated its percent increase for I-29.1 in its DY 4 and DY 5 goal. The metric requires the provider to calculate the percent increase of patients.

No recommendations at this time.

N/A

HHSC Response to Recommendations for the Project

N/A

MSLC recommended updates to Milestone I-29.1 by recalculating the percent increase on the Phase 4 Master Summary since current calculation is incorrectly using the total number of patients in the numerator. HHSC suggested to change this metric to a customizable since it is used as a QPI. Provider agreed this recommendation.

HHSC changed QPI metric from I-29.1 to I-101.1 (deleted this one) and replaced with I-101.1. Goals stayed the same.

Walmart General Hospital 113701683.1.1

4

Milestones I-25.1 milestones complete.

0 of 1 DY 2 milestones complete.

of 1 DY 3 milestones complete.

Provider did not submit the appropriate provider contracts as requested by HHSC for DY 2.

Provider did not submit the appropriate provider contracts as requested by HHSC for DY 4.

The provider’s QPI measurement (I-18.2) is currently measured in encounters. The metric chosen by the provider requires the QPI be measured in patients.

Provider did not reference the CMS QIPP Narrative for Milestone P-3 for this project option.

Consider adding a requirement to have provider submit a curriculum for health education and wellness classes for Milestone P-3 for this project option.

Possible Plan Modification: Provider should consider updating its narrative to show how the wellness center and health education classes together make up a self-management program and how the project impacts the Medicaid/Low-income uninsured population.

Possible Plan Modification: Provider should consider options for increasing its QPI numbers, such as excluding enrollees in the wellness center and/or health education classes, not just those who complete a pre-assessment survey at the wellness center. Attendees at the health education classes are also not currently included in QPI.

Possible Plan Modification: Provider should consider adding a metric to measure the number of clients referred to the wellness center or health classes by physicians in either primary or specialty care or recent hospital discharges as way of showing impact.

HHSC will take this under consideration.

HHSC worked with the provider to add a new metric in DYS.

MSLC recommended updates in narrative to show how the wellness center and health education classes together make up a self-management program. Provider submitted a revised narrative, which is acceptable to HHSC.

MSLC also recommended updates to QPI by expanding population that is reported in QPI. HHSC reviewed project’s achievement and determined that the provider overachieved based on the current definition of the QPI. Provider agreed to increase its QPI goals to 33 in DYS.

MSLC also recommended adding another metric to the project. Provider agreed to add a metric for the submission of a curriculum for health education and wellness classes (DYS metric).

MSLC also recommended updating narrative to reflect MLIU. HHSC does not require providers to reflect in the narrative, since a separate QPI and MLIU summary file is used for these purposes.
Possible Plan Modification:

Provider reported exceeding its goal of 35 patients with a total of 242 patients. On this report, the provider is incorrect. The provider is reporting progress of 40 percent, greatly exceeding its goal of 13 percent. The provider has incorrectly reported completion of metric for I-101 on the April DY 3 report.

Possible Plan Modification:

Provider should consider updating its narrative if it has only implemented five of the seven Health Promotion programs for DY 3-5.

Technical Change: Metric I-101 (DY 5): Correct typo on the DY 5 goal number on the Phase 4 Master Summary. It currently states "05" as the goal and should state "105."

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Path Community Hospital 11874904.2.2</td>
<td>3 of 4 DY 2 milestones complete. 2 of 3 DY 3 milestones complete.</td>
<td>All approved milestones are on track to be met. Provider reported that its DY 3 metrics required a full year to measure and therefore did not yet report. Although the provider is including a customizable milestone in DY 3 DY 5 to measure the number of patients receiving transition care, we found this to be acceptable since the provider is also including two other improvement milestones in DY 4 and DY 5 directly from the menu. The provider developed a customizable milestone to report an absolute number instead of having to calculate a percentage.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>Path Community Hospital 11874904.2.3</td>
<td>3 of 4 DY 2 milestones complete. 2 of 3 DY 3 milestones complete.</td>
<td>We determined that the provider has incorrectly reported completion of the milestones I-101, I-102. See Recommendations to HHSC. Baseline numbers for metric P-101 in DY 2 only address five of the proposed seven programs the provider intends to implement.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>North Texas Medical Center 121779003.2.1</td>
<td>1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>Pocono General Hospital 327310404.2.1</td>
<td>2 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>Provider also reported exceeding its goal of patient encounters in the new/expanded clinic by 38 encounters (Goal = 459 encounters; Actual achieved at mid-point = 577 encounters).</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>Haven Paralegal Center 257322005.1.2</td>
<td>2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>Provider also reported exceeding its goal of patient encounters in the new/expanded clinic by 38 encounters (Goal = 459 encounters; Actual achieved at mid-point = 577 encounters).</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
</tr>
<tr>
<td>Houston Regional Medical Center 19613004.1.2</td>
<td>5 of 5 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.</td>
<td>This is a project that could possibly need to be withdrawn as provider was not clear on how they would increase visits. The concern is greater as none of the milestones have been met from both DY 2 and DY 3 at this point.</td>
<td>Possible Project Withdrawal: Provider should consider possible withdrawal from the waiver program if it cannot meet the DY 2 and DY 3 milestones necessary to complete the project.</td>
<td>HHSC considered MSLC suggestion regarding project withdrawal. However, based on the most recent reporting by the provider, the clinic is on track to attain DY 2 and DY 3 targets at the end of DY 4 period. The staffing model appear to be stable.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
APPENDIX 2 - RHP 19

<table>
<thead>
<tr>
<th>Provider</th>
<th>Project ID</th>
<th>Overall Risk Ranking</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>Recommendations to Provider</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electra Memorial Hospital</td>
<td>135049003.3.4</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 2 DY 2 milestones complete. Project is well on track to meet to metrics and has been able to increase QPI through expanded hours and increased space. However, the provider's QPI is dependent on the patient deciding to use the primary care clinic instead of another setting, such as the Emergency Department or Urgent Care.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Electra Memorial Hospital</td>
<td>135049003.1.5</td>
<td>3</td>
<td>3 of 5 DY 3 milestones complete. 2 of 7 DY 3 milestones complete. The provider has chosen several milestones and metrics for each DY. While most of the milestones relate to the processes and improvements related to the expansion of specialty care, including increasing patients, visits, and providers, the provider has chosen a process milestone for DY 5 that is out of place. P-18.1 is measuring encounters in which the patient does not see the provider (labs, pharmacy, diagnostics, etc.). This metric does not conform to the scope of the project. NOTE: Provider has submitted a plan modification to delete P- 18.1.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC recommendation was already resolved through the plan modification. No further changes are needed.</td>
</tr>
<tr>
<td>Electra Memorial Hospital</td>
<td>135049003.3.2.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 2 of 2 DY 2 milestones complete. The provider is using a customizable milestone to measure QPI because the milestones on the menu only allow for the provider to measure a percentage, not an absolute number.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>United Regional Health Care System</td>
<td>135237986.2.1</td>
<td>3</td>
<td>3 of 4 DY 3 milestones complete. 0 of 2 DY 3 milestones complete. The current QPI metric I-101 is measuring the number of unique patients benefiting from the project. While patients may receive an indirect benefit of reduced cost, the project does not directly benefit health outcomes. The patient impact QPI is used in the measure of cost containment.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC recommended adding another milestones to DY 5 that would more clearly focus on the impact of the intervention. Provider does not object to the recommendation, but states that there are a lot of barriers to collecting the information from rural hospitals due to manual systems and intense administrative overhead. In addition, provider will be collecting and sharing information from this project in the learning collaborative. HHSC will finalize implementation of this recommendation in the near future.</td>
</tr>
<tr>
<td>United Regional Health Care System</td>
<td>135237986.2.4</td>
<td>1</td>
<td>1 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has reported progress on DY 2 milestone and is on track to meet its goal.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Seymour Hospital</td>
<td>138353107.1.2</td>
<td>2</td>
<td>2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider stated that it intends to increase QPI between DY 4 and DY 5 by advertising the urgent care clinic to the community and performing community outreach in other healthcare settings, such as the Emergency Department. However, the provider's QPI ultimately relies on patients to decide to use Urgent Care instead of other settings.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
<tr>
<td>Seymour Hospital</td>
<td>138353107.2.3</td>
<td>2</td>
<td>3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported completion of all milestones on the DY 2 campaign report. However, HHSC requested additional information for one of the three metrics for milestones P-18.1 but approved the other two metrics. Provider has reported progress on its DY 3 milestones. There is slight risk as this was a replacement project.</td>
<td>No recommendations at this time.</td>
<td>No recommendations at this time.</td>
<td>N/A</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>
Recommendations to Provider

Provider: University of Texas Health Science Center at San Antonio

- NA
- Milestones are not on track to be met currently. Provider has reassigned staff, opened the clinic in February 2014, which has resulted in delays for treating patients. Project has seen 29 patients of 195 in the first two months and expects to meet 120 of 195 by the end of the reporting period, which appears reasonable based on the reassignment of staff.

Provider: Driscoll Children's Hospital

- NA
- Milestones are not on track to be met currently. Provider has reassigned staff, opened the clinic in February 2014, which has resulted in delays for treating patients. Project has seen 29 patients of 195 in the first two months and expects to meet 120 of 195 by the end of the reporting period, which appears reasonable based on the reassignment of staff.

Provider: Border Region Behavioral Health Center

- NA
- Milestones are not on track to be met currently. Provider has reassigned staff, opened the clinic in February 2014, which has resulted in delays for treating patients. Project has seen 29 patients of 195 in the first two months and expects to meet 120 of 195 by the end of the reporting period, which appears reasonable based on the reassignment of staff.

Recommendations to HHSC

- NA
- No recommendations at this time.

Recommendations to HHSC

- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
- No recommendations at this time.
APPENDIX 2 - RHP 20

Recommendations to Provider

<table>
<thead>
<tr>
<th>Provider Project ID</th>
<th>Overall Risk Rating</th>
<th>Narrative Describing Mid-Point Assessment Score Justification</th>
<th>Recommendations to HHSC</th>
<th>HHSC Response to Recommendation for HHSC</th>
<th>HHSC Response to Recommendations for the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unidentified Children's Hospital 332612355.2.100</td>
<td>2 of 2 DY 2 milestones complete</td>
<td>This is a 6-year project and therefore did not have DY 2 milestones. DY 3: 1 of 4 DY 3 milestones complete</td>
<td>Provider is on track to complete the remaining DY 3 metrics by the end of DY 3. Clarification is needed on how to report on milestone 1-102.1.</td>
<td>HHSC should clarify how the provider should report on DY 3 milestone 1-102.1. This goal states &quot;7 over baseline&quot; and the provider states 142 met on the sign-off summary. The baseline is 134, so the goal should state 141. No recommendations at this time.</td>
<td>MSLC recommended a reduction in QPI so the provider will get back on track if the milestones have not been met before the end of the year.</td>
</tr>
<tr>
<td>Unidentified Medical Center 162033801.2.1</td>
<td>3 of 4 DY 2 milestones complete</td>
<td>DY 2 P-10 is looking for patients included in an inquiry (survey), in DY 2 this milestone was met. DY 3: 9 of 10 states they have not completed any surveys from October - March. Provider states &quot;We are committed to continue to participate in the 1115 Waiver project and are working towards meeting all DY 3 metrics and milestones by year end.&quot;</td>
<td>Possible Plan Modification: Recommend a reduction in QPI based on QPI changes, unless the project becomes outside of ranges compared to other projects, and HHSC can decrease project's valuation.</td>
<td>HHSC does not change valuation based on QPI. HHSC recommended a reduction in QPI so the provider will get back on track if the milestones have not been met before the end of the year. Prior to the mid-point assessment, HHSC worked with the provider and their QPI was updated at that time. HHSC did not contact the provider on this recommendation.</td>
<td></td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121987102.2</td>
<td>2 of 2 DY 2 milestones complete</td>
<td>Due to late approval of the project by CMS, milestones have been delayed. The narrative states the expected client impact for demonstration years, but DY 4 milestone 5 states the expected client impact with a baseline for fiscal year 2012. Provider is on track to complete the remaining DY 3 metrics by the end of DY 3. Provider will report on remaining DY metrics during the October reporting period.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC recommended the provider clarify DY 4 milestone 1-5 baseline goals to state whether the baseline should be based on a fiscal year or a demonstration year. HHSC contacted the provider who clarified that FY12 is equivalent to DY1. This was only mentioned in DY4 for metric 1-5, so due to timing, no system changes were made.</td>
</tr>
<tr>
<td>City of Laredo Health Department 137917402.2</td>
<td>4 of 4 DY 2 milestones complete</td>
<td>There is no baseline for DY 2 so we are unable to determine what progress, if any, has been made for DY 3. There is no mention of changing the requirement for &quot;at risk patients&quot; stating they had to attend the Diabetes Self Management (DSM) in the sign-off summary. Unable to determine the progress based on the information provided, but with significant changes the project could be back on track. A plan modification will need to be submitted in order to clarify the criteria for their QPI. Possible Plan Modification: Provider should clarify the criteria for the target population to include baseline information. Note: During the site visit it was stated by the provider that DSM is the same as DSME, therefore, the provider should include an explanation on the supporting documentation to state DSM is the same as DSME.</td>
<td>No recommendations at this time.</td>
<td>Technical Change: Provider should update their narrative to state their various programs. The health and wellness resource center offers programs to include healthy cooking classes with portion control, Zumba classes, walking club, and health screenings which will help to achieve their category 3 outcomes.</td>
<td>NA</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center 121987102.1.3</td>
<td>2 of 2 DY 2 milestones complete</td>
<td>The training manual is completed, but not yet approved, thus hindering the overall progress of the project. Once this has been approved, the project should likely progress and remain on track.</td>
<td>No recommendations at this time.</td>
<td>NA</td>
<td>MSLC did not have any recommendations.</td>
</tr>
</tbody>
</table>

HHSC Response to Recommendations for HHSC

Provider had to update DY3 baseline as MSLC comment is no longer applicable. For non-QPI metrics, the numeric goal may be the increase number or the full achievement number.

MSLC recommended HHSC should clarify how the provider should report on DY3 milestone 1-102.1. This goal states "7 over baseline" and the provider states 142 met on the sign-off summary. The baseline is 134, so the goal should state 141. Prior to receiving the recommendation from MSLC, the provider had to update DY3 baseline, so the MSLC comment is no longer applicable. For non-QPI metrics, the numeric goal may be the increase number or the full achievement number.

MSLC recommended HHSC to clarify the criteria for the target population to include baseline information.

HHSC found that the provider submitted baseline data in the QPI template during October 2020 reporting and additional changes were not needed. HHSC did not contact the provider on this recommendation.

HHSC did not contact the provider on this recommendation.