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

For the Reporting Period Ending
April 30, 2014

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

[redacted]

Austin, TX
May 27, 2015

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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

Assessment as of April 2014

Our risk assessment ranking was limited to information provided by project reporting as of April 2014. Therefore, the assessment of risk did not take into consideration progress made by a project between April 2014 and the date of this report. We acknowledge the likelihood that providers may have experienced either significant progress or possibly unforeseen delays since the April 2014 reporting period. Although it did not affect our assessment of compliance, risk, and progress reflected in this report, information pertaining to the current project status obtained by Myers and Stauffer since the April reporting period (e.g., email communications with providers and site visits) was used during our development of recommendations for project improvement.

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).

Overall Assigned Risk Factors
1 = On Track – Very low risk indicating project is more than likely to meet intended goals.
2 = Very Likely To Be On Track – Low risk indicating project more than likely to meet intended goals with minimal challenges.
3 = Likely To Be On Track – Medium risk indicating project could meet intended goals, but some challenges must be overcome.
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.
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.

Based on the results of our assessment, we developed specific recommendations for providers as either plan modifications to address areas of potential noncompliance 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:

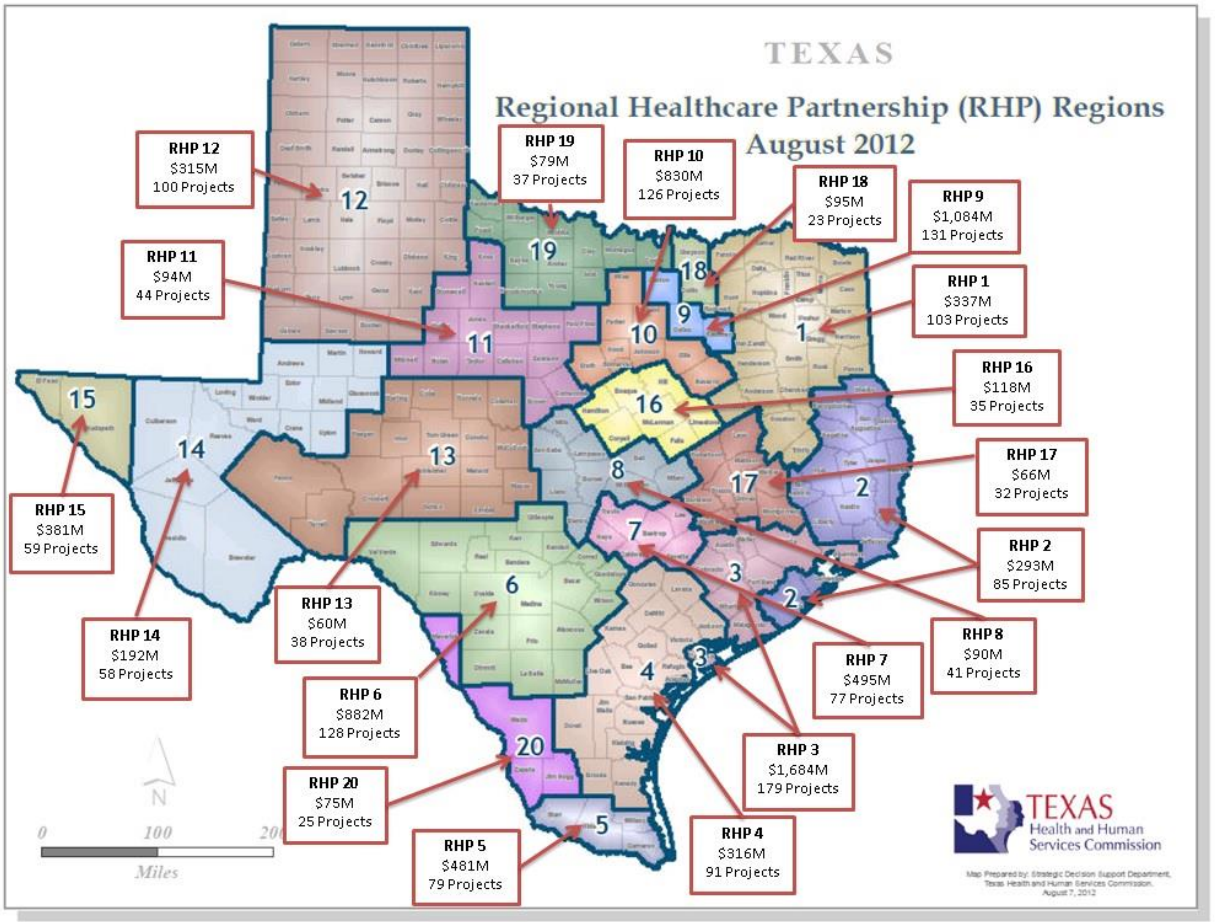
Category 1 - Infrastructure development lays the foundation for delivery system transformation through investments in people, places, processes and technology.

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.

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

Detailed Results Per RHP

RHP 1

Location: 28 counties in Northeast Texas: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, and Wood.

Population: 1,289,873 residents

Total of Projects in RHP: 103

Total DSRIP Funds: $337,353,431.43[1]

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.

- East Texas Medical Center – Tyler (020812601.2.1)
- East Texas Medical Center – Tyler (020812601.2.2)
- Good Shepard Medical Center (094095902.2.1)
- East Texas Medical Center – Trinity (121817401.1.1)
- University Physician Associates (127278302.1.1)
- University Physician Associates (127278302.2.22)
- East Texas Medical Center – Crockett (137319306.1.1)
- East Texas Medical Center – Pittsburg (138374715.1.1)
- East Texas Medical Center – Athens (139173209.2.2)
- Red River Regional Hospital (177870603.2.3)

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 Healthcore (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 Healthcore 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

Location: 16 counties in Southeast Texas: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler.

Population: 1,460,000 residents

Total Number of Projects in RHP: 85

Total DSRIP Funds: $293,444,016.62[2]

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:
    - 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.
    - 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: $1,683,843,730[3]

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.

- West Houston Medical Center (094187402.2.1)
- The University of Texas Health Science Center – Houston (111810101.1.10)
- The University of Texas Health Science Center – Houston (111810101.1.8)
- The University of Texas Health Science Center – Houston (111810101.1.2)
- The University of Texas Health Science Center – Houston (111810101.1.9)
- The University of Texas Health Science Center – Houston (111810101.2.3)
- Mental Health and Mental Retardation Authority of Harris County (113180703.1.12)
- Mental Health and Mental Retardation Authority of Harris County (113180703.2.1)
- Mental Health and Mental Retardation Authority of Harris County (113180703.2.9)
- Mental Health and Mental Retardation Authority of Harris County (113180703.1.11)
- Matagorda Regional Medical Center (130959304.1.1)
- Matagorda Regional Medical Center (130959304.1.3)
- Matagorda Regional Medical Center (130959304.2.1)
- Harris County Hospital District Ben Taub General Hospital (133355104.1.4)
- Harris County Hospital District Ben Taub General Hospital (133355104.1.8)
- Harris County Hospital District Ben Taub General Hospital (133355104.2.1)
- Harris County Hospital District Ben Taub General Hospital (133355104.2.5)
- Fort Bend County Clinical Health Services (296760601.2.3)
- The Methodist Hospital (137949705.2.1)

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

Location: 19 counties in South Texas: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria.

Population: 747,000 residents

Total Number of Projects in RHP: 91 projects

Total DSRIP Funds: $315,542,183[4]

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[5]

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

Location: 20 counties in South-Central Texas: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.

Population: 2,300,000 residents

Total Number of Projects in RHP: 128

Total DSRIP Funds: $882,370,495[6]

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:
  - 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."
  - 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.
  - 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[7]

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[8]

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[9]

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.

- UT Southwestern Medical Center – Faculty Practice Plan (126686802.1.12)
- UT Southwestern Medical Center – Faculty Practice Plan (126686802.1.6)
- UT Southwestern Medical Center – Faculty Practice Plan (126686802.1.7)
- UT Southwestern Medical Center - Faculty Practice Plan (126686802.1.4)
- UT Southwestern Medical Center - Faculty Practice Plan (126686802.2.2)
- UT Southwestern Medical Center – Faculty Practice Plan (126686802.2.6)
- Parkland Memorial Hospital (127295703.2.10)
- Methodist Dallas Medical Center (135032405.2.3)
- Denton County MHMR Center (135234606.2.1)
- Denton County MHMR Center (135234606.2.2)
- Denton County MHMR Center (135234606.2.3)
- Baylor University Medical Center (139485012.2.1)
- Baylor University Medical Center (139485012.2.5)
- Trinity Medical Center (195018001.2.1)

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 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[10]

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)
- 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[11]

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.

[11] 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

Location: 47 counties in the Texas Panhandle: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hansford, Hartley, Hemphill, Hockley, Howard, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, and Yoakam.

Population: 890,820 residents

Total Number of Projects in RHP: 100

Total DSRIP Funds: $315,369,790[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[13]

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[14]

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.

RHP 17

Location: 9 counties in Eastern Central Texas: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker and Washington.

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[19]

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[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.

[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.

    - **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.

    - **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.

RHP 1 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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
East Texas Medical Center - Quitman 017624002.1.1	1	1	1	1	1	1	3	3	3
East Texas Medical Center - Tyler 020812601.1.3	1	1	1	1	1	2	5	4	5
East Texas Medical Center - Tyler 020812601.2.1	1	2	1	3	1	2	4	4	4
East Texas Medical Center - Tyler 020812601.2.2	1	2	1	3	1	2	4	4	4
East Texas Medical Center Tyler 020812601.2.3	1	1	1	3	2	2	3	3	3
Texoma Community Center 084434201.1.3	1	1	1	1	1	1	2	3	2
Texoma Community Center 084434201.1.4	1	1	1	3	2	2	3	2	2
Texoma Community Center 084434201.2.2	1	1	1	1	2	1	2	3	2
Good Shepherd Medical Center 094095902.2.1	1	2	1	3	2	2	4	3	4
Mother Frances Hospital 094108002.1.2	2	1	1	3	1	1	3	3	3
Mother Frances Hospital 094108002.1.3	1	1	1	1	1	1	2	3	2
Mother Frances Hospital 094108002.2.2	1	1	1	1	2	1	2	3	2
East Texas Medical Center Trinity 121817401.1.1	1	1	1	1	1	2	4	4	4
University Physician Associates 127278302.1.1	2	1	1	1	2	2	4	3	4

UTHSCT - MSRDP (University Physician Associates) 127278302.1.11	1	1	2	1	1	2	2	1	1
UTHSCT - MSRDP (University Physician Associates) 127278302.1.13	1	1	1	3	1	2	4	2	3
UTHSCT - MSRDP (University Physician Associates) 127278302.1.9	1	1	1	1	2	2	3	2	2
UTHSCT - MSRDP (University Physician Associates) 127278302.2.16	1	1	1	1	1	2	2	2	2
UTHSCT - MSRDP (University Physician Associates) 127278302.2.17	1	1	1	3	2	2	3	3	3
UTHSCT - MSRDP (University Physician Associates) 127278302.2.19	1	1	1	3	1	2	4	2	3
UTHSCT - MSRDP (University Physician Associates) 127278302.2.22	1	1	1	1	1	2	4	4	4
UTHSCT - MSRDP (University Physician Associates) 127278302.2.23	1	1	1	1	1	2	3	3	3
East Texas Medical Center - Clarksville 130862905.1.1	1	1	1	1	1	2	5	4	5
Hopkins County Memorial Hospital 131037704.2.1	1	1	1	3	3	2	5	1	3
Hunt Regional Medical Center Greenville 131038504.1.1	1	1	1	1	1	1	1	1	1
Hunt Regional Medical Center Greenville 131038504.1.3	1	1	1	3	2	2	4	2	3
East Texas Medical Center - Crockett 137319306.1.1	2	1	1	1	1	2	4	3	4
Community Healthcore 137921608.1.3	1	1	1	1	2	2	5	4	5

East Texas Medical Center Pittsburg 138374715.1.1	1	2	1	1	1	2	4	4	4
Titus Regional Medical Center 138913209.1.2	1	2	1	1	2	2	4	4	4
Titus Regional Medical Center 138913209.2.1	1	1	1	3	3	2	5	1	3
Titus Regional Medical Center 138913209.2.2	1	2	1	3	2	2	3	3	3
East Texas Medical Center - Athens 139173209.2.1	1	1	1	3	2	2	5	5	5
East Texas Medical Center - Athens 139173209.2.2	1	1	1	3	1	2	4	4	4
East Texas Medical Center Athens 139173209.2.3	1	1	1	3	2	2	4	2	3
East Texas Medical Center - Gilmer 168447401.1.1	1	1	1	1	2	2	4	4	4
Red River Regional Hospital 177870603.2.2	1	2	1	3	2	2	4	2	3
Red River Regional Hospital 177870603.2.3	3	2	1	1	2	3	4	4	4
Andrews Center 751281410.2.3	1	2	1	1	1	2	2	2	2

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Coastal Health & Wellness 019053001.1.1	1	2	2	1	2	2	4	5	5
University of Texas Medical Branch Hospital 094092602.1.10	1	1	2	1	1	2	1	1	1
University of Texas Medical Branch Hospital 094092602.1.2	1	1	2	1	2	2	3	3	3
University of Texas Medical Branch Hospital 094092602.1.3	1	1	2	1	1	2	3	3	3
University of Texas Medical Branch Hospital 094092602.1.7	1	1	2	3	2	2	4	3	4
University of Texas Medical Branch Hospital 094092602.1.9	1	1	2	1	2	2	3	2	2
University of Texas Medical Branch Hospital 094092602.2.1	2	1	2	3	1	2	2	2	2
University of Texas Medical Branch Hospital 094092602.2.11	1	1	2	3	2	2	2	2	2
University of Texas Medical Branch Hospital 094092602.2.2	1	1	2	1	1	2	1	2	1
University of Texas Medical Branch Hospital 094092602.2.8	1	1	2	3	3	2	3	3	3
Baptist Hospitals of Southeast Texas 094148602.2.1	1	1	1	3	1	2	4	2	3
Baptist Hospitals of Southeast Texas 094148602.2.2	1	1	1	3	1	2	4	3	4
Spindletop Center 096166602.1.1	2	2	1	3	2	3	4	3	4
Spindletop Center 096166602.1.6	1	2	1	1	2	3	3	3	3
Spindletop Center 096166602.2.10	3	1	1	3	2	3	5	2	4

Spindletop Center 096166602.2.11	1	2	1	3	1	2	3	3	3
Spindletop Center 096166602.2.3	1	1	1	3	1	2	3	1	2
Spindletop Center 096166602.2.9	1	1	1	3	1	3	3	3	3
Physician Practice affiliated with UTMB 109372601.1.1	1	1	2	1	2	2	4	4	4
Physician Practice affiliated with UTMB 109372601.2.2	1	2	2	1	1	2	4	4	4
Physician Practice affiliated with UTMB 109372601.2.3	1	2	2	1	1	2	2	1	1
Brazosport Regional Health System 112671602.1.1	1	1	1	1	1	2	2	2	2
Angleton-Danbury Medical Center 121805903.1.3	2	1	1	1	2	2	3	2	2
Nacogdoches Memorial Hospital 131030203.2.2	1	1	1	3	1	3	2	2	2
The Gulf Coast Center 135222109.1.2	1	1	1	3	1	2	3	3	3
The Gulf Coast Center 135222109.2.2	1	1	1	1	1	2	3	3	3
Burke Center 136367307.2.1	1	1	1	3	1	2	3	2	2
Burke Center 136367307.2.100	1	1	1	3	1	N/A	4	N/A	4
Tyler County Hospital 136381405.2.1	1	1	1	3	1	2	2	2	2
CHRISTUS Hospital 138296208.1.1	1	1	2	3	2	2	3	1	2

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Bayshore Medical Center 020817501.1.1	3	1	1	1	2	1	3	3	3
Bayshore Medical Center 020817501.1.2	2	1	1	1	1	1	3	3	3
Memorial Hermann Northwest Hospital 020834001.1.2	2	1	1	3	2	2	2	2	2
Memorial Hermann Northwest Hospital 020834001.1.4	2	1	1	3	1	1	3	1	2
Memorial Hermann Northwest Hospital 020834001.2.1	2	1	1	3	1	1	3	2	2
Texana Center 081522701.1.1	2	1	1	1	1	1	2	3	2
Texana Center 081522701.1.3	2	1	1	1	1	2	4	3	4
Baylor College of Medicine 082006001.1.1	2	1	2	3	1	1	3	4	4
City of Houston Department of Health and Human Services 093774008.1.1	3	1	1	3	1	2	3	2	2
City of Houston Department of Health and Human Services 093774008.1.2	1	1	1	3	2	2	4	4	4
City of Houston Department of Health and Human Services 093774008.1.3	2	1	1	3	2	2	4	4	4
City of Houston Department of Health and Human Services 093774008.1.4	3	1	1	1	1	3	2	3	2
City of Houston Department of Health and Human Services 093774008.2.1	1	1	1	3	1	2	3	2	2

City of Houston Department of Health and Human Services 093774008.2.10	3	1	1	1	1	1	3	2	2
City of Houston Department of Health and Human Services 093774008.2.2	2	1	1	1	1	1	4	4	4
City of Houston Department of Health and Human Services 093774008.2.4	2	2	1	3	2	1	4	3	4
City of Houston Department of Health and Human Services 093774008.2.7	2	1	1	1	1	1	3	3	3
City of Houston Department of Health and Human Services 093774008.2.8	3	1	1	1	2	2	3	3	3
City of Houston Department of Health and Human Services 093774008.2.9	3	1	1	3	1	1	4	4	4
West Houston Medical Center 094187402.2.1	3	1	1	3	2	1	4	3	4
Spindletop Center 096166602.2.1	2	1	1	1	1	1	3	1	2
Spindletop Center 096166602.2.2	3	1	1	3	2	3	3	3	3
The University of Texas Health Science Center - Houston 111810101.1.10	3	2	1	1	3	1	4	4	4
The University of Texas Health Science Center - Houston 111810101.1.2	2	1	2	1	2	1	3	4	4
The University of Texas Health Science Center - Houston 111810101.1.5	2	1	1	3	1	1	2	4	3
The University of Texas Health Science Center - Houston 111810101.1.7	3	1	1	1	2	1	2	4	3
The University of Texas Health Science Center - Houston 111810101.1.8	3	1	1	3	2	1	3	4	4
The University of Texas Health Science Center - Houston 111810101.1.9	1	1	1	3	2	1	4	4	4

The University of Texas Health Science Center - Houston 111810101.2.3	2	1	1	1	2	1	4	4	4
The University of Texas Health Science Center - Houston 111810101.2.6	1	1	1	1	1	1	2	1	1
The University of Texas Health Science Center - Houston 111810101.2.8	3	1	1	3	1	1	2	3	2
University of Texas M.D. Anderson Cancer Center 112672402.2.2	2	1	1	1	1	1	3	3	3
University of Texas M.D. Anderson Cancer Center 112672402.2.3	2	1	1	3	1	1	3	2	2
University of Texas M.D. Anderson Cancer Center 112672402.2.4	2	1	1	3	1	1	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.1.1	2	1	1	3	1	2	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.1.11	2	1	1	1	2	2	4	4	4
Mental Health and Mental Retardation Authority of Harris County 113180703.1.12	2	1	1	3	2	2	4	4	4
Mental Health and Mental Retardation Authority of Harris County 113180703.1.4	2	1	1	3	1	2	4	2	3
Mental Health and Mental Retardation Authority of Harris County 113180703.1.5	2	1	1	3	1	2	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.1.6	2	1	1	3	1	2	2	3	2
Mental Health and Mental Retardation Authority of Harris County 113180703.1.7	2	1	1	3	1	2	2	3	2
Mental Health and Mental Retardation Authority of Harris County 113180703.1.9	2	1	1	1	1	2	3	2	2

Mental Health and Mental Retardation Authority of Harris County 113180703.2.1	3	2	1	3	2	3	4	4	4
Mental Health and Mental Retardation Authority of Harris County 113180703.2.2	3	1	1	3	1	2	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.2.3	3	1	1	1	1	2	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.2.4	3	1	1	1	1	1	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.2.5	3	1	1	3	1	1	3	3	3
Mental Health and Mental Retardation Authority of Harris County 113180703.2.9	2	2	1	3	2	1	4	3	4
OakBend Medical Center 127303903.1.1	3	1	1	1	1	1	3	1	2
OakBend Medical Center 127303903.1.3	3	1	1	1	2	1	3	1	2
OakBend Medical Center 127303903.2.1	3	1	1	3	2	1	3	1	2
Matagorda Regional Medical Center 130959304.1.1	2	1	2	3	2	1	4	4	4
Matagorda Regional Medical Center 130959304.1.3	2	1	1	3	2	3	4	4	4
Matagorda Regional Medical Center 130959304.2.1	2	1	1	3	2	3	3	4	4
Tomball Regional Hospital 131044305.1.1	1	3	1	3	3	2	5	5	5
El Campo Memorial Hospital 131045004.2.1	3	1	1	3	1	2	3	2	2
Harris County Hospital District Ben Taub General Hospital 133355104.1.1	1	1	2	1	2	3	4	4	4
Harris County Hospital District Ben Taub General Hospital 133355104.1.11	2	1	2	3	1	2	2	3	2

Harris County Hospital District Ben Taub General Hospital 133355104.1.12	2	1	2	3	1	1	2	2	2
Harris County Hospital District Ben Taub General Hospital 133355104.1.13	2	1	2	1	2	1	3	3	3
Harris County Hospital District Ben Taub General Hospital 133355104.1.14	1	1	2	1	2	3	3	4	4
Harris County Hospital District Ben Taub General Hospital 133355104.1.15	3	1	2	3	2	2	3	3	3
Harris County Hospital District Ben Taub General Hospital 133355104.1.17	2	1	2	1	2	2	3	3	3
Harris County Hospital District Ben Taub General Hospital 133355104.1.2	1	1	2	1	2	3	4	4	4
Harris County Hospital District Ben Taub General Hospital 133355104.1.3	3	1	2	3	2	2	3	3	3
Harris County Hospital District Ben Taub General Hospital 133355104.1.4	1	1	2	1	2	2	4	4	4
Harris County Hospital District Ben Taub General Hospital 133355104.1.5	1	1	2	1	1	2	3	2	2
Harris County Hospital District Ben Taub General Hospital 133355104.1.6	1	1	2	1	1	2	3	2	2
Harris County Hospital District Ben Taub General Hospital 133355104.1.8	2	2	2	1	1	2	4	3	4
Harris County Hospital District Ben Taub General Hospital 133355104.1.9	3	1	2	3	1	1	3	2	2
Harris County Hospital District Ben Taub General Hospital 133355104.2.1	2	1	2	3	2	2	4	3	4
Harris County Hospital District Ben Taub General Hospital 133355104.2.2	1	1	2	1	1	3	3	3	3

Harris County Hospital District Ben Taub General Hospital 133355104.2.3	2	1	2	1	1	1	3	3	3
Harris County Hospital District Ben Taub General Hospital 133355104.2.4	2	1	2	1	1	1	3	3	3
Harris County Hospital District Ben Taub General Hospital 133355104.2.5	3	1	2	3	1	3	4	4	4
Harris County Hospital District Ben Taub General Hospital 133355104.2.8	2	1	2	1	2	3	4	4	4
Harris County Hospital District Ben Taub General Hospital 133355104.2.9	1	1	2	1	1	1	2	3	2
Columbus Community Hospital 135033204.1.1	2	3	1	3	2	3	4	2	3
Memorial Hermann Hospital 137805107.1.1	2	1	1	3	2	1	3	2	2
Memorial Hermann Hospital 137805107.1.2	3	1	1	3	1	1	3	2	2
Memorial Medical Center 137909111.1.1	2	1	1	1	1	1	3	2	2
Memorial Medical Center 137909111.2.1	2	1	1	1	1	1	3	3	3
Memorial Medical Center 137909111.2.2	2	1	1	3	2	2	4	2	3
Memorial Medical Center 137909111.2.3	1	1	1	3	2	2	3	3	3
The Methodist Hospital 137949705.2.1	2	1	1	3	2	2	2	4	3
Texas Children's Hospital 139135109.1.1	2	3	1	1	1	1	3	2	2
Texas Children's Hospital 139135109.1.11	2	2	1	1	1	1	3	3	3
Texas Children's Hospital 139135109.1.12	1	2	1	1	1	1	2	2	2
Texas Children's Hospital 139135109.1.15	2	2	1	1	1	1	2	2	2
Texas Children's Hospital 139135109.1.16	3	2	1	1	1	1	2	2	2
Texas Children's Hospital 139135109.1.2	2	2	1	1	1	1	2	2	2

Texas Children's Hospital 139135109.1.3	2	2	1	1	1	1	2	2	2
Texas Children's Hospital 139135109.1.4	2	3	1	1	1	1	2	2	2
Texas Children's Hospital 139135109.1.7	2	3	1	1	1	1	3	3	3
Texas Children's Hospital 139135109.1.8	1	2	1	1	1	1	2	2	2
Texas Children's Hospital 139135109.1.9	2	2	1	3	1	1	3	3	3
Texas Children's Hospital 139135109.2.1	1	1	1	1	1	1	2	1	1
Methodist Willowbrook Hospital 140713201.2.1	2	1	1	1	2	2	3	3	3
St. Joseph Medical Center 181706601.2.2	1	1	1	1	1	2	3	2	2
Rice Medical Center 212060201.1.2	1	1	1	3	2	1	2	3	2
Rice Medical Center 212060201.1.3	1	1	1	1	2	1	3	3	3
Rice Medical Center 212060201.1.4	2	1	1	1	2	1	3	2	2
Rice Medical Center 212060201.2.2	2	1	1	3	2	2	3	3	3
Rice Medical Center 212060201.2.3	2	2	1	3	2	2	3	2	2
Fort Bend County Clinical Health Services 296760601.1.1	1	1	1	1	2	1	2	3	2
Fort Bend County Clinical Health Services 296760601.1.2	2	1	1	1	1	2	2	2	2
Fort Bend County Clinical Health Services 296760601.2.3	2	1	1	3	2	2	4	4	4
Fort Bend County Clinical Health Services 296760601.2.4	2	1	1	3	2	2	2	3	2
OakBend Medical Center 127303903.2.101	1	1	1	1	1	N/A	1	N/A	1

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
CHRISTUS Spohn Hospital Beeville 020811801.1.1	1	1	1	1	1	1	1	2	1
CHRISTUS Spohn Hospital Beeville 020811801.1.3	1	1	1	1	2	1	3	3	3
The Corpus Christi Medical Center - Bay Area 020973601.1.1	1	1	1	1	2	1	4	5	5
Memorial Hospital 121785303.1.3	1	1	1	1	1	1	3	2	2
CHRISTUS Spohn Hospital Kleberg 136436606.1.2	1	1	1	1	2	1	2	2	2
The Corpus Christi Medical Center - Bay Area 020973601.1.4	1	1	1	3	1	1	4	3	4
CHRISTUS Spohn Hospital Corpus Christi 121775403.1.4	1	1	2	1	1	1	1	2	1
Driscoll Children's Hospital 132812205.1.1	1	1	2	1	1	1	2	2	2
DeTar Hospital Navarro 094118902.1.3	1	1	1	1	2	1	1	2	1
CHRISTUS Spohn Hospital Beeville 020811801.2.1	1	2	1	1	1	1	1	2	1
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1	1	1	1	3	1	1	3	1	2
MHMR of Nuces County 138305109.2.1	1	1	1	1	1	1	2	2	2
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.10	1	1	2	1	1	1	1	2	1
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.5	3	1	2	3	3	1	3	4	4
CHRISTUS Spohn Hospital Alice 094222902.2.1	1	1	1	1	2	1	1	2	1

Gulf Bend Center 135254407.2.1	1	2	2	1	2	1	3	3	3
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.4	1	1	2	1	2	1	2	2	2
CHRISTUS Spohn Hospital Kleberg 136436606.2.3	1	1	1	1	2	1	2	2	2
Camino Real Community Services 121990904.2.1	1	1	2	1	1	1	1	1	1
Driscoll Children's Hospital 132812205.1.2	1	1	2	3	1	1	3	3	3
Driscoll Children's Hospital 132812205.1.3	1	1	2	1	1	1	3	2	2
DeTar Hospital Navarro 094118902.2.1	3	1	1	1	1	1	4	2	3
Driscoll Children's Hospital 132812205.2.3	1	1	2	1	1	1	2	1	1
The Corpus Christi Medical Center - Bay Area 020973601.2.2	1	1	1	1	2	1	1	2	1
CHRISTUS Spohn Hospital Alice 094222902.2.3	2	2	1	3	1	1	3	1	2
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.11	1	1	2	1	1	1	4	2	3
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.9	2	1	2	3	1	1	3	1	2
Citizens Medical Center 137907508.2.1	1	1	1	1	2	1	2	4	3
The Corpus Christi Medical Center - Bay Area 020973601.1.5	1	1	1	1	2	1	3	3	3
Yoakum Community Hospital 112673204.1.1	1	1	2	1	2	1	3	3	3
Driscoll Children's Hospital 132812205.1.5	3	1	2	3	1	1	4	3	4
The Corpus Christi Medical Center - Bay Area 020973601.2.1	1	1	1	1	2	1	3	3	3
Coastal Plains Community Center 080368601.2.1	1	1	1	1	1	1	4	4	4
Memorial Hospital 121785303.2.1	1	1	1	1	2	1	3	3	3
Corpus Christi-Nueces County Public Health District 130958505.2.3	1	1	1	1	2	2	3	3	3

Memorial Hospital 121785303.2.2	1	1	1	1	2	1	5	5	5
Citizens Medical Center 137907508.1.100	1	1	1	1	1	N/A	3	N/A	3

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 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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
UT Health Science Center San Antonio 085144601.1.1	1	2	2	1	2	2	1	3	2
McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.104	1	1	2	1	1	1	3	3	3
McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.105	1	1	2	3	1	1	3	3	3
Doctor's Hospital at Renaissance 160709501.1.4	3	1	1	3	2	1	3	1	2
Doctor's Hospital at Renaissance 160709501.1.101	1	1	1	1	3	1	4	4	4
Doctor's Hospital at Renaissance 160709501.1.3	1	2	1	1	2	2	4	4	4
McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.103	1	1	2	1	1	1	1	1	1
University of Texas Health Science Center San Antonio 085144601.1.100	1	1	2	1	3	3	4	4	4
Knapp Medical Center 135035706.1.100	1	1	1	1	2	2	1	1	1
Tropical Texas Behavioral Health 138708601.1.4	1	1	1	1	1	1	3	2	2
UT Health Science Center San Antonio 085144601.1.3	1	1	2	1	2	1	4	3	4
Doctor's Hospital at Renaissance 160709501.1.106	1	1	1	3	3	1	4	4	4
Doctor's Hospital at Renaissance 160709501.1.2	1	2	1	1	2	1	3	3	3
Driscoll Children's Hospital 132812205.1.1	1	2	1	1	1	2	4	1	2
Doctor's Hospital at Renaissance 160709501.1.100	1	1	1	1	2	1	4	4	4
Valley Regional Medical Center 020947001.1.100	1	1	1	1	2	1	3	4	4

UT Health Science Center San Antonio 085144601.2.1	1	1	2	1	1	1	1	1	1
Columbia Rio Grande Healthcare dba Rio Grande Regional 112716902.2.101	1	1	1	1	2	1	1	2	2
University of Texas Health Science Center- Houston 111810101.2.101	1	1	2	1	2	1	2	3	2
Border Region Behavioral Health Center 121989102.2.1	1	1	1	1	2	2	4	4	4
Driscoll Children's Hospital 132812205.2.1	1	1	1	1	1	1	1	2	1
Tropical Texas Behavioral Health 138708601.2.4	1	1	1	1	1	1	1	2	2
Tropical Texas Behavioral Health 138708601.2.2	1	1	1	1	1	1	1	1	1
Starr County Memorial Hospital 136332705.2.1	2	1	1	1	2	1	1	3	2
UT Health Science Center San Antonio 085144601.2.2	1	1	2	1	1	1	1	1	1
McAllen hospitals LP dba Edinburg Regional Medical 094113001.2.100	1	1	2	1	2	2	2	2	2
Tropical Texas Behavioral Health 138708601.2.1	1	1	1	1	1	2	2	2	2
Tropical Texas Behavioral Health 138708601.2.7	1	1	1	1	1	2	2	2	2
UT Health Science Center San Antonio 085144601.1.2	1	1	1	1	2	2	4	4	4
Border Region Behavioral Health Center 121989102.1.2	2	2	1	1	1	2	4	5	5
University of Texas Health Science Center- Houston 111810101.1.100	1	1	2	1	2	2	4	3	3
Border Region Behavioral Health Center 121989102.2.2	2	2	1	1	2	2	3	3	3

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
University of Texas Health Science Center at San Antonio 085144601.1.2	3	1	1	3	1	1	3	3	3
University of Texas Health Science Center at San Antonio 085144601.1.23	2	1	1	1	1	3	3	3	3
CHRISTUS Santa Rosa Hospital 020844901.2.2	1	1	1	1	1	1	2	2	2
The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.5	1	1	1	1	1	1	2	2	2
University Hospital 136141205.2.100	1	1	1	3	1	N/A	2	N/A	2
University of Texas Health Science Center at San Antonio 085144601.1.1	2	1	1	1	2	1	1	3	2
University of Texas Health Science Center at San Antonio 085144601.1.20	2	1	1	3	1	1	3	3	3
Peterson Regional Medical Center 127294003.1.1	1	1	1	3	2	1	3	3	3
University of Texas Health Science Center at San Antonio 085144601.2.5	3	1	1	3	1	1	3	3	3
Baptist Medical Center 159156201.2.1	2	1	1	1	2	1	2	2	2
University of Texas Health Science Center at San Antonio 085144601.1.11	2	1	1	3	2	1	2	4	3
Frio Regional Hospital 112688002.1.1	2	1	1	1	1	1	4	4	4

Dimmit County Memorial Hospital 112690603.1.2	1	1	1	1	2	1	3	4	4
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.1.1	1	1	1	1	2	1	3	3	3
University Hospital 136141205.1.9	1	2	1	3	2	1	3	1	2
CHRISTUS Santa Rosa Hospital 020844901.1.1	1	1	1	3	1	1	2	2	2
University of Texas Health Science Center at San Antonio 085144601.1.16	2	1	1	1	1	1	2	2	2
University of Texas Health Science Center at San Antonio 085144601.1.13	2	1	1	3	2	1	4	4	4
Methodist Hospital 094154402.1.1	2	1	1	3	1	1	2	3	2
University of Texas Health Science Center at San Antonio 085144601.1.15	2	1	1	3	1	1	3	3	3
Medina Regional Hospital 133260309.1.2	2	1	1	1	2	1	2	2	2
University Hospital 136141205.1.4	2	1	1	3	1	1	2	2	2
Val Verde Regional Medical Center 119877204.1.3	1	1	1	1	2	1	2	2	2
University Hospital 136141205.1.11	1	1	1	3	1	1	2	2	2
Connally Memorial Medical Center 135151206.1.2	1	1	1	1	1	1	3	3	3
Baptist Medical Center 159156201.1.2	1	1	1	1	1	1	2	2	2
University of Texas Health Science Center at San Antonio 085144601.1.9	2	1	1	3	1	1	2	3	2
University of Texas Health Science Center at San Antonio 085144601.1.6	2	2	1	1	3	2	5	5	5
The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.1.5	3	1	1	1	2	1	4	3	4
University Hospital 136141205.1.3	2	1	1	1	1	1	2	2	2

University Hospital 136141205.1.6	2	1	1	1	1	1	2	2	2
University Hospital 136141205.1.10	1	1	1	3	2	1	3	1	2
University Hospital 136141205.1.2	1	1	1	1	1	1	2	2	2
San Antonio Metropolitan Health District 091308902.1.1	1	1	1	1	1	1	3	2	2
Community Medicine Associates 092414401.1.1	1	1	1	1	2	1	2	2	2
Baptist Medical Center 159156201.1.3	2	1	1	1	1	1	2	2	2
University of Texas Health Science Center at San Antonio 085144601.1.5	1	1	1	1	2	1	3	3	3
University of Texas Health Science Center at San Antonio 085144601.1.7	1	1	1	3	1	2	3	3	3
Dimmit County Memorial Hospital 112690603.1.1	1	1	1	3	1	1	2	2	2
CHRISTUS Santa Rosa Hospital 020844901.2.1	1	1	1	3	1	1	2	3	2
Peterson Regional Medical Center 127294003.2.1	1	1	1	3	2	1	3	1	2
Texas Center for Infectious Disease 133257904.2.1	1	1	1	1	2	1	2	2	2
Methodist Hospital 094154402.2.1	1	1	1	1	1	1	2	2	2
University Hospital 136141205.2.3	2	1	1	1	1	1	2	2	2
Methodist Hospital 094154402.2.2	1	1	1	1	2	1	2	2	2
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.2	2	1	1	1	1	1	2	2	2
The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.2	1	1	1	1	2	1	2	2	2
Nix Health Care System 112676501.2.2	1	1	1	1	1	1	2	2	2

Nix Health Care System 112676501.2.3	2	1	1	1	1	1	2	2	2
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 133340307.2.6	1	2	1	1	1	1	2	2	2
San Antonio Metropolitan Health District 091308902.2.3	1	1	1	1	1	1	2	3	2
University of Texas Health Science Center at San Antonio 085144601.2.1	2	1	1	3	2	2	4	4	4
Guadalupe Regional Medical Center 138411709.2.1	2	1	1	3	1	1	2	2	2
The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.4	1	1	1	3	1	1	3	1	2
University Hospital 136141205.2.9	2	1	1	1	1	1	2	2	2
Community Medicine Associates 092414401.2.2	1	1	1	1	1	1	3	2	2
University of Texas Health Science Center at San Antonio 085144601.2.4	1	1	1	1	1	1	2	2	2
University Hospital 136141205.2.2	2	1	1	3	1	1	2	2	2
Nix Health Care System 112676501.2.1	2	1	1	3	1	1	3	2	2
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 133340307.2.1	1	1	1	1	1	1	3	1	2
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1	1	1	1	1	1	1	3	1	2

RHP 7 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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Central Texas Medical Center 121789503.1.1	2	1	1	1	1	1	3	3	3
Dell Children's Medical Center 186599001.1.1	1	1	1	1	1	1	2	3	2
Austin Travis County Integral Care 133542405.1.2	1	1	1	3	1	2	2	2	2
St. Mark's Medical Center 176692501.1.1	2	1	1	3	1	1	3	3	3
University Medical Center at Brackenridge 137265806.1.4	1	1	1	1	2	2	2	3	2
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.1.1	2	1	1	1	2	1	2	3	2
Community Care Collaborative 307459301.1.4	2	1	1	3	1	2	3	2	2
Community Care Collaborative 307459301.1.3	1	1	1	1	2	2	2	4	3
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.1.3	1	1	1	1	1	1	3	3	3
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1	2	1	1	1	1	1	2	2	2
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.11	1	1	1	1	1	1	3	1	2

Community Care Collaborative 307459301.2.5	2	1	1	3	1	2	3	3	3
University Medical Center at Brackenridge 137265806.2.7	1	1	1	1	1	1	2	3	2
Community Care Collaborative 307459301.2.7	1	1	1	3	2	2	3	3	3
City of Austin - Health & Human Services Department 201320302.2.2	1	1	1	3	2	1	2	3	2
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.7	1	1	1	1	2	1	2	3	2
University Medical Center at Brackenridge 137265806.2.6	1	1	1	1	1	1	3	3	3
Austin Travis County Integral Care 133542405.2.4	1	1	1	1	1	1	2	2	2
University Medical Center at Brackenridge 137265806.2.3	1	1	1	1	1	1	2	3	2
City of Austin - Health & Human Services Department 201320302.2.6	1	1	1	3	1	1	3	3	3
University Medical Center at Brackenridge 137265806.2.9	1	1	1	1	1	1	2	3	2
Community Care Collaborative 307459301.2.4	1	1	1	1	1	2	3	3	3
Dell Children's Medical Center 186599001.2.1	1	1	1	1	1	1	2	2	2
Community Care Collaborative 307459301.2.6	1	1	1	1	1	1	2	2	2
Dell Children's Medical Center 186599001.2.2	2	1	1	1	1	2	2	2	2
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.5	1	1	1	1	1	2	3	3	3
Austin Travis County Integral Care 133542405.2.6	1	1	1	1	1	1	2	2	2
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.9	1	1	1	1	1	1	2	3	2

University Medical Center at Brackenridge 137265806.1.2	1	1	1	1	1	2	2	3	2
University Medical Center at Brackenridge 137265806.1.5	1	1	1	3	2	2	3	3	3
University Medical Center at Brackenridge 137265806.2.5	1	1	1	1	1	1	3	3	3
University Medical Center at Brackenridge 137265806.2.8	1	1	1	1	1	1	3	3	3
City of Austin - Health & Human Services Department 201320302.2.1	1	1	1	3	1	1	3	1	2
City of Austin - Health & Human Services Department 201320302.2.3	1	1	1	3	1	1	3	3	3
Community Care Collaborative 307459301.2.1	2	1	1	1	2	2	2	3	2

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.**

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

Scott and White Hospital - Llano 020840701.2.2	1	2	1	1	2	2	2	2	2
Little River Healthcare 183086102.1.1	3	2	1	1	3	2	4	3	4

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Texas A&M Health Science Center / Baylor College of Dentistry 009784201.1.2	2	1	1	1	1	2	2	2	2
Texas A&M Health Science Center / Baylor College of Dentistry 009784201.1.3	1	1	1	3	1	2	4	2	3
Texas Health Presbyterian Hospital Dallas 020908201.1.1	1	1	1	3	1	1	3	3	3
Texas Health Presbyterian Hospital Dallas 020908201.2.2	1	1	1	1	1	1	4	2	3
Medical City Dallas Hospital 020943901.1.1	1	1	1	3	1	1	3	2	2
Medical City Dallas Hospital 020943901.1.2	2	1	1	3	1	1	4	3	4
Medical City Dallas Hospital 020943901.2.3	1	1	1	1	1	1	2	2	2
Texas Health Presbyterian Hospital Denton 020967801.2.1	2	1	1	1	1	1	3	3	3
Las Colinas Medical Center 020979301.2.1	1	2	1	1	1	1	4	4	4
Medical Center of Lewisville 094192402.2.1	1	2	1	1	1	1	4	4	4
Medical Center of Lewisville 094192402.2.2	1	1	1	1	1	1	2	3	2
Doctor's Hospital at White Rock Lake 094194002.2.1	1	1	1	1	1	2	3	3	3
Denton Regional Medical Center 111905902.2.1	1	1	1	1	1	2	3	2	2
Denton Regional Medical Center 111905902.2.2	1	1	1	1	1	2	4	3	4

Baylor Medical Center at Irving 121776204.1.1	1	1	1	1	1	2	3	3	3
Baylor Medical Center at Irving 121776204.1.2	2	1	1	1	1	1	4	3	4
Baylor Medical Center at Irving 121776204.2.2	1	1	1	1	1	1	2	2	2
Baylor Medical Center at Irving 121776204.2.3	1	1	1	1	1	1	2	2	2
Baylor Medical Center at Irving 121776204.2.5	1	1	1	1	2	1	4	4	4
Baylor Medical Center at Garland 121790303.1.1	1	1	1	1	1	1	3	3	3
Baylor Medical Center at Garland 121790303.2.2	1	1	1	1	1	2	2	2	2
Baylor Medical Center at Garland 121790303.2.3	1	1	1	1	1	1	2	2	2
Baylor Medical Center at Garland 121790303.2.5	1	3	1	1	2	1	4	4	4
Lakes Regional MHMR Center 121988304.1.2	2	2	1	3	1	2	3	3	3
Lakes Regional MHMR Center 121988304.2.1	1	1	1	3	1	2	3	1	2
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.2	1	1	1	1	2	2	4	4	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.12	1	2	1	3	2	2	4	4	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.6	3	2	1	3	3	2	4	3	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.7	1	1	1	3	3	2	5	5	5
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.8	1	1	1	3	2	2	3	2	2
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.10	2	1	1	3	2	2	3	3	3
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.9	1	1	1	1	2	2	3	3	3

UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.4	1	2	1	3	2	2	4	4	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.1	1	2	1	3	2	2	3	3	3
UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.2	1	2	1	1	1	2	3	2	2
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.6	1	2	1	3	2	2	4	3	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.5	1	2	1	3	3	2	3	3	3
UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.3	1	2	1	1	1	2	3	3	3
Parkland Memorial Hospital 127295703.1.6	1	1	1	1	2	2	2	3	2
Parkland Memorial Hospital 127295703.1.1	1	1	1	1	1	2	2	3	2
Parkland Memorial Hospital 127295703.1.4	1	1	1	3	3	2	3	2	2
Parkland Memorial Hospital 127295703.1.3	1	2	1	3	2	2	3	3	3
Parkland Memorial Hospital 127295703.1.7	1	1	1	1	2	2	2	2	2
Parkland Memorial Hospital 127295703.1.5	1	2	1	3	2	2	3	3	3
Parkland Memorial Hospital 127295703.2.1	1	1	1	1	2	2	2	2	2
Parkland Memorial Hospital 127295703.2.11	2	1	1	1	2	2	4	2	3
Parkland Memorial Hospital 127295703.2.9	1	1	1	1	2	2	2	2	2
Parkland Memorial Hospital 127295703.2.4	1	1	1	3	2	2	4	2	3
Parkland Memorial Hospital 127295703.2.10	2	1	1	3	2	2	4	3	4
Parkland Memorial Hospital 127295703.2.5	2	2	1	3	3	2	3	3	3
Parkland Memorial Hospital 127295703.2.12	1	1	1	3	2	2	3	2	2

Parkland Memorial Hospital 127295703.2.6	1	1	1	1	2	2	2	2	2
Methodist Dallas Medical Center 135032405.2.1	1	2	1	1	1	1	4	2	3
Methodist Dallas Medical Center 135032405.2.3	1	1	1	3	1	2	4	4	4
Denton County MHMR Center 135234606.2.1	1	1	1	3	1	3	4	3	4
Denton County MHMR Center 135234606.2.2	1	2	1	1	3	3	3	4	4
Denton County MHMR Center 135234606.2.3	2	2	1	1	3	3	4	4	4
Denton County Health and Human Services 136360803.2.2	2	1	1	1	1	1	3	3	3
Dallas County MHMR dba Metrocare Services 137252607.1.2	1	1	1	1	1	2	3	1	2
Dallas County MHMR dba Metrocare Services 137252607.2.4	1	1	1	1	1	2	1	1	1
Children's Medical Center of Dallas 138910807.1.2	1	2	1	3	1	2	3	3	3
Children's Medical Center of Dallas 138910807.1.4	1	1	1	3	1	2	4	2	3
Children's Medical Center of Dallas 138910807.2.2	1	1	1	1	2	2	3	2	2
Children's Medical Center of Dallas 138910807.2.4	1	1	1	1	1	2	2	2	2
Baylor University Medical Center 139485012.1.1	1	1	1	1	1	2	3	3	3
Baylor University Medical Center 139485012.1.2	1	1	1	1	1	1	3	3	3
Baylor University Medical Center 139485012.2.1	1	1	1	1	1	1	4	4	4
Baylor University Medical Center 139485012.2.5	1	1	1	1	2	2	4	4	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.2	1	2	1	3	2	2	4	3	4
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.4	1	2	1	3	2	2	3	3	3

UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.1	1	2	1	1	1	2	4	1	2
Trinity Medical Center 195018001.2.1	1	1	1	1	3	2	4	3	4
Methodist Richardson Medical Center 209345201.2.1	1	2	1	1	1	1	4	2	3
Methodist Richardson Medical Center 209345201.2.2	1	2	1	1	1	1	2	2	2

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 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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Medical Center of Arlington 020950401.2.1	1	1	1	3	1	2	3	4	4
Medical Center of Arlington 020950401.2.2	1	1	1	1	1	1	3	2	2
Medical Center of Arlington 020950401.2.3	1	1	1	1	1	2	2	2	2
Cook Children's Medical Center 021184901.1.1	1	1	1	3	2	2	3	4	4
Cook Children's Medical Center 021184901.1.2	2	1	1	3	2	2	4	3	4
Cook Children's Medical Center 021184901.1.3	2	1	1	3	3	2	4	4	4
Tarrant County/dba Tarrant County Public Health 022817305.1.1	1	1	1	1	2	2	2	3	2
Tarrant County/dba Tarrant County Public Health 022817305.2.3	1	1	1	3	3	2	3	3	3
Tarrant County/dba Tarrant County Public Health 022817305.2.4	1	1	1	3	1	2	2	2	2
Tarrant County/dba Tarrant County Public Health 022817305.2.8	1	1	1	1	1	2	2	3	2
MHMR of Tarrant County 081599501.1.2	1	1	1	1	2	2	2	1	1
MHMR of Tarrant County 081599501.2.2	1	1	1	1	2	2	3	2	2
North Hills Hospital 094105602.2.1	1	1	1	1	1	1	3	2	2
Plaza Medical Center of Fort Worth 094193202.2.1	1	1	1	1	1	2	4	4	4
Plaza Medical Center of Fort Worth 094193202.2.2	1	1	1	1	1	2	2	3	2
Huguley Memorial Medical Center 109574702.2.1	1	1	1	3	1	2	2	2	2

Huguley Memorial Medical Center 109574702.2.2	1	1	1	1	2	2	2	2	2
Texas Health Harris Methodist Hospital Fort Worth 112677302.2.1	1	1	1	3	1	2	3	1	2
Texas Health Harris Methodist Hospital Fort Worth 112677302.2.2	1	1	1	1	1	2	3	2	2
Texas Health Harris Methodist Hospital Fort Worth 112677302.2.4	1	1	1	1	2	1	2	1	1
Texas Health Harris Methodist Hospital Fort Worth 112677302.2.5	1	1	1	3	1	1	3	3	3
Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.1	1	1	1	1	2	2	4	2	3
Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.2	1	1	1	1	2	2	2	2	2
Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.3	1	1	1	1	1	2	2	2	2
Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.4	1	1	1	3	1	1	4	4	4
Lakes Regional MHMR Center 121988304.1.1	1	1	1	1	1	2	2	2	2
Lakes Regional MHMR Center 121988304.1.3	1	1	1	1	1	2	3	2	2
JPS Health Network 126675104.1.2	1	1	1	3	1	2	3	3	3
JPS Health Network 126675104.1.3	1	1	1	1	1	2	2	2	2
JPS Health Network 126675104.1.5	1	1	1	3	2	2	3	3	3
JPS Health Network 126675104.2.11	1	1	1	3	2	2	3	3	3
JPS Health Network 126675104.2.12	1	1	1	1	1	2	3	2	2
JPS Health Network 126675104.2.14	1	1	1	1	3	2	2	2	2
JPS Health Network 126675104.2.3	1	1	1	1	2	2	2	2	2
JPS Health Network 126675104.2.6	1	1	1	1	1	2	2	1	1
JPS Health Network 126675104.2.7	1	1	1	3	1	2	3	3	3
Texas Health Harris Methodist Hospital Azle 127304703.2.1	1	1	1	1	1	1	4	2	3
Helen Farabee Center 127373205.1.2	1	1	1	1	1	2	3	2	2

Wise Regional Health System 130606006.2.1	1	1	1	1	1	2	4	2	3
Texas Health Arlington Memorial Hospital 130614405.2.1	1	1	1	1	1	2	1	1	1
Pecan Valley Centers for Behavioral and Developmental Healthcare 130724106.1.1	1	1	1	1	2	2	3	4	4
Pecan Valley Centers for Behavioral and Developmental Healthcare 130724106.2.1	1	1	1	1	2	2	3	3	3
Baylor All Saints Medical Center at Fort Worth 135036506.1.1	1	1	1	1	1	2	3	3	3
Baylor All Saints Medical Center at Fort Worth 135036506.1.2	1	1	1	1	1	2	3	3	3
Baylor All Saints Medical Center at Fort Worth 135036506.2.4	1	1	1	1	1	2	2	2	2
Baylor All Saints Medical Center at Fort Worth 135036506.2.5	1	1	1	1	1	2	2	2	2
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.1	1	1	1	1	1	2	4	4	4
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.3	2	1	1	3	1	2	4	2	3
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.4	1	1	1	1	1	2	2	2	2
Children's Medical Center 138910807.1.2	1	1	1	3	1	2	2	2	2
Children's Medical Center 138910807.1.3	1	1	1	3	1	2	3	3	3
Children's Medical Center 138910807.2.1	1	2	1	3	1	2	3	1	2
University of North Texas Health Science Center 138980111.1.4	1	1	1	1	2	2	2	2	2
University of North Texas Health Science Center 138980111.1.7	1	1	1	1	2	2	1	3	2
University of North Texas Health Science Center 138980111.1.8	1	1	1	3	2	2	3	1	2

University of North Texas Health Science Center 138980111.2.6	1	1	1	1	2	2	3	2	2
JPS Physician Group 162334001.1.1	1	1	1	1	2	2	2	4	3
Methodist Mansfield Medical Center 186221101.2.1	1	1	1	1	1	1	4	2	3
Wise Clinical Care Associates 206106101.2.1	1	1	1	1	2	2	3	2	2
Glen Rose Medical Center 216719901.1.1	1	1	1	1	2	2	4	4	4
Glen Rose Medical Center 216719901.2.1	1	2	1	3	2	2	5	4	5

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.**

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

Mitchell County Hospital 136325111.1.2	3	1	1	3	2	1	4	3	4
Hendrick Medical Center 138644310.1.2	1	1	1	1	2	2	3	3	3
Mitchell County Hospital 136325111.2.1	1	2	1	3	3	3	4	4	4

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Texas Tech University Health Sciences Center-Lubbock 084599202.1.2	1	1	2	3	2	1	2	2	2
Childress Regional Medical Center 133250406.1.1	1	1	1	3	1	1	3	2	2
University Medical Center 137999206.1.4	3	1	1	1	1	1	3	1	2
Medical Arts Hospital 189947801.1.2	3	1	1	1	1	1	4	2	3
Lynn County Hospital District 094180903.2.1	2	1	1	3	1	1	3	2	2
Cogdell Memorial Hospital 136330107.1.3	1	1	1	1	1	1	1	2	1
Collingsworth General Hospital 126840107.2.3	1	2	1	1	1	1	3	3	3
Parmer County Community Hospital, Inc. 137343308.2.3	1	2	1	3	1	1	3	2	2
Covenant Medical Center 139461107.2.1	1	1	1	1	2	1	2	1	1
Golden Plains Community Hospital 197063401.2.1	2	1	1	3	1	1	3	1	2
Texas Tech University Health Sciences Center-Lubbock 084599202.1.1	1	1	2	1	2	1	1	2	1
StarCare Specialty Health System 084897001.1.1	1	1	1	3	2	1	3	3	3
StarCare Specialty Health System 084897001.1.2	3	1	1	3	2	1	3	3	3
Memorial Hospital 094121303.2.1	1	1	1	1	2	2	4	4	4
Sunrise Canyon Hospital 136492909.2.1	1	1	1	1	1	1	1	1	1

City of Amarillo Department of Public Health 065100201.1.1	1	1	1	1	2	2	4	4	4
Memorial Hospital 094129602.1.1	2	1	1	1	1	1	3	1	2
University Medical Center 137999206.1.3	1	1	1	1	2	1	2	2	2
Helen Farabee Center 127373205.1.2	1	1	1	1	1	1	3	1	2
Pampa Regional Medical Center 178848102.1.1	2	1	1	3	1	1	3	3	3
Hereford Regional Medical Center 133544006.1.1	1	1	1	1	1	1	2	2	2
Memorial Hospital 094129602.1.3	1	1	1	1	1	1	1	2	1
Coon Memorial Hospital and Home 130826407.1.3	1	3	1	1	3	3	4	4	4
Hereford Regional Medical Center 133544006.2.2	2	2	1	1	2	1	3	3	3
City of Amarillo Department of Public Health 065100201.2.2	1	1	1	1	1	1	3	2	2
Covenant Medical Center 139461107.2.3	1	1	1	1	2	1	2	3	2
Childress Regional Medical Center 133250406.2.1	3	1	1	1	1	1	3	3	3
Texas Tech University Health Sciences Center-Lubbock 084599202.2.1	1	1	2	1	1	1	2	2	2
Cogdell Memorial Hospital 136330107.2.1	2	1	1	3	1	1	3	2	2
Collingsworth General Hospital 126840107.2.1	1	1	1	1	2	1	2	3	2
Ochiltree General Hospital 112704504.2.1	2	1	1	1	2	1	3	3	3
Texas Tech University Health Sciences Center-Amarillo 084563802.2.1	2	1	1	1	1	1	2	3	2
Texas Tech University Health Sciences Center-Lubbock 084599202.2.3	2	1	2	3	2	1	2	4	3

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.**

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

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.**

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

Midland Memorial Hospital 136143806.2.3	3	2	1	1	1	1	3	2	2

RHP 15 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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Texas Tech HS Ctr Family Med 084597603.1.5	3	1	2	1	1	1	4	2	3
Texas Tech HS Ctr Family Med 084597603.1.6	1	1	2	1	1	1	3	1	2
Texas Tech HS Ctr Family Med 084597603.1.8	2	1	2	3	1	1	3	1	2
Texas Tech HS Ctr Family Med 084597603.1.1	2	1	2	3	1	1	3	3	3
Las Palmas Medical Center 094109802.2.3	2	1	1	3	2	1	3	3	3
University Medical Center of El Paso 138951211.2.2	1	1	1	1	1	1	3	2	2
City of El Paso Department of Public Health 065086301.1.2	1	2	1	1	2	1	4	4	4
City of El Paso Department of Public Health 065086301.1.5	1	1	1	1	2	1	3	3	3
Texas Tech HS Ctr Family Med 084597603.1.4	2	1	2	1	1	1	4	4	4
Las Palmas Medical Center 094109802.1.1	1	1	1	1	2	1	3	4	4
Providence Memorial Hospital 130601104.1.2	2	1	1	1	2	1	3	3	3
Sierra Providence East Medical Center 196829901.1.2	2	1	1	3	2	1	3	3	3
City of El Paso Department of Public Health 065086301.1.1	1	1	1	1	2	1	2	3	2
University Medical Center of El Paso 138951211.1.1	2	1	1	3	1	1	3	2	2
University Medical Center of El Paso 138951211.1.2	1	1	1	3	1	1	2	2	2
Las Palmas Medical Center 094109802.1.4	2	2	1	1	2	1	3	2	2

Las Palmas Medical Center 094109802.1.5	1	1	1	3	2	1	3	2	2
Providence Memorial Hospital 130601104.1.3	2	1	1	3	2	1	3	2	2
Emergence Health Network 127376505.1.2	2	1	1	3	1	1	3	3	3
Emergence Health Network 127376505.1.3	3	1	1	3	1	1	3	3	3
University Medical Center of El Paso 138951211.1.8	1	1	1	1	1	1	2	4	3
Texas Tech HS Ctr Family Med 084597603.1.7	2	1	2	1	1	1	2	2	2
City of El Paso Department of Public Health 065086301.1.3	1	1	2	1	1	2	2	2	2
Las Palmas Medical Center 094109802.1.3	1	1	1	1	2	1	2	2	2
Texas Tech HS Ctr Family Med 084597603.1.3	2	1	2	3	1	1	3	2	2
Sierra Providence East Medical Center 196829901.1.3	2	1	1	1	2	1	2	2	2
City of El Paso Department of Public Health 065086301.2.1	1	1	1	3	2	1	3	2	2
University Medical Center of El Paso 138951211.2.8	2	1	1	3	1	1	3	3	3
University Medical Center of El Paso 138951211.2.9	1	1	1	3	1	1	2	2	2
El Paso Children's Hospital 291854201.2.1	3	2	1	1	1	1	3	2	2
University Medical Center of El Paso 138951211.2.3	1	1	1	3	1	1	3	2	2
Las Palmas Medical Center 094109802.2.1	2	1	1	1	2	1	1	1	1
University Medical Center of El Paso 138951211.2.7	1	1	1	1	1	1	2	2	2
Emergence Health Network 127376505.2.2	1	1	1	1	1	1	3	4	4

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 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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Central Counties Services 081771001.1.1	1	2	1	3	2	1	3	3	3
Central Counties Services 081771001.1.3	1	1	1	1	2	1	2	2	2
Goodall-Witcher Healthcare Foundation 137075109.1.4	1	1	1	1	1	2	2	2	2
Hamilton General Hospital 121792903.1.4	1	1	1	3	3	1	3	3	3
Hamilton General Hospital 121792903.1.3	2	1	1	1	2	2	2	2	2
Heart of Texas Region MHMR Center 084859002.2.1	1	1	1	1	3	1	4	4	4
Coryell Memorial Hospital 134772611.2.7	1	1	1	1	1	1	3	3	3
Goodall-Witcher Healthcare Foundation 137075109.2.1	1	3	1	1	2	1	4	4	4
Limestone Medical Center 140714001.2.1	1	1	1	1	1	1	3	3	3
Goodall-Witcher Healthcare Foundation 137075109.1.5	1	1	1	3	3	2	4	4	4
Hamilton General Hospital 121792903.2.10	1	1	1	3	1	2	3	3	3

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Texas A&M Physicians 198523601.2.3	1	1	1	1	1	1	2	2	2
Brazos County Health District 130982504.1.1	1	1	1	1	1	1	3	3	3
Scott & White Hospital 135226205.2.1	1	1	1	3	2	1	2	2	2
Conroe Regional Medical Center 020841501.1.2	1	1	1	3	3	1	4	4	4
Huntsville Memorial Hospital 189791001.1.1	3	1	1	3	1	2	4	4	4
Huntsville Memorial Hospital 189791001.1.2	1	1	1	3	1	1	3	3	3
Huntsville Memorial Hospital 189791001.1.4	1	1	1	3	1	1	3	3	3
Huntsville Memorial Hospital 189791001.1.100	3	2	1	1	3	1	4	4	4
St. Joseph Regional Health Center 127267603.2.1	1	1	1	3	3	1	2	2	2
MHMR Authority of Brazos Valley 136366507.2.1	1	1	1	3	1	1	3	2	2
Texas A&M Physicians 198523601.1.2	1	1	1	3	3	1	3	2	2
Texas A&M Physicians 198523601.2.4	1	1	1	1	1	1	1	1	1
Texas A&M Physicians 198523601.2.2	1	1	1	1	1	1	2	2	2
Montgomery County Public Health District 311035501.2.100	1	1	1	1	1	1	2	2	2
College Station Medical Center 020860501.2.1	1	1	1	1	1	1	2	2	2

RHP 18 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.**

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

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.**

RHP Provider Project ID	Compliance with Plan	Core Components	Federal Funding	Clarity of Metrics	Patient Impact	Lessons Learned	Step One: Compliance and Challenges	Step Two: Progress	Overall Risk Ranking
Texoma Community Center 084434201.1.1	1	1	1	3	1	2	4	1	2
Texoma Community Center 084434201.1.4	1	1	1	1	2	2	4	2	3
Texoma Community Center 084434201.2.1	1	1	1	3	1	2	3	3	3
Hamilton Hospital 110856504.2.2	1	1	1	3	2	2	5	2	4
Wilbarger General Hospital 112707803.1.1	1	1	1	3	1	2	4	4	4
Faith Community Hospital 119874904.2.2	1	1	1	1	1	2	2	1	1
Faith Community Hospital 119874904.2.3	2	1	1	1	1	2	3	3	3
North Texas Medical Center 121777003.2.1	1	1	1	1	2	2	2	1	1
Nocona General Hospital 127310404.2.1	1	1	1	3	2	2	2	3	2
Helen Farabee Center 127373205.1.2	1	1	1	1	2	2	3	1	2
Graham Regional Medical Center 130613604.1.2	1	1	1	3	1	2	5	5	5
Electra Memorial Hospital 135034009.1.4	1	1	1	1	1	2	2	2	2
Electra Memorial Hospital 135034009.1.5	1	1	1	1	1	2	3	2	3
Electra Memorial Hospital 135034009.2.2	1	1	1	3	1	2	2	2	2
United Regional Health Care System 135237906.2.1	1	1	2	3	3	3	3	3	3

United Regional Health Care System 135237906.2.4	1	1	1	1	2	3	1	1	1
Seymour Hospital 138353107.1.2	1	1	1	1	1	1	2	2	2
Seymour Hospital 138353107.2.3	1	1	1	1	1	2	2	2	2

RHP 20 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.**

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

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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
East Texas Medical Center - Quitman 017624002.1.1	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The project is on pace to surpass DY 4 & DY 5 goals in the DY 3 reporting period.	Recommend that consideration of possible impact on project valuation should be given if possible plan modification is submitted and approved.	**Possible Plan Modification:** DY 4 and DY 5 goals may need to be adjusted based on the results of DY for metric I-12.1. At mid-point DY 3, provider was on track to fulfill DY 5 goal of increased visits by 20 percent over baseline.	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 HHSC and provider consider adjusting goals based on DY3 performance. During DY3 reporting, provider updated the baseline, which resulted in provider not reaching DY4 and DY5 goal during DY3, therefore HHSC was not requesting that the provider revisit the goals for DY4 and DY5.
East Texas Medical Center - Tyler 020812601.1.3	5	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider submitted a plan modification to adjust its baseline to include visits to the entire psych department. However, the purpose of the project was to recruit a full-time psychiatrist for outpatient and partial hospitalization services. The new provider hired by the project left their 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).	Discuss possible withdrawal of project. 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.	**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 goals 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.	HHSC contacted provider to discuss the proejct status.	Provider withdrew the project.
East Texas Medical Center - Tyler 020812601.2.1	4	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The criteria used by the provider to determine which non-emergent patients will receive a referral to a PCP is not clear. In a similar project from another provider, the provider noted that it's possible that all non-emergent may receive a referral. There is a risk that the provider could treat non-emergent patients in the ED instead of providing a referral in order to stay in line with the goal when in fact the provider could refer almost all non-emergent patients without a PCP to a primary care setting.	No recommendations at this time.	**Possible Plan Modification:** The provider should consider including 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.	N/A	Provider withdrew the project.
East Texas Medical Center - Tyler 020812601.2.2	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 as required by the Category 2 Menu.	No recommendations at this time.	**Possible Plan Modification:** 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.	N/A	Provider withdrew the project.
East Texas Medical Center - Tyler 020812601.2.3	3	1 of 1 of DY 2 milestones complete. 1 of 2 of DY 3 milestones complete. Although the provider does describe specific interventions in the narrative (measuring and improving the patient experience), how this project specifically benefits the patient health outcomes is not part of the project and therefore a higher risk ranking is warranted. Provider is using a customizable improvement milestone I-101.1 to measures its QPI in DY 4 and DY 5 because the available metrics do not specifically measure patients or encounters. 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.	No recommendations at this time.	**Possible Plan Modification:** 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.).	N/A	MSLC recommended that the provider clarifies metric description for Metric I-101.1 in DY4 and DY5 since both Milestone and Metric had the description. HHSC followed up with the provider who agreed with this recommendation. Metric was updated to reflect: Number of individuals who increased their knowledge about their plan of care as a result of patient education.
Texoma Community Center 084434201.1.3	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 started but it is dependent on the anchor completing a task, which they have not done as of the April DY 3 reporting period.	No recommendations at this time.	**Technical Change:** In order to show an increased percentage between DY 4 and DY 5, provider should use the same baseline for Metric 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.	N/A	MSLC recommended updating I-11.1 in DY4 and DY5, because the provider was not using numerator and denominator the way MSLC understood it should be used. Since this metric is primary used for measuring and reporting the QPI goals, HHSC suggested to provider changing this milestone to a customizable one and just measuring the number of individuals, as required by QPI. Provider agreed with this recommendation. HHSC has changed project's QPI metric I-11.1 to a customizable one I-101.1 based on the provider's response. QPI goals did not change.

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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
Texoma Community Center 084434201.1.4	2	1 of 1 of DY 2 milestones complete. 0 of 1 of 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	MSLC did not have any recommendations.
Texoma Community Center 084434201.2.2	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The building renovations on the residential facility ran into delays and has kept the project from enrolling its first clients. However, the QPI goal for P-3.1 is eight individuals and unless other circumstances arise, the provider is likely to meet its goal of enrolling/serving eight individuals in DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Good Shepherd Medical Center 094095902.2.1	4	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. At mid-point, the provider has not yet hired or trained patient care navigators and therefore no patient encounters have occurred. The provider's goal is to train 500 patient navigators and serve 550 individuals in DY 3. Without training the patient navigators, provider may not be able to meets its QPI goals. Provider's QPI goals between DY 3 and DY 5 are using two different measurements. (I-6.1 in DY 4 and I-6.2 in DY 3 and 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.	**Technical Change:** Provider should report Metric I-6.2 as the QPI measure for DY 4 instead of I-6.1 to keep consistent with DY 3 and DY 5. **Possible Plan Modification:** Provider should consider deleting either I-7.1 or I-8.1 in DY 5. Provider did not report any progress as of mid-point DY 3 and therefore its focus should be on achieving the QPI metric I-6.2. While the measure of ED visit reduction is important for this project option, both measures are similar and may use the same individuals in part of the measurement for both metrics.	N/A	MSLC recommended to standardize QPI selection and make I-6.2 a QPI metric in DY4 instead of provider having multiple metrics designated as QPI. Provider agreed with this recommendation. HHSC updated the system to reflect that I-6.2 is a QPI metric in DY4 with the goal of 550 individuals. I-6.1 remained in the project but as non-QPI metric. Goal for I-6.1 did not change.
Mother Frances Hospital 094108002.1.2	3	3 of 3 DY 2 milestones complete. 0 of 4 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 patients served. Currently, the provider is measuring the number of physicians, mid-level staff, and other staff hired.	No recommendations at this time.	**Technical Change:** Provider is using Metric P-11.1 in DY 4 and DY 5 as a way to measure clinic expansion. However, provider is measuring the number of specialists hired. Metric P-11.1 requires the provider measure the number of patients served. Provider could change P-11.1 to I-22.1, using the "number of specialist providers in targeted specialties" measure. However, I-22.1 does require the provider to use a numerator and a denominator. In this case, the use of a numerator and a denominator does not help to explain the provider's goal and purpose, which is to expand the clinic by hiring new providers. Therefore, a customizable process milestone should also be an option.	N/A	MSCL recommended to change P-11 into I-22.1 or a different metric that would more accurately reflect what provider is measuring. HHSC has changed P-11 in DY4 and DY5 to a customizable milestones I-101 (I-22.1 was still requiring a numerator and denominator which was not necessary for this goal). Goals did not change.
Mother Frances Hospital 094108002.1.3	2	2 of 2 DY 2 milestones complete. 1 of 3 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	MSLC did not have any recommendations.
Mother Frances Hospital 094108002.2.2	2	1 of 1 DY 2 milestones complete. 0 of 2 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	MSLC did not have any recommendations.
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 metric. However, the supporting documentation submitted by the provider actually shows a decrease in the number of visits from the previous year despite an increase in hours. Provider explained that it plans to increase the number of visits by increasing referrals to the primary care clinic from the urgent care clinic.	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 I-12.1 metric in DY 5. The provider may not be able to reach its target as it reported a decrease in the volume of visits before and after the DSRIP expansion.	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.	MSCL recommended revisiting the project's goals due to change in volume of visits. HHSC checked in with the provider about the status of the project and the need for adjustments. Provider state that they will keep their goals and metrics without changes.

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University Physician Associates 127278302.1.1	4	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.	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 October reporting, provider was able to hire a dentist, and in April of DY4 was almost half way meeting its QPI. HHSC will not initiative discussions at this time related to possible changes in service delivery.
UTHSCT - MSRDP (University Physician Associates) 127278302.1.11	1	1 of 1 DY 2 milestones complete. 0 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.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
UTHSCT - MSRDP (University Physician Associates) 127278302.1.13	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. There is risk that the provider does not intend to complete its I-12.1 metric according to the menu.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider using a customizable milestone if it does not intend to use the calculation described in the menu for Metric I-12.1. The menu requires the provider to show an increase in utilization of appropriate crisis alternatives compared to usage at other RHP sites. However, based on the information submitted on the April DY 3 report, it appears that the provider is only reporting the number of individuals admitted to its crisis unit as well as the percent increase in utilization over baseline of its own crisis unit. There is no indication that the provider intends to calculate the number of individuals served by the project and the number of individuals who use alternatives at other RHP sites. In order to calculate the metric according to the menu, the provider would need to obtain data from other providers.	N/A	MSLC recommended that the provider shows increase in goals for I-12.1 based on the metric language. Since this metric was used primarily as a QPI metric, HHSC discussed with provider, and changed I-12.1 in DY4 and DY5 to I-101.1. Goals remained the same.
UTHSCT - MSRDP (University Physician Associates) 127278302.1.9	2	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Two of the DY 3 milestones include training of staff (P-2.1) and the development of referral reports (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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
UTHSCT - MSRDP (University Physician Associates) 127278302.2.16	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
UTHSCT -MSRDP (University Physician Associates) 127278302.2.17	3	1 of 2 DY 2 milestones complete. 0 of 2 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
UTHSCT - MSRDP (University Physician Associates) 127278302.2.19	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project is at risk due to deficiencies in data collection. Project should be on track if provider can get adequate EHR and EMR data. The intent of the DY 4 and DY 5 goals are not clear. The metric used by the provider to measure the number of individuals who receive a PCP appointment is different from the metric on the Category 2 menu.	No recommendations at this time.	**Possible Plan Modification:** Provider should 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 use metric I-6.4 instead of I-6.1, which would allow provider accurately report information meeting metric's intent. Provider agreed with the change. HHSC changed I-6.1 into I-6.4 in DY4 and DY5. Goals remained the same.
UTHSCT - MSRDP (University Physician Associates) 127278302.2.22	4	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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. Provider reported serving 16 patients out of a goal of 175 for Metric I-11.1. The provider's total cumulative QPI goal by DY 5 is to serve 800 individuals.	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 I-11.1 metric in DY 5. The provider may not be able to reach its target population due to the technical changes it cited in its progress report, including connectivity issues in rural areas and availability of broadband services to the low-income population.	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 revisiting DY5 goals for QPI. HHSC checked October reporting. During Oct. DY3 reporting the provider achieved their goal for this metric. Based on this, HHSC did not initiate discussions related to changing DY5 goals.

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UTHSCT - MSRDP (University Physician Associates) 127278302.2.23	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Project is at risk due to difficulties in getting the transportation needed to service a large geographic area in an outpatient setting. Provider has cited access to transportation as a key component for success of the project. As of mid-point, provider had not yet enrolled any individuals in the program (goal is to enroll 41).	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-3.1 metric in DY 5. The provider may not be able to reach its target population 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 compare to other projects, and HHSC can decrease project's valuation.	MSLC recommended revisiting DY5 goals for QPI. HHSC checked October reporting. The project had a delay in starting. During Oct. DY3 reporting, provider requested carryforward but stated that they expect to be able to meet their goals now that the project is underway. Based on this, HHSC did not initiate discussions related to changing DY5 goals.
East Texas Medical Center - Clarksville 130862905.1.1	5	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reported near completion of its QPI goals at mid-point without hiring a new provider and by expanding its clinic by only four hours.	Discuss a possible withdrawal as clinic has now been closed.	**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.
Hopkins County Memorial Hospital 131037704.2.1	3	1 of 1 DY 2 milestones complete. 3 of 3 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Hunt Regional Medical Center Greenville 131038504.1.1	1	1 of 1 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Provider reported completing 1979 visits out of a goal of 2400 visits at mid-point for metric I-12.1. Provider intends to further increase visits in DY 4 and DY 5 by referring patients to the primary care clinic from its patient navigation and transition care DSRIP projects.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Hunt Regional Medical Center Greenville 131038504.1.3	3	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The project option, Performance Improvement and Reporting Capacity, receives a higher ranking in terms of 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 outcome of the project is a quality program using real time data to drive quality improvement. 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	MSLC did not have any recommendations.
East Texas Medical Center - Crockett 137319306.1.1	4	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Although provider reported meeting its P-4 goal (to increase primary care hours) in DY 2, the provider reported about the same volume of visits as the year before. This is a concern as DSRIP is funding more hours without an increase in the number of visits. Further information from the provider indicated that the provider intends to increase its volume of visits through an increase in urgent care referrals and marketing in the community.	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 I-12.1 metric in DY 5. The provider may not be able to reach its target as it reported the same volume of visits before and after the DSRIP expansion.	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.	Provider withdrew the project.
Community Healthcore 137921608.1.3	5	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project is at high risk due to original hosting site (UT Health Northeast) denying the provider clinic space to operate the ambulatory detox program. Provider is searching for another site, but success of program is in doubt. Provider requested a plan modification to move all milestones into the next year; however, the project has potential for withdrawal if medical services cannot be provided.	Ensure that some type of MOU or agreement is in place between collaborating entities. This project was dependent on operating in conjunction with a medical provider due to the clinical nature of ambulatory detox. Discuss for possible withdrawal if provider cannot obtain a partnership with a medical practice.	**Possible Project Withdrawal:** Provider should consider possible withdrawal from the waiver program if medical services cannot be provided.	The provider requested changes during the July plan modification process, however the changes did not modify the project but rather changed the scope of the project entirely. If the provider can not meet the intent of the original project, withdrawal may be a good option.	MSLC recommended adjustments to the project to allow the project to remain on track. HHSC is working with the provider on determining acceptable changes to the project. Provider suggested that instead of ambulatory detoxification program the project implements an inpatient detoxification program in a hospital setting. HHSC is open to such change because there is a need in the region for this type of projects. Once changes are finalized, HHSC will update milestones and metrics in the system. Provider already submitted a revised narrative.

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East Texas Medical Center Pittsburg 138374715.1.1	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:** Provider 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.	N/A	MSLC recommended revising the project/QPI goals to allow provider meet its goals. HHSC checked subsequent to April reporting, project development. provider submitted a plan modification that changed a definition of the visit to broaden and increase visits: include all visits such as clinic visits, consults, and surgeries pertaining to general surgery and ortho and that both general surgery and orthopedic surgery capacity expansion has been provided through arrangements with local physician providers and not through direct employment with ETMC, providing maximum benefit to the community. This should help provider reach its goals. Based on this, HHSC did not initiate discussions related to changing DY5 goals.
Titus Regional Medical Center 138913209.1.2	4	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has not been able to hire an endocrinologist and has not completed any milestones. Unless the provider can hire an endocrinologist, the project cannot continue as written and should be noted for possible withdrawal.	Discuss for possible withdrawal of project. 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.	**Possible Project Withdrawal:** Provider should consider possible withdrawal from the waiver 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.
Titus Regional Medical Center 138913209.2.1	3	1 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Although the provider has completed its milestones, the project was given a higher ranking d 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 Plan Modification:** Provider should consider adding a second measure 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-7.	N/A	MSLC recommended to add another metric to the project to include a more descriptive measure for this project. HHSC checked subsequent to April reporting 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.
Titus Regional 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 carry forward 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.	N/A	MSLC recommended 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 measures by I-14. In both cases provider defined the area of measurement: for the first milestone it is "Decrease in patient time to provider from baseline," and 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.
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 percentage between DY 3 and DY 5.The provider would need to rely on an 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-emergent cases in the ED has decreased significantly.	No recommendations at this time.	**Possible Plan 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-emergent cases that present initially to the ED.	N/A	MSLC recommended adjusting the QPI metric, because based on interview with the provider, the current QPI - I-6.3 may not be attainable as written. Provider explained that the project is referring non-urgent patients to a primary care setting. Goals were set based on the 2012 data. To address the issue, HHSC worked with the provider and updated I-6.3 to reflect that the goal is to increase the number of non-urgent ED patients to primary care setting. HHSC reflected revised goals for the metric in the baseline/Goal statement and in custom description for the metric. QPI goals did not change.
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 Plan Modification:** The provider should consider replaing 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 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.	N/A	MSLC recommended to replace metric ID I-11.1 with the customizable I-101, because provider used I-11.1 only for QPI purposes and to show percent change. Provider agreed with this change. HHSC changed I-11.1 (QPI) into a customizable metric I-101 so the provider just reports on the number of people and not the percent change.

APPENDIX 2 - RHP 1

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
East Texas Medical Center Athens 139173209.2.3	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is using a customizable improvement metric I-101.1 to measures its QPI in DY 4 and DY 5 because the available metrics do not specifically measure patients or encounters.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider clarifying 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.).	N/A	MSLC recommended to clarify metric I-101.1 because milestone and metric language read the same and metric did not have sufficient details. HHSC updated metric (I-101.1) description in DY4 and DY5 to : Number of unique individuals who are positively impacted by improvements resulting from Patient education. This should address MSLC recommendation.
East Texas Medical Center - Gilmer 168447401.1.1	4	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 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.	Discuss possible project withdrawal due to closing of clinic.	**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.
Red River Regional Hospital 177870603.2.2	3	1 of 1 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Project uses customizable milestone to measure "positively impacted individual." 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider clarifying 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.).	N/A	MSLC recommended that provider clarify its metric description for Metric I-101.1 in DY4 and DY5, since milestone 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.
Red River Regional Hospital 177870603.2.3	4	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider including a description of the facility renovation in the project narrative and why it was needed. Provider should also 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 DY 4 and DY 5.	N/A	MSLC recommended that provider updates 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.
Andrews Center 751281410.2.3	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

APPENDIX 2 - RHP 2

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
Coastal Health & Wellness 019053001.1.1	5	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	Discuss for possible withdrawal of project.	**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 DY3 - hiring of additional staff(hiring of 2 provider, 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.	MSLC recommended that the project withdraw due to delays in hiring primary care providers. HHSC contacted the provider to determine the project status. Provider stated that although there was initially a delay in hiring staff, they have seen an increase in number of 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 3 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, 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.
University of Texas Medical Branch Hospital 094092602.1.10	1	1 of 1 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. No significant risks to future progress were noted at this time.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Medical Branch Hospital 094092602.1.2	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Medical Branch Hospital 094092602.1.3	3	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Medical Branch Hospital 094092602.1.7	4	1 of 2 DY 2 milestones complete. 0 of 2 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. 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 date 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider a reduction in QPI if it is not able to obtain the needed data from RHP 2 sites. Also, 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.	NA	MSLC recommended to consider a reduction in QPI if provider continues to have challenges in receiving data from hospitals in RHP 2. Also, 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. Provider agreed with this recommendation, since they continued to experience challenges in getting discharge data from other providers in timely fashion. Based on providers request, HHSC updated QPI goal to 9,204 from 10,557 since the project was still within the ranges. HHSC also added a metric to DY5 (provider volunteered to add a metric since there was a reduction in QPI) - I-101.1- Regional Impact Assessment of Collaborative Activities I-101.1 Metric: Analyze and report on regional learning collaborative efforts through a formal assessment, including, but not limited to, surveys, lessons learned and self-reported results generated by regional providers who implement practices learned through collaborative participation. Goal of the metric -14 reports, one report for each provider participating in collaboration.

APPENDIX 2 - RHP 2

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
University of Texas Medical Branch Hospital 094092602.1.9	2	5 of 5 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. There was concern during the mid-point review as to how the provider would measure its I-11.1 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 stratifiers 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 those disparities will be updated and modified in DY 5 as required by the Category 1 Menu.	No recommendations at this time.	**Technical Change:** Percentage goal calculation for Metric I-9.1 in DY 5 is incorrect. The Phase 4 Summary indicates a goal of 50 percent of unique patients registered with designated REAL data fields. The provider reports a total impact goal of 18,200 individuals out of a total of 26,000 individuals. Using the total impact figures (as was done with DY 3 and DY 4 calculations), this calculates to a 70 percent registration rate, not 50 percent.	NA	MSLC recommended that for DY5 I-9.1, the correct percentage included in the baseline/goal language should be 70% and not 50%. This was based on the calculation of 5,200 in DY5 + 5,200 in DY4 + 7,800 in DY3 out of 26,000 total unique patients registered. A similar calculation appeared to be used for DY4 (5,200 in DY4 + 7,800 in DY3 out of 26,000 patients = 50%). HHSC updated DY5 to 70% and informed the provider.
University of Texas Medical Branch Hospital 094092602.2.1	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 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 with 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.	No recommendations at this time.	**Possible Plan Modification:** The provider should consider adding a different milestone to measure the total number of enrolled patients' primary care visits at all provider facilities and not just primary care clinics. The provider has included two measures for its DY 5 I-16.1 metric, one for visits and one for patients.	NA	HHSC did not follow up with the provider to split out DY5 I-16.1 into two metrics as recommended by MSLC. Providers were allowed to use customized metric descriptions as well as customized numerator and denominator descriptions. A metric could also have multiple goals. For QPI metrics such as I-16.1, as long as the QPI grouping matches the metric description, this was acceptable. In this case, the QPI grouping of encounters matches I-16.1 percent of primary care visits at medical home. The percentage of patients is additional information that must also be reported for I-16.1.
University of Texas Medical Branch Hospital 094092602.2.11	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. There is slight risk as to the measurement of the I-14.1 QPI in DY 4 and DY 5. The provider's narrative indicates that the clinical pharmacist will assist with reconciliation of medications for patients discharged from the emergency department. However, the language of the goal metric indicates patients who are "discharged from hospitalization." Hospitalization could also include patients discharged for inpatient admissions who occupied a bed in another hospital department (Med/Surg, Ortho, BMT, ICU, etc.).	No recommendations at this time.	**Technical Change:** Provider should update the Phase 4 Master Summary for I-14.1 in DY 4 and DY 5 to indicate which patient population will be specifically measured. The current patient population notes "discharges from hospitalizations" but is not specific to ED discharges.	NA	MSLC recommended that for DY4-5 I-14.1, that the patient population does not state ED discharges in the numerator and denominator descriptions as described in the project narrative. It appears that the standard numerator and denominator descriptions were used. HHSC updated the Baseline/Goal language to address the recommendation to: %=number of targeted patients with mediations reconciled (targeted TBD by Performing Provider) when discharged from ED/total number of targeted patients discharged from ED during a specific time period.
University of Texas Medical Branch Hospital 094092602.2.2	1	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Medical Branch Hospital 094092602.2.8	3	2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	**Possible Plan Modification:** The provider should consider reporting its measurement of cost containment in DY 4 and DY 5 using a separate milestone. The Category 2 Menu requires the provider show improvements in cost containment. Currently, the provider is only reporting the number of patient encounters in I-7.1.	NA	MSLC recommended that a metric be added to DY5 to measure improvements in cost containment to strengthen the project. The provider added a customizable milestone with two metrics to measure the decrease in average total cost per case for DRG 470 and DRG 195.
Baptist Hospitals of Southeast Texas 094148602.2.1	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The project's narrative is similar to the provider's navigation project (094148602.2.2) narrative and has a high risk of duplicating the same activities and outcomes. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

APPENDIX 2 - RHP 2

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
Baptist Hospitals of Southeast Texas 094148602.2.2	4	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Project proposes to enhance discharge instructions for patients with chronic diseases and to provide follow-up to ensure a smooth transition from discharge to a lower level of care. The project is high risk due to the similarity with the provider's other project, Chronic Care Management Model. Both projects are aimed at improving post-discharge planning. Challenges reported by the provider include limited resources to which patient navigators can send individuals. In some cases, patients may exhaust their options and the SmartHealth Clinic becomes the patients' source for primary care. Although the project coordinator reported that the number of outside referrals have increased, expanding the program has been difficult. While the clinic has conducted over 1,300 office visits, the provider is reporting patients and therefore the QPI is lower.	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 program, 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 diagnoses. The intent of the navigation program according to 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 agrees that the project may count all patients served by the navigation program	MSLC recommended that the Baseline/Goal language in P-3.1 delete specific diagnoses 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 898 in DY4. • DY5: The total number of targeted patients for September 2011 – August 2012 was 285. Goal: Increase to a cumulative total of 2,609 patients served. This will include 1,075 patients served in DY5 by the patient navigation program who are uninsured, underserved, indigent, on 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.
Spindletop Center 096166602.1.1	4	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reported challenges to the project, including delay in project approval (DY 2) and remodel of the clinic location (DY 3). Project was chosen for review by HHSC due to decrease in QPI. Additional information received from the provider noted that encounters could be increased through expanded hours and networking with various healthcare organizations, such as managed care organizations, local hospitals, indigent care clinics, and local schools. However, the nature of behavioral health treatment differs from the needs of the chronic disease population. Since most behavioral health visits will be focused on therapy and medication management, in-person visits to conduct diagnostic procedures are not required at behavioral health office visits. The current menu option for expanded specialty care is more aligned with addressing physician shortages in the chronic physical disease fields and may not translate to the needs of behavioral health population.	No recommendations at this time.	**Possible Plan Modification:** The provider should consider customizing its QPI milestone to measure encounters instead of visits, which would allow the provider to include phone updates and consults. **Possible Plan Modification:** The provider should consider including metric I-23.2 (number of unique patients) as a way to show that more than a few patients benefit from the program. According to the Category 1 Menu, the improvement milestone chosen by the provider (I-23.1) requires the provider report on the number of specialty care visits. The provider is currently reporting encounters, which is different from visits.	NA	Because I-23.1 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 DY5 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.
Spindletop Center 096166602.1.6	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Challenges stated on DY 3 April report indicated that crisis stabilization beds were not yet available. Without the beds, provider will not be able to meet its DY 4 and DY 5 QPI. To increase the number of clients served by the program, the provider stated that patients who need longer-term support will be identified, including patients with frequent readmissions, patients referred from other programs, and patients who have been abandoned by their community support system.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

APPENDIX 2 - RHP 2

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
Spindletop Center 096166602.2.10	4	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. We have identified multiple risks with this project: The sustainability of the project without DSRIP funding is also a concern given the cost per individual and the provider has chosen a customizable milestone that does not adhere to the intent of the other improvement milestones for option 2.13.1 (to measure the impact of an intervention on a targeted population). The other improvement milestones on the menu measure the impact of an intervention on individuals using various measurement options. The provider is using a milestone that is simply a count of the number of individuals in apartments. Milestone P-3 on the menu measures the number of individuals served.	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).	NA	MSLC recommended that an improvement milestone be added to DY5 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 DY5 metric because their Category 3 requires a stretch activity in which they will be reporting on impacts such as adherence to mental health treatment plans, gaining employment, attending school/college, and other functional status measures. Adding one of the suggested Category 2 metrics to DY5 would be redundant information that will already be reported in Category 3.
Spindletop Center 096166602.2.11	3	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 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 wellness program.	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. 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).	NA	MSLC recommended that an improvement milestone be added to DY5 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 DY5 metric because the 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 096166602.2.3	2	1 of 1 DY 2 milestones complete 0 of 1 DY 3 milestones complete 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.	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. 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).	NA	MSLC recommended that an improvement milestone be added to DY5 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 DY5 metric because their Category 3 outcome is Quality of Life assessment that measures functional status. Adding one of the suggested Category 2 metrics to DY5 would be redundant information that will already be reported in Category 3.
Spindletop Center 096166602.2.9	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 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. For its QPI goal (I-101), the provider intends to show improvement by increasing the number of families served on a cumulative basis, but is not increasing the goal from DY to DY. Therefore, the provider should indicate its baseline and cumulative totals on the Phase 4 Master Summary.	No recommendations at this time.	**Technical Change:** Provider should indicate baseline for I-101 on the Phase 4 Master Summary as a way to show improvement between demonstration years. **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).	NA	MSLC recommended that the baseline be added to I-101.1. This 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	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
Physician Practice affiliated with UTMB 109372601.1.1	4	0 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider cannot begin progress on DY 3 milestones until the gap assessment from DY 2 is complete. The milestones the provider needs 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 at mid-point, 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-24.1 has been carried forward to DY 4.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Physician Practice affiliated with UTMB 109372601.2.2	4	1 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider had 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.	**Possible Plan Modification:** Due to the number of milestones from DY 2 and DY 3 requiring carryforward to the next demonstration year, the provider should consider evaluating its metrics and deleting metrics that will not directly affect patient impact.	NA	MSLC recommended that the provider delete DY4-5 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 109372601.2.3	1	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Upon our initial review, MSLC determined that the target population and measurement for metrics I-13.1 and I-14.1 appeared similar. Additional information was received from the provider indicating that I-14.1 is measuring Medicaid/Unfunded cases while I-13.1 is measuring all clinical cases. The metrics were chosen by the provider as a way to show operating room efficiency and increased availability for patients.	No recommendations at this time.	**Technical Change:** Revise the language for Metric I-14.1 in DY 4 and DY 5 to specify that the provider intends to measure Medicaid/Unfunded encounters as a way to distinguish this metric from metric I-13.1 (in which the provider is measuring all clinical cases, not just Medicaid). Although the goal specifies these different target populations, the metric should also include the target population.	NA	MSLC recommended revisions to I-13.1 and I-14.1. Goal language for I-14.1 specifies Medicaid/pending/unfunded population and measures a percentage while I-13.1 is the total QPI population metric. HHSC is not requesting changes from the provider based on the measurement of different items.
Brazosport Regional Health System 112671602.1.1	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	**Possible Plan Modification:** The provider should consider separating the current I-15.2 goals into different metrics for DY 4 and DY 5. Since the provider will begin measuring QPI in DY 4 to track primary care and urgent care visits, which are different services, the metrics should also be calculated separately.	NA	MSLC recommended that I-15.2 be split into two QPI metrics for DY5 to track primary care and urgent care visits separately. Provider requested to maintain current single QPI metric I-15.2 as is.
Angleton-Danbury Medical Center 121805903.1.3	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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 prenatal care management which seems more in line with the Expand Specialty Care Services project option.	HHSC should consider updating projects that must specifically hire physicians who completed the OB/GYN residency programs such that they are considered an expansion of specialty care instead of expansion of care as they are currently classified. This is because patients seeking out primary care services will not necessarily benefit from the expansion of OB/GYN services.	No recommendations at this time.	HHSC will consider updating to Project Area 1.9 for waiver renewal/extension if the project continues.	MSLC did not have any recommendations.
Nacogdoches Memorial Hospital 131030203.2.2	2	1 of 1 DY 2 milestones complete 0 of 2 DY 3 milestones complete 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 individuals. According to the Category 2 menu, this metric is specific to measuring scores.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider using a customizable milestone to measure its QPI (the number of individuals showing improvement in satisfaction scores). The current metric used by the provider requires a measure of a percent improvement in patient satisfaction scores and not the specific number of individuals showing improvement in scores.	NA	MSLC recommended that I-20.1 be split into two metrics, I-20.1 that measures improvement in patient satisfaction scores and a separate customizable milestone that measures QPI impact. Provider requested to split I-20.1 into I-20.1 that measures improvement in patient satisfaction scores and a customizable metric for the QPI impact of individuals participating in patient improvement processes.
The Gulf Coast Center 135222109.1.2	3	1 of 1 DY 2 milestones complete 0 of 2 DY 3 milestones complete The improvement milestone used 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 this project.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider changing Metric I-11.1 to a customizable milestone. Metric I-11 is specific to measuring the use of mobile clinics compared to the use of other community-based settings. The other milestones for 1.12.2 do not measure utilization. Also, the provider is not comparing utilization to other settings. The intent of its QPI metric is to report an increase in the utilization of a specific service.	NA	MSLC recommended that I-11.1 be updated to a customizable milestone. HHSC allowed providers to use customized numerator and denominator descriptions for metrics in the DSRIP menu. 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.

APPENDIX 2 - RHP 2

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
The Gulf Coast Center 135222109.2.2	3	0 of 1 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider has not completed its DY 2 milestone as of mid-point DY and is slightly behind on DY 3 milestones. Provider's DY 5 goal for metric I-5.1 is listed as achievement of 100 percent of patients who show an improvement in functional status.	HHSC should consider potential impact on project valuation if plan modification to reduce QPI is submitted and approved.	**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 this metric due to the extremely unpredictable nature of the behavioral health population.	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 DY5 I-5.1 goal be changed from 100% which is not feasible to another goal. Provider requested to update DY5 goal to 42.5%.
Burke Center 136367307.2.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is including an additional QPI measure in its I-18.1 metric in DY 4 and DY 5. According to the Category 2 menu, metric I-18.1 requires the provider measure improvements in standardized health measures. While the total number of individuals served may provide explanation for the denominator, this metric should be reported separately.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider adding a separate metric to report the measure of the number of individuals served. Metric P-6.1 is an option and could be continued through DY 4 and DY 5.	NA	MSLC recommended that I-18.1 be split into I-18.1 that measures the improvement in at least one identified risk area and a QPI metric of P-6.1 Number of participants receiving peer services. Provider agreed with the split between I-18.1 and P-6.1.
Burke Center 136367307.2.100	4	No DY 2 Milestones. This is a 3 year project. Project was not included on the DY 3 April Report. It is unclear how the project will measure QPI with reasonable assurance. Provider states that it will measure individuals reached through website visitors, online views of videos, "Likes" on its Facebook page, Twitter retweets, direct mail, and direct outreach to organizations and employers. These metrics cannot be accurately measured and do not necessarily reflect the impact of the community as a whole. For example, one individual may view a video more than once or retweet multiple Twitter messages. There is also the potential for overlap of unique individuals for I-6.2 QPI metrics.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider deleting I-6.2 metric for the population defined as "community members." This milestone requires a defined population and "the community" cannot be accurately quantifiable. There is no assurance that the provider will be able to provide accurate measurement of QPI. Measuring web traffic and other metrics will not give an accurate representation of "the community" as not all members will have access to such resources.	NA	MSLC recommended that the first I-6.2 be deleted. HHSC worked with the provider in Feb/Mar 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.
Tyler County Hospital 136381405.2.1	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. The QPI metric chosen by the provider (I-20.1) requires a 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 the number of individuals experiencing improvement in patient satisfaction scores. According to the Category 2 menu, this metric is specific to measuring scores.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider using a customizable milestone to measure its QPI (the number of individuals showing improvement in satisfaction scores). The current metric used by the provider requires a measure of a percent improvement in individual patient satisfaction scores and not the specific number of individuals showing improvement in scores.	NA	MSLC recommended that I-20.1 be split into two metrics, I-20.1 that measures improvement in patient satisfaction scores and a separate customizable milestone that measures QPI impact. Provider agreed with the split between I-20.1 and customizable I-101.1.
CHRISTUS Hospital 138296208.1.1	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider's QPI milestone (I-12) for DY 4 and DY 5 is measuring patients. However, the baseline established by the provider in DY 2 for this milestone is measuring visits.	No recommendations at this time.	**Technical Change:** Milestone I-12 in DY 4 and DY 5 - Provider should change the unit of measure in the metric goal from "patients" to "visits" to stay consistent with the DY 2 baseline measurement in P-102. Provider established a baseline in DY 2 of visits and should not be measuring patients in DY 4 and DY 5.	NA	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 correctly visits.

APPENDIX 2 - RHP 3

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
Bayshore Medical Center 020817501.1.1	3	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. As of April DY 3 provider has hired 1 of 4 FTEs and has begun the planning for the extension of hours to 37.50 as necessary for DY 3 goals. Bayshore states that they are on track to reach their QPI metric goal of 1255 for DY 3 but give no specific progress update. Noted lack of clarity regarding the baseline being used for metric I-12.1 for DY 3 - DY 5. Unclear if the number of encounters was being counted over a pre-DSRIP baseline. Upon follow up, provider clarified that the DY 3 metric goal of 1,255 encounters is over the pre-DSRIP baseline of 7,566 encounters.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider stating that metric I-12.1 for DY 3 -DY 5 is an increase over the pre-DSRIP baseline as stated below. DY 3 DY 4 DY 5 Total Pre-DSRIP Baseline 7,566 7,566 7,566 QPI 1,255 1,685 2,115 5,055 Total Encounters 8,821 9,251 9,681 27,753 Technical Change: Update project narrative to be in line with metric goals and baselines as stated above.	N/A	M&S recommended revising the QPI metric language to add the pre-DSRIP baseline to DYs 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 DY3 reporting shows a pre-DSRIP baseline of 7,566; 2) the Baseline/Goal language for the DY4 and DY5 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.
Bayshore Medical Center 020817501.1.2	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has participated in 1 of 2 face to face learning collaboratives and they report being on track to meet their 2310 QPI metric encounter goal. Noted lack of clarity regarding QPI metric I-12.1 which stated the percentage goal to be calculated using the number of patients seen using medical or surgical subspecialties. This project relates to telepsychiatry visits so this seemed out of line with the project. Noted that provider support had all names redacted to the effect that the support could not justify the number of individuals hired and that there were no sign in sheets provided for the training to determine if all the staff were trained. Provider clarified, "We do not believe the mention of medical and surgical subspecialties is out of line with the project...Psychiatric services are a medical specialty with subspecialties such as…Child and Adolescent Psychiatry, Geriatric Psychiatry, Addiction Psychiatry…Since the provision of a psychiatric assessment through this program could lead to a referral to one or more of those subspecialties, we believe the mention of medical or surgical subspecialties to be appropriate."	HHSC should consider requiring that all future supporting documentation for training require a listing of the individuals trained as well as when and where the training took place. HHSC should consider requiring future supporting documentation for hiring metrics include some unique employee identifier (i.e.: name, employee id, etc.), date of hire, and what position the person is being hired for.	No recommendations at this time.	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.	M&S recommended that HHSC consider requiring that all future supporting documentation for training require a listing of the individuals trained as well as when and where the training took place. They also recommended that HHSC consider requiring future supporting documentation for hiring metrics to include some unique employee identifier (ie: name, employee id, etc), date of hire, and what position the person is being hired for. 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.
Memorial Hermann Northwest Hospital 020834001.1.2	2	3 of 3 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. Provider's hiring has exceeded the metric goal for P-101.1 and provider has attended 6 of 12 RHP meetings. There is a lack of clarity regarding the percentage goals in QPI metric I-13.1 and the tracking of the impact to "targeted patients."	No recommendations at this time.	**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.	N/A	M&S recommended removing the percentage goals and references to "targeted patients" for QPI metrics I-13.1 for DY4 and DY5 for greater metric clarity. HHSC agreed that the metric language for QPI metric I-13.1 in DYs 4 and 5 should be clarified by removing the percentage goals and references to "targeted patients." Current and revised language for this metric is provided below. 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. Revised DY4 Baseline/Goal - DY4 Goal: Increase the number of encounters by 43,000 over pre-DSRIP baseline. Current DY5 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 61,320 patient encounters in DY5. Revised DY5 Baseline/Goal - DY5 Goal: Increase the number of encounters by 61,320 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.

APPENDIX 2 - RHP 3

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
Memorial Hermann Northwest Hospital 020834001.1.4	2	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 6 of 12 RHP meetings and the expansion of hours was 84 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.	No recommendations at this time.	**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.	N/A	M&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&S also recommended updating metric I-12.1 to either remove the percentage increase or make it in line with the encounter goal for DY4 and DY5. Provider reports a baseline of 5,982 visits in DY2 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 - DY4 Goal: Increase the number of encounters by 11,900 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 - DY5 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.

APPENDIX 2 - RHP 3

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
Memorial Hermann Northwest Hospital 020834001.2.1	2	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.	No recommendations at this time.	**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.	N/A	M&S recommended updating the M/LIU percentage in the project narrative to be more in line with actual project activities and the QPI summary. HHSC does not require providers to update narrative to reflect the M/LIU , as the MLIU percentage of record is in the QPI summary. M&S recommended removing the goals relating to a percentage increase over the baseline be removed from metric I-21.1 for DY3 to DY5 since the baseline for this project is zero due to it being a new project. HHSC agrees that the metric language for QPI metric I-21.1 in DYs 4 and 5 should be revised by removing the percentage goals. However, HHSC disagrees that the metric language for this metric in DY3 should be revised. Current and revised language for this metric for DYs 4 and 5 is provided below. Current DY4 Baseline/Goal - Baseline/Goal: 10% increase over baseline established in DY2 as calculated by numerator- number of individuals in the target population reached by the chronic care management program and denominator- number of individuals in the target population. Patient impact of 600 encounters in DY4. Revised DY4 Baseline/Goal - DY4 Goal: Increase of 600 encounters above pre-DSRIP baseline. Current DY5 Baseline/Goal - Baseline/Goal: 15% increase over baseline established in DY2 as calculated by numerator- number of individuals in the target population reached by the care management program and denominator- number of individuals in the target population. Patient impact of 1200 patient visits in DY5 (encounters). Revised DY5 Baseline/Goal - DY5 Goal: Increase of 1,200 encounters above 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.
Texana Center 081522701.1.1	2	3 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
Texana Center 081522701.1.3	4	2 of 2 DY 2 milestones complete. 1 of 2 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 & 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.

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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
Baylor College of Medicine 082006001.1.1	4	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reports 831 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, "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 comingled with non DSRIP funds and activities."	No recommendations at this time.	**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.	N/A	M&S recommended updating the manner in which baselines are stated for metrics I-103.1 and I-104.1 for DY4 and DY5 in order to demonstrate an increase over the baselines as stated in the metric goals. HHSC agrees that the metric language for I-103.1 should be revised, though in a different way. The language for the DY4 metric is inconsistent with the Baseline/Goal language for the DY5 metric, so HHSC is revising the DY5 metric Baseline/Goal to match the DY4 metric Baseline/Goal. The current and revised Baseline/Goal language for the DY5 metric is provided below. DY5 Custom Metric Description - Increase STI treatments and/or screening. DY5 Current Baseline/Goal - Goal: 1600 visits for STI screening and counseling. DY5 Revised Baseline/Goal - DY5 Goal: 1600 visits for STI treatments and/or screening. HHSC agrees that the metric language for I-104.1 should be revised, though in a different way. The current and revised metric language is provided below. DY4 Current Custom Metric Description - Increase contraception services by 50% over baseline. DY4 Revised Custom Metric Description - Increase the number of individuals who receive contraception services. DY4 Current Baseline/Goal - Goal: 750 patients who accept contraception in DY4. DY4 Revised Baseline/Goal - Goal: 750 patients will receive contraception services in DY4. DY5 Current Custom Metric Description - Increase STI treatment services by 100% over baseline. DY5 Revised Custom Metric Description - Increase the number of individuals who receive contraception services. DY5 Current Baseline/Goal - Goal: 1,000 patients who accept contraception in DY5. DY5 Revised Baseline/Goal - Goal: 1,000 patients will receive contraception services in DY5. HHSC sent the revised language to the provider indicating that if a response was not received by a certain date, HHSC would implement the milestones/ metrics changes. The provider did not respond by that date, so HHSC made the changes.

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City of Houston Department of Health and Human Services 093774008.1.1	2	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. As of April DY 3 the expansion of the dental clinic program was implemented and 5 of 5 MOUs were established. A program was also implemented to increase dental services to pregnant women and children. 3000 of 4415 individuals have been seen as of April DY 3. Metric I-101.1 in DY 4 and DY 5 uses the terms individuals and encounters interchangeably within the metric goal. Provider states that the baseline for DY 3 P102.1 is a pre-DSRIP baseline of 9,285 so to demonstrate their goal of 4,415 encounters in DY 3 they had to demonstrate a total of 13,700 encounters. The DY 4 - DY 5 percentage increases in metrics I-101.1 are intended to be over the DY 3 baseline.	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	M&S recommended updating metric I-101.1 goals in DY4 and DY5 so that the term individuals is replaced with encounters for greater clarity. HHSC agreed to clarify the metric I-101.1 goals in DY4 and DY5. Current and revised goals are provided below. DY4 Current Baseline/Goal - Goal: Increase by 5% over baseline the number of individuals that access services in past 12 months, population includes pregnant women (315 in DY 4) and children (4320 in DY 4). 5% Increase represents 4635 encounters accessing services. DY4 Revised Baseline/Goal - DY4 Goal - Increase the number of encounters by 4,635 over pre-DSRIP baseline. DY5 Current Baseline/Goal - Goal: Increase by 10% over baseline the number of individuals that access services in past 12 months, population includes pregnant women (331 in DY 5) and children (4537 in DY 5). 10% Increase represents 4868 encounters accessing services. (encounters) DY5 Revised Baseline/Goal - DY5 Goal - Increase the number of encounters by 4,868 over pre-DSRIP baseline. HHSC sent the revised language to the provider indicating that if a response was not received by a certain date, HHSC would implement the milestones/ metrics changes. The provider did not respond by that date, so HHSC made the changes.
City of Houston Department of Health and Human Services 093774008.1.2	4	4 of 4 DY 2 milestones complete. 1 of 5 DY 3 milestones complete. A final protocol was updated for the ETHAN program but data had not yet begun to be collected as of April DY 3.Due to project delays regarding IT and staffing the ETHAN project did not fully implement by April DY 3. A plan was created for the expansion of internet based services but the project had not yet begun to conduct patient monitoring's. As of April DY 3 the provider has served 0 of 3600 individuals. Metrics I-17.1 in DY 4 and DY 5 state that the goals are a percentage increase over the baseline but no clear baseline has been established. Provider states that currently the project Medical Director is available to fill in on the days that are not covered by other physicians. Provider also states that they worked closely with the City of Houston IT Department and leveraged many partnerships within the community to ensure proper installation, configuration, and utilization of IT products and services. Provider states that they intend DY 3 to serve as the baseline for metric I-17.1 in DY 4 and DY 5.	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	M&S recommended updating metrics I-17.1 in DY4 and DY5 to state a clear baseline. HHSC did not agree that this change was absolutely necessary because the provider can provide both the baseline and the documentation showing that they met the goal during reporting. Therefore HHSC did not make the recommended changes.
City of Houston Department of Health and Human Services 093774008.1.3	4	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Due to project delays with partner agreements and IT, the GOH project was unable to implement program in this reporting period but the project was successful in establishing partnerships with other facilities for referrals and delivery of services. Provider attended 1 of 2 learning collaborative meetings as of April DY 3 and has served 0 of 60 patients. Provider support for DY 3 metric P-6.5 may be insufficient to support metric achievement due to some of the MOU's not being signed. The program is intended to impact only the elderly population but the DY 4 and DY 5 metrics I-14.1 are worded towards treating "special population" individuals which, according to the metric description may include children, special needs patients, pregnant women and/or the elderly. Provider reports overcoming their initial technical issues through manual extraction of data from patient records, extra coding by IT personnel, quality checks, and development of the BOH Fee Ticket Database to collect information on program participants.	HHSC should consider requiring future support regarding contracts with other entities require that the contracts submitted be signed by all parties.	**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.	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.	MSLC 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. MSLC also recommended updating wording of DY5 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. HHSC disagrees with this recommendation because the Custom Metric Description specifically states that the metric is "Increasing the number of elderly accessing dental services," and therefore, it is not necessary to change the goal language.

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City of Houston Department of Health and Human Services 093774008.1.4	2	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 so a PSDA cycle cannot be established until October reporting. 1327 of 6000 individuals have been served as of April DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
City of Houston Department of Health and Human Services 093774008.2.1	2	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 544 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.	No recommendations at this time.	**Technical Change:** Update DY 5 metric I-8.1 goal for homes inspected to state a goal of 110 (10% increase from 100).	N/A	M&S recommended updating the DY5 metric I-8.1 goal for homes inspected to state a goal of 110 (10% increase from 100). HHSC agreed that the goal for DY5 metric I-8.1 should be changed from 105 homes inspected to 110 homes inspected. HHSC sent the revised language to the provider requesting a response by a certain date, and the provider never responded, so HHSC updated the goal as recommended.
City of Houston Department of Health and Human Services 093774008.2.10	2	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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
City of Houston Department of Health and Human Services 093774008.2.2	4	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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.

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City of Houston Department of Health and Human Services 093774008.2.4	4	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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. Phase 4 Master Summary shows the project as being Project option 2.11.1 rather than 2.7.1 which is listed on the project narrative. The April DY 3 Sign off summary states the project area as 2.11 while the project option in 2.7.1. QPI summary states 2.11.1. DY 4 metrics P-101.1 and I-102.1 states a goal of establishing a baseline for the number of hospitals utilizing this intervention and demonstrating improvement over this baseline within the same DY. Metrics I-8.1 and metrics I-101.1 appear to be measuring the same patient population. Provider clarified that as of April 2014 sufficient staff had been hired and 183 patients had been seen. Provider states that the project option for this project is 2.7.1 and that they will work with HHSC to rectify this discrepancy with the project option and the milestones. Provider states intent to resolve the confusion with metric I-8.1 and I-101.1 with the reconciliation of the project option.	No recommendations at this time.	**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.	N/A	MSLC recommends updating the 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. The correct project area for this project is 2.11, and the correct project option is 2.11.1 (per the DSRIP Online Reporting System). Going forward, 2.11 and 2.11.1 will be listed as the project area and project option for this project in the periodic updated versions of the Phase 4 Master Summary and QPI Summary issued by HHSC. Also, HHSC has revised the project narrative to reflect 2.11 and 2.11.1 as the project area and project option. HHSC has notified the provider that the project narrative has been updated.
City of Houston Department of Health and Human Services 093774008.2.7	3	2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. The project has reported the execution of a learning and diffusion strategy for testing, spread and sustainability and has performed process/improvement evaluation on a bi-yearly basis. Provider has reported serving 35 of 200 individuals by April DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
City of Houston Department of Health and Human Services 093774008.2.8	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Due to project delays regarding IT and staffing issues the project reports 0 of 150 individuals enrolled by April DY 3. The provider reports that the program has been performing continuous improvement interventions but this will not be reported until October DY 3. Noted that provider did not fill out the April DY 3 project sign off summary information for this project. Noted that provider is counting only individuals enrolled rather than individuals receiving services. Provider stated that there was an oversight during the reporting process in April DY 3 and that the information was submitted in the Needs More Information window. Provider notes that the IT issues have been resolved after their initial difficulties but that although they were able to meet initial staffing goals, maintaining staff continues to be an issue.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider measuring QPI metrics P-3.1 in DY 4-5 by counting the number of individuals receiving services, rather that just counting the number of individuals enrolled to meet requirement to measure patient impact. **Technical Change:** Update project narrative Category 2 expected patient benefits section be to reflect the project activities as stated in the metrics in the Phase 4 Master Summary.	N/A	M&S recommended that the provider consider measuring QPI metrics P-3.1 in DY4-5 by counting the number of individuals receiving services, rather that just counting the number of individuals enrolled to meet requirement to measure patient impact. HHSC agrees to change QPI metrics P-3.1 in DY4-5 from the number of individuals enrolled to the number of individuals receiving services. However, HHSC does not agree to change QPI metric P-3.1 in DY3, as DY3 is over. HHSC updated the QPI metrics P-3.1 as follows: DY4 Revised Baseline/Goal - Goal: Implementation of program according to project plan. Target # of individuals receiving services is 180. DY5 Revised Baseline/Goal - Goal: Increase # of individuals receiving services through the program. Target # of individuals receiving services is 200. HHSC sent the revised language to the provider indicating that if a response was not received by a certain date, HHSC would implement the milestones/ metrics changes. The provider did not respond by that date, so HHSC made the changes. M&S also recommended updating the project narrative Category 2 expected patient benefits section to reflect the project activities as stated in the metrics in the Phase 4 Master Summary. As the metric goals of record are in the Cooper system, HHSC does not agree that the project narrative needs to be updated.

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City of Houston Department of Health and Human Services 093774008.2.9	4	3 of 3 DY 2 milestones complete. 1 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 diffusion 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-DY 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 1080 over five years. There will be a 20% increase over DY 3 in DY 4 and a 40% increase over DY 3 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.	No recommendations at this time.	**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 DY 5: Baseline: 300 individuals in DY 3; Goal: 40% increase over DY 3 baseline; total of 420 individuals for DY 5.	N/A	M&S recommended updating the QPI metric goals because they were incorrectly stated in regards to their percentage increases from the baseline established in DY3 as follows: DY3: Goal: 300 individuals DY4: Baseline: 300 individuals in DY3; Goal: 20% increase over DY3 baseline; total of 360 individuals in DY4 DY5: Baseline: 300 individuals in DY3; Goal: 40% increase over DY3 baseline; total of 420 individuals for DY5. However, the metric language had been changed after the date of this recommendation to remove the percentage increases from the baseline/goal, so no changes were needed.
West Houston Medical Center 094187402.2.1	4	1 of 1 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
Spindletop Center 096166602.2.1	2	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 9 of 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
Spindletop Center 096166602.2.2	3	1 of 1 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. Provider's QPI metric I-11.1 for DY 4 states a 5% goal as being 10 individuals but in DY 5 it states a 5% goal as being 12 individuals.	No recommendations at this time.	**Technical Change:** Update metric I-11.1 for DY 5 to correctly state 6% instead of 5% to reflect the 12 participants .	N/A	M&S recommended that metric I-11.1 be updated for DY5 to correctly state 6% instead of 5% to reflect the 12 participants. Based on subsequent HHSC review, we determined that this change was not necessary since because the provider deleted I-11.1 and replaced it with a customizable metric I-101.1through change requests. Therefore HHSC did not make the recommended changes.

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The University of Texas Health Science Center - Houston 111810101.1.10	4	1 of 3 DY 2 milestones complete. 0 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 0 of 500 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 workup guidelines as required from DY 2 carryforward 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
The University of Texas Health Science Center - Houston 111810101.1.2	4	2 of 2 DY 2 milestones complete. 0 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 0 of 7200 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, "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." 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
The University of Texas Health Science Center - Houston 111810101.1.5	3	2 of 3 DY 2milestones complete. 0 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 20,390. 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.	No recommendations at this time.	**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.	N/A	M&S recommended updating metric I-13.1 for DY3 - DY5 to more clearly state the percentage increase in utilization goal aligns with the numerical increase in patient encounters. HHSC agreed to clarify the goal for the DY4 and DY5 metrics I-13.1 but not the DY3 metric, as DY3 is over. The current and revised baseline/goals are provided below. DY4 Current Baseline/Goal - Increase utilization of advice line by 6.5% as calculated by number of targeted patients that access the advice line out of total number of targeted patients. Goal: Increase by 20,000 answered calls over previous year, for a total of 70,000 encounters in DY5 over baseline. Total impact of 130000 encounters over baseline. DY4 Revised Baseline/Goal - DY4 Goal - Increase utilization of advice line (encounters) by 50,000 over pre-DSRIP baseline. DY5 Current Baseline/Goal - Increase utilization of advice line by 6.5% as calculated by number of targeted patients that access the advice line out of total number of targeted patients. Goal: Increase by 20,000 answered calls over previous year, for a total of 70,000 encounters in DY5 over baseline. DY5 Revised Baseline/Goal - DY5 Goal - Increase utilization of advice line (encounters) by 70,000 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.

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The University of Texas Health Science Center - Houston 111810101.1.7	3	2 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. 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 in DY 3. 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 have not yet been reported for achievement.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
The University of Texas Health Science Center - Houston 111810101.1.8	4	2 of 3 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. 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 clinician 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. Lack of clarity noted in QPI metric I-101.1 which is counting "unique individuals for whom the risk of hospital acquired conditions is reduced." Lack of clarity noted in the usage of the term "vice chairs" in DY 3 P-6.1 goals. Provider states, "The goal is to monitor the dosing of blood thinners such a Heparin and Enoxaparin in high risk DVT patients and to ensure the timeliness of administering these drugs with the use of the early detection tool created by the team "VTE Advisor."" Provider clarified that the term "vice chairs" is inappropriate since there are no positions within their organization with that title. Provider reports currently the team has met all DY 2 and DY 3 milestones by the September 30th deadline and they are on target to meet their DY 4 milestones.	No recommendations at this time.	**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."	N/A	M&S recommended updating the wording for DY4 and DY5 QPI metric I-101.1 metric to state that individuals are identified as having a reduced risk by the usage of the VTE Advisor early detection tool. HHSC agreed to change the Custom Milestone Description for I-101.1 in DY4 and DY5 from "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, so HHSC updated the milestones/ metrics accordingly. M&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.
The University of Texas Health Science Center - Houston 111810101.1.9	4	2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 11,602 increased number of visits. Provider's DY 2 carryforward metric goal of community outreach has not yet been reported for achievement. Lack of clarity noted regarding the baseline for DY 5 metric I-11.1. Project has noted significant delays due to construction issue and hiring that may impact future progress. Provider states that baseline for metric I-11.1 will be established in DY 4. Provider reports having staff work out of other UTP Physician clinics to begin providing services so that they could start catching up on their metrics. Through community outreach and partnering with local organizations the project is working to try to get back on track.	No recommendations at this time.	**Technical Change:** Update DY 5 metric I-11.1 to state that the baseline being used for demonstrating the increase in patient satisfaction will be established in DY 4.	N/A	M&S recommended that DY5 metric I-11.1 be updated 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-11.1 needed to be updated to state that the 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.

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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
The University of Texas Health Science Center - Houston 111810101.2.3	4	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 12,480 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 effect 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.	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.	HHSC always reviews any submitted plan modification request to reduce QPI with an eye toward valuation.	M&S recommended that the provider consider possible decreasing the QPI based on the provider's updated needs assessment information. M&S 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. M&S 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.
The University of Texas Health Science Center - Houston 111810101.2.6	1	3 of 3 DY 2 milestones complete. 2 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.

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The University of Texas Health Science Center - Houston 111810101.2.8	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider has completed 0 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.	No recommendations at this time.	**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.	N/A	M&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. DY4 Current Baseline/Goal - 1.25% of UTP patients needing behavioral health services (numerator - Number of individuals receiving both physical and behavioral health care in project sites; denominator- Number of individuals receiving services in project sites) Patient impact: 1000 individuals served in DY4. DY4 Revised Baseline/Goal - 1.25% of UTP patients needing behavioral health services (numerator - Number of individuals receiving both physical and behavioral health care in project sites; denominator- Number of individuals receiving services in project sites) Patient impact: 1000 individuals receiving both physical and behavioral health services in DY4. DY5 Current Baseline/Goal - 1.5% of individuals receiving both physical and behavioral health care services at the project site (numerator - Number of individuals receiving both physical and behavioral health care in project sites; denominator- Number of individuals receiving services in project sites) Patient impact: 1250 individuals served in DY5. DY5 Revised Baseline/Goal - 1.5% of individuals receiving both physical and behavioral health care services at the project site (numerator - Number of individuals receiving both physical and behavioral health care in project sites; denominator- Number of individuals receiving services in project sites) Patient impact: 1250 individuals receiving both physical and behavioral health services in DY5. HHSC sent the revised language to the provider and the provider agreed with the revised language, so HHSC updated the milestones/ metrics accordingly.
University of Texas M.D. Anderson Cancer Center 112672402.2.2	3	5 of 5 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.

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University of Texas M.D. Anderson Cancer Center 112672402.2.3	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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."	No recommendations at this time.	**Possible Plan Modification:** Provider should consider having QPI metrics P-2.1 and I-5.1 for DY 3 - DY 5 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.	N/A	M&S recommended that the provider consider having QPI metrics P-2.1 and I-5.1 for DY3 - DY5 clearly count patient impact through the providing of services, rather than simply track patient enrollment. They recommended that the provider count the number of unique individuals who have received some form of smoking cessation counseling during the demonstration year to meet the requirement demonstrating patient impact. HHSC agreed that QPI metric P-2.1 in DY4 and DY5 should be clarified to show to show patient impact through the provision of services, rather than simply patient enrollment. However, HHSC disagreed that QPI metric I-5.1 for DY3 should be clarified, as DY3 is over. P-2.1 DY4 Current Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. Patient impact: Anticipate enrolling an additional 2,400 participants over DY3 baseline. (individuals) DY4 Revised Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. 2,400 unique individuals above pre-DSRIP baseline receive some form of smoking cessation counseling in DY4. DY5 Current Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. Patient impact: Anticipate enrolling an additional 350 participants over DY4 (individuals). DY5 Revised Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. 2,750 unique individuals above pre-DSRIP baseline receive some form of smoking cessation counseling in DY5. HHSC sent the revised language to the provider abut the provider did not agree with the revised language. They proposed the following alternative language: DY4 Current Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. Patient impact: Anticipate enrolling an additional 2,400 participants over DY3 baseline (individuals). DY4 Revised Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. 2,400 unique individuals above pre-DSRIP baseline receive some form of smoking prevention and cessation education in DY4. DY5 Current Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. Patient impact: Anticipate enrolling an additional 350 participants over DY4 (individuals). DY5 Revised Baseline/Goal - Goal: Expand project implementation and document any revisions to implementation strategy as well as continue outcome testing. 2,750 unique individuals above pre-DSRIP baseline receive some form of smoking prevention and cessation education in DY5. HHSC agreed with this revised proposed language and updated the milestones/ metrics accordingly.

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University of Texas M.D. Anderson Cancer Center 112672402.2.4	3	4 of 4 DY 2milestones complete. 0 of 4 DY 3 milestones complete. Provider has reported delays due to the current mammography van having structural damage and the new van's delivery date has been delayed. This may cause delays in the ability to serve patients. Provider has reported 258 of 800 patient encounters for DY 3. Supporting documentation for DY 2 metrics P-102.1 and P-103.1 may be insufficient to demonstrate metric achievement. Noted a lack of clarity regarding why the encounter goals were higher than the number of individuals served. Provider clarified that a single patient may have multiple encounters for follow up visits, biopsies, ultrasounds, and other services beyond just giving mammograms.	HHSC should consider requiring that all supporting documentation for training require a listing of the individuals trained as well as when and where the training took place. 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 to clearly state the baselines as listed in the semi-annual reports. **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. This will more clearly explain the encounter to individual ratio for the project. **Technical Change:** Update 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 6 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 for payment and made the payments. HHSC does not plan to require the provider to submit additional supporting documentation to demonstrate achievement of these metrics. Going forward, HHSC will consider requiring that all supporting documentation for training (Metric P-101.1 in DYs 4 and 5) include a listing of individuals trained as well as when and where the training took place. Going forward, HHSC will consider requiring that clinical collaboration agreements being used for supporting documentation be signed by all parties in order to be accepted for metric achievement.	HHSC will consider MSLC recommendation regarding supporting documentation for training and clinical collaboration, review our current policies and incorporate in future reviews if recommended steps are missing. M&S recommended updating the project narrative to clearly state the baselines as listed in the semi-annual reports. However, HHSC does not believe this is necessary, since HHSC does not require providers to update narratives with every reporting period. M&S recommended 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 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. HHSC sent the following proposed revised language to the provider: Current DY4 Custom Metric Description - Number of service encounters provided to women ages 40 to 69 during the reporting period Current DY4 Baseline/Goal - Baseline:800 Goal: 1200 encounters in DY4 for a total of 1,020 individuals served in DY4. Revised DY4 Custom Metric Description - Number of service encounters (including mammograms and additional treatments such as breast ultra-sounds and biopsies) provided to women ages 40 to 69 during the reporting period. Revised DY4 Baseline/Goal - Goal: 1200 encounters in DY4 for a total of 1,020 individuals served in DY4. Current DY5 Custom Metric Description - Number of service encounters provided to women ages 40 to 69 during the reporting period Current DY5 Baseline/Goal - Baseline:1200 Goal: 1500 encounters in DY5 for a total of 1,275 individuals served in DY5. Revised DY5 Custom Metric Description - Number of service encounters (including mammograms and additional treatments such as breast ultra-sounds and biopsies) provided to women ages 40 to 69 during the reporting period. Revised DY5 Baseline/Goal - Goal: 1500 encounters in DY5 for a total of 1,275 individuals served in DY5. The provider agreed with the revised language, so HHSC updated the milestones/ metrics accordingly. M&S also recommended updating 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 6 clinics in DY4 and 8 clinics in DY5. HHSC agreed with this recommendation and proposed the following revised language to the provider:

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University of Texas M.D. Anderson Cancer Center 112672402.2.4	3	(continued)	(continued)	(continued)	(continued)	Current DY4 Baseline/Goal - Baseline of six clinics/Goal of two clinics each demonstrating improved adherence to eligibility process as calculated by the number of women who are offered the service of the Expansion of Project VALET (numerator) and the number of women who are eligible for the Expansion of Project VALET (denominator), for an overall or average adherence rate of 65% across all the clinics. Revised DY4 Baseline/Goal - Goal: Demonstrate improved adherence to eligibility process as calculated by the number of women who are offered the service of the Expansion of Project VALET (numerator) and the number of women who are eligible for the Expansion of Project VALET (denominator), for an overall or average adherence rate of 65% across the six clinics. Current DY5 Baseline/Goal - Baseline of eight clinics/Goal of two clinics each demonstrating improved adherence to eligibility process as calculated by the number of women who are offered the service of the Expansion of Project VALET (numerator) and the number of women who are eligible for the Expansion of Project VALET (denominator) for an overall or average adherence rate of 65% across all the clinics in DY5. Revised DY5 Baseline/Goal - Goal: Demonstrate improved adherence to eligibility process as calculated by the number of women who are offered the service of the Expansion of Project VALET (numerator) and the number of women who are eligible for the Expansion of Project VALET (denominator) for an overall or average adherence rate of 65% across the eight clinics in DY5. The provider agreed with the revised language, so HHSC updated the milestones/ metrics accordingly.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.1	3	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider has achieved 1 of 3 DY 3 milestones and reports overachieving QPI metric goal by seeing 494 patients when they only needed 250 patients. 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 consisted of 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians and that additional Clinical Team Leaders and Rehab staffs were hired. Provider states that"one new clinic" will be defined as a clinical team to serve in one of the 5 clinics. Provider confirmed that the use of a mobile clinic is not a part of the project's activities.	Consideration should be given to project valuation if plan modification to increase QPI is submitted and approved.	**Possible Plan Modification:** Provider should consider increasing QPI due to significant overachieving in April DY 3. **Technical Change:** Update metric I-102.1 in DY 5 to remove the term "mobile clinics" from the project goals.	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.	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 by DSRIP revenue. Their original QPI proposal was based only the number of individuals served by the DSRIP funded team. In reporting the QPI they incorrectly included services by everyone even the 2 additional teams that were not funded through DSRIP. Therefore, HHSC informed them that they should have only reported individuals served by the 1 DSRIP-funded team in the DY3 QPI Reporting Template for both projects 113180703.1.1 & 113180703.1.5. Therefore, they needed to submit a revised DY3 QPI Reporting Template for each of these two projects that only includes the individuals served by the DSRIP-funded team. Once HHSC receives their revised DY3 QPI Reporting Templates, we can determine if their actual DY3 QPI achievement is greater than their DY5 QPI goal. If so, the DY5 QPI goal will need to be increased. 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.

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Mental Health and Mental Retardation Authority of Harris County 113180703.1.11	4	2 of 2 DY 2milestones complete. 2 of 5 DY 3 milestones complete Project appears to be having difficulty staying on track. DY 3 Metric P-4.1 goal was to hire 10 staff as of April DY 3 reporting no staff has been hired. The provider cites the need for facility shower renovations and difficulty securing a location for the CRU. Provider states that to date the project has hired 21 of the 28 staff needed for the program which will be reported in Apr DY 4. A building has been purchased and is undergoing renovations but the provider states that they are going to utilize a smaller agency owned property until renovations are complete. Provider plans to begin serving clients by mid-April.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.12	4	No DY 2 reporting. 0 of 4 DY 3 milestones complete . As of April DY 3 only 1 of 4 locations needed by DY 3 had been reported, no individuals were hired, and no patients had been seen. Project did not get started on time and there was no reported progress specifically related to DY 2 metrics. Noted several metric goals using the wording "establish a baseline and decrease by X% of baseline" but it was unclear how the baseline could be established and improved upon within the same DY. Provider states, "We were able to hire a Practice Manager for this project who has been able to successfully hire the staff. We have successfully secured 4 school locations for this project, which completes the 'necessary renovations' requirement. We were able to report having served in excess of the targeted DY 3 QPI during October reporting. This project is on track."	No recommendations at this time.	**Technical Change:** Update DY 3 metric I-13.1 and DY 4 metrics I-13.1, I-102.1, and 101.2 so as to clearly state when the baseline will be established for the metrics and when the reported improvement upon the baselines will begin.	N/A	M&S recommended that DY3 metric I-13.1 and DY4 metrics I-13.1, I-102.1, and 101.2 be updated to clearly state when the baseline will be established for the metrics and when the reported improvement upon the baselines will begin. HHSC did not agree that these metrics needed to be updated to include the baseline period, as 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.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.4	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reports 81 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 consisted of 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians and that additional Clinical Team Leaders and Rehab staffs were hired. Provider states that"one new clinic" will be defined as a clinical team to serve in one of the 5 clinics. Provider confirmed that the use of a mobile clinic is not a part of the project's activities.	Recommend future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.	**Technical Change:** Update metric I-102.1 in DY 4 and DY 5 to remove the term "mobile clinics" from the project's goals.	HHSC will take this into account in the future.	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. M&S also recommended updating metric I-102.1 in DY4 and DY5 to remove the term "mobile clinics" from the project's goals. HHSC and the provider agreed to do so and updated the milestones/ metrics accordingly.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.5	3	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider reports significantly over achieving their DY 3 QPI metric P-6.1 by seeing 1127 individuals when the goal was only 250 individuals. 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. 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 consisted of 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians and that additional Clinical Team Leaders and Rehab staffs were hired. Provider states that"one new clinic" will be defined as a clinical team to serve in one of the 5 clinics. Provider confirmed that the use of a mobile clinic is not a part of the project's activities.	Consideration should be given to project valuation if plan modification to increase QPI is submitted and approved.	**Possible Plan Modification:** Provider should consider possible significant increase in QPI due to DY 3 overachievement. **Technical Change:** Update metric I-102.1 in DY 4 and DY 5 to remove the word "mobile clinic" from the project's goals.	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.	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 by DSRIP revenue. Their original QPI proposal was based only the number of individuals served by the DSRIP funded team. In reporting the QPI they incorrectly included services by everyone even the 2 additional teams that were not funded through DSRIP.

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Mental Health and Mental Retardation Authority of Harris County 113180703.1.5	3	(continued)	(continued)	(continued)	(continued)	Therefore, HHSC informed them that they should have only reported individuals served by the 1 DSRIP-funded team in the DY3 QPI Reporting Template for both projects 113180703.1.1 & 113180703.1.5. Therefore, they needed to submit a revised DY3 QPI Reporting Template for each of these two projects that only includes the individuals served by the DSRIP-funded team. Once HHSC receives their revised DY3 QPI Reporting Templates, we can determine if their actual DY3 QPI achievement is greater than their DY5 QPI goal. If so, the DY5 QPI goal will need to be increased. 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.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.6	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete 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 "1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians" and that " additional Clinical Team Leaders and Rehab staffs were hired to strength actual services provided to achieve the targeted outcomes." Provider states, "One new clinic is defined as creating a clinical team to serve in one of the 5 clinics." Provider confirmed that the use of a mobile clinic is not a part of the project's activities.	Recommend future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.	**Technical Change:** Update metric I-102.1 in DY 4 and DY 5 to remove the term "mobile clinics" from the project's goals.	HHSC will take this into account in the future.	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. 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.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.7	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete 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 consisted of 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, and 12 Rehabilitation Clinicians and that additional Clinical Team Leaders and Rehab staffs were hired. Provider states that"one new clinic" will be defined as a clinical team to serve in one of the 5 clinics. Provider confirmed that the use of a mobile clinic is not a part of the project's activities.	Recommend future supporting documentation for hiring metrics require date of hire and what position the person is being hired for.	**Technical Change:** Update metric I-102.1 in DY 4 and DY 5 to remove the term "mobile clinics" from the project's goals.	HHSC will take this into account in the future.	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. 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.
Mental Health and Mental Retardation Authority of Harris County 113180703.1.9	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.

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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
Mental Health and Mental Retardation Authority of Harris County 113180703.2.1	4	0 of 1 DY 2 milestones complete. 0 of 3 DY 3 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 services but stated that primary care services were already being provided at the locations 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.	**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.) **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 the 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 initiative goals decrease since project's valuation is above $5 mln.	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 DYs 3-5 and if so, how they planned to address this. The provider responded that they anticipate some difficulty in achieving the 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 in 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.

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Mental Health and Mental Retardation Authority of Harris County 113180703.2.2	3	1 of 1 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Project has served 506 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. 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.	Consideration should be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.	**Possible Plan Modification:** Provider should consider increasing QPI due to significant over achieving in DY 3. **Possible Plan Modification:** Provider should consider restating the goals for metrics P-3.1 to either remove the reference to enrolling additional individuals over DY 3 or adjust the total number of individuals impacted during each DY to reflect the additional individuals enrolled in DY 3. **Technical Change:** Update the project narrative to be in line with the metric goals as stated in the Phase 4 Master Summary. **Technical Change:** Update DY 4 and DY 5 metrics I-104.1 and I-104.2. to clearly state what baselines will be used to demonstrate improvement.	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.	M&S recommended 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. M&S further recommended that the provider consider restating the goals for metrics P-3.1 to either remove the reference to enrolling additional individuals over DY3 or adjust the total number of individuals impacted during each DY to reflect the additional individuals enrolled in DY3. HHSC agreed with the recommendation to increase the goal for QPI metric P-3.1 and clarify the language. The current goals are 300 in DY3, 800 in DY4, and 800 in DY5. The actual DY3 achievement was 1,353, so HHSC worked with the provider to revise the DY5 goal to one that is greater than 1,353 and clarify the language. The revised metric language is as follows: 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. 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. M&S also recommended updating DY4 and DY5 metrics I-104.1 and I-104.2. to clearly state what baselines will be used to demonstrate improvement. HHSC disagrees that metrics I-104.1 and I-104.2 in DY4 and DY5 needs 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.
Mental Health and Mental Retardation Authority of Harris County 113180703.2.3	3	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 1500 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 Husk's request. Provider states, "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." Provider stated that they have been hiring more care providers to get the QPI goals back on track for future years.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.

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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
Mental Health and Mental Retardation Authority of Harris County 113180703.2.4	3	1 of 1 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Project has enrolled 68 individuals by April DY 3 when the goal for DY 3 was only 40 individuals. Baselines for DY 3 are being established. Noted significant over-achieving of QPI metrics as of April DY 3. Provider support for DY 2 metric P-2.1 appears to be insufficient to support the creation of project plan. Support for this metric was training certificates and meeting notes while the data source for this metric states "written plan."	Consideration should be given to the potential impact on valuation if plan modification to increase QPI is submitted and approved.	**Possible Plan Modification:** Provider should consider QPI increase due to significant over-achieving in DY 3. **Technical Change:** Update the project narrative to be in line with metric goals as stated in the Phase 4 Master Summary.	HHSC does not plan to increase the QPI metric goal in DY5 and therefore does not plan to adjust valuation.	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 DY3, 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 are 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 updates narrative.
Mental Health and Mental Retardation Authority of Harris County 113180703.2.5	3	1 of 1 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider reports being 234 individuals away from their baseline of 1000 individuals that they must serve before they can begin achievement of their QPI goal of 200 individuals. The hiring and training of staff has been completed and baselines are in the process of being established. Provider support for DY 2 metric P-2.1 appears to be insufficient to support the designing of specialized interventions through project plans. Support provided included documents related to the training and hiring of staff as well as board meeting minutes while the data source for the metric states "written plan." Noted lack of clarity regarding what would count as "services" being provided for metric P-3.1. Provider states, "An individual is counted as having received an MCOT service if they received a documented face-to-face contact with one of the providers on the team. Providers for services contacts include doctor, nurse, case manager, licensed clinician and psych tech. "	No recommendations at this time.	**Technical Change:** Update QPI metrics goals as XX number of unique individuals over the 1400 individual baseline noted in the project narrative for greater clarity.	N/A	M&S recommended updating the QPI metric goals as XX number of unique individuals over the 1400 individual baseline noted in the project narrative for greater clarity. HHSC does not agree that the QPI metric goals need to be updated to reflect the pre-DSRIP baseline, as the pre-DSRIP baseline is included in the QPI Reporting Template and is the pre-DSRIP baseline of record. Therefore, HHSC did not make the recommended changes.
Mental Health and Mental Retardation Authority of Harris County 113180703.2.9	4	3 of 4 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. DY 2 Milestone 1: 2 out of 6 metrics related to planning carried forward. No carryforward reporting in Apr DY 3. The provider has reported challenges with space allocation at a non-MHMRA site location, recruitment of an LCSW with experience working with identified population group, data sharing, and numerous delays with the project. Noted patient impact listed in metric I-38.1 for DY 4 and DY 5 included all individuals served and not a reflection of the percentage increase in patients with customized care. Total impact listed on metric I-38.1 rather than on the QPI metrics I-101.1 and I-101.2 in DY 4 and DY 5. Asked provider about possible overlap in metrics I-38.1 and I-101.1/101.2. Provider stated that metrics I-101.1 and 101.2 are the QPI metrics for this projecand the 140 reported in DY 4 and the 140 reported in DY 5 are unduplicated individuals. Provider states," I-38.1 is not the QPI metric for this project, but the intent of this metric is to improve on the discharge planning for individuals served through this project. This metric should reflect not the 140 capacity but rather the percentage of that 140 who will receive customized care plans, which should read as follows: DY 4: 50% of 140 of the individuals served will receive a customized care plan = 70 DY 5: 75% of 140 of the individuals served will receive a customized care plan = 105"	No recommendations at this time.	**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:** Add the total percentage impact to the individuals being listed on QPI 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.	N/A	HHSC agrees that revisions need to be made to Metric I-38.1 in DY4 and DY5, Metric I-101.1 in DY4, and Metric I-101.2 in DY5. HHSC suggested to the provider that these metrics be revised to as follows, and the provider agreed: 1. Change I-38.1 from a QPI metric to a non-QPI metric and revise the metric language and goals to be consistent with the 3-year project menu. 2. Change I-101.2 in DY5 to I-101.1 in DY5 and increase the goal so that it is higher than the DY4 goal. 3. Make I-101.1 in DY4 and DY5 a QPI metric. HHSC updated the DSRIP Online Reporting System to reflect these changes on 5/21/15. HHSC will update the QPI summary to reflect that the QPI metric is I-101.1 in DY4 and DY5.

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OakBend Medical Center 127303903.1.1	2	2 of 2 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider developed a Cross-Functional Team to evaluate the Chronic Disease Registry Program of .56% of their overall personnel when the goal was only .01% 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 for metric P-4.1 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 I-15.1 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.	Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved. 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 valuation as the project does not have a DY3 QPI metric, and therefore, the provider could not have achieved the DY5 QPI metric goal in DY3. 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. 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.	M&S recommended that the provider consider increasing QPI in DY4 and DY5 due to significant overachievement of DY3. M&S further recommended that consideration be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved. Provider does not have a QPI metric in DY3. During reporting period, provider reported serving a number of individuals (including them in the registry), however, this number was lower than DY4 goal and significantly lower then DY5 goal. Therefore, HHSC is not requesting that the provider increase its goals. HHSC will consider MSLC recommendation regarding supporting documentation for implementation of a chronic disease registry at multiple locations, review our current policies and incorporate in future reviews if recommended steps are missing.
OakBend Medical Center 127303903.1.3	2	1 of 1 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Noted possible future over-achievement due to hiring an 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 DYs 3-5 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."	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
OakBend Medical Center 127303903.2.1	2	1 of 1 DY 2 milestones complete. 1 of 1 DY 3 milestones complete. Provider established a steering committee in DY 3 as required for metric completion. 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.	No recommendations at this time.	**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.	N/A	M&S recommended updating metrics I-16.1 for DY4 and DY5 to clearly state the baseline period on which a percent increase is based upon. HHSC disagrees that metrics I-16.1 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. Therefore, HHSC did not make the recommended changes.
Matagorda Regional Medical Center 130959304.1.1	4	1 of 2 DY 2 milestones complete. 0 of 2 DY 3 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 should be zero since there was no prior clinic and all encounters during the DSRIP project should be counted towards QPI. Support for DY 2 metric P-11.1 was notably weak in demonstrating achievement of the metric. Provider stated, "The Specialty Care Expansion project is a new service line to Matagorda 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 MRMC 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. Consideration should be given to the potential impact on project valuation if either plan modification is submitted and approved.	**Possible Plan Modification**: Provider should consider decreasing QPI goal for metric I-23.1 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.	HHSC will review its policies and adjust as necessary. 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 decreasing QPI in DY4. HHSC is not considering decreases to DY4 QPI since HHSC received recommendations when the providers are getting ready to report on DY4, therefore this recommendation, cannot be implemented. Regarding the second possible plan modification, HHSC does not believe this is a necessary modification. Since there was no service provided in the prior year, it is clear that the baseline from the prior year is zero.

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Matagorda Regional Medical Center 130959304.1.3	4	1 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 24, 2014 so there were 0 of 500 encounters reported 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 begin 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, including the 500 encounters in DY 3 that was established as a baseline. Since the use of MEOHP after hour services is a new service, the QPI stated in metrics I-12.1 in DY 3 through DY 5 should be the total patient encounters for each period instead of only stating the increase over the prior period as being the QPI for each DY. **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	MSLC recommended provider 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 1,250 over prior reporting period (DY3). Provider reported 500 in DY3, so DY4 would be 1,750. This is clear in QPI template. Technical change 1: Provider has already reported on this metric for DY3 and it was approved so no change/update 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 DY4." It is unclear why M&S believe that provider has reported a zero baseline. Reporting review would look for a total of 625 patients served. A change is not necessary.
Matagorda Regional Medical Center 130959304.2.1	4	1 of 2 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 completed their needs assessment for their DY 2 carryforward metric. Noted lack of clarity regarding the use of the terms "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 patients with repeated 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 15% 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-10.3 in DY 5 is meant to demonstrate the 15% increase in patients as noted in P-3.1. **Technical Change:** Update the metric P-3.1 in DY 4 and DY 5 and metric I-10.3 in DY 5 to all use the term "individuals served" instead of referring to "individuals enrolled."	NA	MSLC recommended updating I-10.2 to demonstrate a percent increase. Goal for I-10.3 in DY5 does not reference a percentage increase, but rather a documentation of increased number of unique patients served by program. The goal for I-10.3 is not necessarily related to P-3.1. Technical Change: The language for P-3.1 in the Planning Protocol reads that way ("individuals enrolled" rather than "individuals served"), so changing it for this one provider would not be a consistent approach to this metric.
Tomball Regional Hospital 131044305.1.1	5	0 of 1 DY 2 milestones complete. 0 of 2 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. Note: 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."	HHSC should consider discussions of possible project withdrawal if provider initiates such a process.	**Possible Plan Modification:** Provider should consider possible withdrawal of project due to lack of progress with any elements of this project and not having any confirmed plans on how to go forward with the project.	NA	Provider withdrew the project.
El Campo Memorial Hospital 131045004.2.1	2	3 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.	**Possible Plan Modification:** 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	MSLC recommended adjusting the way QPI is calculated to reflect the number of patients with improved patient experience. However for this project, QPI metric has been reported and was approved to capture the number of individuals surveyed.

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Harris County Hospital District Ben Taub General Hospital 133355104.1.1	4	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reported working on establishing the increase in hours at the temporary location while the new clinic site had been determine and would be established in May. Provider hired 0 of 4 new positions and reported 0 of 1000 patient encounters as of April DY 3. Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.1.2 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. See project 133355104.1.8 regarding federal funding. Provider stated that HHSC instructed them to use the same percentage for all new clinic locations based on their current overall percentage of Medicaid/Uninsured patients seen at existing clinic locations. Provider stated that despite the early challenges the project was able to successfully meet their DY 3 encounter goal on time and as of DY 4 the new permanent site is open and seeing patients.	No recommendations at this time.	No recommendations at this time.	N/A	M&S did not have any recommendations.
Harris County Hospital District Ben Taub General Hospital 133355104.1.11	2	1 of 1 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider reports that the registry capacity has been identified with one chronic disease which is in development and is expected to achieve this by October DY 3. 43% of the 70% of employees require to be assigned to the evaluation of the registry were achieved by April DY 3. With a go-live date of April 2014, they provider expects training to be completed by the end of DY 3. No reported progress on the 5000 patients enrolled in the registry. Noted that Metric I-16.1 in DY 5 states that the goal is for 40% of patients in the registry have at least 1 contact in the prior year period and it states this to be 4000 visits despite the fact that the patients registered in DY 4 will be 12,500 which is not in line with the numerical goal. Provider states, "The percentage goal is still 40%; however, the numeric goal was not updated during the plan modifications process. We expect to meet the percentage improvement goal and reach a number above the original 4,000 visits. "	No recommendations at this time.	**Possible Plan Modification:** Provider should update the number of individuals enrolled in DY 5 metrics I-12.1 to more accurately reflect alignment with the percentage goals for patient contact.	N/A	MSLC recommended to update goals for the metric. HHSC believes that MSLC meant to refer to I-16.1 (not I-12.1) in their possible plan modification recommendation. The goal for I-16.1 is that 40% of patients in the registry have at least 1 contact in prior year. The DY4 goal for number enrolled in registry was 10,000, so 40% would be 4,000 visits as reflected in goal language for I-16.1 in DY5. No action necessary.
Harris County Hospital District Ben Taub General Hospital 133355104.1.12	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 20% of 25% training goal reported completed and 1 of 2 analysts were reported hired by April DY 3. 0 of 3 employees were reported trained through the train the trainer event. Possible additional federal funds were noted and addressed in the site visits. Noted lack of clarity in the goals for metrics P-6.1 in DY 3-5 regarding how many staff would be trained and what baseline would be used to show a percentage increase. Provider stated that they have identified, and reported in DY 3, a baseline of 250 employees as Quality Champions within their respective departments, to include a combination of new and existing staff. These employees now qualify as Innovation Center staff because they are serving as innovators for purposes of this project. Their plan is to ensure that the 250 baseline is maintained and they will continue to train their Quality Championsfor this metric. They do not plan to hire additional staff in upcoming DYs.	No recommendations at this time.	**Technical Change:** Update the goals for metrics P-6.1 in DY 3-5 to be more in line with the actual project activities and state clear goals and baselines. The provider states 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.	NA	MSLC recommended updating the goals for metrics P-6.1 in DY3-5. HHSC removed the word "Hire" from the goal for clarity so that it reads: Train additional 50% Center of Innovation staff in quality and efficiency improvement principles. Before making this change, HHSC confirmed with provider that goal does not include hiring of staff.
Harris County Hospital District Ben Taub General Hospital 133355104.1.13	3	1 of 1 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. For of increasing specialists by 16.4% the provider reported increasing by 21% and the 21% of staff were trained with a goal of only 16% by April DY 3. Provider submitted no specific progress update for the number of encounters achieved towards the baseline goal of 9,240. Possible additional federal funds were noted and addressed in the site visits. Note change in baseline for FTEs is mentioned in April DY 3 sign off summaries but not reflected in the Phase 4 Master Summary baselines and goals for metric I-22.1.	No recommendations at this time.	**Technical Change:** Update metric I-22.1 baselines of 28.5 to reflect what is stated in the Phase 4 Master Summary.	N/A	MSLC recommended to update baseline for I-22.1. HHSC believes that no action is necessary; reporting system reflects accurate baseline(s) for each DY.

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Harris County Hospital District Ben Taub General Hospital 133355104.1.14	4	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 0 of 1 new primary care clinics 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 1.1.2 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 April DY 4 and continue our marketing efforts to meet the 10,000 visits goal in DY 4 by October 2015."	No recommendations at this time.	**Technical Change:** Update the QPI Summary to represent more accurate Medicaid/Uninsured percentages based upon the actual populations being served in each location.	N/A	MSLC recommended to update the QPI summary to reflect accurate MLIU percent. No action necessary at this point; summary will be updated based on percentages reported.
Harris County Hospital District Ben Taub General Hospital 133355104.1.15	3	1 of 1 DY 2 milestones complete. 0 of 4 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 April 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 (10/2/2011 – 9/30/2012). The QPI metric baseline is 30,223 with goals to increase by 478 in DY 3, 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.	No recommendations at this time.	**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.	NA	MSLC recommended updating P-101.1 to state a patient impact. Metric P-103.1 is from DY3 and has already been reported and approved; no change needed.
Harris County Hospital District Ben Taub General Hospital 133355104.1.17	3	1 of 1 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. 0 of 3 additional FTE dentists and 1 FTE dental hygienists have been hired. Dental services have been added to 2 of 3 sites and some patients are being seen although there is no specific progress towards the 1,070 goal given.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Harris County Hospital District Ben Taub General Hospital 133355104.1.2	4	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Hours for the temporary site has 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 April DY 3. Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.1.2 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."	No recommendations at this time.	**Technical Change:** Update the QPI Summary to represent more accurate Medicaid/Uninsured percentages based upon the actual populations being served in each location.	N/A	No action necessary; summary will be updated based on percentages reported.

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Harris County Hospital District Ben Taub General Hospital 133355104.1.3	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 0 of 4 providers were hired although they have begun interviewing now and have identified 2 providers that will begin in September 2014 and 1 provider that will begin June 2014. 0 of 2500 completed visits were reported as of April DY 3. Noted lack of clear baseline for DY 3-DY 5 QPI metric I-12.1. Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.1.2 projects used the same Medicaid/Uninsured percentage despite the clinics being in different locations. Provider states, "the baseline for number of completed visits was established pre-DSRIP in DY1 (10/2/2011 – 9/30/2012) The completed visits baseline is 258,913 in DY1 with goals to increase by 2,500 in DY 3, 20,000 in DY 4 and 30,000 in DY 5."	No recommendations at this time.	**Technical Change:** Clearly state the pre-DSRIP baseline being used for DY 3-DY 5 metrics I-12.1 Technical Change: Update QPI Summary to more clearly state that the MILU percentages are based upon the actual populations being served in each location.	NA	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 2: QPI summary will be updated by HHSC.
Harris County Hospital District Ben Taub General Hospital 133355104.1.4	4	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones completed. Existing sites have been identified to temporarily provide temporary expansion of services but 0 of 2 clinics were established as of April DY 3. 0 of 9 new providers were hired and 0 of 1500 encounters were achieved. Noted the use of temporary facilities may impact different patient populations depending on where the temporary sites are located. Possible additional federal funding was noted. Provider site visit showed 2 new clinics open and currently seeing patients. Patient volume is promising and may offer the ability to get back on track. Provider ensured that temporary sites being used (for this project and all similar projects) were within the same zip code as the clinics they intended to build. Provider stated that meeting their DY 4 hiring goal was economically not feasible for this project due to the high costs and the provider believes that they can meet their intended QPI goal with a lower number of provider FTEs. 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider a possible reduction in FTEs for metric DY 4 P-5.1 goal due to the economic factors stated by the provider.	NA	MSLC recommended changing the goals for P-5.1 Provider was approved for carryforward of October DY3 reporting for metric P-5.1 (increased number of providers) and in the answers to the questions for their carryforward request they indicated that they hired 5 providers in DY3 and were prepared to onboard the remaining 4 for DY3 goal in early 2015 when the clinic opens. It does not appear that there is a need for a plan modification related to staff hiring, and provider did not request one during DY3.
Harris County Hospital District Ben Taub General Hospital 133355104.1.5	2	1 of 1 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. 1 of 1 new clinics were established, 1 of 1 provider was hired, and 3054 of 500 visits were completed as of Apr DY 3. Noted significant risk of overachieving but plan modifications have already been proposed to increase the QPI metric goals for DY 4 and DY 5. Noted that supporting documentation for the number of encounters may not be sufficient to demonstrate metric achievement because there was no information provided to ensure that duplication of information was not taking place.	HHSC should require future supporting documentation for the number of patient encounters include enough information, such as date of encounter, patient identification number, or other information in order to determine that there is no duplication of encounters taking place.	**Technical Change:** Update the QPI Summary to represent more accurate Medicaid/Uninsured percentages based upon the actual populations being served in each location.	HHSC will consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review our 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 for the compliance monitoring work providing additional verification of the reported information.	MSLC recommended to update the QPI summary to reflect accurate MLIU percent. No action necessary for technical change; summary will be updated based on percentages reported. HHSC will consider MSLC's recommendations regarding supporting documentation for the number of patient encounters, review our 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 for the compliance monitoring work providing additional verification of the reported information.
Harris County Hospital District Ben Taub General Hospital 133355104.1.6	2	1 of 1 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 1 of 2 new primary clinics have been opened and 1 of 3 new same day clinics have been opened as of April DY 3. Project is using temporary sites to start seeing patients before the new clinics open. 4.6 of 11 FTE providers have been hired and 3,343 of 3,000 encounters have been completed as of April DY 3. Significant risk of overachieving based upon the number of encounters completed by April DY 3 . Possible additional federal funds were noted and addressed in the site visits. Noted that all 1.1.2 projects used the same Medicaid/Uninsured percentage despite the clinics being in different locations.	Consideration should be given to project valuation if plan modification to increase QPI is submitted and approved.	**Possible Plan Modification:** Provider should consider an increase in QPI based on DY 3 QPI overachievement.	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 consideration of QPI goal increases based on DY3 achievement. Provider did overachieve in DY 3 (3343 achieved vs 300 goal), however, provider was nowhere close to DY 4 goal of 21,000 and DY5 goal of 31,500. HHSC is not going to request a goal increase based on this information.

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Harris County Hospital District Ben Taub General Hospital 133355104.1.8	4	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. As of April DY 3, the project is slightly off track reporting only 1707 of 5500 completed patient visits through the referral program. Provider does not intend to meet any of the core components through this referral project, but the FQHCs that will be providing the patient visits will be fulfilling the core components as needed. Lack of clarity in continuity of reporting between the FQHC's 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 3 QPI goal. For DY 4 thus far they reported only 647 additional encounters over their DY 3 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.	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.	Yes	MSLC recommended 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 mln, HHSC is not initiating goals change.
Harris County Hospital District Ben Taub General Hospital 133355104.1.9	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	**Technical Change:** Update metric I-11.1 in DY 5 to state "pediatric patients receiving BH services" instead of "pediatric patients seeking BH services" in order to demonstrate actual patient impact.	N/A	MSLC recommended to update metric I-11.1 in DY5. No action necessary; I-11.1 Metric (and provider goal) already reads "patients receiving BH services" and "not seeking services".
Harris County Hospital District Ben Taub General Hospital 133355104.2.1	4	2 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. The central fill facility build-out is in progress and the go line date is scheduled for June 9, 2014. 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. Noted DY 3 - DY 5 metric I-101.1 states a percent increase over a baseline of 0 percent which is unclear. Project delays caused the facility to not go live until July 2014. Noted a lack of clarity regarding whether QPI metric goals were intended to be monthly targets or annual targets. Provider states, "The goals of 40%, 50% and 60% would be calculated by dividing the number of prescriptions that are filled through the use of automation by the total number of prescriptions dispensed to all patients. In short, it is the percentage of dispensed prescriptions filled by the central fill technology." Provider also states that they are currently meeting most of their DY 4 goals and are on track for reporting purposes. Provider cites that proper training and marketing to our clinic sites allowed them to meet the goal. The provider states that the QPI goals will be tracked monthly and , "through improved processes and program expansion, we expect to reach the goals of 40%, 50% and 60% of prescriptions being filled through automation by the final month of each respective demonstration year (monthly goal)."	No recommendations at this time.	**Technical Change:** Update metric I-101.1 for DY 3-DY 5 to be stated as 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:** Remove the references to monthly goals from the DY 4-DY 5 QPI metric I-101.1 goals since the goals are meant to be measured on an annual basis , not a monthly basis.	NA	MSLC recommended two technical changes for the project. Technical Change 1: Metric is to increase the number of prescriptions filled at central fill. Their goal for DY4 is for 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 DY3 and it was approved. Technical Change 2: 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 DY3.
Harris County Hospital District Ben Taub General Hospital 133355104.2.2	3	1 of 1 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. 2 of 6 patient navigators have been hired and trained. 0 of 5% increase in PCP referrals have taken place because the provider will start seeing patients in May 2014. 0 of 200 patients have been enrolled in the program as of April DY 3 and 1 of 2 semi-annual learning collaboratives have been attended.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Harris County Hospital District Ben Taub General Hospital 133355104.2.3	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reports having the essential elements of a dashboard but the dashboard is not yet completed. The decrease in LOS has been achieved in one of 2 pavilions 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.

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Harris County Hospital District Ben Taub General Hospital 133355104.2.4	3	1 of 1 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. QPI metric I-10.3 reports 24 out of 200 individuals. Provider stated in April DY 3 reporting they will continue working towards their goal. for DY 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/menu. We further defined our goal in the actual goal verbiage, which was allowed."	Consideration should be given to the potential impact on project valuation if plan modification to increase QPI is submitted and approved.	**Possible Plan Modification:** Provider should consider decreasing QPI goal for metric I-10.3 to a more achievable value should the provider feel future QPI goal is unattainable.	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 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 mln, HHSC is not initiating goals change.
Harris County Hospital District Ben Taub General Hospital 133355104.2.5	4	3 of 5 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. 6 clinics have been identified but only 2 of the 3 letters of commitment have been signed as of April DY 3. Staff has been partially increased but the goal of 40% increase has not been met so the training goal can also not be met. The increase number of refills handled by the refill clinic was not yet completed as of April DY 3. The 25% increase in target population reached by the program is only partially completed. Of the 2500 required patient encounters, the provider states that they are behind on the completion of this metric due to the delay in hiring. Lack of clarity noted in the DY 3-DY 5 metric goals for I-101.1 as to whether it was meant to be a percentage increase from the baseline as a annual total or a monthly total. Noted lack of clarity regarding metric I-21.2 goal of "individuals served." Note 4. Metric I-103.1 goals for DY 3 to DY 5 state an increase in the number of patients to specified goals, such as "increase the number of patient visits to 2500" in DY 3 but do not state the baseline. Provider states, "The refill goals listed are annual total increases from the baseline of 2,197 established in DY 2 (10/1/12 – 9/30/13) and applies to DY 3 and DY 4...The services that will count toward the QPI goal include completed appointments and telephone encounters that patients have received for anticoagulation services provided by Pharmacists. The baseline of 2,756 was established in DY1 (10/2/2011 – 9/30/12)." Provider states, "The baseline for this metric is 26,000 visits established in DY1 (10/2/2011 – 9/30/12). "	No recommendations at this time.	**Technical Change:** Update DY 4 and DY 5 metric I-101.1 to state that the goal will be an annual increase over the baseline of 2,917 as established in DY 2. **Technical Change:** For DY 4 and DY 5 metric I-21.2, provider should clearly listing 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.	NA	MSLC recommended two technical changes for the project. Technical change 1: This change is not needed. Since baseline was established in DY2, that amount will be referenced during reporting review. Technical Change 2: Metric I-12.2 requires documentation of "increased number of individuals served by innovative program," so goal of number of individuals served is appropriate.
Harris County Hospital District Ben Taub General Hospital 133355104.2.8	4	1 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider is significantly behind on metric achievement. The hiring for the call center appears to have been completed but the implementation of the call center has not yet been completed. Provider is finalizing onboarding of providers to meet DY 2 carry forward metric of 1.0 teams so the goal of 0.5 MD FTEs and 1.5 NP FTEs for a total of 1.5 multidisciplinary teams has not yet been completed. The goal of 442 patients seen through house calls above the baseline has not yet been reported for achievement. The project has previously reported budget constraints causing delays in hiring. Noted significant change in baseline. Provider stated that hiring MDs and NPs is consistently an issue and they are working with affiliated medical schools (BCM and UT) to ensure positions are released and filled in a timely manner to ensure their project is successful. Provider reports that the impact on this project has been minimal. Provider also states, "We had an inaccurate baseline which has now been updated. As reported in DY 3, our new baseline is 445 patients and goals have been adjusted and approved accordingly. "	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.

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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
Harris County Hospital District Ben Taub General Hospital 133355104.2.9	2	5 of 5 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. Provider has completed a 5% increase of the 20% increase in providers using the algorithm. The 30% increase in primary care providers using algorithms has not yet been completed. Goal of 5% decrease of rejected referrals from baseline for diabetes clinics has been noted to be partially complete. The goal of 7% decrease of rejected referrals from baseline for rheumatologic clinics is also noted to be partially completed. The goal of 2500 unique individuals impacted by algorithmic workups is partially completed. 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Columbus Community Hospital 135033204.1.1	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. As of April DY 3 reporting, the provider had not started metric P-4.1. DY 3 does not have a QPI metric. The following discrepancies were noted with metric I-12.1 in DY 4 and DY 5: - Metric I-12.1 does not have a QPI impact in DY 4, but does in DY 5. - There is not a stated baseline in DY 4 or DY 5. - DY 4 does not contain a numerical goal (goal for DY 5 metric is 200 encounters). - Unclear why the percentage increase (17.02%) in DY 4 is a higher percentage increase than in DY 5 (10%).	No recommendations at this time.	**Technical Change:** Goal for Metric I-12.1 in DY 4 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 provide can measure the percent increase in DY 4.If the provider prefers to keep its percent increase goal, a baseline should be clearly established.	NA	MSLC recommended to revise the goal for I-12.1 in DY4. HHSC agrees that I-12.1 should be revised to include a numeric goal. Metric is "Number of telemedicine visits" but goal is 17.02% increase. Project narrative states that provider plans to provide 150 telemedicine visits in DY4. (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: Baseline/Goal: Increase percentage of telemedicine visits provided by this specialty out of total number of patients referred for this specialty service by 17.02%. 150 telemedicine visits provided in DY4.
Memorial Hermann Hospital 137805107.1.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. As of April DY 3 1 of 2 clinics have been opened and 3 of 8 additional PCP's have been hired. Project is likely to remain on track. Lack of clarity in QPI metrics due to percentage goals listed. 5% expected Medicaid/Uninsured impact. Provider stated that during Phase II of the development of the DSRIP projects, HHSC required providers to specify numeric goals as their QPI. At that time,they stated that they would provide 246,000 visits in DY 4 and 258,000 visits in DY 5. The provider calculated these goals by using an estimated baseline and applying percentage goals of 5% and 10%. The actual baseline, reported in DY 2, was lower than the estimated baseline. However, as was clarified in Phase IV of DSRIP revisions, their QPI goals for DY 4-5 are now both numerical, 246,000 visits and 258,000 visits respectively.	Recommend closely reviewing the Medicaid/Uninsured percentage for this project going forward since it is significantly lower than most projects	No recommendations at this time.	HHSC is open to including this project on the compliance monitoring list if this is MSLC's recommendation.	HHSC is open to including this project on the compliance monitoring list if this is MSLC's recommendation.
Memorial Hermann Hospital 137805107.1.2	2	3 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. Provider reports that the internal documents and Operational Manual is in development and will be completed by October reporting. Data is also being collected for the written action plan and 5 of 9 staff have been hired. Project is likely to remain on track. Lack of clarity noted in QPI metrics regarding percentage increases and the term "appropriate alternatives." Provider reports, "As was clarified in Phase IV of DSRIP revisions, Memorial Hermann's I-12.1 QPI goals for DY 4-5 are now both numerical, 3,100 individuals and 5,400 individuals respectively" and " We define "appropriate alternatives" as a safe setting within Memorial Hermann's outpatient clinics that is staffed with mental health specialists trained to provide evidenced based treatment for the mentally ill... This project is an entirely new Memorial Hermann program that did not exist prior to DSRIP; as a result, the baseline for QPI metric I-12.1 is zero."	Consider revision of 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 reporting the number of encounters at the alternate setting and cannot report an X% increase in DY 4 due to a baseline of zero.	No recommendations at this time.	HHSC agreed with this recommendation and revised I-12.1	Based on Myers & Stauffer's finding, HHSC believes the QPI Metric 1-12.1 should be changed to renumbered I-12.2, "Number of individuals served using appropriate crisis alternatives." Provider is already planning to report a number, not a percentage. HHSC made this change and notified provider.

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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
Memorial Medical Center 137909111.1.1	2	3 of 3 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider has hired 6 staff and the OBGYN 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. Noted lack of clear baseline for DY 4 and DY 5 metric I-102.1. DY 4 metric I-101.1 states of goal of "develop office staff" but this is not further clarified. Provider states that the term "develop staff" refers to hiring and training staff.	No recommendations at this time.	**Technical Change:** Update DY 4 metric I-101.1 goal to state that the metric goal is to hire and train staff rather than stating that the goal is to develop office staff. **Technical Change:** Provider should recalculate its percentage increase in DY 5 for Metric I-102.1. The percent increase calculation using the DY 4 and DY 5 numerical goals is 211 percent.	NA	MSLC recommended two technical changes for this project. Technical change 1: There is no metric I-101.1 in DY4 for this project, and no metric goal in DY4 to develop office staff. Technical change 2 is for DY5. Agree that an increase from 480 specialty visits in DY4 to 1012 is 211% increase, not 15%. Provider responded with agreement with HHSC's suggested language for reporting system. Updated reporting system with following: Baseline: 480 encounters in DY4. Goal: Increase number of specialty visits to 1012 encounters in DY5. Total impact of 1492 encounters. Numeric Goal: 1012
Memorial Medical Center 137909111.2.1	3	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Metric 102.1 regarding the completion of the pharmacy operating system was marked NMI by HHSC in April DY 3 for insufficient supporting documentation. Monthly RHP meetings attended appear to be on track. Noted that the DY 3 support shows the receipt of equipment for the installation of the system signed in February of DY 3 and shows the contract date starting Oct 1, 2013. However, the provider reported a month's worth of activity occurring in September 2013.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Memorial Medical Center 137909111.2.2	3	2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. HHSC denied DY 2 metric P-1.1, "As noted in August, the assigned individual does not seem qualified to meet the metric as their role is not an executive level. Metric is not approved and is no longer eligible for payment." Provider attempted to report the integration of patient experience into employee training in April DY 3 but HHSC denied it due to it being an annual metric goal. Provider reports 25% of 100% employees with specific patient experience objectives in their job descriptions by April DY 3. Noted that sample size of 600 for an encounter goal of 300,000 seems small . Also noted that DY 5 metric I-101.1 does not state a baseline from which the percentage improvements will be made. It is unclear why the provider is demonstrating 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. 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.	Recommend considering the potential impact on project valuation if metric is removed from DY 4.	**Possible Plan Modification:** 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 was already demonstrated in DY 3 metric P-6.1.	Even if a metric were to be removed, valuation would not be impacted, because the funding would be spread among remaining milestones/metrics within that demonstration year.	MSLC recommended removing P-6.1 in DY4 because they believe the metric is already achieved. Provider DY3 goal was that 90% of new FT 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.
Memorial Medical Center 137909111.2.3	3	2 of 2 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Provider has completed the implementation plan and completed 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 3" although HHSC approved the metric for achievement in Apr DY 3. Lack of clarity noted in DY 4 and DY 5 metric I-102.1 in regards to whether the goal is stated as counting individuals or encounters.	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 states, "completion of implementation plan for each workgroup formed in DY 3" it is important to ensure that each work group for this project be mentioned specifically in the implementation plan in order to prove metric achievement.	**Technical Change:** Update the DY 4 and DY 5 metric I-102.1 goals to clearly state that the goal is 600 individuals per year, as stated in the QPI Summary.	HHSC agrees with this recommendation.	Agree that I-102.1 should be changed to individuals. Phase 4 change 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.

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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
The Methodist Hospital 137949705.2.1	3	6 of 7 DY 2 milestones complete. 0 of 7 DY 3 milestones complete. Although DY 2 metric carryforward for hiring was noted as being compiled, HHSC marked the metric NMI because they could not locate the supporting documentation. 10% of the 50% of training was completed. HHSC could not find the support for the high risk tool and discharge checklist as well as the support for the 3 transition care partners. 20% of 50% of staff training was accomplished and the 60% increase in high risk patients discharged with customized care plans has not yet been completed. The enhanced screening of patients has not yet begun and 0 of 2330 patients received Follow-Up After Hospitalization for Mental Illness within 7 and 30 days. Noted that DY 4 and DY 5 metrics I-43.1 state a goal of an increase in percentage above the baseline of target population receiving improved care but the metric description states a decrease in preventable readmissions. Metric I-42.1 in DY 3-DY 5 does not have a clearly stated baseline from which to demonstrate the percentage increase. Provider support for all metrics was found to be linked into the documents provided so there was no reason for NMI in DY 3. Provider states that they will be challenged to achieve the proposed QPI encounters for DY 4 and DY 5 and that they would be willing to consider a plan modification to reduce QPI.	Consideration should be given to project valuation if plan modification to reduce QPI is submitted and approved.	**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.	NA	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 % improvement over baseline, or a % decrease in PPAs and PPRs. Contacted provider and updated reporting system.
Texas Children's Hospital 139135109.1.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 11,815 specialty care visits of the baseline of 20,031 of which their goal is to have 500 additional encounters. Provider has participated in 1 of 2 learning collaboratives. Note: Provider's core components listed in the project narrative are not the same core components as lasted in the Category 1 Menu for 4 year projects. Asked provider to clarify core components and they still listed ones that were different from the Category 1 Menu.	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.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.11	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 5,061 specialty care visits of the baseline of6,408 of which their goal is to have 641 additional encounters. Provider has participated in 1 of 2 learning collaboratives. Noted discrepancy in core components as noted in project 139135109.1.1	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.12	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 9,852 specialty care visits of the baseline of 18,252 of which their goal is to have 588 additional encounters. Provider has participated in 1 of 2 learning collaboratives. Noted discrepancy in core components as noted in project 139135109.1.1 This project has been noted as a benchmark project due to the significant challenges the project has overcome and their 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.

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Texas Children's Hospital 139135109.1.15	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 15,001 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, "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).	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Children's Hospital 139135109.1.16	2	2 of 2 DY 2 milestones complete. 0 of 3 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	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.2	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3milestones 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	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.3	2	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 2,991 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	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.4	2	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	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.7	3	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 collaborative. 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, "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)."	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Texas Children's Hospital 139135109.1.8	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 10,005 specialty care visits of the baseline of 16,226 of which their goal is to have 1,622 additional encounters. Provider attended 1 of 2 learning collaboratives. Noted discrepancy in core components as noted in project 139135109.1.1.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Texas Children's Hospital 139135109.1.9	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has had 1,133 specialty care visits of the baseline of 1,198 of which their goal is to have 47 additional encounters. Provider attended 1 of 2 learning collaborative. 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, "The baseline used for metric I-23.1 in DY 3-DY 5 is 23,950 encounters. This baseline was established using volume in FY12 (October 1, 2011-September 30, 2012)."	No recommendations at this time.	**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.	NA	MSLC 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.
Texas Children's Hospital 139135109.2.1	1	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has enrolled 65 patients of the goal of 123 new enrollees. Provider attended 1 of 2 learning collaboratives.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Methodist Willowbrook Hospital 140713201.2.1	3	6 of 7 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. Provider reported hiring 15 FTEs as needed for their DY 2 Carryforward metric but HHSC was unable to find support. Provider also stated that they completed the development of high-risk tool and discharge checklist as well as a community partnership agreement but HHSC was also unable to find that support and marked these metrics NMI. Provider reports 10% of the 50% training being completed. Note: the QPI metrics do not specifically state what baseline they will be using. Also, DY 4 and DY 5 Metric I-43.1 description states a % decrease in the preventable all-cause admissions and readmissions but the goal is a % increase above the baseline, average from DY 2 and DY 3. Provider states that they have already contacted HHSC regarding the discrepancies in metric I-43.1 and were told that the baseline/goal would be used to measure achievement, not the metric description. Provider requests a change to the wording of the numerator and denominator due to inability to access regional data.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
St. Joseph Medical Center 181706601.2.2	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has been participating in bi-weekly conferences and the provider has seen 219 out of the 281 patients required for DY 3. Note that project is highly likely to overachieve by the and of DY 3. Note the provider also had a high valuation ($19,585 per individual). The provider has already submitted a plan modification to increase QPI.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Rice Medical Center 212060201.1.2	2	1 of 1 DY 2 milestones complete. 1 of 1 DY 3 milestones complete. A needs assessment was created in DY 2. Provider reported in April DY 3 that they are on track to develop and finalize an implementation plan for its telepsychiatry program. Provider did note some challenges but they appear to be addressing them. It was noted that the QPI summary did not include the patient impact from metric P-4.1 in DY 3 and the total patient impact for DY 4 and DY 5 listed in the metrics also did not include the DY 3 activity.	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 DY 3 metric P-4.1.	NA	MSLC recommended updates to I-12.1 Provider did not have a QPI metric in DY3, so it is unnecessary to update the QPI metric in DY4 and DY5 with data from a different metric.
Rice Medical Center 212060201.1.3	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has reported 0 of 750 encounters met as of April DY 3. Last reporting period the have established a temporary location. Plans for the permanent location are underway: the location agreement has been finalized and is awaiting confirmation. The primary provider's initial supply needs have been confirmed and are being secured. The start-up supply and equipment list has been finalized and where necessary, procurement activities are underway.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have recommendations for this project.
Rice Medical Center 212060201.1.4	2	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reports being on track to hire at least 2 nurses by the end of DY 3 but reported progress as of April DY 3 being 0 nurses hired. Note the DY 4 metric I-17.1 references 700 patient visits from DY 3 when that was not a metric for this project. The same principle applies for the percentage increase referenced for the same metric in DY 5. If the unique patients are being measured in DY 4 and DY 5 within this same metric, the DY 3 patients should also be a part of the QPI impact for this project. Provider stated that since this was an entirely new service prior to the Waiver, they did not know what the FastTrack service's first year volume (the project baseline) would be. As such, the provider set its DY 4 and DY 5 goals for the project as percentage goals. During March 2013 valuation feedback, HHSC required them to provide an estimated numeric patient impact so they had to estimate its first year volume, which they thought would be 700 patient visits. They used the baseline estimate to calculate its DY 4 and DY 5 goals based on 42% and 100% increase over baseline, or 1000 visits in DY 4 and 1400 visits in DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Rice Medical Center 212060201.2.2	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete Provider reports progress in creating a disease management model for DY 3. Lack of clarity noted in the QPI metrics as listed in the Phase 4 Master Summary and the QPI Summary. The QPI summary lists the DY 4 metric goal as being 745 patients and the DY 5 goal as being 320 patients. However, the metric wording appears that the additional 320 patients should be on top of the individuals being served in DY 4 which would make the total DY 5 patient impact 1065.	No recommendations at this time.	**Technical Change:** Update the DY 5 metric I-17.1 goal to clearly state that the DY 5 patient impact is 1065, which would be 320 individuals above the DY 4 patient impact. **Technical Change:** Update the QPI Summary to show the DY 5 QPI as being 1065 individuals.	NA	MSLC recommended updating DY5 metric I-17.1 HHSC agrees that the DY5 goal for I-17.1 should be 1065 to show the impact of DY4 + the additional patients served in DY5. HHSC updated reporting system to reflect numeric goal of 1065 in DY5.
Rice Medical Center 212060201.2.3	2	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reports progress on developing an implementation strategy and will establish the Certified Diabetes Teaching Center in DY 3. Lack of clarity noted in the QPI metrics as listed in the Phase 4 Master Summary and the QPI Summary. The QPI summary lists the DY 4 metric goal as being 600 individuals and the DY 5 goal as being 200 individuals. However, the metric wording appears that the additional 200 individuals should be on top of the individuals being served in DY 4 which would make the total DY 5 patient impact 800 individuals.	No recommendations at this time.	**Technical Change:** Recommend updating the DY 5 metric I-6.1 goal to clearly state that the DY 5 patient impact is 800, which would be 200 individuals above the DY 4 patient impact. **Technical Change:** Update the QPI Summary to show the DY 5 QPI as being 800 individuals.	NA	MSLC recommended updating DY5 metric I-6.1 HHSC agrees that the DY5 goal for I-6.1 should be 800, but it appears this has already been updated in the online reporting system and the Phase 4 summary, so no action necessary.

APPENDIX 2 - RHP 3

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
Fort Bend County Clinical Health Services 296760601.1.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is still in the process of hiring and training dispatch workforce and a training manual has been established. Guidelines for crisis services and operational protocols have not yet been completed 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.
Fort Bend County Clinical Health Services 296760601.1.2	2	1 of 1 DY 2 milestones complete. 1 of 3 DY 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.
Fort Bend County Clinical Health Services 296760601.2.3	4	1 of 1 DY 2 milestones complete. 0 of 3 DY 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 DY 3 metric P-103.1 baseline states TBD by DY 3 baseline data. DY 5 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.
Fort Bend County Clinical Health Services 296760601.2.4	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 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 DY 5 Metric I-101.1 does not state baseline from which to measure the 100% increase in target population reached. Provider states 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 DY 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 DY3).
OakBend Medical Center 127303903.2.101	1	No DY 2 milestones. This is a 3 year project. 2 of 2 DY 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

APPENDIX 2 - RHP 4

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
CHRISTUS Spohn Hospital Beeville 020811801.1.1	1	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Testing has begun on the disease management registry and should be full 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Beeville 020811801.1.3	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. HHSC 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
The Corpus Christi Medical Center - Bay Area 020973601.1.1	5	0 of 1 of DY 2 milestone complete. 0 of 3 of DY 3 milestones complete. Project delayed due to hiring, with significant improvement the project could get back on track. Provider needs to give more detail about the project progress in its sign-off summaries.	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.	**Possible Withdrawal:** The project should hire staff prior to the end of DY 3 or a withdrawal should be considered.	Based on October reporting, it appears that clinic was fully staffed in September 2014 although they carried forward all DY3 milestones to provide time to gather documentation.	MSLC stated that the project should hire staff prior to the end of DY3 or a withdrawal should be considered. Provider hired all needed staff by the end of DY3 (by Sept 2014). Based on this information, HHSC is not recommending withdrawal since the provider should be able to catch up in DY4. In Progress Update, provider indicated that they should be able to meet DY3 QPI in DY4.
Memorial Hospital 121785303.1.3	2	1 of 1 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Kleberg 136436606.1.2	2	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Although patients have not been seen, their QPI is low enough 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
The Corpus Christi Medical Center - Bay Area 020973601.1.4	4	0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestone complete. Milestone I-101 is not clear and needs to be changed to be measurable. With significant improvement the project could get back on track.	No recommendations at this time.	**Possible Plan Modification:** Milestone I-101 is not written in a way that the milestone can be measured appropriately. Clarification needs to be made as to how the provider is going to accurately measure the milestone.	NA	MSLC recommended updating QPI metric I-101 because MSCL said the goals are not measurable. HHSC reviewed this metric, and determined that the metric has measurable annual goals. In the Baseline/Goals section, provider also lists weekly goals, but the reporting will be done on annual basis, which is set in the goals for the metric. Based on this, HHSC did not do any edits to the metric.
CHRISTUS Spohn Hospital Corpus Christi 121775403.1.4	1	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.1.1	2	4 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

APPENDIX 2 - RHP 4

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
DeTar Hospital Navarro 094118902.1.3	1	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 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.	Recommend 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 delays.	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 suggested revisiting DY5 goals, since the provider had delay in hiring providers. Based on October review, provider reported hiring of additional staff in August. It appears they are on track and don't need to revisit DY5 goals.
CHRISTUS Spohn Hospital Beeville 020811801.2.1	1	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1	2	1 of 1 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider is overachieving their QPI milestone. A plan modification exists to fix this. Provider should remain on track.	Recommend that consideration be given to the potential impact on project valuation if plan modification is approved.	**Possible Plan Modification:** Milestone I-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 compare to other projects, and HHSC can decrease project's valuation.	MSLC recommended to update P-3.1 to reflect that the baseline would include high utilizers of ED. Since P-3.1 is DY3 metric, HHSC cannot update it. Instead, HHS updated the narrative of the project to reflect that that the pre-DSRIP baseline is 0, and the goals for QPI would include high utilizers of ED. Provider agreed with the updates to the narrative.
MHMR of Nueces County 138305109.2.1	2	2 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider has seen 30 of 75 patients and it appears they will complete their goal prior to the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.10	1	2 of 2 DY 2 milestones complete. 0 of2 DY 3 milestones complete. Provider has seen 343 of the 800 patients and it appears they will meet their goal prior to the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.5	4	1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestonescomplete. The project does not have a coherent goal for DY 4 & DY 5 metric I-22.1. Their QPI goal is 1,707 individuals for both demonstration years with the metric measuring a percentage of patients referred to a Behavioral Health Provider. The project was not approved for DY 2 Metric P-4.1 due to inadequate supporting documentation. They have also not started either metric for DY 3 due to staff turnover. Provider attempted to make changes to their QPI without a plan modification, but these were rejected by HHSC.	Recommend that HHSC follow up with the provider regarding DY 2 Metric P-4.1 that was not paid. The provider stated at the site visit that this was due to a technical error and that the documents were submitted under their Cat 3 project and they feel they should have been paid.	**Possible Plan Modification:** Clarification of QPI Metric I-22.1 for DY 4 & 5 as there are multiple measurements within the same metric. It is unclear what the actual goal should be. At the site 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 DY2 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 BH/Depression. The issue was discussed with waiver management.	MSLC recommended to adjust the QPI metric I-22 by splitting it into multiple metrics since it had several goals. Provider first wanted to remove secondary information related to Medicaid/LIU, but then agreed to split the metrics. Due to the discussion with the provider, HHSC ran out of time to make DY4 changes, therefore, only DY5 change was made. QPI metric remained I-22, and the goals did not change. HHSC created I-101 that reflects a number of Medicaid and low income uninsured individuals receiving access to specialty services. All goals for MLIU remained the same.
CHRISTUS Spohn Hospital Alice 094222902.2.1	1	2 of 2 DY 2 milestones complete. 1 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Gulf Bend Center 135254407.2.1	3	4 of 4 DY 2 milestones complete. 1 of 5 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.	Recommend 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 delays.	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.	MSCL recommended to revisit the project's goals due to delay in hiring key staff. HHSC checked the subsequent reporting by the provider, and saw that provider reported hiring a PCP and are on the way of meeting their DY3 QPI goal. Since the project is over $5 million, and the provider is making progress, HHSC will not be talking to provider regarding changes to the goals.

APPENDIX 2 - RHP 4

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
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.4	2	1 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. HHSC approved milestone for DY 2 to be carried forward. A system is in place to begin referring patients, but has not been implemented yet. Provider needs to refer 25 patients and this appears to be achievable prior to the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Kleberg 136436606.2.3	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The provider is currently collecting data and will report completion by the end of the reporting period. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Camino Real Community Services 121990904.2.1	1	3 of 3 DY 2 milestones complete. 2 of 2 DY 3 milestones complete. Provider has completed its QPI goals for the year. Provider appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.1.2	3	4 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider has seen 2,931 of 7,700 patients at midpoint and would be able to see more patients prior to the end of October DY 3. DY 3 milestones delayed due to training staff. However, given the carryforward option, it appears that the provider can meet their QPI. Potential that milestones might not be met in a timely manner.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.1.3	2	2 of 2 DY 2 milestones complete. 3 of 6 DY 3 milestones complete. Provider has seen 1,711 of 2,600 patients. They have partially completed the task force for their quality improvement initiative and the documentation of the task force meetings (milestone P-102). They have expanded a specialty care clinic and have seen 166 of their goal of 400, so they are on track to complete this before the end of the year (milestone P-11). Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	**Possible Plan Modification:** Recommend adding milestone P-11 in the next DYs, since this is an expansion of a specialty care clinic.	NA	MSLC recommended adding milestone P-11 in the next DYs, since this is an expansion of a specialty care clinic. HHSC reviewed the language of P-11 and determined that it is primary used for the number of new specialty clinics. Provider responded that they are not planning to add any new clinics in DY5 since they already opened two clinics. Based on that HHSC did not add P-11 to DY5.
DeTar Hospital Navarro 094118902.2.1	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. HHSC is concerned that the provider opened a clinic at a different location and that the provider needs to provide services to low income and Medicaid clients as proposed in the project. We agree with HHSC and asked the provider to submit demographic and Medicaid information for the zip code or surrounding area for the new location of the clinic to prove it will see the same population as stated in the approved plan. Provider submitted the zip code information for the clinic in question. Provider responded stating the second location would help better serve the Medicaid/Low Income Uninsured population. Please reference email sent from Jace Jones on December 18, 2014 to the HHSC Waiver mailbox.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.2.3	1	6 of 6 DY 2 milestones complete. 3 of 5 DY 3 milestones complete. Provider has seen patients and plans on showing their achievement at the end of the reporting period. Provider appears to be overachieving their QPI goals. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	**Possible Plan Modification**: Recommend increasing their goal for Milestone I-101 as it appears they are overachieving. **Possible Plan Modification**: Recommend increasing their goal for Milestone I-103 as it appears they are overachieving.	NA	MSLC recommended increasing goals for I-101 and I-103. Provider already submitted Plan Modification to increase goals for I-101.1 and I-103.1. Both change requests were approved. HHSC considers these recommendations addressed.

APPENDIX 2 - RHP 4

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
The Corpus Christi Medical Center - Bay Area 020973601.2.2	1	3 of 3 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Alice 094222902.2.3	2	1 of 2 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.11	3	2 of 3 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. HHSC is concerned about the DY 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 a+G30 and 450 providers in safety/efficiency protocols. This training will impact nearly 400,000 patient encounters. HPI state that results include "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." 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Spohn Hospital Corpus Christi 121775403.2.9	2	2 of 2 DY 2 milestones complete. 0 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. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Citizens Medical Center 137907508.2.1	3	5 of 5 DY 2 milestones complete. 4 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.	Recommend that consideration be given to the potential impact on project valuation if plan modification is approved.	**Possible Plan Modification:** Recommend decreasing the QPI for milestone I-16, since the provider is delayed in training and has yet to report seeing QPI.	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 decreasing QPI goals for the project. However, in October reporting, provider reported QPI achievement of 6869 individuals that exceeded their DY3 goal of 1119 and DY5 goal of 1,678. HHSC recommends that the provider increase their DY5 goal rather than decreasing QPI goals. HHSC is in the process of increasing the goals in collaboration with provider.
The Corpus Christi Medical Center - Bay Area 020973601.1.5	3	0 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Initial panning 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

APPENDIX 2 - RHP 4

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
Yoakum Community Hospital 112673204.1.1	3	0 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project delayed due to hiring and training of faculty, but they expect to have the staff hired and trained and will report completion in October DY 3 reporting. They are currently working to get a system in place to track the patients and also expect completion by October DY 3 reporting. New clinic space is almost complete and when this opens the provider states they will meet their QPI. They have limited space currently and it has hindered their progress. Potential that milestone(s) might not be met in a timely manner.	Recommend 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-12 since the new clinic is not yet opened.	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.	MSCL recommended revisiting goals for milestone I-12 since the new clinic is not yet opened. In October reporting, provider reported QPI achievement of 1334 encounters in less than 4 months that exceeded their DY3 goal of 1119. Based on this, HHSC will not consider discussing decrease of QPI goals for this project.
Driscoll Children's Hospital 132812205.1.5	4	4 of 4 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. The provider states that the initial baselines were provided including data from RHP 4 & RHP 5. The new baselines include only RHP 4. There are also several plan modifications that have been approved and the narrative will need to be updated to reflect these changes. Currently, the project QPI metrics #1 & #2 I-23.1 are at risk for not being met as the baselines are inaccurate. There have been multiple plan modifications submitted including decreasing the QPI, resulting in a change to the project valuation. The project also reports in the April DY 3 Sign-Off Summary for Metric P-104 the revised baseline hours include each operating clinic date with total hours representing the first patient checked in for the day until the last patient checked out. Any patient encounters whose check out times were not correctly represented were excluded.	The provider has submitted plan modification requesting deletion of DY 4 & DY 5 Metric #2 of Milestone I-23.1 due to several challenges faced with receiving referrals for anatomy scans. We agree with HHSC in not approving this plan modification, the metric should remain as is and the provider should request a carryforward if needed. We agree with HHSC approving the change to the baseline program hours for DY 3 metric P-104, but keeping the original metric measuring operating hours. During the site visit, the provider stated some challenges with being able to measure operating hours. Recommend that consideration be given to 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.	(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.	MSLC recommended revisiting goals for this project since the provider has concerns of meeting their QPI for DY4 & DY5. 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.
The Corpus Christi Medical Center - Bay Area 020973601.2.1	3	0 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Identifying the top chronic conditions (I-10) and implementation of standardizing care (P-2) is in progress and will be reported as complete in October DY 3 reporting. The provider is developing the protocols for the nursing unit and will begin seeing patients once these protocols are in place.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Coastal Plains Community Center 080368601.2.1	4	7 of 9 DY 2 milestones complete. 1 of 10 DY 3 milestones complete. Provider has hired all staff with the exception of one FTE in the Alice clinic (P-5: total FTE for this goal is 7.05). A plan is in process to develop a integrated behavioral health and primary care services within collocated sites (P-6). A plan, do, study, act (PDSA) is in process (P-7). Provider has seen 537 of 1,000 patients and is on target to complete their QPI before the end of the reporting period (I-8) and will also show a treatment plan for a percentage of these patients (I-9) . Provider has shown a decrease in no show appointments to .05% and they need a 2% decrease (I-10). Provider has not shown an increase in positive results in standardize health (I-11), but has started to see a decrease in admission/readmission rates (I-101). Patients reporting satisfaction with integrated services cannot be achieved unless carried forward since the baseline wasn't set in DY 2 (I-12). Milestone I-102 is overachieving. They have seen 288 of 125 patients halfway through DY 3. Request a plan modification to increase the goal for this milestone.	Consideration should be given to potential impact on project valuation if plan modification is approved.	**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 compare to other projects, and HHSC can decrease project's valuation.	MSLC recommended increasing goals for I-102 since the provider overachieved the goals for DY3. Provider agreed that it can be increased. HHSC updated in DSRIP system the goal for I-102.1 in DY5 from 425 to 467.5, based on the provider response. This is a Non-QPI metric.

APPENDIX 2 - RHP 4

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
Memorial Hospital 121785303.2.1	3	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.	No recommendations at this time.	No recommendations at this time.	Provider noted that they have not begun project as of October reporting but will begin in two months.	Provider withdrew the project.
Corpus Christi-Nueces County Public Health District 130958505.2.3	3	DY 2 Not included in sign-off summary, project awaiting 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Memorial Hospital 121785303.2.2	5	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.	No recommendations at this time.	No recommendations at this time.	Confirmed that this project was withdrawn	Provider withdrew the project.
Citizens Medical Center 137907508.1.100	3	This is 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 BH 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 "EOU" 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.	No recommendations at this time.	No recommendations at this time.	NA	NA

APPENDIX 2 - RHP 5

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
UT Health Science Center San Antonio 085144601.1.1	2	1 of 2 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Hiring delays due to a start date in the next DY (DY 3). Need to hire additional faculty and the provider states this will be completed prior to the end of the year. Two participants are in a training course and have until the end of DY 3 to complete, provider states they will complete in June 2014. Once the faculty is hired, the provider anticipates reporting primary care visits which start in DY 4.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.104	3	This is a 3-year project therefore it does not have any DY 2 milestones. 2 of 5 DY 3 milestones complete. Milestones delayed to due to a lack of trauma patient visits and continuing education for new hires. Potential that milestone(s) might not be met in a timely manner.	Consideration should be given to potential impact on project valuation if reduction in QPI is approved.	**Possible Plan Modification:** Recommend reducing the QPI for I-23, since the provider has only seen 2,263 of 9,058.	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.	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 DY5 QPI goal is not achievable, they can submit a request to adjust the DY5 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 DY5. HHSC has recommended to the provider that they review the status of the project and request adjustments for DY5 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.
McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.105	3	This is a 3-year project therefore it does not have any DY 2 milestones. 0 of 3 DY 3 milestones complete. Training staff on processes, guidelines and technology for referrals is in process. The provider has installed and implemented the EMR (Electronic Medical Records). Provider has seen 1,650 of 3,623 patients thus far in DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Doctor's Hospital at Renaissance 160709501.1.4	2	2 of 2 DY 2 milestones complete. 3 of 5 DY 3 milestones complete. The clinic did not open until May 8, 2014, but the provider states they will report on achievement at the end of the DY 3 reporting period. Although the milestones are not completed, the project appears to remain on track. In milestone I-23.1 DY 4 & DY 5, the goals currently state the annual number of patient visit slots attributable to new faculty physicians and the number of additional patient visits. Visit slots and actual encounters are two separate elements. The QPI is based on encounters, not to be confused with number of patients slots made available. The provider deleted milestone I-22, but this is necessary to support the goal listed in the narrative to increase access.	No recommendations at this time.	**Possible Plan Modification:** Recommend a plan modification for I-23 in DY 4 & DY 5. Provider needs to clarify the goal and this language should be consistent from DY to DY. **Possible Plan Modification:** Recommend the provider add milestone I-22 back into the project to support the goal listed in the narrative to increase access.	N/A	MSLC recommended updating I-23 in DY4 and DY5, which is QPI metric, to make sure that baselines are similar, because provider was using different baseline statements. HHSC updated the baseline for DY4 and DY5 metric I-23: 0, No faculty existed at the beginning of DY2. No trainees available in DY 2. Both DY4 and DY5 baseline/goals were adjusted to reflect the QPI visits attributable to new faculty physicians and residents. Updated language makes it more simple to understand how QPI is achieved. MSLC also recommended to add I-22 to the project in DY5. Provider previously had I-22, but then it was replaced by I-23 when HHSC required that each project reflects a QPI. Provider responded that increase in staff makes increase in visits possible, which is reflected in I-23, and requested not to add I-22 in DY5. HHSC is OK with not adding this milestone, because provider has several milestones in DY5 that reflect project's activities.
Doctor's Hospital at Renaissance 160709501.1.101	4	This is a 3-year project therefore it does not have DY 2 milestones. 0 of 3 DY 3 milestones complete. Project is not progressing due to the provider waiting for CMS approval.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Doctor's Hospital at Renaissance 160709501.1.3	4	1 of 5 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. The provider submitted a DY 2 sign-off summary for October, but they failed to report on milestones 3, 4, & 5 (P-4, I-14, & I-105). DY 2 Milestone 2 (P-2) states to hire 2 faculty staff which were not hired in DY 2 and not met in the carryforward sign-off summary. The other milestones in DY 2 which were not reported on relate to training, developing a curriculum, and increasing the patient visit slots that are available that cannot be reported on until the faculty staff are hired. Additionally, the DY 3 milestones cannot be completed until the staff from DY 2 are hired.	No recommendations at this time.	**Possible Plan Modification:** Recommend reducing the QPI for I-101, since the provider is delayed in hiring staff to allow their QPI to be achievable in future DYs.	N/A	MSCL recommended revisiting goals for this project since the provider had a delay in hiring staff. Based on subsequent reporting, provider is still dealing with catching up with project's goal and is in the process of meeting its DY3 QPI goals. Since the project is over $5 million and has not requested a decrease in QPI goals via plan modification process, HHSC is not initiating goals decrease for this project.

APPENDIX 2 - RHP 5

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
McAllen hospitals LP dba Edinburg Regional Medical 094113001.1.103	1	This is a 3-year project therefore it does not have DY 2 milestones. 3 of 4 DY 3 milestones complete. Provider has seen 96 of 137 patients. Provider appears to remain on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
University of Texas Health Science Center San Antonio 085144601.1.100	4	This is a 3-year project therefore it does not have DY 2 milestones. 0 of 3 DY 3 milestones complete. Project is not progressing due to the provider waiting for CMS approval.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Knapp Medical Center 135035706.1.100	1	This is a 3-year project therefore it does not have DY 2 milestones. 2 of 2 DY 3 milestones complete. Provider has opened their clinic and hired staff. Provider is on track to see patients in DY 4.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Tropical Texas Behavioral Health 138708601.1.4	2	1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has seen 1,912 of 3,490 patients. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	**Possible Plan Modification:** Recommend that provider should change milestone P-3 to have goals across DY 3-DY 5, instead of only DY 3.	N/A	MSCL recommended including P-3 in subsequent years, since the goal of P-3 was to train staff by the end of DY5. Provider agreed with this recommendation. Based on that, HHSC added P-3 in DY4 with the goal of 63 staff and P-3 in DY5 with the goal of 125 staff to be trained.
UT Health Science Center San Antonio 085144601.1.3	4	1 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Milestones delayed due to hiring difficulties. This project was approved late which has set back the progress; with significant improvements the project could get back on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Doctor's Hospital at Renaissance 160709501.1.106	4	This is a 3-year project therefore it does not have DY 2 milestones. 0 of 5 DY 3 milestones complete. Project is not progressing due to the provider waiting for CMS approval.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Doctor's Hospital at Renaissance 160709501.1.2	3	2 of 2 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Project delayed due to hiring and training of faculty. Potential that milestone(s) might not be met in a timely manner.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.1.1	2	4 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider has seen 3,013 of 3,740 patients for I-101 and a plan modification was submitted by the provider to increase their QPI. The other two milestones are related to training their staff and attending a learning collaborative and will be met prior to the end of the DY 3 reporting period.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Doctor's Hospital at Renaissance 160709501.1.100	4	This is a 3-year project therefore it does not have any DY 2 milestones. 0 of 3 DY 3 milestones complete. Project is not progressing due to the provider waiting for CMS approval.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Valley Regional Medical Center 020947001.1.100	4	This is a 3-year project therefore it does not have any DY 2 milestones. 0 of 5 DY 3 milestones complete. An expansion plan and a location for the clinic has been developed and the clinic is currently being built (P-11). Until the clinic is built, the remaining milestones cannot be met which include increasing hours (I-22) and seeing patients (1,000 encounters) (I-23 & I-34). Provider is conducting weekly reviews of challenges faced (P-20). Potential that milestone(s) might not be met in a timely manner.	No recommendations at this time.	**Possible Plan Modification:** Recommend a reduction in QPI for milestones I-23 and I-34, since the provider does not have an operational clinic by April DY 3.	N/A	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 DY5 QPI goal is not achievable, they can submit a request to adjust the DY5 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 DY5. HHSC has recommended to the provider that they review the status of the project and request adjustments for DY5 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.

APPENDIX 2 - RHP 5

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
UT Health Science Center San Antonio 085144601.2.1	1	3 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. In April DY 3, provider has seen approximately 2,000 of the 3,000 patients at this rate provider will meet this milestone (P-101). The other milestones that are partially complete are expanding primary care team roles and determining a panel size for the primary care teams and should be completed prior to the end of the DY 3 reporting period.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Columbia Rio Grande Healthcare dba Rio Grande Regional 112716902.2.101	2	This is a 3-year project therefore it does not have any DY 2 milestones. 0 of 3 DY 3 milestones complete. Provider has started the development of the innovational strategy and plan (milestone P-2) and has attended a learning collaborative (milestone P-8). Once the planning is completed they will begin to see patients for an innovative intervention (milestone I-6). Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
University of Texas Health Science Center- Houston 111810101.2.101	2	This is a 3-year project therefore it does not have any DY 2 milestones. 0 of 4 DY 3 milestones complete. Provider has started the initial planning of the evidence based innovational project for the target population (P-2). Although the milestones are not completed, the project appears to remain on track. The provider needs to execute the evaluative process for the project innovation (P-4), then they can start to see patients (I-5). They also need to participate in two learning collaboratives (P-7).	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Border Region Behavioral Health Center 121989102.2.1	4	0 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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. During a phone conference, the provider stated they are now exceeding their QPI (met 61 of 20 patients) and have hired staff as of their October DY 3 reporting. Need clarification on milestone P-5 since it is achieving a level 4 of interaction and is used as the baseline for milestone P-6 which states level 4 interaction.	No recommendations at this time.	**Possible Plan Modification**: Recommend increasing the QPI for milestone P-5, since the provider is overachieving this milestone. **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.	N/A	MSLC recommended updating P-5 and increasing QPI goals. P-5 is a DY3 only metric and HHSC is not updating DY3 metrics at this time. Provider was open to an increase in QPI goals - HHSC Changed P-6 QPI metric goal to 100 in DY5 (from 50).
Driscoll Children's Hospital 132812205.2.1	1	3 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider has increased 886 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Tropical Texas Behavioral Health 138708601.2.4	2	2 of 2 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider has seen 162 of 150 patients. Provider still needs to improve the percentage of patients with self management goals, has increased 504 of 2,500 encounters completed by chronic care nurses, and has provided 11 of 12 examples of how to improve CQI. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Tropical Texas Behavioral Health 138708601.2.2	1	2 of 2 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider has seen 209 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

APPENDIX 2 - RHP 5

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
Starr County Memorial Hospital 136332705.2.1	2	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider is in the process of implementing a program to improve efficiencies, which is their DY 3 milestone. Although the milestones are not completed, the project appears to remain on track. 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 & 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.	No recommendations at this time.	**Possible Plan Modification:** It appears the project is measuring both percent improvement and increased patient volume in DY 4 & DY 5, but the project is using different metrics for each DY. Recommend a plan modification to add I-16.1 in DY 4 and I-14.1 in DY 5 to separate the two elements being measured.	N/A	MSLC recommended adjusting 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 this recommendation. HHSC updated system to reflect that I-14 is a QPI metric in DY5, I-14 replaced I-16. QPI goals did not change.
UT Health Science Center San Antonio 085144601.2.2	1	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider has seen 234 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should clarify the baseline for DY 4 and DY 5 for P-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.	N/A	MSLC recommended clarifying baseline for P-101 (a non-QPI metric) in DY4 and DY5. Provider agreed with this recommendation. Based on provider's response, HHSC updated P-101 Baseline in DY4 and DY5 to reflect 0, since this is new project, which has a pre-DSRIP baseline of 0.
McAllen hospitals LP dba Edinburg Regional Medical 094113001.2.100	2	This is a 3-year project therefore it does not have any DY 2 milestones. 0 of 5 DY 3 milestones complete. Provider has started enrolling the primary care settings into the remote behavioral health consultation services and will complete by 6/1/14, are conducting a needs assessment, are working on agreements between parties for the virtual psychiatric consultations so they can provide these services to patients, and will provide ideas and solutions every week after 7/1/14 when they expect to complete the implementation of the project. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Tropical Texas Behavioral Health 138708601.2.1	2	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Provider has seen 162 of 299 patients. Provider is in the process of evaluating the integration of primary and behavioral health services to provide ideas and solutions to CQI. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Tropical Texas Behavioral Health 138708601.2.7	2	2 of 3 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider has seen 42 of 90 patients and has participated in one of two learning collaboratives. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
UT Health Science Center San Antonio 085144601.1.2	4	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 key leadership to get the program started and they resigned. This has led to a delay, but when 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

APPENDIX 2 - RHP 5

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
Border Region Behavioral Health Center 121989102.1.2	5	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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
University of Texas Health Science Center- Houston 111810101.1.100	3	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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Border Region Behavioral Health Center 121989102.2.2	3	1 of 1 DY 2milestones 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

APPENDIX 2 - RHP 6

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
University of Texas Health Science Center at San Antonio 085144601.1.2	3	4 of 4 DY 2 milestones complete. 1 of 5 DY 3 milestones complete. No significant risks that appear to be preventing the provider from meeting their DY 3 metrics. QPI metric I-11.1 reports 4,060 out of 3,500 encounters as of April DY 3. HHSC did not accept this metric as completed. The provider submitted a response during the NMI period. Project narrative does not reflect the milestones and metrics listed on the Phase 4 Master Summary for DY 3. Some metrics did not have the Baseline/Goal section on the Phase 4 Master Summary filled in which makes it unclear what will be required in order to achieve metrics.	No recommendations at this time.	**Technical Change:** Update the narrative to reflect the goals listed on the Phase 4 Master Summary. **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.	NA	MSLC recommended that the provider update the narrative to reflect the goals listed on the Phase 4 Master Summary and 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: DY2 Metric P-1.1, DY2 Metric P-3.1, DY4 Metric I-17.1 and DY4 Metric I-17.2. Since this information is accurately reflected in the workbook and the QPI summary , HHSC did not contact the provider with the recommendations.
University of Texas Health Science Center at San Antonio 085144601.1.23	3	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestone complete. Provider appears to be on track to meet their QPI metric. QPI metric I-23.1 reports 247 out of 544 encounters as of April DY 3. The provider noted in April DY 3 they were having challenges identifying PA and SW qualified applicants to fulfill hiring metric I-22.1. Provider stated that a PA was hired effective 06/16/2014 and the SW was hired effective 07/01/2014.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
CHRISTUS Santa Rosa Hospital 020844901.2.2	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-14.1 reports 44 out of 74 patients allowing home visits as of April DY 3 reporting.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.5	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metric. QPI metric I-14.1 reports 61out of 92 individuals as of April DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Hospital 136141205.2.100	2	This is a 3-year project therefore it does not have any DY 2 milestones. Project was not included on the DY 3 April Report. The Phase 4 Master Summary was used to make the MPA assessment. The project risk ranking is based on the following issues: The stated baseline is zero in the narrative. DY 4 & DY 5 QPI Metric I-11.2 use different baselines.	No recommendations at this time.	**Technical Change:** Revise 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.	NA	MSLC recommended that the baseline listed in the 3-Year Projects Workbook for DY4 and DY5 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.
University of Texas Health Science Center at San Antonio 085144601.1.1	2	1 of 1 DY 2 milestone 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 metrics. As of April DY 3, numerical progress was not reported on QPI metric I-101.1; however, the provider states they expect to report in the October 2014 reporting period.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Health Science Center at San Antonio 085144601.1.20	3	1 of 1 DY 2 milestone complete. 1 of 3 DY 3 milestones complete. QPI metric I-101.1 reports 109,455 out of 20,000 individuals as of April DY 3. HHSC did not accept this metric as completed because HHSC could not tell how many individuals were positively impacted by the improvements out of the 109,455 individuals that were reported. The provider submitted a response during the July NMI period.	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 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 109,455 individuals were positively impacted by the quality improvements via surveys.	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 the provider should consider decreasing QPI goal for metric I-101.1 to a more achievable value if they are not able demonstrate that 20,000 out of the 109,455 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.

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Peterson Regional Medical Center 127294003.1.1	3	1 of 1 DY 2 milestone 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 metrics. QPI metrics start in DY 4. Provider reported as of April DY 3 that they have not been able to find a data analyst. Provider stated that they hired a fulltime Decision Support Analyst in July 2014. Project narrative indicates that this project's target population is diabetic patients but the QPI metric goals in DY 4 and DY 5 of 1800 and 2800 individuals do not state diabetic patients as being the patients targeted.	No recommendations at this time.	**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.	NA	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.
University of Texas Health Science Center at San Antonio 085144601.2.5	3	4 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. QPI metric P-3.1 reports 62 out of 180 individuals enrolled as of April DY 3. The provider had discrepancies between the goals stated in the project narrative and the Phase 4 Master Summary. In the project narrative the provider sets goals for seeing unique patients as 120/360/360 for DY 3, DY 4, and DY 5, respectively. However, the Master summary states the goals as 180/540/720. 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 set the baseline as 120.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider updating the 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.	NA	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 DY4 and DY5 and the goal is intended to be 360 for both DY4 and DY5. HHSC confirmed the baseline and goals with the provider and updated the reporting system to reflect the correct goals for DY4 and DY5.
Baptist Medical Center 159156201.2.1	2	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Health Science Center at San Antonio 085144601.1.11	3	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 were in the final stages of recruiting the last hires. 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 upon increasing the number of clinical providers and the opening date of the clinic. 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 1-12.1 as stated in the Master Summary. There is lack of clarity with I-12.1 in DY 5 relating to increased unique patients visiting the clinic. 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.	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 decreasing the QPI goal for metric I-12.1 to a more achievable value due to difficulty in hiring. **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. **Technical Change:** Update the Phase 4 Master Summary to be reflective of it's intended goals for QPI metric I-12.1. **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.	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.	Provider withdrew the project.
Frio Regional Hospital 112688002.1.1	4	0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. None of the milestones for DY 2 or DY 3 had been met as of April DY 3 reporting, due to difficulties in hiring. 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.	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 decreasing the QPI goal for metric I-12.1 to a more achievable value due to delay in hiring and training staff.	HHSC does not change valuation based on QPI changes	MSLC recommended that the provider consider decreasing QPI goal for metric I-12.1 to a more achievable value due to delay in hiring and training staff. HHSC followed up with the provider to get status of the project and to see if the provider felt the DY5 goals were still attainable. The provider indicated in their response that after getting clarification from HHSC staff they feel comfortable with the project and it seems things are on track and the provider expects to meet their goals.

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Dimmit County Memorial Hospital 112690603.1.2	4	2 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. As of April DY 3, the provider only achieved 2 of their 4 DY 2 metrics. The provider also had not started 3 of their 4 DY 3 metrics. Provider reported that the ED fast track will not be implemented until March 2014 and the nurse advice line will not be started until April 2014. In DY 2 provider reports that considerable time was taken to select an urgent medical advice line vendor, design protocols, and assign nurses to the advice line. The provider stated that the ED fast track was implemented and advertising efforts have been increased in order to meet future metrics. The provider also stated they hired an additional RN that has committed to do the all week nurse advice line.	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 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 advise line.	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 provider should consider decreasing QPI goal for metric I-101.1 to a more achievable value due to delays with the ED Fast Track and the nurse advise line. HHSC followed up with the provider to get status of the project and to see if the provider felt the DY5 goals were still attainable. The provider indicated that in analyzing the numbers for the Nurse Advice Line, the numbers they had projected will not be attainable for DY5. They felt that a reachable goal would be 401 patients that have called the Nurse Advice Line by DY5. HHSC checked valuation and since the project was still within range after the reduction, updated the online reporting system to reflect the new DY5 QPI goal (401 for DY5).
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.1.1	3	2 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. The provider stated that they initiated a plan modification in August 2014 that was approved to broaden the availability of this service to include child crisis respite in addition to Therapeutic Foster Care. The provider also stated that they have increased the number of contractors and they anticipate meeting the QPI for DY 4 and DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Hospital 136141205.1.9	2	2 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. 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 just be 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 136141205.1.10, 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.	No recommendations at this time.	**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 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 Psychiatric Emergency Services (PES) in order to distinguish themselves from the QPI in 136141205.1.10, 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).	NA	MSLC recommended that the project narrative be updated to include the core components as mentioned in the Category 1 Menu. HHSC did not request the provider make this update since the information will be included in reporting. MSLC also recommended the Phase 4 Master summary be updated to reflect the intended baselines of zero for DY5 metrics P-6.1 and I-101.1 as being zero; to specify the individuals for QPI metric I-101.1 (metric #2) have to be related to Psychiatric Emergency Services (PES) in order to distinguish themselves from the QPI in 136141205.1.10, which is related to the Crisis Intervention Unit (CIU); and to reflect only one metric labeled I-101.1 in DY4 and DY5 (currently two metrics labeled I-101.1). The workbook had previously been updated to show a baseline of zero for I-101.1 and to show only one metric labeled I-101.1. HHSC followed up with the provider to let them know the workbook would be updated to specify that the individuals for metric I-101.1 have to be related to psychiatric emergency services (PES). The provider agreed with this change and HHSC updated the workbook accordingly.
CHRISTUS Santa Rosa Hospital 020844901.1.1	2	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 I-12.1 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-5.1 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 0 providers. As DY 2 and DY 3 focused on the Westover Clinic, Santa Rosa's DY 2 baseline was 0 and going forward, Santa Rosa's DY 4 - DY 5 baseline will be 13. The provider also stated Santa Rosa DY 3-5 goals for P-5.1 are as follows: DY 3 Add 2 additional physicians (Westover) DY 4 Add 1 additional physician (downtown and Westover) DY 5 Add 1 additional physician (downtown and Westover)	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master summary to reflect the provider's intended baselines for metric P-5.1 in DY 3 - DY 5.	NA	MSLC recommended that the provider update the Phase 4 Master summary to reflect the provider's intended baselines for metric P-5.1 in DY3-DY5. HHSC contacted the provider regarding MSLC's recommendation. The provider agreed with the recommendation and the reporting system was updated accordingly.

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University of Texas Health Science Center at San Antonio 085144601.1.16	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. QPI metric P-104.1 reports 30 out of 60 individuals as of April DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Health Science Center at San Antonio 085144601.1.13	4	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project is behind schedule and it is unclear if they will be able to achieve their goals by the end of DY 3. As of April DY 3 reporting, QPI metric I-102.1 had not started. The goal was to report 720 individuals positively impacted by improvements. Provider cites difficulties in getting the project going due to the project not being approved until Sept 2013. Unclear baselines/goals for metric P-101.1. As P-101.1 in DY 2 lists the baseline as zero, the baselines for DY 3 and DY 3 should also be zero. The provider stated that all DY 3 metrics and milestones were completed and approved and they believe they are on track. It is noted that the project appears to have made significant progress since April DY 3 reporting.	No recommendations at this time.	**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.	NA	MSLC recommended the Phase 4 Master summary be updated to reflect the provider's intended baselines being zero for metric P-101.1 in DY3-DY5. This is a training metric and the curriculum was developed in DY2. HHSC informed the provider of the recommendation and updated the reporting system accordingly.
Methodist Hospital 094154402.1.1	2	1 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. The provider does not report numerical progress towards QPI metrics, but states they are both on track to be met by October DY 3 reporting. The baselines for I-12.1 in DY 4 and DY 5 are not listed on the Phase 4 Master Summary.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master summary to: 1. Reflect the intended baselines for both QPI metrics labeled I-12.1 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).	NA	MSLC recommended the Phase 4 Master summary be updated to reflect the intended baselines for both QPI metrics labeled I-12.1 in DY4 and DY5 and reflect only one metric labeled I-12.1 in DY4 and DY5 (currently two metrics labeled I-12.1). HHSC allowed providers to use the same metric number when they were serving two different populations so this was not changed. HHSC notified the provider of the recommendation to update the metric to reflect the intended baselines. The provider agreed to the changes and the reporting system was updated accordingly.
University of Texas Health Science Center at San Antonio 085144601.1.15	3	1 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. As of April DY 3, the provider had not completed metric P-1.1 in DY 2 due to hospital policy of not participating in surveys due to hospital regulation. QPI metric I-18.1 reports 46 out of 200 individuals as of April DY 3. In regards to Metric I-18.1, the narrative states a goal of 100, 200, 400 "patients" served by teleaudiology consultation for DY 3, DY 4 and DY 5, respectively; however, the Master Summary states 200, 400, 400 telehealth "encounters" for the same period. The provider stated that DY 2 metric P-1.1 was not accepted as completed by HHSC during October DY 3 reporting. The provider also stated funding is a concern for this project and they could see more patients if there were more funding. Note: The provider stated they achieved 287 teleaudiology encounters, which exceeded the DY 3 goal of 200.	No recommendations at this time.	**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.	NA	MSLC recommended that the project narrative be updated to align with the goals in the Phase 4 Master Summary for metric I-18.1 in DY3-DY5 and QPI measurement as being encounters, as stated in the Phase 4 Master Summary. HHSC did not follow-up with the provider on these recommendations since the workbook and the QPI summary contain the accurate information.
Medina Regional Hospital 133260309.1.2	2	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 I-101.1, but states they anticipate reporting 50 individuals by October DY 3 reporting.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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University Hospital 136141205.1.4	2	3 of 3 DY 2 Milestone complete. 2 of 3 DY 3 Milestone 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 anticipate reporting 144 visits by October DY 3 reporting. The baseline used in metric I-12.1 is zero in DY 3, but it is based on prior years in DY 4 and DY 5.	No recommendations at this time.	**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 - DY 5.	NA	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 DY4 - DY5. The most recent workbook already reflected the correct baseline so HHSC did not contact the provider about the recommended changes.
Val Verde Regional Medical Center 119877204.1.3	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Hospital 136141205.1.11	2	3 of 3 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 I-101.1, but states they anticipate reporting 30 visits by October DY 3 reporting. 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.	No recommendations at this time.	**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 - DY 5.	NA	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 DY4 - DY5. The most recent workbook already reflected the correct baseline so HHSC did not contact the provider about the recommended changes.
Connally Memorial Medical Center 135151206.1.2	3	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. The provider completed QPI metric I-12.1 as of April DY 3. 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 completed. The provider submitted a response during the NMI period.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baptist Medical Center 159156201.1.2	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. The provider does not report numerical progress towards QPI metric I-23.1, but states they are slightly more than half way there as of April DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Health Science Center at San Antonio 085144601.1.9	2	3 of 3 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. The provider did not report numerical progress towards QPI metric I-12.1, but stated they were 80% towards their goal as of April DY 3. The provider submitted metrics P-2.1 as complete in April DY 3; however, HHSC did not accept this metric as completed. The provider submitted a response during the NMI period. There is lack of clarity with regards to the baseline for metric I-12.1 in DY 3, DY 4, and DY 5. The Starting Point/Baseline section of the project narrative does not align with the project goals and baselines listed in the Category 1 or 2 expected patient benefits section or Phase 4 Master Summary.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to reflect the following baselines intended by the provider to be used for QPI metric I-12.1 in DY 3 - DY 5: DY 3 Goal - 6684 DY 4 Goal - 20% increase from DY 3 - 8020 visits. Total impact of 14,704 (6684+8020). DY 5 Goal - 20% increase from DY 4 - 9624 visits. Total impact of 24,328 (14,704+9624). Cumulative total impact of 24,328 encounters. **Technical Change:** Update the Category 1 expected patient benefits section and the Starting Point/Baseline section of the project narrative to align with the baselines intended to be used for QPI metric I-12.1.	NA	MSLC recommended technical edits to QPI metric I-12.1 and updates to narrative. HHSC did not update I-12.1 because the most recent workbook contains the correct information related to QPI metric I-12.1. HHSC did not request provider do updates to the narrative, since the workbook reflects updated information.
University of Texas Health Science Center at San Antonio 085144601.1.6	5	0 of 4 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. No progress made on project to date and provider states an intent to withdraw the project in April of 2014. Provider stated on 02/27/15 that they are submitting a withdrawal form for this project as soon as it returns from the administrative signature process. The provider also stated they have been unable to keep this project on track due to turnover within the department and the request to withdraw should be received by HHSC the following week.	No recommendations at this time.	No recommendations at this time.	NA	Provider withdrew the project.

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The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.1.5	4	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project is behind schedule and it is unclear if they will be able to achieve their QPI goal by the end of DY 3 because it is not started. In April DY 3 reporting, the provider cited difficulties in identifying and securing of the new site in an underserved area where the new Children's Campus would be located as well as difficulties with hiring Mental Health Providers in Bexar County. The supporting documentation provided for DY 2 metric P-3.1 (Doc #s 21, 22, 23, 24) does not look like it pertains directly to this specific project and some procedures were dated pre-DSRIP. The documents submitted do not state the protocols of this specific project. The project narrative was unclear regarding metric I-101.1 as compared to the Master Summary. The project narrative states DY 4 goal of 48 while the Master Summary states DY 4 goal of 64. The project narrative states DY 5 goal of 62 while the Master Summary states DY 4 goal of 87. During the site visit, the provider stated the Manual of Operations was in essence 3 projects in one. Some policies and procedures of the program were already in place pre-DSRIP and there was no need to rewrite them again. It was recommended to the provider that support specify the policies and procedures that would be applicable to the specific project. The provider stated that the program opened in July 2014. The center hosts three programs namely Crisis Center, Individual Treatment, and Dual Diagnosis treatment. Hiring challenges were overcome by casting a wide net. Provider stated the QPI goal for DY 3 was met as of October DY 3 reporting.	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 and DY 5 of 64 and 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 DY4 and DY5 of 64 and 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.
University Hospital 136141205.1.3	2	3 of 3 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 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.	No recommendations at this time.	**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 - DY 5.	NA	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 DY4 - DY5. 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.
University Hospital 136141205.1.6	2	1 of 1 DY 2 milestone complete. 1 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. The baseline used in metric I-12.1 is zero in DY 3, but it is based on prior years in DY 4 and DY 5. The provider stated the intended baseline to be used in this metric is a pre-DSRIP baseline of zero.	No recommendations at this time.	**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 - DY 5.	NA	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 DY4 - DY5. 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.
University Hospital 136141205.1.10	2	2 of 2 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Provider achieved all their DY 3 metrics, as of April DY 3. QPI metrics start in DY 4. 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 just be 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 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). Note: There are 2 separate metrics labeled I-101.1 in the Phase 4 Master Summary for DY 4 and DY 5.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to: 1. Reflect the intended baselines 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 and DY 5 (currently there are two metrics labeled I-101.1).	NA	MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baselines for DY5 metrics P-6.1 and I-101.1; 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); and reflect only one metric labeled I-101.1 in DY4 and DY5. HHSC worked with the provider and updated the reporting system to reflect a baseline of zero for metric P-6.1 in DY5 and to specify that the individuals for metric I-101.1 have to be related to the crisis intervention unit (CIU).

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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
University Hospital 136141205.1.2	2	3 of 3 DY 2 milestones complete. 1 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
San Antonio Metropolitan Health District 091308902.1.1	2	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 7,402 out of the of the 8,126 individuals as of April DY 3 reporting. DY 5 QPI goal for this metric is 13,540; 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 "Detailed service plans should be solidified prior to the end of the previous school year, in advance of summer break." • Obtaining consent forms during the enrollment process may yield improved participation rates and improved efficiency in distribution of consent forms. • Teachers, school nurses and administrators 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, review facility requirements and pre-post-clinic activities will improve overall project efficiency.		No recommendations at this time.	NA	MSLC did not have any recommendations.
Community Medicine Associates 092414401.1.1	2	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baptist Medical Center 159156201.1.3	2	3 of 3 DY 2 milestones complete. 1 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Health Science Center at San Antonio 085144601.1.5	3	1 of 2 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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 delays 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 stated that location would be changed due to a lack of space at the downtown location (UHS). During the site visit, 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 the hiring challenge has been overcome. Provider stated that project 085144601.1.23 is dealing with epilepsy/ seizures and 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 they would easily be able to meet the same 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 infers it was based on individuals and not encounters.	NA	MSLC recommended the Phase 4 Master Summary be updated to reflect the baseline intended to be used by the provider for QPI metric I-23.1 in DY3 - DY5 of 150 patient visits per month. HHSC worked with the provider and updated the reporting system to reflect the intended baseline.
Dimmit County Memorial Hospital 112690603.1.1	2	1 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 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.	**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.	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 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 DY3 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. 1 of 3 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. 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. DY 3 Baseline 47,539 DY 4 Baseline 49,675 DY 5 Baseline 51,772	NA	MSLC recommended the Phase 4 Master Summary be updated to reflect the baseline intended to be used by the provider for QPI metric I-12.1 in DY3 - DY5. HHSC worked with the provider and updated the reporting system to reflect the correct baseline.

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Peterson Regional Medical Center 127294003.2.1	2	1 of 1 DY 2 milestone 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider revising or replacing metric I-12.1, as per the provider, it no longer aligns with the intent of the project. The provider is requesting one of the two change requests: 1. Change current DY 4 and DY 5 Milestone I-12.1, Metric and Goal. Proposed: P-12 Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-12.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning collaborative seminars or meetings at least twice a year beginning in DY 4. 2. Redefine the existing ED patient population metric to be better aligned with the services provided through Project RED. - Reduce ED Visits by 5% for the proportion of the diabetic population that receives the new Project Red discharge process as an inpatient. - The provider states this option does not align as closely to their current Cat 3 as option #1, which addresses readmissions.	NA	MSLC recommended the provider should consider revising or replacing metric I-12.1, as per the provider, it no longer aligns with the intent of the project. The provider was requesting to change their improvement milestone I-12 to a weaker process milestone P-12. HHSC worked with the provider and updated the baseline/goal language for metric I-12.1 and added metric P-12.1 in DY4 and 5.
Texas Center for Infectious Disease 133257904.2.1	2	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Methodist Hospital 094154402.2.1	2	2 of 2 DY 2 milestones complete. 1 of 4 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Hospital 136141205.2.3	2	3 of 3 DY 2 milestones complete. 4 of 5 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-16.3, but states they are on track to complete the goal.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Methodist Hospital 094154402.2.2	2	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.2	2	2 of 2 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-3.1 reports 6 out of 8 individuals as of April DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.2	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Nix Health Care System 112676501.2.2	2	3 of 3 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-13.1 reports 363 out of 600 individuals as of April DY 3. QPI metric I-13.1 states the baseline is "145 ACE admissions in DY 1" in the April DY 3 Sign-Off Summary; however, the Phase 4 Master Summary does not list a baseline for this metric in DY 3 - DY 5.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to reflect the intended baselines for QPI metric I-13.1 in DY 3 - DY 5.	NA	MSLC recommended updating the Phase 4 Master Summary to reflect the intended baselines for QPI metric I-13.1 in DY3 - DY5. 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.
Nix Health Care System 112676501.2.3	2	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 P-3.1 reports 390 out of 600 individuals as of April DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 133340307.2.6	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 36 out of 40 individuals as of April DY 3. DY 5 QPI goal is 140.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
San Antonio Metropolitan Health District 091308902.2.3	2	3 of 3 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. QPI metric I-6.1 reports 340 out of 1,000 individuals as of April DY 3. 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.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master summary to: 1. Reflect the intended baselines of zero for both QPI metrics labeled I-6.1. 2. Reflect only one metric labeled I-6.1 in DY 3 - DY 5. (currently two metrics are labeled I-6.1).	NA	MSLC recommended the Phase 4 Master summary be updated to reflect the intended baselines of zero for both QPI metrics labeled I-6.1 and reflect only one metric labeled I-6.1 in DY3 - DY5. Since the reporting system already reflected the baseline of zero for I-6.1 in DY3, HHSC did not feel the need to repeat this across the remaining DYs. HHSC allowed providers to use the same metric if they were serving two different populations. HHSC did not contact the provider with these recommendations.
University of Texas Health Science Center at San Antonio 085144601.2.1	4	0 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. As of April DY 3, none of the DY 2 or DY 3 metrics were completed due to delay in getting the project started. In Oct DY 2 reporting, the project had been put on hold awaiting approval of CMS. In Apr DY 3, the provider reported approval from the UTHSCSA Internal Review Board was needed. The provider also reported a delay in hiring 2 required LVN with fluency in English and Spanish. The baselines are missing from metrics P-3.2, P-102.1, P-103.1, P-104.1 and P-105.1. The provider stated that they achieved all DY 2 milestones by October DY 3 reporting. The project also stated that changes were made that will enable the project to serve more children and achieve their goals. Additionally, the provider stated the baseline for metrics P-3.2, P-102.1, P-103.1, P-104.1 and P-105.1 are a pre-DSRIP baseline of 0.	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 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. **Technical Change:** Update the Phase 4 Master Summary to reflect the intended baselines for the following metrics: P-3.2, P-102.1, P-103.1, P-104.1 and P-105.1. The provider stated the baseline for these metrics is a pre-DSRIP baseline of 0.	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.	Provider withdrew the project.
Guadalupe Regional Medical Center 138411709.2.1	2	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 I-101.1 reports 117 out of 210 individuals as of April DY 3. QPI metric I-101.1 does not have a stated baseline.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to include the intended baseline for QPI metric I-101.1 to be 0.	NA	MSLC recommended the Phase 4 Master Summary be updated to include the intended baseline for QPI metric I-101.1 to be 0. The reporting system already reflected the intended baseline so HHSC did not need to take any action on this recommendation.

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The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 137251808.2.4	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric P-3.1 reports 125 out of 125 individuals as of April DY 3; however, the provider has not reported it as complete because they are conducting further analysis to ensure the integrity of the data. DY 5 metric I-5.1 does not have a clearly stated baseline for the 30% of individuals referenced.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to include the intended baseline for metric I-5.1 in DY 5. The provider stated, the DY 4 QPI (for metric P-3.1) is the baseline for DY 5 metric I-5.1.	NA	MSLC recommended the Phase 4 Master Summary be updated to include the intended baseline for QPI metric I-101.1 I-5.1 in DY5. The provider stated, the DY4 QPI (for metric P-3.1) is the baseline for DY5 metric I-5.1. HHSC updated the reporting system to reflect the intended baseline.
University Hospital 136141205.2.9	2	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 I-101.1, but states they are on track to complete the goal. 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.	No recommendations at this time.	**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	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 DY4 and DY5. Since the information would be reviewed during reporting as reflected in the QPI template, HHSC did not contact the provider for updates to the QPI metric baseline.
Community Medicine Associates 092414401.2.2	2	2 of 2 DY 2 milestones complete. 1 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 I-19.2, but states they are on track to complete the goal.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of Texas Health Science Center at San Antonio 085144601.2.4	2	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. QPI metric I-17.1 reports 173 out of 200 individuals as of April DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Hospital 136141205.2.2	2	3 of 3 DY 2 milestones complete. 3 of 5 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-16.1, but states they are on track to complete the goal. QPI metric I-16.1 does not reference a specific baseline.	No recommendations at this time.	**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	MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baseline of zero to be used for QPI metric I-16.1. The most recent workbook already reflected this so no additional action was taken. HHSC did not contact the provider with this recommendation.
Nix Health Care System 112676501.2.1	2	4 of 4 DY 2 milestones complete. 3 of 5 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-12.1 reports 413 out of 500 individuals as of April DY 3. The goals from the Phase 4 Master Summary are not aligned with the goals in the narrative. 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. Metrics I-15.1 and I-17.1 do not contain clear baselines and goals on the Phase 4 Master Summary. For example, Baseline/Goal section for I-17.1 in DY 4 states, "Goal 70%".	No recommendations at this time.	**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. **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 70%".	NA	MSLC recommended that the project narrative be updated so that the QPI goals listed on the Phase 4 Master Summary align with the goals listed in the project narrative. HHSC did not request updates to the narrative since the workbook and the QPI summary both contain the correct information. HHSC is not asking providers to update narrative when there are other sources for the most updated information, which is in this case a QPI summary file. MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baselines and goals listed for I-15.1 and I-17.1. HHSC did not implement this recommendation since this information would be reviewed during reporting, and based on DSRIP reporting system all necessary information including numerator and denominator is included in the metrics. HHSC did not contact the provider with MSLC's recommendations.

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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
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 133340307.2.1	2	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1	2	1 of 1 DY 2 milestone complete. 2 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

APPENDIX 2 - RHP 7

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
Central Texas Medical Center 121789503.1.1	3	0 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete. There are no significant risks that appear to be preventing the provider from meeting their DY 3 metrics. QPI metric I-12.1 reports 2,742 out of 5,700 encounters. The provider states while their progress is slightly short of the goal they anticipate successful achievement with the addition of a PCP in August 2014. DY 2 metric # P-5.1 was not met during the April DY 3 carry forward because primary care provider will not start employment until August 2014.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Dell Children's Medical Center 186599001.1.1	2	2 of 3 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, 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. C315	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Austin Travis County Integral Care 133542405.1.2	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone 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-23.1; however, the provider states the project is currently on track to meet the metric. The QPI Summary states the goal in DY 4 for metric I-23.1 is 4,222; however, the Phase 4 Master Summary states the goal is 4,422.	No recommendations at this time.	**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.	NA	MSLC recommended a technical change for DY4 QPI. DY4 I-23.1 goal was addressed through the QPI cleanup process with HHSC.
St. Mark's Medical Center 176692501.1.1	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The provider may exceed QPI metric I-23.1 as they report seeing 935 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. Unclear if the second metric labeled I-22.1 in DY 5 was intended to be listed on the Phase 4 Master Summary as it does not list a baseline or goal. Additionally, QPI metric I-23.1 does not reference a baseline for DY 3 - DY 5.	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.	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.
University Medical Center at Brackenridge 137265806.1.4	2	1 of 1 DY 2 milestone complete. 0 of 4 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.1.1	2	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone 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-101.1 had not started. Provider reported in April DY 3 that once locations are established, the Mobile Clinic will provide services to a total of 50 individuals by 9/30/2014. Provider stated that DY 3 metric I-101.1 was achieved in October 2014 reporting and DY 4 metric is expected to be achieved by April 2015. Provider has submitted a plan modification request to HHSC to change from a mobile clinic to a mobile team serving clients at clinic locations.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
Community Care Collaborative 307459301.1.4	2	2 of 2 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics as of April DY 3 reporting. Provider exceeded QPI metric goal for I-14.1 in DY 3 as they reported 106 out of 100 individuals as of April DY 3 and QPI metric goal for I-101.1 in DY 3 as they reported 1,284 out of 750 encounters as of April DY 3. DY 5 QPI goals are 350 for I-14.1 and 3,500 for I-101.1. The baseline is not referenced in the Phase 4 Master Summary for QPI metrics I-14.1 and I-101.1 (the April Sign Off Summary lists the baseline as being 453 in DY 1 for I-14.1 and 3059 in DY 1 for I-101.1). Additionally, the goals for I-14.1 as written in the Phase 4 Master Summary are not clear.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to reflect: 1. The baselines intended for QPI metrics I-14.1 and I-101.1. 2. The intended goals for QPI metric I-14.1.	NA	MSLC recommended to add baseline information to the QPI metrics and make technical changes to the goals. HHSC is not adding baselines to QPI metrics because this will be captured in the QPI Template during reporting. Goals for I-14.1 were clarified through Plan Mods.
Community Care Collaborative 307459301.1.3	3	1 of 1 DY 2 milestone complete. 0 of 3 DY 3 milestones complete. DY 3 milestones had not started as of April DY 3. The provider reported challenges with implementation and site selection. Provider stated that DY 3 milestones were met by the end of the demonstration year.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.1.3	3	1 of 1 DY 2 milestone complete. 0 of 3 DY 3 milestones complete. In April DY 3, the provider reports challenges with hiring staff for metric P-4.1, which could potentially cause delays in the achievement of QPI metrics. As of April DY 3, numerical progress was not reported on QPI metric I-101.1; however, the provider stated they began seeing patients in Bastrop County. Provider stated that all positions are presently filled.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services 126844305.2.1	2	2 of 2 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-3.1 reports 10 out of 18 individuals as of April DY 3. The narrative states the goal for DY 4 is to serve 20 people and 24 for DY 5; however, the goal in the Master Summary Workbook for metric I-101.1 in DY 4 is to serve 22 and 28 in DY 5.	No recommendations at this time.	**Technical Change:** Update the project narrative to align with the QPI goals listed in the Phase 4 Master Summary for metric I-101.1 in DY 4 and DY 5.	NA	MSLC recommended that the narrative be updated to reflect the most recent QPI goals. HHSC is noting that project narratives may be outdated regarding QPI goals while the intended QPI goals will be included in the milestones/metrics and QPI Summary.
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.11	2	1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. Provider overachieved QPI metric I-101.1 in DY 3 as they reported 161 out of 30 individuals as of April DY 3. Noted 1 Plan Mod request: 1) Provider is requesting to increase QPI for DY 4 and DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Community Care Collaborative 307459301.2.5	3	3 of 3 DY 2 milestones complete. 0 of 5 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 metrics I-6.1 and I-101.1. In April DY 3 reporting, the provider stated the new microsite has been designed and will launch in April 2014. The provider did not express concern regarding the achievement of their QPI metrics and stated their site had been launched. The narrative states the project will increase LARC consultations integrated into patient visits by 5,000 in DY 5; however, the patient impact for I-101.1 (consultations) is only 2,200 for DY 3-DY 5.	No recommendations at this time.	**Technical Change:** Update the project narrative to align with the goals for LARC consultations integrated into patients visits, as stated in the Phase 4 Master Summary.	NA	MSLC recommended that the narrative be updated to reflect the most recent QPI goals. HHSC is noting that project narratives may be outdated regarding QPI goals while the intended QPI goals will be included in the milestones/metrics and QPI Summary.

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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
University Medical Center at Brackenridge 137265806.2.7	2	4 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Community Care Collaborative 307459301.2.7	3	1 of 1 DY 2 milestone complete. 0 of 5 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 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.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary and the QPI Summary to reflect the provider's intended goals for QPI metric P-2.2 (DY 3 goal: 500; DY 4 goal: 750; DY 5 goal: 1,000).	NA	MSLC recommended that the QPI goals be updated to reflect the intended goals of DY4 750 and DY5 1000 above pre-DSRIP baseline of 0. HHSC made these updates to the QPI goals and informed the provider.
City of Austin - Health & Human Services Department 201320302.2.2	2	1 of 1 DY 2 milestone 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 metrics. Metric P-3.1 reported 57 out of 140 individuals as of April DY 3. QPI metric starts in DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.7	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. 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 3 reporting they plan to meet this metric by 9/30/14.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Medical Center at Brackenridge 137265806.2.6	3	2 of 2 DY 2 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 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 137265806.2.6 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). 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 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Austin Travis County Integral Care 133542405.2.4	2	2 of 2 DY 2 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 metrics. As of April DY 3, numerical progress was not reported on QPI metric P-3.1; however, the provider states the project is currently on track to meet the metric.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
University Medical Center at Brackenridge 137265806.2.3	2	3 of 3 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, numerical progress was not reported on QPI metric I-101.1; however, the provider stated they anticipate meeting this metric in October 2014.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
City of Austin - Health & Human Services Department 201320302.2.6	3	2 of 3 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. QPI Metric I-102.1 reported 641 out of 3,500 encounters in April DY 3 reporting. The provider update during April DY 3 reporting stated progress was being achieved and is expected to ramp up significantly with the addition of an RN Senior, who will begin administering additional vaccinations, expected to begin in mid-May. Unclear QPI measurement type for I-102.1. The QPI summary states individuals. The Phase 4 Master Summary metric description states encounters; however, the Baseline/Goal states individuals. Unclear measurement of QPI goals. I-102.1 in DY 3 states increase in target population reached by 2%, but then states same monthly goal of 285 as DY 2 (I-7) and lists annualized QPI goal of 3,500. The monthly goal should be 291 (2% over 285). Similar calculation issues in DY 4 and DY 5.	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 decreasing the QPI goal in metric P-102.1 to a more achievable value given the delays experienced. **Technical Change:** Update the QPI Summary and Phase 4 Master Summary to reflect the provider's intent to measure QPI by encounters, not individuals. **Technical Change:** Update the Phase 4 Master Summary to reflect the following goals for DY 2 metric I-7.1 and QPI metric P-102.1 in DY 3 - DY 5, as intended by the provider: Metric I-102.1: DY 2 = 280 monthly client encounters, DY 3 = 285 monthly encounters, DY 4 = 291 monthly encounters, and DY 5 = 297 monthly client encounters. This translates annually into 3360 client encounters for DY 2, 3420 for DY 3, 3492 for DY 4 and 3564 for DY 5.	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 a decrease in QPI goals due to project delays, update the QPI grouping from individuals to encounters, and clarify the QPI goals. Through the separate QPI cleanup process, HHSC worked with the provider to change the QPI grouping from individuals to encounters and clarify the goals. Based on the QPI grouping change, provider did not request changes in QPI goals. HHSC did not follow up with the provider regarding decreasing QPI.
University Medical Center at Brackenridge 137265806.2.9	2	6 of 6 DY 2 milestones complete. 0 of 4 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Community Care Collaborative 307459301.2.4	3	3 of 3 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, numerical progress was not reported on QPI metric I-5.1. As of April DY 3, the provider reported 44 outreach events and 2670 individuals have been reached for metric P-104.1. However, this results in an average attendance of 61 people per outreach event and the goal states the average will be 75 people.	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 decreasing QPI goal in metric I-5.1 to a more achievable value given the difficulty getting the required attendance numbers during outreach events.	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 to follow up with the provider regarding the current project status and whether the DY5 QPI goal for I-5.1 3250 patients receiving STI and HIV tests over baseline remains to be achievable. This was changed to include all patients through Plan Mods rather than patients under 25 as when it was reviewed by MSLC. Provider requested to decrease DY5 from 3250 to 3000 on 4/15/15. Provider stated: Due to several changes at the state level, our contracted provider for this service has seen its patient population contract. We continue to work towards our QPI goal, but based on these non-DSRIP factors, meeting just the baseline is taking longer than anticipated. HHSC approved the change because the lower QPI was still within valuation guidelines.
Dell Children's Medical Center 186599001.2.1	2	2 of 2 DY 2 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 metrics. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Community Care Collaborative 307459301.2.6	2	3 of 3 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, numerical progress was not reported on QPI metric I-10.1; however, the provider states they plan to meet this goal by the end of DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
Dell Children's Medical Center 186599001.2.2	2	3 of 3 DY 2 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 metrics. As of April DY 3, numerical progress was not reported on QPI metric I-17.1; however, the provider states the project is currently on track to meet the metric.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.5	3	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. QPI metric I-101.1 reports 8 out of 40 individuals as of April DY 3. The provider mentions challenges with gaining trust with Veterans. Provider stated that during outings and other activities, the Veterans begin to open up regarding their issues. The provider also stated that as of October 2014 reporting, the DY 3 metric had been achieved on the project is continuing on target for achieving DY 4 metrics.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Austin Travis County Integral Care 133542405.2.6	2	1 of 1 DY 2 milestone 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 metrics. As of April DY 3, numerical progress was not reported on QPI metric P-101.1; however, the provider states the project is currently on track to meet the metric.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Hill Country MHMR Center (dba Hill Country MHDD Centers) 133340307.2.9	2	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. QPI metric I-101.1 reports 7 out of 25 encounters as of April DY 3. The provider mentioned challenges with hiring peer specialists. Provider stated that the project is on track to meet DY 3 metrics on time and DY 4 metrics right around the end of DY 4.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Medical Center at Brackenridge 137265806.1.2	2	2 of 2 DY 2 milestones complete. 0 of 4 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-102.1; however, the provider stated they anticipate meeting this metric in October 2014.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
University Medical Center at Brackenridge 137265806.1.5	3	1 of 1 DY 2 milestone complete. 0 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 100,000 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Medical Center at Brackenridge 137265806.2.5	3	3 of 4 DY 2 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 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 Performing Provider's Chronic Care Management" (137265806.2.6). 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 this DSRIP project and DSRIP project (137265806.2.6) each provide distinct services at different points along the continuum of care.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University Medical Center at Brackenridge 137265806.2.8	3	3 of 4 DY 2 milestones complete. 0 of 2 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 3. The provider had not reported on DY 2 metric I-101.1 as of April DY 3. The provider stated that 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
City of Austin - Health & Human Services Department 201320302.2.1	2	1 of 1 DY 2 milestone complete. 1 of 2 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.

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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
City of Austin - Health & Human Services Department 201320302.2.3	3	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.	No recommendations at this time.	**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.	NA	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.
Community Care Collaborative 307459301.2.1	2	4 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.	No recommendations at this time.	No recommendations at this time.	NA	NA

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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
Round Rock Medical Center 020957901.1.1	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider states they will report on their achievement for DY 3 milestones in the next reporting period (October 2014). Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Williamson County & Cities Health District 126936702.1.3	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Policies and procedures related to milestone P-4 for DY 3 have been drafted but are not yet finalized. Provider stated that they will be finalized in the next reporting period (October 2014). Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services 126844305.1.5	2	1 of 1 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Community behavioral healthcare services have seen 55 individuals of 125 per the progress on milestone I-101 in DY 3. Provider added a new clinic location which is not stated in the project narrative and there does not appear to be a plan modification for the new location. Although the milestones are not completed, the project appears to remain on track.	Consideration should be given to possible impact on project evaluation if plan modification is submitted and approved.	**Possible Plan Modification:** Recommend a plan modification to increase the QPI for Milestone P-4. Provider states a new clinic was opened and this should allow for a higher QPI impact. Provider states this will not increase the QPI, however there does not seem to be a clear explanation as to why that would be the case. **Possible Technical Change:** Recommend adding the location of the new clinic in the narrative.	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 an increase the QPI for Milestone P-4 because they felt the provider "far exceeded" their DY3 QPI goal. HHSC did not ask providers to increase their DY4 QPI goals. Also, although the provider did exceed their DY3 goal, it did not surpass the DY5 QPI goal. HHSC did not follow-up with the provider on this recommendation. MSLC recommended the narrative be updated to reflect addition of the location of the new clinic. HHSC updated the narrative and sent it to the provider for their review.
Central Counties Services 081771001.1.5	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Slow acquisition/installation of equipment has put most areas of project off-track and will not allow for patients to be seen until installed. All DY 2 carry-forward milestones have been met and DY 3 milestones are in progress. There is a possibility that milestone(s) might not be met in a timely manner.	Consideration should be given to possible impact on project evaluation if plan modification is submitted and approved.	**Possible Plan Modification:** Recommend a reduction in QPI in order to allow the provider to remain on track for their future goals.	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 reduction in QPI in order to allow the provider to remain on track for their future goals. Based on DY3 achievement, HHSC felt an increase in QPI was needed and contacted the provider to check status of the DY5 QPI goals. The provider indicated they felt the goal for DY5 could be increased. HHSC updated the reporting system accordingly.
Central Counties Services 081771001.1.4	3	2 of 2 DY 2 milestones complete. 3 of 5 DY 3 milestones complete. Patient impact has been slower than expected and have only seen 80 of 700 encounters because they are limited to 8 beds due to facility requirements and training of staff. Possible that milestone(s) might not be met in a timely manner.	Consideration should be given to possible impact on project valuation if plan modification to reduce QPI is approved. Consideration should be given to type of supporting documentation requested from providers that would indicate that positions have actually been filled.	**Possible Plan Modification:** Recommend a reduction in QPI in order to allow the provider to remain on track for their future goals.	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. Need more guidance on what type of documentation M&S thinks should be requested for hires if the HR letter with names, positions, and hire dates is not acceptable.	MSLC recommended reduction in QPI in order to allow the provider to remain on track for their future goals. Because the project is valued over $5 million, HHSC did not agree with the recommendation and let the provider know we did not agree with the recommendation from MSLC.
Scott and White Hospital - Llano 020840701.2.1	3	2 of 2 DY 2 milestones complete. 1 of 1 DY 3 milestones complete. Overachieving DY 3 QPI milestone I-101. Provider has seen 102 of 50 patients halfway through DY 3. Their DY 5 goal is 200 (cumulative 400). All milestones and metrics are on track.	Consideration should be given to possible impact on project evaluation if plan modification is submitted and approved.	**Possible Plan Modification:** Recommend an increase of QPI for I-101 milestone. A possible improvement milestone would be adequate in order to show yearly improvement in QPI.	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 an increase of QPI for I-101 milestone. HHSC contacted the provider with the recommendation and the provider requested to keep their original QPI goal. HHSC will follow-up with the provider in May 2015 with proposed increases in QPI.
Williamson County & Cities Health District 126936702.2.2	2	1 of 1 DY 2 milestones complete. 2 of 3 DY 3 milestones complete. Although the milestones are not completed, the project appears to remain on track. Provider has seen 10,144 of 10,000 individuals in DY 3. Although they are overachieving in DY 3, their DY 4 goal is 42,000 and their DY 5 goal is at 54,000.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
Bell County Public Health District 088334001.2.1	1	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Although the milestones are not completed, the project appears to remain on track. Provider has seen 379 of 570 individuals. HHSC selected as high risk, but we do not see this as high risk after review. Semi-annual reports specifically states males only, like the clarification in the Narrative which is why this was selected as high risk.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Williamson County & Cities Health District 126936702.2.1	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. All DY 2 milestones met and DY 3 milestones are in progress. Provider has seen 1,143 of 2,824 individuals. The milestone I-101 states 2,824 encounters, but the progress of the 1,143 is individuals. There is a plan modification to change the 2,824 encounters to individuals. The provider has only met 40% halfway through the year and if this were still encounters I could see this being more achievable. Additionally, they have only trained 1 of 3 staff on their patient navigator, which could be a cause for the delay. There is a possibility that milestone(s) might not be met in a timely manner.	No recommendations at this time.	No recommendations at this time.	Provider reported DY3 achievement of 1807 in October when DY5 goal is 1800. Provider trained 4 patient navigators in DY3.	MSLC did not have any recommendations for this project, however, HHSC felt the provider should consider an increase in DY5 QPI. HHSC contacted the provider and the provider indicated they did not wish to increase QPI. HHSC let the provider know we would contact them in May 2015 with recommendations for a DY5 QPI increase.
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services 126844305.2.1	3	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. On pace for overachieving DY 3 QPI milestone P-3. Provider has seen 14 individuals of their goal of 12. All milestones and metrics are on track. A plan modification has been approved to increase their QPI goals for DY 4 & DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Central Counties Services 081771001.1.2	4	2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project approval delayed accomplishment of goals. Making steady progress to get back on track by providing documentation of the broadband connection in the area and by providing inventory of the new telemedicine equipment purchased. DY 3 milestones have not started yet, but provider has shown the ability to meet their milestones by carrying them forward.	Consideration should be given to possible impact on project valuation if plan modification to reduce QPI is approved.	**Possible Plan Modification:** Recommend a reduction in QPI since the project received late approval.	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 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.
Seton Highland Lakes Hospital 094151004.2.1	1	4 of 4 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Although the milestones are not completed, the project appears to remain on track. Provider states they will meet their QPI by the next reporting period. HHSC selected the progress as high risk for making changes to the narrative and not describing the changes. We do not feel as though this was an issue while assessing risk.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Scott and White Hospital - Llano 020840701.2.2	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The provider is currently assessing their rapid improvement cycle, but will make adjustments and begin the next test change, which will include the measurement of the individuals (QPI). The project option is to apply process improvement methodology to improve quality and efficiency (project option 2.8). This system which is in the testing phases is key to the project being successful. Although the milestones are not completed, the project appears to remain on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Little River Healthcare 183086102.1.1	4	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 thereby 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.	Consideration should be given to project valuation if plan modification to increase QPI is approved.	**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.	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 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.

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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
Texas A&M Health Science Center / Baylor College of Dentistry 009784201.1.2	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider identified a secondary population in its narrative (Dentistry students who receive community-based clinical training) but such a measure is not included in the metrics. Provider reported progress on DY 3 Metric I-14 of 968 individuals over baseline (out of a goal of 1500 individuals).	No recommendations at this time.	**Possible Plan Modification:** The provider should consider including a metric in DY 5 measuring the number of dentistry students trained by the project to stay consistent with the project narrative. According to the Category 1 Menu, the provider could choose P-1.2 (Establish/increase rotations for dental residents) or a customizable metric.	NA	MSLC recommended the provider consider including a metric (either P-1.2 or a customizable metric) in DY5 measuring the number of dentistry students trained by the project. HHSC contacted the provider and updated the reporting system by adding a customizable metric (I-101.1) to DY5.
Texas A&M Health Science Center / Baylor College of Dentistry 009784201.1.3	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. For metric P-6.3, the goal is to increase the number of schools participating in the program. However, additional information received from the provider indicated that the provider is reporting the number of visits rather than the number of schools participating. Provider noted that some schools received more than one visit due to increased demand. In DY 3 metric I-14 the provider reported serving 779 children out of a goal of 1800 children. For this metric, the provider is measuring all children who receive a screening, not just children who receive the sealant treatment.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider measuring Metric P-6.3 according to the Category menu ("Number of Schools Participating in the school-based sealant program") or should consider including a description indicating how the milestone will be measured. If the provider intends to count the number of school visits, then the language of the metric should change indicate this measure. **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.	NA	MSLC recommended the description of Metric P-6.3 on the Phase 4 Master Summary be updated to follow the menu or include a description indicating how the milestone will be measured. HHSC found that the language in the workbook aligned with the menu and no changes were needed. HHSC did not follow up with the provider on this recommendation. MSLC recommended the provider consider adding Metric I-14.2 to specifically measure the number of children receiving sealants. HHSC worked with the provider and I-14.2 was added to DY5. MSLC recommended deletion of 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. HHSC updated the reporting system by deleting language for populations not included.
Texas Health Presbyterian Hospital Dallas 020908201.1.1	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestonescomplete. Provider has not increased hours (P-4.1) as of mid-point DY 3 and did not increase the number of staff. Provider reported 179 encounters out of a goal of 400 encounters for Metric I-12.1 as of mid-point DY 3. Provider is using Metric I-15.1 to measure encounters, yet the Category 1 menu specifies a measure of "percentage of target population reached." Metric I-15.1 is specific to a target population (patients with three or greater ED visits per year).	No recommendations at this time.	**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.	NA	MSLC recommended the provider consider changing Metric I-15.1 to Metric I-15.2 to more accurately reflect what provider is reporting on. HHSC worked with the provider and updated the reporting system by replacing I-15.1 with I-15.2 in DY5.
Texas Health Presbyterian Hospital Dallas 020908201.2.2	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The purpose of the project is to partner with the faith community to encourage congregants to take an active role in managing their chronic conditions. The project relies on volunteers to recruit and enroll project participants. Provider noted it has been a challenge to retain volunteers and to find congregations with which to partner. Project staff has also had difficulty enrolling participants online due to limited Wi-Fi access at targeted locations. This may present a risk in meeting DY 4 and DY 5 QPI goals.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Medical City Dallas Hospital 020943901.1.1	2	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider requested carryforward of DY 2 metric P-3.2. As of mid-point, provider reported near-completion of the metric (1978 consults delivered out of a goal of 2000). As of mid-point DY 3, the provider reported 326 encounters out of a goal of 2400 encounters and a rural outreach director was hired to expand the program. Provider submitted a plan modification to delete DY 4 and DY 5 metrics I-102.1 and I-17.3 and replace with a milestone to measure the number of new sites implementing the tele health program.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Medical City Dallas Hospital 020943901.1.2	4	1 of 1 DY 2 milestones complete. 0 of 2 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Medical City Dallas Hospital 020943901.2.3	2	4 of 4 DY 2 milestones complete. 0 of 2 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Health Presbyterian Hospital Denton 020967801.2.1	3	3 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider experienced turnover of one patient navigator but was able to hire a replacement for June 2014. Provider reported progress on its 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Las Colinas Medical Center 020979301.2.1	4	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 945 of 3266 calls (for metric I-101.1). The targeted number of calls in DY 4 is (6,646) and in DY 5 (12,076). There is risk that the provider may not be able to achieve such a high volume of calls.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Medical Center of Lewisville 094192402.2.1	4	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Medical Center of Lewisville 094192402.2.2	2	4 of 4 DY 2 milestones complete. 0 of 2 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Doctor's Hospital at White Rock Lake 094194002.2.1	3	1 of 1 DY 2 milestones complete. 0 of 2 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. This 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Denton Regional Medical Center 111905902.2.1	2	4 of 4 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported progress on DY 3 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Denton Regional Medical Center 111905902.2.2	4	0 of 2 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Irving 121776204.1.1	3	2 of 2 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Irving 121776204.1.2	4	2 of 2 of DY 2 milestones complete. 0 of 3 of 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Irving 121776204.2.2	2	3 of 3 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Irving 121776204.2.3	2	3 of 3 DY 2 milestones complete. 0 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Baylor Medical Center at Irving 121776204.2.5	4	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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. Also, they were not able to hire a manager for the program until December 2013. The provider has 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-D5 QPI goals. However, there is also risk in meeting DY 4-DY 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Garland 121790303.1.1	3	2 of 2 of DY 2 milestones complete. 0 of 2 of DY 3 milestones complete. 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 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Garland 121790303.2.2	2	3 of 3 DY 2 milestones complete. 0 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. For DY 3, Metric I-101.1 the provider has seen 199 unduplicated patients out of a goal of 250 unduplicated patients. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Garland 121790303.2.3	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported serving 510 individuals out of a goal of 960 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor Medical Center at Garland 121790303.2.5	4	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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. Also, they were not able to hire a manager for the program until December 2013. The provider has engaged pharmacy residents to help develop the program and see patients and they anticipate seeing patients in May. This delay poses a risk in meeting their DY 3 goals (to serve 300 individuals) which are tied to their DY 4-D5 QPI goals. There is also risk in meeting DY 4-DY 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Lakes Regional MHMR Center 121988304.1.2	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The provider is required to report a percentage for Milestone I-17.1 according to the category menu. 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. If the provider wants to also include the number of individuals, metric P-3.2 should be used in DY 4 and DY 5.	No recommendations at this time.	**Possible Plan Modification:** The provider should consider 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 intent of the milestone I-17, according to the menu, is to measure utilization as proxy for access to care. If the provider wants to also include the number of individuals, metric P-3.2 should be used in DY 4 and DY 5.	NA	MSLC recommended the provider should change 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.

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Lakes Regional MHMR Center 121988304.2.1	2	2 of 2 DY 2 milestones complete. 1 of 1 DY 3 milestones complete. Provider exceeded its enrollment goals by five as mid-point and reported its DY 3 metric complete (P-101.1). The current metric calculation on the Phase 4 Master Summary for metric I-5.1 is not the same for DY 4 and DY 5. DY 4 measurement describes "number of individuals" while the DY 5 measurement describes "percentage of individuals."	No recommendations at this time.	**Technical Change:** Provider should change the language of Metric I-5.1 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.	NA	MSLC recommended the language of Metric I-5.1 in DY4 be changed to match the language for DY5. HHSC found that the information in the reporting system matched and no additional changes were needed.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.2	4	3 of 4 DY 2 milestones complete. 1 of 6 DY 3 milestones complete. The expansion of the primary care network involves recruiting and contracting a number of existing clinics in the region to join the already established UT Southwestern Primary Care Network (UTSCAP.) The provider is using the newly acquired clinics to state that the project goals are being met: primary care capacity is being expanded and office hours are expanded. However, there is a risk that adding already established clinics does not necessarily correlate into expanded access to care. There is always the potential that the contracted clinics are full and will not accept new patients.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.12	4	1 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. The provider is measuring QPI as 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.	No recommendations at this time.	**Technical Change:** 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.	NA	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. HHSC asked the provider to update the narrative with an explanation of how patient impact will be measured. The revised narrative was received and reviewed.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.6	4	3 of 3 DY 2 milestones complete. 2 of 5 DY 3 milestones complete. The project was flagged by CMS and HHSC for two main reasons: 1) the data system/vendor software that the provider is using appears to be used in multiple projects as documentation and 2) it appears that the provider has used the hiring of one data analyst to prove that a new improvement office was established. After reviewing, the provider did submit a policy and procedure document for the office (which was requested by HHSC as proper documentation). The provider's QPI metric I-101.1 is "number of individual physicians receiving the population management reports." However, the goal is measured in "individuals" with "100 percent Medicaid/Low-Income Uninsured." The provider's narrative states that the patient benefit is reduced duplicative testing, reduced readmissions, and better health as a result of improved tracking and reporting.	No recommendations at this time.	**Technical Change:** Provider should delete its goal of 100 percent Medicaid for metric I-101.1 in DY 4 and DY 5. The project as described by the provider should benefit the entire system, not just Medicaid. There is risk that the provider will report only Medicaid benefit and not the system as a whole. **Technical Change:** The current language of the metric I-101.1 does not reflect the goal. The metric states the number of physicians receiving reports while the goal is measured in terms of the number of individuals served. The metric language should be changed to describe how the goal will be measured.	NA	MSLC recommended the provider delete its goal of 100 percent Medicaid for metric I-101.1 in DY4 and DY5. The MLIU summary states the MLIU as 100% and the provider did not submit a plan modification request to change this, so HHSC did not contact the provider on this recommendation. MSLC recommended the language of the metric I-101.1 be changed to describe how the goal will be measured. HHSC worked with the provider to clarify the language and updated the reporting system accordingly.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.7	5	0 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider requested carryforward of all DY 2 milestones which were not yet complete as of mid-point DY 3. The provider reports that DY 3 milestones have not yet started as the provider is still deciding on how to implement the expanded training. Additionally, the metric being used to calculate QPI (metric I-101.1) does not directly measure patient impact, but rather the number of trainees in the program. This particular project will not have a direct, measurable patient impact because it is centered around Medicaid Provider Training. Increased training does not necessarily correlate to direct quantifiable patient impact. The metric, I-101, is a duplicate of Metric I-11.1, which measures the same thing - the enrollment of providers in the training program.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider revising metric I-101.1 to measure the number of patients who benefit from the project, such as the number of patients seen by providers who have attended the training. While metric I-11.1 mentions Medicaid visits, this measure is not included in the menu and should be customizable. Provider also needs to ensure that it has a way to accurately measure patient impact and show that the impact was directly related to the project.	NA	MSLC recommended the provider should revise I-101.1 to measure the number of patients who benefit from the project, such as the number of patients seen by providers who have attended the training. While metric I-11.1 mentions Medicaid visits, this measure is not included in the menu and should be customizable. Provider also needs to ensure that it has a way to accurately measure patient impact and show that the impact was directly related to the project. HHSC contacted the provider to work with them on adding a milestone that would strengthen the project and demonstrate direct patient impact. The provider let us know that they submitted a request to withdraw this project. At this point, the project is considered withdrawn.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.8	2	2 of 2 of DY 2 milestones complete. 0 of 4 of DY 3 milestones complete. Provider has not yet completed measurement of its QPI metric (I-101.1) in DY 3 but provided a progress update and noted that the metric is about 50 percent complete as of mid-point.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.10	3	2 of 2 DY 2 milestones complete. 2 of 5 DY 3 milestones complete. Provider reported completion of three of its five DY 3 milestones. HHSC approved two out of the three but requested additional information for metric I-12.1. The metric states that three new hires must be graduates or new workers, whereas the provider hired three people still in the training program. Any significant issue with hiring could prevent the provider from reaching its patient encounter QPI metric. The provider's QPI (I-101.1) is dependent on acquiring additional faculty and community health workers.	No recommendations at this time.	**Technical Change:** 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.	NA	MSLC recommended the provider delete the calculation in the goal description for Metric I-12.1. HHSC's assessment is that the provider is reporting in line with the menu and did not contact the provider with this recommendation.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.9	3	2 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Two significant risks were noted by the provider during the reporting period: 1) Training accreditation process is time-consuming. The provider notes that this accreditation is something they need to apply for yearly and could negatively affect this project if accreditation isn't granted or requirements are too time-consuming and restrictive to the continuance of larger class sizes. 2) Also, one major way the provider was going to increase the number of Physician Assistants (PA) in the community was to lower the requirement of time spent on the training program from 30 to 24 months. Provider notes that this idea was not welcomed by the faculty and wasn't pursued. Both avenues that provider is using to increase their Primary Care Workforce (larger classes and less time requirement) have clearly run into some major problems that could result in fewer than expected PAs in the workforce and affecting their ability to meet their future QPI measured goals, which is patient encounters by PA's.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.1.4	4	2 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. There is risk that some of the goals in DY 4 and DY 5 are duplicative of other metrics and that stated metrics are not measured according to the Category 1 Menu, including the following: 1) Metric I-12.1 and P-3.2 are both measuring telemedicine specialty visits. 2) Metric I-17.3: Provider has not described how it intends to measure improved access to specialists using this metric.	No recommendations at this time.	**Technical Change:** Metric I-17.3: Provider should provide a better description of its metric and goal as to what the provider is actually measuring and the specific unit of measurement.	NA	MSLC recommended the provider should provide a better description of its metric and goal as to what the provider is actually measuring and the specific unit of measurement. Since the provider describes the metric and goal in DY3, HHSC does not feel it is necessary for the information to be repeated in subsequent years.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.1	3	3 of 4 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider requested carryforward of its DY 2 I-17.1 metric and noted that it was struggling to accurately document the reminders sent to patients. The provider notes in the semi-annual reporting that it was faced with staffing challenges, having lost a physician and clinic manager which caused duplication of training efforts and delays. The provider does not report that replacements were hired or how this affected the project and the provider's ability to meet it's goals. Provider also notes that it is having a difficult time tracking and compiling documentation to prove progress on some milestones and metrics, such as numbers of physicians who received training, etc.	No recommendations at this time.	**Technical Change:** Provider needs to include a percentage goal for I-16.1. 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.	NA	MSLC recommended the provider include a percentage goal for I-16.1. HHSC worked with the provider and updated the reporting system with updated language for the baseline/goal of metric I-16.1.
UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.2	2	1 of 1 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. The implementation of the program was ahead of schedule and resulted in the DY 3 QPI goal to be exceeded (228 consults out of a goal of 200 consults at mid-point). This overachieving triggered a plan modification that was approved by HHSC that changed the QPI goals in DY 4 and DY 5 to be increased. The increase was substantial, from 200 encounters in DY 2 to 675 in DY 4 and 1000 in DY 5. There is a slight risk with increasing the QPI as the metric goal also requires 100 percent Medicaid/Low-Income Uninsured.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.6	4	1 of 2 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. 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 (six 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.	HHSC should revise the calculation on the Cat 2 menu for I-8.1. Currently, the metric states "X percent increase" yet a percent calculation is included. These are two different measures. Metric I-9.1 description requires provider to "increase the number of patients" yet also includes a percentage calculation. If the calculation is required, then the metric language needs to change to state "increase the percentage of patients." Revise the language for metric I-18.1. If utilization is the goal, then the metric should be revised to state "increase the number of computerized provider order entries per person." Metric I-12.1: A calculation should only be included if a percentage is required. The metric states "increase the number" indicating that a comparison calculation is not required.	**Technical Change:** Metric I-8.1: 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. **Technical Change:** 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. **Technical Change:** Metric I-18.1: Revise the language of the metric. The metric states "increase the number of order entries," not "increase the number of order entries per person." Provider is reporting three goals: a percent increase, number of patients, and a percent calculation from the menu. **Technical Change:** 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 or a number from which a percentage can be calculated. **Technical Change:** Metric I-16.1: 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 or a number from which a percentage can be calculated.	HHSC will take recommendations into consideration for the next round of RHP menu revisions.	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 DY3 and DY4. HHSC agreed with this and suggested the provider replace their QPI metric I-8.1 with a customizable metric in DY5. The provider requested that the metric be changed for both DY4 and DY5, so HHSC updated the reporting system with these changes. MSLC recommended the provider include either a number or percentage be included in Metrics I-9.1, I-11.1, and I-16.1. HHSC did not think the provider needs to include this information and did not contact the provider on these recommendations.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.5	3	1 of 3 of DY 2 milestones complete. 0 of 7 of DY 3 milestones complete. 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.	No recommendations at this time.	**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.	NA	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.
UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.3	3	3 of 4 DY 2 milestones complete. 1 of 6 DY 3 milestones complete. HHSC noted that the provider's supporting documentation did not demonstrate achievement of the goal for P-2 in DY 2 and provider is no longer eligible for payment. Provider noted that its progress on its QPI metric (metric I-15.1) is behind the pace after two quarters of data. The provider hired additional staff which should help them make up this difference.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.1.6	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported partial completion of its DY 3 metric P-5.1 (1 of 2 additional primary care providers hired) and has not yet started it P-1.1 metric to establish schedules for its expanded clinic space. Provider will not report QPI measurement until DY 4, which will be measured in the number of annual visits over DY 4 and DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.1.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has reported difficulties with hiring additional physicians. Provider reported progress on its DY 3 Metric I-12.1 of 5627 visits out of a goal of 12000 additional visits over baseline for a total of 19,500 visits in DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Parkland Memorial Hospital 127295703.1.4	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider's goal for DY 5 I-8.2 does not include a numeric goal. The Category 1 menu requires the provider to report on the number of performance activities that used dashboard data, not simply the number of dashboards created. I-101.1 Milestone description is the same as the metric description. This is a QPI metric.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider revising its DY 5 goal for Metric I-8.2 to include the performance activities that used data from the dashboards. The provider's goal is to "prepare, distribute, and use the four dashboards described in the narrative." However, the Category 1 menu requires the provider to report on the number of performance activities that used dashboard data. The intent of this milestone is to demonstrate how quality dashboards are used to drive performance improvement. **Technical Change:** Provider should provide a description of the customizable milestone I-101. Currently, the milestone language is the same as the metric language. The milestone should describe the intent of the measurement, including any benefit or outcomes provided by the intervention being measured.	NA	MSLC recommended the provider consider revising its DY5 goal for Metric I-8.2 to include the performance activities that used data from the dashboards. HHSC worked with the provider and updated the reporting system to reflect the appropriate goal for this metric. MSLC also recommended the provider provide a description of the customizable milestone I-101, since the milestone language is the same as the metric language. HHSC updated the reporting system with the description submitted by the provider.
Parkland Memorial Hospital 127295703.1.3	3	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Although the provider's numeric goal for I-15.1 is actually increasing over DY 4 and DY 5, the percentage goal, which is required by the metric, is decreasing over DY 4 and DY 5.	No recommendations at this time.	**Technical Change:** 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	MSLC recommended the provider should also report a percent increase figure between DY4 and DY5 as a way to show an increase for metric I-15.1 over DY4 and DY5. HHSC determined that since the provider is following the menu (numerator/denominator), percent increase is not required; the percent changed can be obtained from comparing DY4 and DY5. Based on this information, HHSC recommended the provider use a metric from the 3 year menu. The provider agreed and HHSC updated the reporting system by replacing metric I-15.1 with I-15.2.
Parkland Memorial Hospital 127295703.1.7	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider noted it was struggling to implement two tests on a weekly basis for metric P-11.1 in DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.1.5	3	2 of 2 DY 2 milestones complete. 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. In the project narrative, the provider stated their challenges include extensive appointment wait times, regional physician shortage, and collecting accurate and consistent data to measure progress to goals and patient scheduling systems, policies, and protocols. The gap assessment identifies an additional challenge of limited space.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.2.1	2	2 of 2 DY 2 milestones have been met. 1 of 2 DY 3 milestones have been met. 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.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.2.11	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider reported partial completion of its DY 3 metric P-5.1 (primary care team panel size) and P-13.1 (testing of a new ideas). Provider reported that it has not achieved progress on its P-3.1 metric (establish primary care team). It is possible that current progress could prevent progress on QPI measurement in DY 4 (for I-12.1).	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.2.9	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. This project intends to target patients being discharged from an inpatient status with HIGHER SOCIAL COMPLEXITY AND LOWER MEDICAL COMPLEXITY. For DY 3 metric P-7.1, provider reported completion of the metric; however, HHSC requested additional information.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Parkland Memorial Hospital 127295703.2.4	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Parkland Memorial Hospital 127295703.2.10	4	3 of 3 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Patient impact will be measured using the PressGaney satisfaction surveys that are already in place. Inpatient impact will be measured in DY 4 and outpatient population will be measured in DY 5. The measure for I-107.1 is the number of patients measured. The actual scores is the Category 3 outcome measure. This project develops the project procedures and initiatives as the method for increasing patient satisfaction scores for the Category 3 measure. The project uses multiple customizable milestones not included on the project menu, including employee screening processes, and employee reward and recognition programs. Other improvement milestones include implementing action plans as a way to improve and developing organization displays. Project staff explained that these milestones are needed to help change a culture currently focused on safety to a culture that also includes customer service. All of these milestones help to prepare a basis for measuring an increase in patient satisfaction in the Category 3 outcomes.	No recommendations at this time.	**Technical Change:** I-104.1 should be separate metrics since two different populations are being measured. **Technical Change:** Provider should provide a description of milestone I-107 that differs from the language of the metric. Also, provider should define how it intends to measure impacted patients.	NA	MSLC recommended that metric I-104.1 should be separate metrics since two different populations are being measured. HHSC did not agree with the assessment that two different populations were being measured and did not follow-up with the provider on this recommendation. MSLC recommended the provider should provide a description of milestone I-107 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.
Parkland Memorial Hospital 127295703.2.5	3	1 of 1 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. 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 metrics. 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 calculations.	No recommendations at this time.	**Technical Change:** Description of the milestone and metric for I-101.1 in DY 4 and DY 5 should be different. The metric should describe what the provider intends to measure and the milestone should include a description of the overall intent of the associated metrics.	NA	MSLC recommended that the description of the milestone and metric for I-101.1 in DY4 and DY5 should be different. HHSC requested updated language for the milestone and metric from the provider and updated metric I-101.1 in DY5 in the reporting system based on the provider's response.
Parkland Memorial Hospital 127295703.2.12	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 9 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).	No recommendations at this time.	**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.	NA	MSLC recommended the measure of efficiency in I-13.1 should be included in a separate milestone, such as I-14 because the provider has included two measures in its I-13.1 metric in DY4 and DY5. HHSC found that the provider was only measuring the number of OPAT patients served and did not contact the provider on this recommendation.
Parkland Memorial Hospital 127295703.2.6	2	1 of 1 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider has reported completion of one DY 3 milestone and development of its other three milestones in DY 3. No substantial risks were noted that could prevent the provider from completing its DY 4 goals.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Methodist Dallas Medical Center 135032405.2.1	3	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Methodist Dallas Medical Center 135032405.2.3	4	0 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.	No recommendations at this time.	**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.	NA	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.
Denton County MHMR Center 135234606.2.1	4	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 #3: I-13 (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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider deleting the second goal in DY 5 I-14.1 measure (20% increase in productivity) and including it in a separate measure. Metric I-16.1 is an option.	NA	MSLC recommended the provider should consider deleting the second goal in DY5 I-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.
Denton County MHMR Center 135234606.2.2	4	3 of 3 DY 2 milestones complete. 0 of 4 of 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Denton County MHMR Center 135234606.2.3	4	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-1.1 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Denton County Health and Human Services 136360803.2.2	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is implementing a vaccination program to provide immunizations to adult Medicaid and low-income primary care patients served through Denton County Health Department clinics. While the project is progressing, there is a risk associated with the target population of the project. As currently defined, the target population does not give a large enough pool of patients to meet the QPI goals submitted by the provider for DY 4 and DY 5. Provider also notes a challenge that not all identified eligible patients will accept the vaccinations. If off-site visits occur, there needs to be a way to track the patient and immunization data to properly QPI as well as make sure that individuals are measured for QPI and not number of vaccines administered (encounters). Provider clarified the target population and outreach of program that will help meet it's QPI goals moving forward. Provider also indicates that off-site clinics are intended and all patients will be vetted for DSRIP compliance via patient forms that indicate insurance and income levels. The number of unique patients vaccinated will be tracked in the provider's own database to prevent vaccination encounters from being counted as individual's being vaccinated. Each individual patient is tracked and that number reported, regardless of the number of vaccines that particular patients receives.	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.	No recommendations at this time.	HHSC will take this into consideration.	MSLC did not have any recommendations.
Dallas County MHMR dba Metrocare Services 137252607.1.2	2	3 of 3 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider reported overachieving on its goal to serve 250 clients at the clinic for metric P-6.1. They reported seeing 1137 clients, a combination of both new patients and patients already established at other clinic sites who transferred due to convenience in location of the new clinic. Provider was well on-track at mid-point in DY 3 to meet its DY 3 goal for metric P-6.1. Provider submitted a plan modification to increase its QPI goals in DY 4 and DY 5.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Dallas County MHMR dba Metrocare Services 137252607.2.4	1	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reported enrolling 61 children as of mid-point DY 3 out of a goal of 64 children. Provider noted on its April DY 3 progress update that there was a waiting list of patients to obtain access to the program.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Children's Medical Center of Dallas 138910807.1.2	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported it had accomplished 4835 primary care and Nurse Advice line encounters for DY 3 metric I-12.1 out of a goal of 8,100 encounters. The DY 3 sign-off summary states that primary care encounters include visits, prescription refills, practice calls with patients and nurse advice line calls. Provider also reported near completion of it's DY 3 P-7.1 metric, recording 35,737 patients with nurse advise line access out of a goal of 50,500 patients. Provider is including night and weekends primary encounters and nurse advice line encounters in the same metric (I-12.1). This metric specifies that only primary care encounters should be measured. The Milestones and Metrics in DY 4 are measured by the number of patients served while DY 5 is measured by the number of calls. In addition, the provider is measuring the number of patients served by the nurse advice line in DY 4 and DY 5 (with metric I-14.1). The Phase 4 Master Summary indicates that the provider is measuring the number of patients in DY 4 and calls in DY 5, including a measure of the percentage of the calls answered in DY 5. This measure is not included in the DY 4 goal even though the metric is the same.	No recommendations at this time.	**Possible Plan Modification:** Provider 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 advise 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.	NA	MSLC recommended the provider consider separating the primary care visits and the nurse advice line encounters into different metrics. MSLC stated 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. HHSC determined the provider could include nurse advice line calls as primary care visits and did not contact the provider with this recommendation. MSLC recommended the provider should change the language of its goal in DY5 to patients. HHSC confirmed intent of the measurement with the provider and updated the reporting system accordingly.

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Children's Medical Center of Dallas 138910807.1.4	3	2 of 2 DY 2 milestones complete. 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 required 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.	No recommendations at this time.	**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.	NA	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.
Children's Medical Center of Dallas 138910807.2.2	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider's DY 5 metric (I-8.1) is to increase access to the health promotion program. Provider indicated that intends to meet its QPI (of increasing percentage of the target population reached) by partnering with school districts, childcare centers, convenience stores, community health workers, housing inspectors, and local prosecutors. However, there is a risk that the provider may not be able to accurately track and measure the number of children used for this QPI measurement.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Children's Medical Center of Dallas 138910807.2.4	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete.. The provider noted that it has started all DY 3 milestones, including the implementation of standardized care transition process in specified patient populations and the development of protocols. Provider also reported partial completion of its I-14.1 metric of serving 582 patients out of a goal of 800 patients having received care according to the care transitions policies, guidelines and protocols.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor University Medical Center 139485012.1.1	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor University Medical Center 139485012.1.2	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The provider is working to increase the number of providers in the network to increase the volume of encounters. 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. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Baylor University Medical Center 139485012.2.1	4	2 of 2 DY 2 milestones complete. 0 of 3 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-21.2, 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor University Medical Center 139485012.2.5	4	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Per DY 3 sign-off summary 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. Also, they were not able to hire a manager for the program until December 2013. The provider has engaged pharmacy residents to help develop the program and see patients and they anticipate seeing patients in May. This delay poses a risk in meeting their DY 3 goals (to serve 700 individuals) which are tied to their DY 4-D5 QPI goals. To show an increase in the number of patients receiving medication management, provider is also reporting a percentage calculation using the cumulative totals, not just the additional patients in each demonstration year. However, is also risk in meeting DY 4-DY 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.2	4	4 of 4 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. 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.	When requesting supporting documentation for QPI, HHSC should require the provider show which specific quality improvement initiative was used for that specific patient.	**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.	HHSC will take this into consideration.	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.
UT Southwestern Medical Center --- Faculty Practice Plan 126686802.2.4	3	2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 patient 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.	No recommendations at this time.	**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. **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.	NA	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 DY4 and DY5. 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.
UT Southwestern Medical Center - St. Paul University Hospital 175287501.2.1	2	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Trinity Medical Center 195018001.2.1	4	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestonescomplete. 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-21.2, 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Methodist Richardson Medical Center 209345201.2.1	3	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Methodist Richardson Medical Center 209345201.2.2	2	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&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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Medical Center of Arlington 020950401.2.1	4	0 of 2 DY 2 milestones complete. 0 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.	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.	NA	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.
Medical Center of Arlington 020950401.2.2	2	4 of 4 DY 2 milestones complete. 0 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 Compliance) 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Medical Center of Arlington 020950401.2.3	2	2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported serving 225 out of the 250 patients needed for milestone I-11.1 in DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Cook Children's Medical Center 021184901.1.1	4	0 of 2 DY 2 milestones complete. 0 of 1 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.	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.	NA	MSLC recommended to update I-12.2 to I-12.1 and decrease QPI goals. HHSC updated DY4-5 I-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.
Cook Children's Medical Center 021184901.1.2	4	1 of 1 DY 2 milestones complete. 1 of 2 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.	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 milestone I-12.2 to I-12.1 to match the stated goals with the goals in the Cat 1 menu.	NA	MSLC recommended to update DY3 P-1.1 to reflect addition of one clinic and update I-12.2 to I-12.1. HHSC approved the reporting of DY3 P-1.1 and will not remove DY3 P-1.1 at this point even though the project intention was for one clinic which was accomplished by DY2 P-1.1. HHSC updated DY4-5 I-12.2 to I-12.1 to align with the intended QPI grouping of visits and informed the provider.

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Cook Children's Medical Center 021184901.1.3	4	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider had not completed any milestones as of the DY 3 April sign off. Delays in construction have been cited for the reason. Provider's goal for P-4.1 on the Phase 4 Summary about adding addtional clinics was not clear. Provider's Narrative and sign off summary state only one new clinic would be opened. The new clinic will share space with provider's new primary care clinic in project number 021184901.1.1 yet both projects have included milestone P-5.1 to hire support staff. Provider has selected a goal of visits for milestone I-14.1 yet the Cat 1 menu goal for the milestone is the number of patients. There is no standard milestone for this project option where the goal is visits. A customizable milestone is needed to report on visits.	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 the goal.	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 not remove DY3 P-4.1 even though the project intention was for one clinic, which was accomplished by DY2 P-4.1 metric. HHSC updated DY4-5 I-14.1 to I-101.1 to align with the intended QPI grouping of visits and informed the provider.
Tarrant County/dba Tarrant County Public Health 022817305.1.1	2	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The Health Information Exchange was not operational as of the DY 3 April Sign off and therefore the provider had not started identifying pertussis cases for the DY 3 metric I-102.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Tarrant County/dba Tarrant County Public Health 022817305.2.3	3	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has cited delays in approval of the project as the primary cause behind lack of milestone achievement. Provider's goal for metric I-5.1 is to measure the number of patients who receive an intervention. The nature of the intervention is not defined.	No recommendations at this time.	**Potential Plan Modification:** Provider should consider adjusting the goal of milestone I-5.1 to a clearly defined quantifiable intervention.	NA	MSLC recommended to update I-5.1 to reflect the intervention. The intervention is described in the narrative rather than the QPI metric so HHSC did not follow up with the provider to update I-5.1.
Tarrant County/dba Tarrant County Public Health 022817305.2.4	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider's metric I-8.1 is a percentage goal to distribute educational material to the target population. It is not clear if the provider's target population is the entire county, certain specific zip codes, or if it is limited to certain disease diagnosis.	No recommendations at this time.	**Potential Plan Modification:** Provider should consider updating the target population for milestone I-8.1 to make clear the overall population on which the percentage goal will be based.	NA	MSLC recommended to update I-8.1 to specify the target population and the percentage. The target population is described in the narrative and calculation of the percentage will be described during reporting which is assumed to be from the narrative: "all residents in Tarrant County with an emphasis on Medicaid and uninsured clients who have been diagnosed with a chronic illness, including but not limited to mental health, hypertension, or diabetes." HHSC did not follow up with the provider to update I-8.1.
Tarrant County/dba Tarrant County Public Health 022817305.2.8	2	2 of 2 of DY 2 milestones complete. 0 of 2 of DY 3 milestones complete. Project has slight risk since metric I-101.1 requires self-reporting of patients who have ceased smoking.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
MHMR of Tarrant County 081599501.1.2	1	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Provider has hired 8 of the needed 10 staff for DY 3 metric P-4.1. Project is on track to meet intended goals.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
MHMR of Tarrant County 081599501.2.2	2	2 of 2 DY 2 milestones complete.. 0 of 3 DY 3 milestones complete. Although the provider had not yet started referring patients to the treatment center as of the April 2014 reporting period, there does not appear to be any signficiant challenges that would impede the provider from achieving the QPI goals.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
North Hills Hospital 094105602.2.1	2	4 of 4 DY 2 milestones have been met. 0 of 3 DY 3 milestones have been met. Provider has administered the sepsis treatment bundle for 20 patients out of a goal of 68 patients in DY 3 for metric I-13.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Plaza Medical Center of Fort Worth 094193202.2.1	4	0 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider reported completing 1,619 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 094193202.2.2	2	4 of 4 DY 2 milestones complete. 0 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 109574702.2.1	2	6 of 6 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The goal of provider's I-13.1 metric for DY 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.	**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 has met the goal. HHSC updated the baseline/goal to specify that CHF patients received hospital care, discharge education and post discharge follow-up and informed the provider.
Huguley Memorial Medical Center 109574702.2.2	2	5 of 5 of DY 2 milestones complete. 0 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 Health Harris Methodist Hospital Fort Worth 112677302.2.1	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. The overall target population needed to determine the percentage goal for metric I-18.1 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-18.1 will be measured. **Possible Plan Modification:** Provider should consider identifying what interventions will be needed in order for a patients to be served by the diabetes CARE team for milestone I-21.2.	NA	MSLC recommended to update I-18.1 to specify the target population and update I-21.2 to specify the intervention. HHSC updated I-18.1 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 linking 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 Health Harris Methodist Hospital Fort Worth 112677302.2.2	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 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 Health Harris Methodist Hospital Fort Worth 112677302.2.4	1	5 of 5 DY 2 milestones complete. 1 of 2 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 Health Harris Methodist Hospital Fort Worth 112677302.2.5	3	2 of 2 DY 2 milestones complete. 0 of 1 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 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 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 QPI 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.

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Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.1	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The goal of provider's DY 3 metric P-9.1 is a percent increase over a baseline. Provider does not give baseline information in narrative or sign off and does not have a milestone to establish a baseline in DY 2. Provider has stated the overall population will be patients with diabetes. It is unclear how provider will determine the overall diabetic population that will be used to measure the percentage goal for metric I-18.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.2	2	4 of 4 DY 2 milestones complete. 0 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 Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.3	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported near-completion of its DY 3 P-3 metric by enrolling 1,193 patients out of a goal of 1,366 patients. As is the case with many navigation programs, the provider's success is dependent on increasing the number of patients in the program. There is always a risk when the provider is relying on an increase in the number of the patients who present to the provider's Emergency Department or other patient unit.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804.2.4	4	2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has reported completing 42 of the needed 118 group visits for DY-3 metric P-10.1. Provider reported completing 192 out of the needed 28,888 visits outside of office for DY 3 metric P-101.1. Provider has cited difficulty recruiting staff, identifying patients, and general construction delays reasons for being behind on the milestone.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider either adding a metric to measure visits in addition to patients or change the DY 4 and DY 5 goals to measure visits. The measurement of visits may be more feasible given the large goals set by the provider in DY 4 and DY 5. The provider's DY 4 and DY 5 goals (for metrics I-17.1 and I-21.1) are based on patients, but the baseline for these measures are based on DY metric P-101.1, which is measured in visits.	NA	MSLC recommended to clarify QPI metrics I-17.1 and I-21.1 that measure patients when the intended QPI grouping is visits. Through the separate Plan Mod process, HHSC approved updating the QPI goals to encounters for I-17.1 and deleting I-21.1. HHSC did not follow up with the provider since the QPI goals had already been clarified.
Lakes Regional MHMR Center 121988304.1.1	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider has reported treating five patients at a crisis alternative out of the needed 25 for DY 3 metric I-12.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Lakes Regional MHMR Center 121988304.1.3	2	2 of 2 of DY 2 milestones complete. 1 of 2 of DY 3 milestones complete. Provider has reported providing services to five out of the needed seven patients for DY 3 metric P-6.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
JPS Health Network 126675104.1.2	3	3 of 3 DY 2 milestonescomplete. 0 of 7 DY 3 milestones complete. Provider's DY 4 metric I-12.1 goal calculation and the Cat 1 menu calculation describe the measurement of the metric in two different ways. The metric calculation on the menu states the measure as the "percent of ED visits in target population who used the call line and were admitted to the hospital divided by the total number of patients in the target population who visited the ED" even though the metric description is the percent of patients who did not use the call line. The provider is calculating a reduction in the number of patients who visited the ED who did not use the call line.	HHSC should consider clarifying the intent and goal description for Milestone I-12.1 for project option 1.6.	No recommendations at this time.	HHSC removed I-12.1 in the skinny menu due to the confusing language	MSLC did not have any recommendations.
JPS Health Network 126675104.1.3	2	3 of 3 DY 2 milestones complete. 1 of 5 DY 3 milestones complete. Provider has cited a high no-show rate for delays in achievement of QPI metric I-23.1. Provide reported 1,534 out of the 9,180 encounters needed for DY 3.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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JPS Health Network 126675104.1.5	3	1 of 1 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. 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.	NA	MSLC did not have any recommendations.
JPS Health Network 126675104.2.11	3	4 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Project does not have direct clinical interventions for Medicaid patients. Patients will have access to their medical records through an online portal, providing some benefit to patients. There is a discrepancy between the phase four summary and QPI summary table for provider's QPI metric I-101.1. The phase four summary stated goal is for 6,000 patients to access the portal in DY 3, 12,000 for DY 4 and 18,000 for DY 5. The QPI summary table gives goals of 6,000 only for each DY.	No recommendations at this time.	**Technical Change:** Update QPI summary table to reflect accurate QPI goals for metric I-101.1.	NA	MSLC recommended to update the QPI Summary to reflect the correct QPI goals of DY4 12,000 and DY5 18,000. HHSC updated the QPI Summary to reflect that goal. Recommendation is addressed. HHSC did not follow up with the provider.
JPS Health Network 126675104.2.12	2	2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has changed from metric I-13.1 to I-101.2 for reporting QPI. For DY 3 provider reported identifying 105 patients of the 224 needed to fulfill the milestone. Project is implementing the use of a sepsis team and the 3-hour sepsis bundle.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
JPS Health Network 126675104.2.14	2	2 of 2 DY 2 milestones complete. 2 of 4 DY 3 milestones complete. Provider reported assigning 5,033 patients to a primary care physician of the needed 4,625 as part of their "connections" program for DY 3 metric I-101.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
JPS Health Network 126675104.2.3	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. As of the DY 3 April sign off provider had not started seeing patients for their QPI metric I-11.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
JPS Health Network 126675104.2.6	1	2 of 2 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider has reported treating 1,200 out of the 1,670 patients needed for milestone I-8.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
JPS Health Network 126675104.2.7	3	13 of 13 DY 2 milestones complete. 2 of 7 DY 3 milestones complete. The goal description for metric I-40.1 makes it appear as though the project is measuring QPI as the total number of discharged patients. The milestone is measuring those patients discharged who received clinician follow-up regarding treatment plans and compliance. There doesn't appear to be measurable patient impact if project options counts attempted contacts. Provider reported making 1,221 out of the 4,100 contacts needed for metric I-40.1.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider updating percentages for I-40.1 based on established baseline and improvement targets in DY 3 Milestone P-102. The percentages for I-40.1 should be DY 3 62.15 percent, DY 4 65.26 percent, and DY 5 68.37 percent. **Technical Change:** Revise language to metric I-40.1 to indicate that milestone is measuring actual contacts with patients and not attempts at contacting patients.	NA	MSLC recommended to update I-40.1 goals and to remove attempts from the goals. HHSC did not contact provider regarding QPI increase, because DY3 achievement did not surpass DY5 goals. During DY4 reporting, provider will need to explain if DY4 achievement is lower than DY3 achievement. Provider submitted information that the project has other strengths so maintained the original goal language with "two attempts".
Texas Health Harris Methodist Hospital Azle 127304703.2.1	3	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider reported completing 140 out of the needed 154 encounters for DY 3 metric I-21.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Helen Farabee Center 127373205.1.2	2	3 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Provider has met all of their DY 3 milestones as of the April reporting period. Provider reported 78 out of the needed 48 encounters for metric I-11.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Wise Regional Health System 130606006.2.1	3	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider has reported treating 35 of the needed 70 patients for DY 3 metric I-103.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Health Arlington Memorial Hospital 130614405.2.1	1	3 of 3 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Provider reported enrolling 26 of the needed 25 patients into the chronic care model program for metric P-9.1.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Pecan Valley Centers for Behavioral and Developmental Healthcare 130724106.1.1	4	1 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider has cited difficulty in obtaining cooperation from other providers. Provider had not started seeing patients for DY 3 metric I-23.1.	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.	**Possible Plan Modification:** Provider should consider reduction in QPI for milestone I-23.1 to a more achievable range due to significant project delays as this will have an impact on DY 4 and DY 5 QPI goals.	NA	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.
Pecan Valley Centers for Behavioral and Developmental Healthcare 130724106.2.1	3	1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor All Saints Medical Center at Fort Worth 135036506.1.1	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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 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. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor All Saints Medical Center at Fort Worth 135036506.1.2	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor All Saints Medical Center at Fort Worth 135036506.2.4	2	3 of 3 DY 2 milestones complete. 0 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. For DY 3, Metric I-101.1 the provider has seen 133 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Baylor All Saints Medical Center at Fort Worth 135036506.2.5	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has reported enrolling 696 patients out of the 1,080 patients needed to complete DY 3 metric I-10.3. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.1	4	4 of 5 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 DY 3 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.3	3	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider intends to use the same individuals for metric I-8.1 in 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider revising language for milestone I-8 to indicate they will be treating many of the same patients each year and not a cumulative total as is stated in the goal.	NA	MSLC recommended that the QPI metric specify that the same individuals will be served across DYs and remove the cumulative totals. Providers may count the same individuals in different DYs because QPI measures workload within a DY rather than unique individuals served across DYs. Cumulative totals were removed as a part of Plan Mods. HHSC did not follow up with the provider.
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 136326908.2.4	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported enrolling 734 patients out of a goal of 1,169 patients. As is the case with many navigation programs, the provider's success is dependent on increasing the number of patients in the program. There is always a risk when the provider is relying on an increase in the number of the patients who must first present to the Emergency Department.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Children's Medical Center 138910807.1.2	2	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Metric I-15.1 has a stated goal of placing a certain percentage of patients into a registry. 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider selecting a percentage goal for milestone I-15.1 and adding a separate milestone for the goal of adding patients to the registry.	NA	MSLC recommended adding a percentage goal to I-15.1 and separating out the QPI goal to a new milestone. HHSC updated I-15.1 to I-15.2 to count patients added to the registry rather than separating out the milestone into two metrics and informed the provider of the change to I-15.2.
Children's Medical Center 138910807.1.3	3	2 of 2 DY 2 milestones complete. 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 required 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. Provider reported that 34 individuals out of a goal of 85 received behavioral health services.	No recommendations at this time.	**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.	NA	MSLC recommending changing I-11.1 to a customizable milestone because the metric measurement did not match the DSRIP menu. HHSC allowed providers to customize numerator and denominator in the Baseline/Goal rather than requiring a new metric. HHSC did not follow up with the provider to change I-11.1 to a customizable milestone.
Children's Medical Center 138910807.2.1	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider adding language to milestone I-12.1 to clarify how a patient is determined to be eligible for a medical home and the type of interactions (e.g. visits or percent of patient's visits) that are needed for a patient to be considered assigned to a medical home. **Possible Plan Modification:** Provider should consider reducing the number of days to contact a new patient for milestone I-13.1.	NA	MSLC recommended to clarify I-12.1 to specify patient eligibility and types of interactions and update I-13.1 to decrease the number of days to contact a new patient. HHSC found that the criteria for eligible patients and types of interactions were defined in DY2 P-2.1. The number of days specified in the goal for I-13.1 matches the metric description. HHSC did not follow up with provider regarding changing I-12.1 or I-13.1.

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University of North Texas Health Science Center 138980111.1.4	2	3 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. No significant risks were noted that could impede the provider's achievement of DY 4 and DY 5 goals.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of North Texas Health Science Center 138980111.1.7	2	2 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. No significant risks were noted that could impede the provider's achievement of DY 4 and DY 5 goals.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
University of North Texas Health Science Center 138980111.1.8	2	3 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. There was a discrepancy between the Phase 4 Master Summary and the QPI summary table for metric I-18.3 which are measuring encounters and individuals, respectively. Provider has clarified that they plan on reporting on individuals.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider revising the language of the goal for milestone I-18.3 to make clear they are reporting on individuals.	NA	MSLC recommended updating I-18.3 QPI goals to reflect QPI grouping of patients instead of encounters. HHSC updated I-18.3 to show the correct QPI grouping of patients and informed the provider.
University of North Texas Health Science Center 138980111.2.6	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider's metric I-1.1, to reduce criminal justice admissions, will require some self-reporting by project participants since some low level interactions do not appear in the Department of Public Safety's database.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
JPS Physician Group 162334001.1.1	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Provider received approval for metric P-11.1 to establish a specialty clinic before construction of the clinic was completed.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Methodist Mansfield Medical Center 186221101.2.1	3	2 of 2 DY 2 milestones complete. 0 of 3 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Wise Clinical Care Associates 206106101.2.1	2	3 of 3 DY 2 milestones complete. 3 of 5 DY 3 milestones complete. Provider reported that hey have started seeing patients for metric P-19.2 but did not report specific numbers.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Glen Rose Medical Center 216719901.1.1	4	0 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider cited contractor delays for the lack of milestone completion.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Glen Rose Medical Center 216719901.2.1	5	0 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The stated goal of this project is to improve patient experience. There are very few details offered by provider for how it will accomplish its objective. Provider had not completed any milestones as of the DY 3 April reporting.	This project may need to be considered for withdrawal.	**Possible Project Withdrawal:** Provider should consider possible withdrawal from the waiver program due to lack of progress and no stated plan on how the goals of the project will be met.	Agree that the provider is behind and carried forward all DY3 metrics	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 CNO who has implemented new processes and an interdisciplinary team to get the project back on schedule and improve patient satisfaction.

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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
Stonewall Memorial Hospital 020992601.1.1	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Project is on track to achieve their milestones.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
West Texas Centers 130725806.1.1	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project appears to be moderately on track for meeting most of DY 3 goals but there may be issues with increasing the patient volume due to delays in hiring a provider. Project goals are in line with the Cat 1 Menu.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Comanche County Medical Center 281406301.1.2	4	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project is off track in achieving its milestones and metrics. DY 2 carry forward metric may be completed in DY 3 but delays with hiring a physician will likely make DY 3 metrics for increase in number of patient visits carry forward to DY 4. Provider stated they hired a physician in March 2014 and they are in negotiations with another physician as of December 8, 2014.	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 decreasing the QPI goal in Metric I-15.2 to a more achievable value due to the difficulties in hiring a physician.	This is a low valued project that is trying to increase QPI by 1000 each year and are quite behind - DY3 goal 1200, DY3 achieved 0. It seems that the provider could decrease DY4 from 2200 to 1400 and DY5 from 3200 to 1800 since they carried forward the DY3 1200 (this is using additional 200 and 400 each DY instead of additional 1000 each DY). Need to determine fairness to other providers not in MPAc 40%/60%=100% MLIU 67.9 per QPI	MSLC recommended a decrease in QPI goal in Metric I-15.2 to a more achievable value due to the difficulties in hiring a physician. The provider requested a decrease in DY4 and DY5 QPI. HHSC let the provider know that we would be able to decrease only the DY5 QPI goal. The reporting system was updated to reflect the new DY5 QPI goal.
Helen Farabee Center 127373205.1.1	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project has risk of falling behind due to difficulties cited by provider in marketing their services to the community. Lessons learned do improve the project and advance the triple aim by increasing the marketing of services to the community which may help the project get back on track by the end of DY 3.	Consider strengthening supporting documentation requirements for proof of hire, i.e. the hiring of the counselor (Supporting Doc = Speck M Proof of Hire) for metric P-4.1 in DY 2.	**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. **Technical Change:** Update Phase 4 Master Summary for metric I-12.1 in DY 3-DY 5 to state QPI measurement as being individuals, not encounters as it is currently stated.	HHSC will review its policies regarding documentation requirements for proof of hire. MSLC can provide suggestions for that proof.	MSLC recommended updates to the Phase 4 Master Summary to reflect accurate percentage increase of 15% (not 10%) over baseline in metric I-11.1 in DY5 and to state QPI measurement as being individuals, not encounters for metric I-12.1 in DY3-DY5. HHSC notified the provider of the changes and update the reporting system accordingly.
Palo Pinto General Hospital 138950412.1.3	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project may experience some delays meeting all DY 3 metrics because the new clinic is not scheduled to open until after July 2014. 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.	The provider is including the patients treated at the pre-existing clinic in their April DY 3 progress update which may not be in line with the metric requirements. We recommend clarification and accuracy of data submitted to support metric being met.	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.	MSLC recommended clarification and accuracy of data submitted to support metric being met since the provider is including the patients treated at the pre-existing clinic in their April DY3 progress update. While inclusion of the pre-DSRIP baseline is appropriate since this is an expansion project, HHSC did communicate the MSLC recommendation to the provide and suggested the provider include a statement on why patients from a pre-existing clinic are included in the reporting.
Fisher County Hospital District 112692202.2.2	1	3 of 3 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. Project appears to be on track for completing all milestones and metrics. Discrepancy noted on DY 5 Metric goal P-3.2 between the QPI Summary and the Phase 4 Master Summary. The provider stated the intended QPI goals were as follows: Additional enrollees — Total enrollees DY 3 50 from DY 2 + 50 new — 100 DY 4 100 from DY 3 + 100 new — 200 DY 5 200 from DY 4 + 150 new — 350 Cumulative total of individuals served over 3 years 650	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.	**Possible Plan Modification:** The intended QPI metrics for P-3.2 in DY 3-DY 5 are not as stated in the QPI Summary (or the Phase 4 Master Summary, which differs from QPI Summary in DY 5). The QPI summary states the QPI will be 100 in DY 3, 200 in DY 4, and 350 in DY 5 for a total impact of 650.	HHSC already made the technical change to DY5 P-3.2 during the Plan Mod process on behalf of the provider.	MSLC recommended changes to metric P-3.2 in DY3-5 to reflect the intended QPI goals. HHSC made these changes during the plan modification process so we did not contact the provider on the MSLC recommendation.
Palo Pinto General Hospital 138950412.2.2	3	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project appears to be on target to meet their DY 3 metric. DY 2 metrics were carried forward and were not reported in the April Carry Forward Sign-off Summary; therefore, their status is unknown as of April.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
Hendrick Medical Center 138644310.2.4	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 2 milestone complete. Project appears to be on track on achieving its DY 3 metrics. Provider is able to track the Medicaid/Uninsured population that attends classes in their onsite classroom and are able to access their information electronically. However, provider reports difficulties tracking attendees at the community outreach events because many people do not want to provide that information on their information sheet. The provider states they try to get them to complete as many forms as possible.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Rolling Plains Memorial Hospital 133244705.2.2	3	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project showed strong progress in DY 2 but in DY 3 reports struggling with the integration of cost allocation systems into their practice. The provider reports training is being received on cost allocation.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Knox County Hospital 121053602.2.1	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. The project appears to be on track as of April DY 3 reporting. The project narrative states that Core Component D will be excluded from this project but gives no justification for this change. DY 5 milestones need clarification. The provider stated that the goal and data source for DY 5 milestone I-18 need to be updated. They also stated that metric I-18.1 is intended to by the QPI metric in DY 5. Note: provider has submitted a plan modification to change narrative to reflect what they are actually doing.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider clarifying and updating the goal for I-18.1 in DY 5. I-18 relates to the number of organization-wide displays of performance but then cites a goal of an increasing patient survey results and lists a number of encounters for the goal. **Technical Change:** Update Phase 4 Master Summary. DY 5 has 2 improvement milestones but only 1 of them appears to have funding attached to its achievement. **Technical Change:** Update narrative to include justification (if deemed acceptable) of the exclusion of Core Component D. **Technical Change:** Update narrative to include Medicaid/Uninsured percentage. **Technical Change:** Update QPI Summary to reflect I-18.1 as the QPI metric.	NA	MSLC recommended the narrative be updated to include justification of the exclusion of core component D. HHSC updated the narrative based on the provider response. MSLC recommended to update the narrative to include MLIU percent. HHSC does not require providers to update narratives to reflect the percent, because QPI and MLIU summary file has all of this information. MSLC recommended the goal for I-18.1 in DY5 be clarified and updated as I-18 relates to the number of organization-wide displays of performance but then cites a goal of an increasing in patient survey results and lists a number of encounters for the goal. HHSC worked with the provider and deleted I-16 in DY5 and added customizable QPI metric I-101.1 (number of unique individuals positively impacted by improvements - number of individuals providing survey responses with a top box score.) for DY5. During the rework of QPI and the change to a different measurement in QPI, provider requested to decrease the QPI numeric goal, which was approved by HHSC since the project was still within the valuation ranges. Change to a customizable metric also addressed the technical edit recommended by MSLC related to extra metric since the new milestone has only one metric.
Haskell Memorial Hospital 112702904.1.2	4	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. There has not been significant progress made on this project as of April DY 3. The provider stated that once they were able to get the physician started in practice in August 2014, there was really no problem in meeting their QPI metric.	No recommendations at this time.	**Technical Change:** Update QPI Summary to reflect QPI goals. The QPI Summary states the QPI goal for DY 4 is both 915 and 515.	NA	MSLC recommended the QPI Summary be updated to reflect QPI goals. This issue was addressed through the plan modification process so HHSC did not follow-up with the provider on the MSLC recommendation.
Hendrick Medical Center 138644310.2.2	3	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider seems to be on track with their goals and metrics and has identified 18 of the 20 individuals needed for DY 3. The project valuation appears high and there is a risk to CQI noted due to the 2 semi-annual meeting notes being very similar. Note: Provider was advised during the site visit for project 138644310.2.3 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.	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 a possible adjustment to increase QPI goals for DY 4 and DY 5 because provider states they have seen 18 of the 20 required patients for DY 3 as of April. A possible adjustment to increase the QPI goals may result in an adjustment to project valuation.	NA	MSLC recommended a possible adjustment to increase QPI goals for DY4 and DY5 because provider states they have seen 18 of the 20 required patients for DY3 as of April. HHSC worked with the provider and updated the reporting system to reflect the revised, increased QPI goals for DY4 and DY5.

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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
Hendrick Medical Center 138644310.2.3	3	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project appears to be on track and reports that the community need was greater than originally anticipated; thus, overachieving as of April DY 3 (698 out of 800 encounters). The project valuation appears high and there is a risk to CQI noted due to the 2 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.	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 adjusting the QPI goals for DY 4 and DY 5. Provider states they have seen 698 of the 800 required patients for DY 3 as of April and are open to an adjustment in QPI goals for DY 4 and DY 5.	NA	MSLC recommended the QPI goals for DY4 and DY5 be increased. HHSC worked with the provider and updated the reporting system to reflect a new, increased goal for DY5 only, since at the time when recommendations were completed HHSC could no longer update DY4 goals.
Hamlin Memorial Hospital 094131202.1.2	2	1 of 1 DY 2 milestone was met. 0 of 1 DY 3 milestone was met. Project narrative does not state what impact they expect to have on the Medicaid/Uninsured population and the first page appears to be incomplete.	No recommendations at this time.	**Technical Change:** Update the narrative to reflect the expected Medicaid/Uninsured population. **Technical Change:** Update the Phase 4 Master Summary to reflect the QPI from the QPI summary for Metric I-7.2.	NA	MSLC recommended the project narrative be updated to reflect the expected M/U 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 M/U population. HHSC did not contact the provider regarding the recommendation to updated the QPI since this was addressed through the plan modification process.
Hamlin Memorial Hospital 094131202.1.3	4	0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. 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 has 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.	No recommendations at this time.	**Technical Change:** Update the Medicaid/Uninsured percentage listed in the project narrative (QPI Summary says 14% Medicaid/24% uninsured).	NA	MSLC recommended an update to the Medicaid/Uninsured percentage listed in the project narrative. HHSC did not require project to include MLIU in the narrative because the QPI summary will contain the correct/most updated information. HHSC did not contact the provider with this recommendation.
Center for Life Resources 133339505.1.1	2	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. This project appears to be crossing over with several other projects from this provider, including 133339505.1.2 in RHP 11. Provider used the same support to claim DY 2 metric achievement for 4 different projects.	Closely review all the telemedicine projects for this provider to ensure that the provider is not getting paid multiple times for the same metric achievements.	**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 using the same support documentation.	HHSC agrees 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.	MSLC recommended the project narrative be updated to reflect the QPI goal as stated in the QPI summary. HHSC did not require providers to include this information in the narrative as the QPI summary contains the most current information. HHSC did not contact the provider on this recommendation. MSLC recommended that 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 using the same support documentation. HHSC contacted the provide and recommended the provider include an explanation during future reporting as to why documentation is the same for multiple regions.
Center for Life Resources 133339505.1.2	2	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. This project appears to be crossing over with several other projects from this provider, including 133339505.1.1 in RHP 11. Provider used the same support to claim DY 2 metric achievement for 4 different projects.	Closely review all the telemedicine projects for this provider to ensure that the provider is not getting paid multiple times for the same metric achievements.	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 using the same support documentation.	HHSC agrees 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.	MSLC recommended that 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 using the same support documentation. HHSC contacted the provider and recommended the provider include an explanation during future reporting as to why documentation is the same for multiple regions.

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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
Mitchell County Hospital 136325111.1.2	4	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Provider reports completion of DY 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 (totaling 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 PCP's hired. There are discrepancies with metric I-12.1 in DY 4 and DY 5. The provider stated there have been numerous changes that have been made with this project and they will have to ask HHSC about the different QPI goals.	Follow up with provider and clarify the goals in metric I-12.1 for DY 4 and DY 5. Clarify with provider the expectation in achieving metric P-5.1 in DY 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 DY 3 by hiring only 1 PCP and because a 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.	**Possible Plan Modification:** Provider should consider clarifying DY 4 and DY 5 goals for metric I-12.1 because a 5% increase over 1600 encounters would be 1680 encounters and DY 4 and DY 5 goals are currently 1632 and 1665 encounters, respectively. **Possible Plan Modification:** Provider should consider ensuring the goal for DY 3 metric P-5.1 is consistent with what is being reported. The goal states the hiring of the additional providers will give them a total of 4 PCPs; however, the provider reported achievement of metric P-5.1 in April DY 3 by hiring only 1 PCP and because a PCP was replaced, the total will only be 3 PCPs. **Technical Change:** Include the Medicaid/Uninsured percentage in the project narrative (QPI Summary says 10% Medicaid/6% uninsured).	1. HHSC agrees that I-12.1 needs to be clarified by removing the percentage goals and leaving the QPI goals of 1632 and 1665 as submitted by the provider in Phase 2. 2. HHSC considered requesting that the provider add P-5.1 to DY5 to demonstrate that the additional PCP has been hired for a total of 4 PCPs, however, HHSC does not pay for maintenance of the process milestones.	MSLC recommended the goals for metric I-12.1 be clarified because the language regarding a percentage increase were making the numerical goals unclear. HHSC worked with the provider and removed the percentage goals for I-12.1 in DY4 and DY5 in the reporting system. MSLC recommended the MLIU percentage be included in the project narrative. HHSC did not require provider to include this information in the narrative so we did not contact the provider with this recommendation. MSLC recommended the provider consider adding P-5.1 to DY5. HHSC did not contact the provider on this recommendation since it was not HHSC policy to pay for maintaining on process milestones.
Hendrick Medical Center 138644310.1.2	3	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Project is moderately off track due to problems hiring a psychiatrist for the region. Provider has the ability to catch up in DY 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 138644310.2.3 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Mitchell County Hospital 136325111.2.1	4	0 of 1 DY 2 milestone complete. 0 of 3 DY 3 milestones complete. 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 DY 5 Milestone P-3 to reflect an annual, not cumulative amount.	No recommendations at this time.	**Technical Change:** Update the Medicaid/Uninsured percentage listed in the project narrative (QPI Summary says 10% Medicaid/6% Uninsured).	NA	MSLC recommended the Medicaid/Uninsured percentage listed in the project narrative be updated. HHSC did not request project to include MLIU in the narrative since the QPI summary would reflect the most current/updated information. HHSC did not contact the provider with this recommendation.

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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
Texas Tech University Health Sciences Center-Lubbock 084599202.1.2	2	3 of 3 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. The provider appears to be on track in meeting DY 3 metrics. QPI metric starts in DY 4. 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. DY 4 and DY 5 metrics I-15.1 reference an increase in "% over the baseline established by milestone 5, metric 2 in DY 3" but there is no such metric listed in the Phase 4 Master Summary. Same issue with metric I-101.1 in DY 4 and DY 5.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to reflect the intended baseline reference for metrics I-15.1 and I-101.1 in DY 4 and DY 5. Metric I-15.1 should reference P-101.2 in DY 3 (instead of milestone 5, metric 2 in DY 3) and metric I-101.1 should reference P-101.3 in DY 3 (instead of milestone 5, metric 3 in DY 3). **Technical Change:** Update April DY 3 Sign off Summary to ensure that it coincides with the QPI Summary; as the QPI Summary states DY 3 does not have a QPI metric and the Sign off Summary states P-101.3 is a QPI metric.	NA	MSLC recommended the Phase 4 Master Summary be updated to reflect the intended baseline reference for metrics I-15.1 and I-101.1 in DY4 and DY5. HHSC worked with the provider and updated the reporting system with the intended baseline for the referenced metrics. MSLC recommended the April DY3 Sign off Summary be updated to ensure that it coincides with the QPI Summary. This issue was corrected during the plan modification process so HHSC did not contact the provider on this recommendation.
Childress Regional Medical Center 133250406.1.1	2	1 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete. 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 overachieved this metric in DY 3; however, DY 4 and DY 5 goals increase to 400 and 600, respectively. QPI metric I-13.1 is measured in encounters but the percentage goal is measured by the number of targeted patients accessing the nurse advice line.	No recommendations at this time.	**Technical Change:** Update the numerator description in the Baseline/Goal section of metric I-13.1 in the Phase 4 Master Summary to reflect the intended QPI measurement of encounters. Currently, the numerator states, "number of targeted patients", which implies individuals. Suggested revision for consideration, "number of targeted patient calls".	NA	MSLC recommended the numerator description in the Baseline/Goal section of metric I-13.1 in the Phase 4 Master Summary be updated to reflect the intended QPI measurement of encounters. HHSC found that the language in the workbook accurately reflected the intended measurement so we did not contact the provider with this recommendation.
University Medical Center 137999206.1.4	2	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 I-12.1 reports 322 out of 450 encounters as of April DY 3. Project narrative lists Cat 1 expected patient benefits for DY 3 to be 20.3% or 130 patients under SNF-ist care. Phase 4 Master Summary reports metric I-101.1 goal is 100 patients. Similar issues noted for DY 4 and DY 5. The project narrative mentions milestone I-15; however, the Phase 4 summary lists I-101 instead. The provider states in the project narrative that population served includes New Mexico.	No recommendations at this time.	**Technical Change:** Update the project narrative to reflect the milestones and metrics listed in the Phase 4 Master Summary. The goals listed in The Category 1 expected benefits section of the project narrative should also be updated to reflect the goals listed in the Phase 4 Master Summary.	NA	MSLC recommended the project narrative be updated to reflect the milestones and metrics listed in the Phase 4 Master Summary. HHSC found that the most recent project narrative reflected the goals and did not contact the provider on this recommendation.
Medical Arts Hospital 189947801.1.2	3	2 of 2 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 I-101.1 reports 645 out of 352 encounters as of April DY 3, but did not report for metric achievement due to not meeting the necessary Medicaid/Uninsured percentage due to all patients being Medicare. The project narrative states provider will be using the number of patients for QPI, but QPI Summary states QPI measurement is by encounters. Most of the milestone numbers listed in the narrative do not correspond to those found in the Phase 4 Master Summary.	Consideration should be given to the potential impact on project valuation if either plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider adjustment to increase QPI goals for metric I-101.1 because provider reports overachievement as of April DY 3 (achieved 645 of the 352 encounters). **Possible Plan Modification:** Provider should consider reducing the Medicaid/Uninsured percentage this project intends to serve since the provider is concerned about the ability to serve the stated 20%. **Technical Change:** Update the project narrative to reflect the intended QPI measurement as being by encounters, as stated in the QPI Summary and the Phase 4 Master Summary. **Technical Change:** Update the project narrative to reflect the milestones and metrics listed in the Phase 4 Master Summary.	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 the provider consider adjustment to increase QPI goals for metric I-101.1 because provider reports overachievement as of April DY3. The provider requested an increase of their QPI goal for this metric during the plan modification process so HHSC did not contact the provider on this recommendation. MSLC recommended the provider consider reducing the Medicaid/uninsured percentage this project intends to serve since the provider is concerned about the ability to serve the stated 20%. HHSC checked with the provider to see if the 20% was attainable and the provider indicated it was. There was no change to the MLIU goal. MSLC recommended the project narrative be updated to reflect the intended QPI measurement as being by encounters and to reflect the milestones and metrics listed in the Phase 4 Master Summary. HHSC did not feel these changes were needed since the workbook and QPI summary would contain the most current and accurate information.
Lynn County Hospital District 094180903.2.1	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-101.1 reports 35 out of 15 patients enrolled as of April DY 3; however, HHSC required more information to show metric achievement. The provider has submitted a plan modification to increase QPI goals. The baseline listed in the April DY 3 Sign-Off Summary for metric P-3.1 in DY 3 is reported as 69 patients in the "Metric Baseline and Baseline Measurement" column; however, the Goal/Baseline column lists the baseline as 60 patients.	No recommendations at this time.	**Technical Change:** Update Phase 4 Master Summary and the April DY 3 Sign-Off Summary to reflect the baseline intended to be used for metric P-3.1 in DY 3. The April DY 3 Sign-Off Summary lists the baseline as being both 60 patients and 69 patients.	NA	MSLC recommended the Phase 4 Master Summary and the April DY3 Sign-Off Summary be updated to reflect the baseline intended to be used for metric P-3.1 in DY3. Since the provider reported achievement of this metric and it was approved, HHSC did not agree that these changes were needed and did not contact the provider on this recommendation.

APPENDIX 2 - RHP 12

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
Cogdell Memorial Hospital 136330107.1.3	1	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 out 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Collingsworth General Hospital 126840107.2.3	3	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 NMI support but no information is available from HHSC to determine if this 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 I-101.1 and P-10.1 in DY 5. The provider noticed 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.	No recommendations at this time.	**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”.	NA	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.
Parmer County Community Hospital, Inc. 137343308.2.3	2	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.	No recommendations at this time.	**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 “to develop at least 1 new survey tool”.	NA	MSLC recommended the goal for metric P-8.1 in DY4 and DY5 be updated to more clearly reflect the provider's intention to “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. 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.
Covenant Medical Center 139461107.2.1	1	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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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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
Golden Plains Community Hospital 197063401.2.1	2	1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete. Provider has met DY 3 metric as of April DY 3 reporting. Provider overachieved QPI metric P-102.1 in DY 3 as they reported 865 out of 300 encounters as of April DY 3. It is unclear if the measurement of QPI is by individuals or encounters. The QPI Summary states reporting is based on individuals. However, the Phase 4 Master Summary states the goal for metric P-102.1 in DY 3 is 300 visits, I-103.1 in DY 4 is 450 visits, and I-101.1 is 600 visits. Also, the total impact for these metrics in DY 4 and DY 5 references individuals. Metric I-103.1 in DY 4 and Metric I-101.1 in DY 5 appear to be the same metrics; however, they are numbered differently. Metric I-101.1 in DY 5 states the increase will be compared to DY 4 in the metric description; however, the Baseline/Goal section says the increase will be compared to DY 3.	Consideration should be given to the potential impact on project valuation if 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 300 encounters). **Technical Change:** Update the QPI Summary and the Phase 4 Master Summary to clarify the provider's intended QPI measurement is encounters. This clarification is also needed on the Baseline/Goal section of metric P-102.1 in DY 3, I-103.1 in DY 4, and I-101.1 in DY 5. **Technical Change:** Update the Phase 4 Master Summary as metric I-103.1 in DY 4 and Metric I-101.1 in DY 5 appear to be the same metrics; however, they are numbered differently. **Technical Change:** Update the Phase 4 Master Summary as metric I-101.1 in DY 5 states the increase will be compared to DY 4 in the metric description; however, the Baseline/Goal section says the increase will be compared to DY 3.	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 the provider consider an adjustment to increase QPI goals because provider reports an overachievement for metric P-102.1 as of April DY3. 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. MSLC recommended the provider update the QPI Summary and 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. MSLC recommended the provider update the Phase 4 Master Summary as metric I-103.1 in DY4 and Metric I-101.1 in DY5 appear to be the same metrics; however, they are numbered differently. HHSC worked with the provider and updated the reporting system so that the DY5 goal matched the DY4 goal. 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 provider's goal and did not contact the provider on this recommendation.
Texas Tech University Health Sciences Center-Lubbock 084599202.1.1	1	2 of 2 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 starts in DY 4. No significant risks were identified.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
StarCare Specialty Health System 084897001.1.1	3	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. As of April DY 3, the provider reports not having hired or trained any of the 8 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. QPI metric starts in DY 4. 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.	NA	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 milestone I.101.1 and updated the reporting system accordingly.

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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
StarCare Specialty Health System 084897001.1.2	3	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. The provider appears to be on track to meet their DY 3 metrics; however, the provider reports not having hired or trained 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, "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." However, the goal for I-12.1 states 50 individuals in DY 4 and 55 individuals in DY 5. There is potential for overlap between the individuals served for this project and for 084897001.1.1. This project is intended to serve adolescents and 084897001.1.1 is intended to serve adults.	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 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, "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." However, the goal for I-12.1 states 50 individuals in DY 4 and 55 individuals in DY 5.	NA	MSLC recommended the provider consider replacing metric I-12.1 in DY4 and DY5 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 metric I-101.1. MSLC recommended the provider update the project narrative to reflect the milestones and metrics stated in the Phase 4 Master Summary and to reflect the goals for the metrics stated in the Phase 4 Master Summary. HHSC felt this changes were not needed since the workbook and QPI summary would have the accurate information and did not contact the provider with these recommendations.
Memorial Hospital 094121303.2.1	4	0 of 2 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Sunrise Canyon Hospital 136492909.2.1	1	1 of 1 DY 2 milestone complete. 2 of 2 DY 3 milestones complete. Provider achieved DY 3 metrics as of April DY 3 reporting. QPI metric starts in DY 4. No significant risks were identified.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
City of Amarillo Department of Public Health 065100201.1.1	4	0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. No significant progress reported as of April DY 3. Provider stated in April DY 3 reporting, "Receipt of the mobile clinic, along with its full implementation, is schedule for August 2014." 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, tattoo events 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 events. 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%.	No recommendations at this time.	**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.	NA	MSLC recommended the provider update the project narrative to reflect the intended Medicaid/uninsured percentage. HHSC updated the narrative and notified the provider of the changes.
Memorial Hospital 094129602.1.1	2	1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete. 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.	**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).	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 the provider consider an adjustment to increase QPI goals because provider reports overachievement for metric I-12.1 as of April DY3. HHSC worked with the provider and updated the reporting system to reflect the new, increased goal for QPI metric I-12.1 in DY5.

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University Medical Center 137999206.1.3	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet DY 3 metric as of April DY 3 reporting. Although DY 3 metric P-101.1 was not considered by HHSC as being achieved as of April DY 3, the provider submitted NMI support during the July NMI period. QPI metric starts in DY 4. Provider narrative states that provider also serves the New Mexico area.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Helen Farabee Center 127373205.1.2	2	3 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Provider met DY 3 metrics as of April DY 3 reporting. Provider overachieved QPI metric P-11.1 in DY 3 as they reported 13 out of 9 encounters as of April DY 3.	Consideration should be given to the potential impact on project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider adjustment to increase QPI goals because provider reports overachievement for metric P-11.1 as of April DY 3 (achieved 13 of the 9 encounters).	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 the provider consider an adjustment to increase QPI goals because provider reports overachievement for metric P-11.1 as of April DY3. HHSC contacted the provider with this recommendation and they requested the QPI not be increased. HHSC let the provider know that we would contact them in May with recommendations for increasing the goals.
Pampa Regional Medical Center 178848102.1.1	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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. DY 5 metric I-12.1 states that the goal is, "Demonstrate 10% improvement over prior reporting period, 1,000 visits in DY 5. Total impact of 2,750 encounters" but the DY 4 goal is 1000 visits. Thus, DY 5 should state a goal of 1100 visits in order to reflect the 10% increase.	No recommendations at this time.	**Technical Change:** Update the QPI goal for metric I-12.1 in DY 5 to reflect the intended 10% increase over DY 4 reporting, which would be 1,100 visits, not 1,000 visits.	NA	MSLC recommended the provider update the QPI goal for metric I-12.1 in DY5 to reflect the intended 10% increase over DY4 reporting, which would be 1,100 visits, not 1,000 visits. HHSC worked with the provider and updated the reporting system to reflect the intended goal for I-12.1 in DY5.
Hereford Regional Medical Center 133544006.1.1	2	1 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-15.2 reports 1,671 out of 2,500 visits as of April DY 3. The establishment of the baseline for QPI metric I-15.2 is unclear. The provider stated the baseline number will soon be revised based on actual DY 1 (10/01/11 – 09/30/12) visits of 28,470.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Memorial Hospital 094129602.1.3	1	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-23.1 reports 370 out of 636 encounters as of April DY 3. 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 milestones metrics that clearly accurately track how the project goal will be met.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Coon Memorial Hospital and Home 130826407.1.3	4	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. No significant progress reported as of April DY 3. Provider reports in April DY 3, "We are proud to say that we are finally in negotiations with a dentist which should be finalized this summer." No reporting provided for DY 2 carry forward metric. Provider stated that they entered into negotiations with an existing provider in the area to purchase their clinic and provide services to our target group. If the provider is able to find a dental provider, the project may be able to get back on track and not fall further behind on DY 3 - DY 5 metrics. DY 3 QPI goal is 50 individuals.	Consideration should be given to project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider decreasing QPI goal in metric I-14.1 to a more achievable value given the delay in finding a dental provider.	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 the provider consider decreasing QPI goal in metric I-14.1 to a more achievable value due given the delay in finding a dental provider. 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 hire a provider.

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Hereford Regional Medical Center 133544006.2.2	3	4 of 4 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. All of the DY 3 metrics have been started as of April DY 3 reporting. QPI metric P-10.1 goal requires 3,000 patients to be included in an inquiry. The provider does not report any numerical progress, but states it has been partially completed.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
City of Amarillo Department of Public Health 065100201.2.2	2	1 of 1 DY 2 milestone complete. 0 of 3 DY 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 DY 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 DY 5 goals are 30% and 35%, respectively.	Consideration should be given to the potential impact on project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider increasing QPI goal because provider reports for metric P-3.1 as of April DY 3 they have enrolled 84 of the 125 individuals. **Possible Plan Modification:** Provider should consider increasing the goal for metric I-101.1 because the provider reports that 63% of the enrollees completed the ARAD program when the goal was only 20%.	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 the provider consider increasing their QPI goal because provider reports for metric P-3.1 as of April DY3 they have enrolled 84 of the 125 individuals. MSLC also recommended the provider consider an adjustment to increase goal for metric I-101.1. HHSC contacted the provider and they indicated they did not wish to increase their goals. HHSC let the provider know we would contact them in May with recommendations for increasing the QPI goal.
Covenant Medical Center 139461107.2.3	2	2 of 2 DY 2 milestones complete. 0 of 3 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Childress Regional Medical Center 133250406.2.1	3	2 of 2 DY 2 milestones complete. 0 of 2 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, "make medical home assignments for as many as 5,000 area patients over the life of the project." The patient impact reflected in I-12.1 shows a total impact of 1,850 patients.	Consideration should be given to the potential impact on project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider decreasing QPI goal in metric I-12.1 to a more achievable based on the significant delays resulting from difficulties with getting patients to adapt to the medical home model which is causing them to fall behind on their QPI metric . **Technical Change:** Update the project narrative to reflect the intended patient impact reflected in the Phase 4 Master Summary. For example, the 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, "make medical home assignments for as many as 5,000 area patients over the life of the project." The patient impact reflected in I-12.1 shows a total impact of 1,850 patients.	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 the provider consider decreasing QPI goal in metric I-12.1 to a more achievable based on the significant delays. Because the provider reported achievement of metric I-12.1 in October DY3 reporting period, HHSC did not contact the provider with this recommendation. MSLC recommended the provider update the project narrative to reflect the intended patient impact reflected in the Phase 4 Master Summary. HHSC worked with the provider and updated the narrative to reflect the intended patient impact.
Texas Tech University Health Sciences Center-Lubbock 084599202.2.1	2	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. QPI metric I-5.1 reports 1,078 out of 1,984 individuals as of April DY 3. No significant risks were identified.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Cogdell Memorial Hospital 136330107.2.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 2 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric I-18.1 reports 350 out of 500 patient visits as of April DY 3. Multiple goals are listed for metric P-9.1 and I-12.1 in DY 4 as well as I-13.1 in DY 5. Multiple goals can threaten the achievement of a metric; thus, potentially threatening payment to the provider.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider separating the goals into different metrics for metrics containing multiple goals. For example, I-13.1 in DY 5 has 3 goals: 1. Reduce patient time to see physician 2. Reduce no shows and cancellations 3. Increase no show call back percentage	NA	MSLC recommended the provider consider separating the goals into different metrics for metrics containing multiple goals. For example, I-13.1 in DY5 has 3 goals and every goal in a metric must be achieved in order to receive payment. HHSC worked with the provider and replaced metric I-13.1 with three customizable metrics for DY5.
Collingsworth General Hospital 126840107.2.1	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. As of April DY 3, the provider has trained 2 of the 8 required staff members. The provider has the remainder of DY 3 to train the remaining staff members. QPI metric starts in DY 4.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.

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Ochiltree General Hospital 112704504.2.1	3	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Tech University Health Sciences Center-Amarillo 084563802.2.1	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 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 6526 patients seen in the prior 12 month period, 96.34%, or 6287, 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Texas Tech University Health Sciences Center-Lubbock 084599202.2.3	3	2 of 2 DY 2 milestones complete. 0 of 4 DY 3 milestones complete. Provider reports that the dashboard is almost done but until it is complete no training can begin for fulfilment 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 to DY 4 and will be reported in October 2015.	Consideration should be given to the potential impact on project valuation if plan modification is submitted and approved.	**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. **Technical Change:** Update the project narrative to include mention of influenza immunizations which is the subject of QPI metric I-13.1.	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 the provider consider decreasing QPI goal in metric I-13.1 to a more achievable value due to the delay in releasing the dashboard. 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. 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.

APPENDIX 2 - RHP 13

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
North Runnels Hospital 020989201.1.1	4	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. No progress has been reported on this project. Project is likely to not achieve DY 2 metrics that carried forward and may have to carry forward its DY 3 metric due to inability to hire a provider. DY 4 and DY 5 metrics do not specifically tie the additional number of visits to the hiring of the provider. Note: The provider informed Myers and Stauffer that they have just hired a new provider. The provider also stated a baseline has not been established for patient visits.	HHSC should follow up with the provider to modify 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 DY4 and 5 will be attributable to the additional provider.	MSCL recommended that the provider clarifies if additional primary care visits are attributable to the new primary care provider, which will make the baseline for this metric 0. HHSC received a confirmation from the provider that the new visits will only be tied to a new provider, and the baseline is 0 visits. HHSC updated the system to reflect this.
Shannon West Texas Memorial Hospital 137226005.1.4	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project appears to be on track as of April DY 3 reporting.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Center for Life Resources 133339505.1.1	2	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Project is overlapping with 4 other projects in various other RHPs. Identical support is being provided for all of the projects thus far.	HHSC should closely review all the telemedicine projects for this provider to ensure that the provider is not getting paid multiple times for the same metric achievements.	When submitting documentation to show achievement of metrics for multiple projects, the provider should submit an explanation of the relationships between the metrics/projects, justifying using the same support documentation.	HHSC agrees 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 agrees 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.
West Texas Centers 130725806.1.1	2	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Project is using temporary additional provider coverage to help them keep working towards their QPI goals while they continue to work to find a more permanent provider. This could cause problems with meeting their metrics regarding training but the overall QPI impact should remain on track for this project. Note: Provider submitted a plan modification to HHSC to remove the percent from I-101.1 in DY 4 and DY 5. Provider states this has been accepted by HHSC.	No recommendations at this time.	**Technical Change:** Update language in Phase 4 Master Summary to state metric I-101.1 in DY 4 and DY 5 is meant to measured by encounters (terms are currently used interchangeably, appointments/persons).	N/A	MSLC recommended updating Phase 4 Master Summary Workbook to clarify that I-101.1 in DY4 and DY5 is meant to measure metrics. 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 DY5 as well.
North Runnels Hospital 020989201.2.2	4	0 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. Project has not reported any progress on DY 2 or DY 3 milestones. The milestones for DY 4 and DY 5 involve tracking the cost per episode per diabetic patient but the overall goal of the project per the project narrative is to get a CT Scan facility for their hospital. Provider reports problems finding funding for the project. Note: During the site visit, the project stated they have not received the CT Scan and are awaiting approval from their Board in December 2014 to purchase it. The provider also stated the diabetic aspect was included by mistake. The provider may attempt to secure a mobile CT Scan.	Confirm receipt of the CT Scan (pending Board approval, set to meet in December 2014 to approve or disapprove).	**Possible Plan Modification:** Provider should consider removing the diabetic aspect from I-101.1 and replace with patients who received a CT scan, to better correlate to the intent of the project. **Possible Plan Modification:** If the Board does not approve the CT scan purchase in December or the project is not able to secure a mobile unit timely, the option of the withdrawal of the project should be considered. **Technical Change:** Provider to update baseline data in order to measure metrics I-101.1 in DY 4-DY 5, which would assist in determining if there would need to be a reduction in QPI metrics.	MSLC recommended that HHSC follows up with the provider to confirm the receipt of CT scan. Provider sent a copy of the 3-year lease of a CT-scan machine starting on April 1, 2015.	MSLC recommended updating I-101.1 to remove the diabetic aspect from the metric and replace with patients who received a CT scan. Since it was an error to include this language in the first place, and since the provider did not report on this metric in DY3, HHSC updated DY3, DY4 and DY5 I-101.1 to delete diabetic population: Goal is to track cost per episode for patients who received a CT scan. MSLC recommended updating the baseline for the metric, which will help determine if reduction in QPI is needed, and to consider the project withdrawal if provider does not obtain the CT scan. Since provider leased the CT-scan and intends to move forward with the project, HHSC is not recommending a project withdrawal, but since the project was delayed, HHSC approved reduction in DY5 QPI, because the project is still within the valuation. Provider will report on the baseline when reports on this metric.
Shannon West Texas Memorial Hospital 137226005.2.1	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project appears to be on track as of April DY 3 reporting.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Heart of Texas Memorial Hospital 138715115.2.1	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Project has not yet reported any progress in reaching students for DY 3 but the project appears to be making significant progress with planning and training.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

APPENDIX 2 - RHP 13

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
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) 133340307.2.4	3	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 DY 5 metrics if not addressed. Project still has the ability to catch up in DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Schleicher County Medical Center 179272301.2.2	4	0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. 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.	HHSC to determine if the provider not planning on achieving PCMH designation during the waiver period still meets the intent of the project. 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 standards)."	**Technical Change:** Update QPI metric I-101.1 for DY 5 in the QPI Summary to read 221 individuals, not 171. **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.	MSLC recommended to determine if the project still meets the intent of the waiver, even though the project is not planning to achieve PCMH designation. Based on the information received by HHSC from the provider, the valuation of the project is not sufficient to cover costs associated with PCMH designation. Provider is willing to restructure the project to provide primary cares services to the population in need.	MSLC recommended updating the QPI goals to reflect accurate numbers. Round 2 Plan Mod file already has 221 as the QPI for DY5. The issue is already corrected. Since provider cannot achieve PCMH designation (total Cat 2 project valuation is about $173 thousand) but is willing to deliver services to the area in need of such services, HHSC is working on changes to the project that would allow the project to continue with provision of services. This work should be completed in May-June
Concho County Hospital 091770005.2.2	1	1 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.	No recommendations at this time.	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	MSCL stated that the project was not included in the reporting files. HHSC followed up on this and determined that the project was included in the RHP13 DY3 NMI Summary - Project Sign Off Summary (State of Texas HHSC - DY3 April DSRIP Reporting). The issue is addressed.
Lillian M. Hudspeth Memorial Hospital 121781205.2.2	1	1 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Shannon West Texas Memorial Hospital 137226005.2.2	2	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 1-15.1. Provider has proposed a plan modification to revise the goal for I-14.1 to only include discharge time and add a milestone to split I-14.1 into 2 metrics.	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 goal for metric I-15.1 due to overachieving in DY 3 (23 staff members were designated as quality champions in DY 3, the goal was 3).	N/A	MSCL recommended increasing goals for I-15.1 in DY4 due to overachieving in DY3. Provider agreed 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.
Reagan Memorial Hospital 121806703.1.2	3	1 of 1 DY 2 milestone complete. 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.	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 reducing QPI goals to a potentially more achievable goal.	N/A	MSCL recommended revisiting 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 – 500 visits DY4 – 1000 visits DY5 – 1500 visits

APPENDIX 2 - RHP 14

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
Permian Regional Medical Center 127298103.1.1	2	1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete. Overachievement occurred for QPI metric I-12.1 in DY 3. The provider reported 3,679 out of the 1,800 encounters as of April DY 3 reporting. Additionally, the provider reported a 3.43% reduction in non-emergent ED visits as of April DY 3 for metric I-12.1. Upon review of the supporting documentation it appears the provider miscalculated this percentage and there was an 11.95% decrease in non-emergent ED visits. 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 visits to the clinic. The intent of the metric is to document an increase in number of visits.	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 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 3% 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 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 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. MSLC also recommended to make QPI metric more clear by either removing secondary information or splitting it into a separate metric. Provider requested to delete secondary goal from QPI metric 'percentage decrease in non-emergent ED visits' from I-12 in DY4 and DY5. HHSC updated I-12 in the system.
Reeves County Hospital 112684904.2.3	2	2 of 2 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. The provider appears to be on track in meeting DY 3 metrics. All 5 DY 3 metrics have been partially completed. Possible overachievement of QPI metric P-10.1 in DY 3. The provider reported 382 out of the 400 surveys 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-10.1 because provider reports overachievement as of April DY 3 (achieved 382 of the 400 surveys).	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 increasing QPI goals since the provider overachieved in DY3. Provider reported achievement of its QPI goal, and DY3 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.
Odessa Regional Medical Center 112711003.2.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete.. 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 goal for I-104.1 in DY 4 and DY 5 contains percentage goals not intended to be included by the provider.	No recommendations at this time.	**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, to avoid confusion. **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 percentage reference in the goal for metric I-104.1 in DY 4 and DY 5, as the provider states it was not their intent.	N/A	MSCL recommended removing percentages from I-104.1 in DY4 and DY5, since it was not provider's intent to include those. Provider agreed with this recommendation. HHSC removed percentages form QPI metric I-104.1 in DY4 and DY5 since it was not a provider intent to include those. MSCL also had a recommendation to update baseline description for I-105.1. HHSC did not update the baseline description for I-105.1 in DY4 since the metric already has the baseline description and the provider can clarify this further during reporting.
Winkler County Memorial Hospital 094204701.1.1	4	1 of 1 DY 2 milestone was met. 0 of 1 DY 3 milestone was met. Provider did not report in April DY 3. The majority of population to be served are located in New Mexico, as stated in the narrative. Many of the milestones and metrics in DY 4 and DY 5 are the exact same as for the milestones and metrics for 081939301.1. For example, the baseline/goal section is the exact same for both projects for metric I-101.1 in DY 4 (I-23.1 in project 081939301.1), "Baseline is TBD. 5% increased number of visits over baseline, 2,611 visits in DY 4. Total impact of 4,700 encounters." Based on a phone conversation with the provider on 02/04/15, the provider did report metric P-101.1 completed in October DY 3. He also stated he does wish to continue with this project; however, HHSC recently informed them their DY 4/DY 5 valuation would be reduced from $930,488 and $899,023 to $95,518 and $78,906 due to data from what appears to be the aforementioned project 081939301.1.1 mistakenly being entered for their project. This project will need updated DY 4 and DY 5 milestones to be able to continue moving forward.	Contact the provider to establish updated milestones for DY 4 and DY 5. The information reported the Phase 4 Master Summary was apparently mistakenly copied from project 081939301.1.1. Note: The primary point of contact for this project is new to the project.	**Possible Plan Modification:** Provider should consider updating milestones for DY 4 and DY 5 as the information reported on the Phase 4 Master Summary was apparently mistakenly copied from another project.	HHSC contacted the provider and worked through a number of issues with provider. At some point, HHSC made a mistake and reflected higher valuation for this project than was actually approved. When HHSC corrected the error and reflected accurate valuation, provider understood it as a reduction in valuation. HHSC worked out a workable solution with the provider.	HHSC contacted the provider and updated milestones for DY4 and DY5. The revised QPI goals are as follows: DY4 = 600, and DY5 = 1,250. HHSC decreased the QPI and kept the originally approved valuation. The justification for allowing a decrease in QPI was that the provider was viewing incorrect information (higher valuation and lower QPI) in July/August 2014 when change requests were due, so the provider did not submit a change request at that time. HHSC notified the provider of the incorrect information in October 2014. In April 2015, the provider indicated that the corrected QPI goals were too high and asked to lower them. Because of the confusion due to HHSC's data entry error, HHSC worked with the provider to establish new QPI goals based on actual provider data, the same way that HHSC would have worked with the provider during the regular change request process in Fall 2014.

APPENDIX 2 - RHP 14

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
Medical Center Hospital 135235306.1.1	4	1 of 1 DY 2 milestone complete. 0 of 3 DY 3 milestones complete. New clinic is 50 to 60% completed 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 their 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.	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-15.2 to a more achievable value because of difficulties in recruiting.	HHSC does not change valuation based on QPI changes.	MSLC 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 $5mln. Provider had an opportunity to request adjustment to goals during plan modification.
Permian Basin Community Centers 138364812.2.1	3	2 of 2 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 reports 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.	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 because of difficulties in securing providers.	HHSC does not change valuation based on QPI changes.	MSCL recommended revisiting 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.
Texas Tech University Health Science Center-Permian Basin 081939301.1.1	3	4 of 4 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 2,089. The goal for QPI metric I-23.1 in DY 3 is 2,089, which is the previously established 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.	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-23.1 to a more achievable value. The QPI goals for metric I-23.1 should increase annually over a previously established baseline. **Technical Change:** Update the Phase 4 Master Summary to reflect the intended percentage increases in QPI for metric I-23.1.	HHSC does not change valuation based on QPI changes.	MSLC 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.
Medical Center Hospital 135235306.1.3	2	2 of 2 DY 2 milestones complete. 0 of 4 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 2,676 visits as of April DY 3. This is not considered significant overachievement because the QPI goal for this metric increases to 4,460 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 4,460 in DY 4 and 8,920 in DY 5 are their targets.	No recommendations at this time.	**Technical Change:** Update the project narrative to reflect the intended QPI increases for metric I-12.1.	N/A	MSLC 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 DSRIP system on metric level.
West Texas Centers 130725806.1.1	2	2 of 2 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

APPENDIX 2 - RHP 14

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
Midland Memorial Hospital 136143806.1.4	2	1 of 1 DY 2 milestone 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-13.1 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 I-13.1 because provider states 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 compare to other projects, and HHSC can decrease project's valuation.	MSLC 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 112711003.1.5	4	1 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 2,592 visits for metric I-23.1. Provider stated that shortfalls in marketing and community education were some of the challenges faced. In order to increase encounters and not fall behind on QPI metrics, additional marketing is planned to increase exposure of the Women's Center to additional areas within the community and surrounding areas. Additional efforts to reach college students on the local campuses and participate in other outreach events are also planned to increase encounter numbers.	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-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 compare to other projects, and HHSC can decrease project's valuation.	MSLC recommended decreasing project's goal 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 081939301.2.1	2	4 of 4 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 NMI 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.	N/A	MSLC did not have any recommendations.
Midland Memorial Hospital 136143806.2.4	3	1 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. I-8.1 in DY 3 is unclear regarding the baselines used. For example, the goal states to increase the number of individuals in the target population by 10% over the number calculated for DY 2; however, the number calculated for DY 2 is not mentioned (the baseline established in DY 1 is 165 and the goal for DY 3 is 300). I-8.1 in DY 4 is unclear regarding the correlation between the numerical goals and the percentage increases. For example, 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 properly calculated as 675 individuals; however, the intended goal for DY 4 may only be 360, not 450 according to the percentages.	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 for metric I-8.1. DY 4 goal is a 20% increase over DY 3 goal of 300 individuals; which would result in a goal of 360. The QPI goal in DY 5 metric I-8.1 may need to be updated to reflect the goal of 50% over DY 4 goal of 360 vs. 50% over DY 4 goal of 450 (as originally calculated).	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 revisiting 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. DY3 reporting period. Based on this, HHSC did not initiate revision of the goals. MSLC also recommended updating percent increase in the QPI metric to 50% instead of 20%. Provider agreed with this recommendation, and HHSC updated the system to reflect 50% increase in DY4 over DY3 level. DY5 already showed 50% therefore, no additional changes needed in DY5.
Martin County Hospital District 136145310.2.1	5	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Progress has been made towards meeting the DY 3 QPI metric goals but the high valuation for this project may mean that the QPI goals are set too low. Note: Project stated in an email to Myers and Stauffer on 02/04/2014 they are no longer participating in DSRIP as of July 2014. The provider also stated they have not notified HHSC of the withdrawal. Myers and Stauffer notified HHSC on 02/04/2015.	Recommend that HHSC reach out to the provider to advise them of the withdrawal process since the provider states that they are no longer participating in DSRIP.	**Possible Project Withdrawal:** If the provider is no longer participating in DSRIP, the provider should consider reaching out to HHSC to inquire about what documentation needs to be submitted in order to officially withdrawal.	HHSC is working with the provider on project withdrawal	Provider withdrew the project.
Medical Center Hospital 135235306.2.3	1	2 of 2 DY 2 milestones complete. 2 of 2 DY 3 milestones 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.	N/A	MSLC did not have any recommendations.

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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
Medical Center Hospital 135235306.2.4	2	1 of 1 DY 2 milestone complete. 2 of 2 DY 3 milestones complete. 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.	Consideration should be given to the 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 I-101.1 because provider reports an overachievement of QPI as of April DY 3 (achieved 333 of the 268 required 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 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 292, based on the provider's response.
Midland Memorial Hospital 136143806.2.3	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. 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 291 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.	Consideration should be given to the 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-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%.	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 increasing QPI goals since the provider overachieved in DY3. 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.

APPENDIX 2 - RHP 15

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
Texas Tech HS Ctr Family Med 084597603.1.5	3	7 of 7 DY 2 milestones complete. 3 of 6 DY 3 milestones complete. Overachievement occurred for QPI metric I-23.1 in DY 3. The provider reported 2,321 of the 550 encounters as of April DY 3 reporting. Provider has submitted a plan modification to increase their QPI based on project achievements in DY 2 and DY 3. The target population section in the project narrative states unique patients will be measured for new surgical providers; however, in DY 3 the provider appears to be counting patients seen by all providers, not just the new providers hired. The provider states in the project narrative that referral areas include New Mexico and Mexico.	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.	N/A	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 both - narrative and metrics included in the Summary workbook and DSRIP system make a complete picture of project activities. In addition, target population maybe a little larger than what is measured in the QPI.
Texas Tech HS Ctr Family Med 084597603.1.6	2	4 of 4 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Overachievement occurred for QPI metric I-15.2 in DY 3. The provider reported 814 of the 400 encounters as of April DY 3 reporting. Provider has submitted a plan modification to increase their QPI based on project achievements in DY 2 and DY 3. Provider is likely to meet or exceed all their metric goals by the end of DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Texas Tech HS Ctr Family Med 084597603.1.8	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Overachievement occurred for QPI metric I-23.1 in DY 3. The provider reported 642 of the 400 encounters as of April DY 3 reporting. Provider has submitted a plan modification to increase their QPI based on project achievements in DY 2 and DY 3. Provider is likely to meet or exceed all their metric goals by the end of DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Texas Tech HS Ctr Family Med 084597603.1.1	3	3 of 4 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. Overachievement occurred for QPI metric I-23.1 in DY 3. The provider reported 2,073 of the 1,250 encounters as of April DY 3 reporting. Provider has submitted a plan modification to increase their QPI based on project achievements in DY 2 and DY 3. Provider stated they were not able to achieve metric DY 2 metric I-22.1 (increase number of ocular care professionals by two) during the carry-forward period. However, the provider stated they are very optimistic they will meet metric I-23 since those specialists for the project are now being hired.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Las Palmas Medical Center 094109802.2.3	3	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Unable to determine how this project will intend to measure their QPI because the project has not yet reported as of April DY 3 their new operational procedures that will improve the efficiency of care management (metric P-4.1 in DY 3). Provider stated that they have identified 4 new operational procedures necessary to improve overall efficiencies and care management in the LPDS emergency department and hospital.	No recommendations at this time.	**Possible Plan Modification:** 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.	N/A	MSLC recommended updating metric I-16.3 for DY4 and DY5 with results from P-4.1 in DY3. HHSC does not have a practice of updating metrics in future years with the reported information from metrics in prior years. HHSC reviewers can always review previously reported information during any review period.
University Medical Center of El Paso 138951211.2.2	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reports being approximately halfway to completion of all their DY 3 metrics, including the required 400 patient encounters. DY 2 metric P-1.1 goal states '300 patient interventions'. It does not appear this was intended as a goal for the project.	No recommendations at this time.	**Technical Change:** Remove "300 patient interventions" from the goal for DY 2 metric P-1.1 as it does not appear the provider intended this to be a goal.	N/A	MSLC recommended updating DY2 metric P-1.1. HHSC does not have a practice of updating metrics in prior years - including DY2 and DY3. 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.

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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
City of El Paso Department of Public Health 065086301.1.2	4	0 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reports minimal progress as of April DY3 reporting. Progress on several health department DSRIP projects has been impeded by lack of funding to recruit/retain project staff. Provider stated that difficulties in recruiting have been overcome by hiring of Project Coordinator, Research Assistant, and Database Administrator to support completion of metrics. Additional personnel including Assistant Director and Lead Epidemiologist are overseeing completion of project deliverables. The plan to catch up on metrics is to collaborate with Texas Tech and, as needed, a database geo-coding consultant to identify persons in need of one or more select preventive health services from the database of patient records.	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 decreasing QPI goal in metric I-12.1 to a more achievable value because of difficulties in recruiting that threaten the achievement of the QPI goal.	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 revisiting project's goals due to difficulties in provider recruitment efforts. HHSC checked on subsequent reporting and noted that the provider met their DY3 goals for several metrics, reported hiring of professional staff and did not request any changes during the change request process. Since provider made a progress on this project, HHSC did not think that the adjustment is needed. HHSC checked with the provider, and they confirmed that the project does not require adjustments.
City of El Paso Department of Public Health 065086301.1.5	3	1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider cited problems recruiting private physicians into the program, leading to only capturing the data of 10% of the local physicians due to lack of administration infrastructure.	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 decreasing QPI goal in metric I-12.1 to a more achievable value because of difficulties in provider enrollment that threaten the achievement of the QPI goal.	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 revisiting project's goals due to difficulties in provider enrollment and in provider's ability to quickly execute legal agreements with participants in a timely manner due to HIPAA concerns. HHSC checked on recent provider enrollment and noted that there was a progress and reaching the agreements, and all stakeholders are working collaboratively to execute legal agreements to begin data exchange. Provider confirmed that there is a progress in project and it does not need adjustment.
Texas Tech HS Ctr Family Med 084597603.1.4	4	3 of 4 DY 2 milestones complete. 0 of 5 DY 3 milestones complete. The lack of progress on DY 2 metric P-14.2 regarding the hiring of a fellowship trained surgical oncologist or breast surgeon has significantly hindered the provider's ability to meet their DY 3 metric goals and will likely cause most of them to carry over. The provider stated during the site visit, there are now 2 candidates for the fellowship trained surgical oncologist position, of which hopefully 1 will accept the position and be hired in July 2015. Provider also stated during the site visit that the CPRIT grant referenced during April DY 3 is not a federal grant and was submitted in reporting by mistake. The provider also stated they also ensure there is no co-mingling of funds by keeping separate accounts and funding codes.	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 decreasing QPI goal in Metric I-23.1 to a more achievable value because of difficulties in recruiting that threaten the achievement of the current QPI goal.	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 provider consider decreasing QPI goal in Metric I-23.1 to a more achievable value because of difficulties in recruiting that threaten the achievement of the current QPI goal. The provider submitted a change request to adjust the QPI goal in metric I-23.1 and HHSC approved this request since the project was still within valuation ranges.
Las Palmas Medical Center 094109802.1.1	4	0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. Provider delays in reporting their DY 2 metric and their delays incurred with their DY 3 metrics may likely cause the provider to have to carry forward some or all of their metrics. Provider stated that with the recruitment of 3 additional providers in DY 4 and DY 5, they expect to report both DY 4 QPI metric (10,800 patient encounters) and DY 5 QPI metrics (16,200 patient encounters) in DY 5. QPI metrics in DY 4 and DY 5 seem to only be counting the increase in patients from the prior year, not the increase in patients from the baseline (0).	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 decreasing QPI goal in Metric I-12.1 to a more achievable value because of delays in provider recruitment that threaten the achievement of the current QPI goal. **Technical Change:** Update the Phase 4 Master Summary and the QPI Summary to reflect the increase in patients seen over the baseline (0). DY 3 = 8,100, DY 4 = 10,800, DY 5 = 16,200.	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 provider consider decreasing QPI goal in Metric I-12.1 to a more achievable value because of delays in provider recruitment that threaten the achievement of the current QPI goal. HHSC did not follow up with the provider regarding QPI goals change, because provider did not request plan modification to address this issue, and given that project is valued just over $5M, this did not meet the criteria of projects that HHSC would consider revising goal for. MSLC also recommended to updated the Phase 4 master summary. HHSC checked it and determined that Phase 4 Master Summary contains the updated numbers. The QPI summary should also be updated by this time to reflect accurate numbers.
Providence Memorial Hospital 130601104.1.2	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider claims 60% completion of the goal for DY 3 metric P-8.1. Provider does not yet report any progress on DY 3 metric I-18.1 which will require them to achieve 18,616 patient encounters by the end of the year. However, the provider does not express any concern in meeting this metric.	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 decreasing QPI goal in metric I-18.1 to a more achievable value should the goal for metric I-18.1 in DY 3 be carried forward and threaten the achievement of QPI goals for I-18.1 in DY 4/DY 5.	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 provider consider decreasing QPI goal to a more achievable value should provider request a carry forward for its QPI metric I-18.1. Provider did not request a carry forward and achieved goals in DY3, therefore, HHSC did not initiate discussions regarding DY5 goal adjustment.
Sierra Providence East Medical Center 196829901.1.2	3	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider anticipates that the training of the champions will be completed by the end of DY 3 but the provider has reported no progress towards the 9,308 patient encounters required in order to meet metric I-18.1 for DY 3.	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 decreasing QPI goal in metric I-18.1 to a more achievable value, should the goal for metric I-18.1 in DY 3 be carried forward and threaten the achievement of QPI goals for I-18.1 in DY 4/DY 5.	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 provider consider decreasing QPI goal to a more achievable value should provider request a carry forward for its QPI metric I-18.1. Provider did not request a carry forward and achieved goals in DY3, therefore, HHSC did not initiate discussions regarding DY5 goal adjustment.

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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
City of El Paso Department of Public Health 065086301.1.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. The provider appears to be on track meeting DY 3 metrics. QPI metric starts in DY 4.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
University Medical Center of El Paso 138951211.1.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider appears to be on their way to meeting their metric goals for DY 3. QPI metric P-14.1 reports 3,512 out of 6,400 as of April DY 3. Phase 4 Master Summary shows DY 3 QPI goal being 6,400 individuals, DY 4 goal as being 11,500 visits, and DY 5 goal as being 16,600 patients. QPI summary states that the above QPI measures should be per encounter.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to reflect the QPI measurement to be encounters for metric P-14.1 in DY 3 and I-23.1 in DY 4 and DY 5. The goals for QPI metrics in DY 3-DY 5 currently show QPI measurement to be individuals for DY 3, visits for DY 4, and patients in DY 5.	N/A	MSLC recommended updating the Phase 4 master summary to reflect encounters for metric P-14-1 in DY3 and I-23.1 in DYs 4 and 5 per the information received from the provider. HHSC cannot update DY3 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 encounters.
University Medical Center of El Paso 138951211.1.2	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider appears to be on track to meet all their metric goals for DY 3. QPI metric P-101.1 reports 5,000 out of 10,000 encounters as of April DY 3. P-101.1 contains references to other metrics. For example, P-101.1 in DY 3 states, "As part of P-6..." and P-101.1 in DY 4-DY 5 states, "As part of I-7.1."	No recommendations at this time.	**Technical Change:** Remove references to other metrics within the metric description for QPI metric P-101.1 in DY 3-DY 5 to avoid possible confusion. For example, P-101.1 in DY 3 states, "As part of P-6..." and P-101.1 in DY 4-DY 5 states, "As part of I-7.1..."	N/A	MSLC recommended that provider removes references to other metrics within the metric description for QPI metric P-101.1 in DY3-DY5 to avoid possible confusion. HHSC made changes to P-101.1 in DY4 and DY5, to delete reference to other metrics and goals set in other metrics (in I-7) and informed the provider.
Las Palmas Medical Center 094109802.1.4	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider achieved their DY 2 metric and reported in April DY 3 they were on track to achieve DY 3 QPI goal of 300 patient encounters. The project narrative states the QPI measurement will be patients; however, the Phase 4 Master Summary and the QPI Summary state the QPI measurement will be encounters.	No recommendations at this time.	**Technical Change:** Update the project narrative to reflect the QPI measurement as being encounters, per the Phase 4 Master Summary and the QPI summary.	N/A	MSLC recommended to update project narrative to reflect the QPI measurement as being encounters, per the Phase 4 Master Summary and the QPI summary. HHSC did not require providers update project narratives in cases when other sources of information (QPI summary or Phase 4 Summary workbook) are available.
Las Palmas Medical Center 094109802.1.5	2	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. Lack of clarity with respect to the baseline in DY 4 and DY 5 metrics I-22.1 may cause some difficulties in determining accomplishment. Provider states, " LPDS plans to increase the number of clinic hours worked by specialty care physicians in the high impact medical specialty areas identified in the milestone by 1,300 hours in DY 4 and 1,560 hours in DY 5, above a baseline established in DY 2. The DY 2 baseline reflects a pre-DSRIP period before LPDS expanded clinic hours through the recruitment of specialty care physicians in the targeted specialty areas, which began in DY 3. The DY 2 baseline remains under development and will reflect the clinic hours worked by 2 Maternal Fetal Medicine specialists contracted with LPDS during this period."	No recommendations at this time.	**Technical Change:** Update the Baseline/Goal for metric I-22.1 in DY 4 and DY 5 to reflect the provider's intent of the number of clinic hours in DY 4 and DY 5 to increase by 1,300 hours and 1,560 hours over an established baseline (which is under development).	N/A	MSLC recommended provider update the baseline/goal for metric I-22.1 in DY4 and DY5 to reflect the provider's intent to increase clinic hours by 1300 in DY4 and 1560 by DY5. Provider is going to increase over the baseline which is still being determined. Provider already included hours goal in the metric and specified that the baseline is under development. HHSC requested that provider submits a baseline, but provider stated that it is still under development. Provider will have to submit baseline during reporting.
Providence Memorial Hospital 130601104.1.3	2	1 of 1 DY 2 milestone complete. 1 of 2 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. Lack of clarity with respect to the baseline in DY 4 and DY 5 for metric I-22.1 may cause some difficulties in determining accomplishment. Project narrative section "Category 1 or 2 expected patient benefits" is unclear as to how many specialists will be hired because it states that 2 specialists will be pursued but also says that the project will add 1 specialist provider.	No recommendations at this time.	**Technical Change:** Update the Baseline/Goal for metric I-22.1 in DY 4 and DY 5 to reflect the provider's intent of the number of clinic hours in DY 4 and DY 5 to increase by 1000 hours and 1344 hours over a Pre-DSRIP baseline. **Technical Change:** Update the project narrative to remove the mention of only recruiting 1 specialist, as the provider states they have hired 2 specialists.	N/A	MSLC recommended provider update the Baseline/Goal for metric I-22.1 in DY4 and DY5 to reflect the provider's intent of the number of clinic hours in DY4 and DY5 to increase by 1000 hours and 1344 hours over a Pre-DSRIP baseline. HHSC updated I-22.1 in DY 4 and DY5 by editing the baseline statement in the Baseline/Goal section: "Baseline: The baseline number of clinic hours for metric I-22.1 is 6,162 hours." Baseline information was submitted to HHSC by provider. MSLC also recommended updating narrative to remove the mention of only recruiting 1 specialist, as the provider states they have hired 2 specialists. HHSC did not require the provider to update the narrative, since HHSC does not require narrative updates after each reporting period as long as provider includes sufficient details for the project during reporting.

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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
Emergence Health Network 127376505.1.2	3	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. QPI metric P-101.1 reports 102 out of 100 individuals as of April DY 3. Baselines and goal for metrics I-10.1 and I-12.1 are not all clearly stated in the Phase 4 Master Summary. Metric I-101.1 does not clearly specify whether "served" patients will include provider's normal patient load or if only the patients being treated by the newly hired providers will count towards metric achievement.	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 3 : 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.	N/A	MSLC recommended provider update Baseline/Goals for metric I-10.1 as intended by the provider. HHSC followed up with the provider and updated DY4 and DY5 . HHSC updated goals for I-10.1 as intended by the provider DY 4: Decrease by 6.57% or by 300 DY 5: 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 states, "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 is 5.25 full-time providers.
Emergence Health Network 127376505.1.3	3	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric P-101.1 reports 100 out of 200 individuals as of April DY 3. HHSC did not accept this metric as completed due to insufficient documentation; however, the provider had the rest of DY 3 to submit the correct documentation. The project narrative states the project option is 1.13.1 and the Phase 4 Master Summary and semi-annual reports state the project option is 1.13.2. There is a discrepancy on the percentage increase and the QPI goal for metric I-12.1 in DY 3-DY 5. The Gap Analysis submitted for DY 2 metric P-2.1 did not establish a baseline of quarterly admissions as is stated in the P-2.1 goal.	HHSC should strengthen supporting documentation requirements as the Gap Analysis submitted for metric P-2.1 in DY 2 did not establish a baseline of quarterly admissions as is stated in the goal. The GAP Analysis or documentation submitted along with the GAP Analysis should reference the establishment of a baseline of quarterly admissions as stated in the goal.	**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-23.1: Each year the agency would increase services by 9%. DY 3 Scenario 1,111 IDD population x .09 percent = 100 individuals DY 4 Scenario 1,111 IDD population x .09 percent = 100 individuals + 100 from DY 3= 200 individuals DY 5 Scenario 1,111 IDD population x .09 percent = 100 individuals + 200 from DY 4= 300 individuals	HHSC will look into strengthening supporting documentation requirements.	MSLC recommended provider update the workbook to reflect accurate project option. HHSC already updated Phase 4 summary to reflect that it is 1.13.1 project option. MSLC also recommended provider update the project narrative, Phase 4 Master Summary, and the QPI Summary to reflect the intended QPI goals for metric I-23.1. HHSC updated QPI metric in DY5 to reflect the goal of 300 instead of 200 that was previously included in DSRIP system, based on the information provider submitted to Myers and Stauffer. HHSC updated the baseline goal for I-12.1 in DY5 to state the following: 300 individuals served (100 new individuals + 200 from DY 4). 100 new individuals represent an increase of 9 percent in utilization of appropriate crisis alternatives from the baseline of 1,111 individuals.
University Medical Center of El Paso 138951211.1.8	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. 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 not many credentialed candidates are available. Provider's difficulty reaching their hiring/training metric for DY 3 has caused them to only conduct 300 of the 2,160 patient interviews for QPI metric I-101.1 by Apr DY 3 and may cause them to fall behind on this 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 through collaboration between the social workers, case managers, and psych teams in order to keep project on track. The provider also developed a program to identify DSRIP patients and trained staff on how to document and track patients in the system. Staff also provides linkages to different services and makes sure that patients don't fall through the cracks in the system. The provider plans to continue moving forward with program despite NP hiring limitation by possibly considering hiring more social workers. Although, getting an NP would help distribute the workload for establishing the relationships for referrals for patients to get them the help that they need and help build stronger relationships with the community resources.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

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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
Texas Tech HS CTR Family Med 084597603.1.7	2	5 of 5 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-23.1 reports 164 out of 152 encounters as of April DY 3. HHSC did not accept this metric as completed due not completing the QPI template during reporting; however, the provider appears to have submitted the required template during the NMI period. The provider submitted a plan modification to HHSC to increase the QPI goals for DY 4 and DY 5. Provider indicated in DY 3 that they only intended to take on 1 additional trainee, despite metric I-31.1 goal stating that the goal was to increase by 100% from DY 2 (2 trainees). Provider supporting documentation for metric P-21.1 for DY 2 is insufficient to show metric achievement. Provider gave 2 copies of the same presentation slides so only 1 of the 2 required learning collaborative presentations were submitted. The provider submitted the other presentation slides during Mid-Point Assessment. Provider stated that this was a clerical error while organizing documents for submittal.	HHSC should strengthen supporting documentation requirements as documentation for metric P-21.1 for DY 2 was insufficient to prove metric achievement. Provider gave 2 copies of the same presentation slides so only 1 of the 2 required learning collaborative presentations were submitted. The documentation provided to support semi-annual meetings should contain information that allows the reviewer to see that two different meetings were attended. Two distinct presentation slides containing different dates would suffice.	**Technical Changes:** Update the goal in metric I-31.1 in DY 3 to clarify the provider's intent to increase the number of trainees by one and not two. **Technical Change:** Update the project narrative to reflect Medicaid/Uninsured percentage listed in QPI Summary (25%M, 20%U).	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.	MSLC recommended that provider update the goal in metric I-131.1 in DY3 to clarify the provider's intent to increase the number of trainees by one and not two. HHSC will not be updating goals for DY3 at this time. This metric was already reported on and approved by HHSC. MSLC also recommended to update project narrative to reflect MLIU percent. HHSC is not requesting all projects to include MLIU because QPI Excel file summary will reflect the correct/most updated info.
City of El Paso Department of Public Health 065086301.1.3	2	2 of 2 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 I-23.1 reports 300 out of 500 patients enrolled as of April DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Las Palmas Medical Center 094109802.1.3	2	2 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metric.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Texas Tech HS CTR Family Med 084597603.1.3	2	5 of 5 DY 2 milestones complete. 0 of 7 DY 3 milestones complete. Provider reports to be on track to meet their DY 3 metrics. QPI metric I-23.1 reports 1,860 out of 300 encounters as of April DY 3. The provider submitted a plan modification to HHSC to increase the QPI goals for DY 4 and DY 5. The Baseline/Goal section of metric I-22.1 in the Phase 4 Master Summary should be updated for DY 2 - DY 5 to better reflect the project's intended goals.	No recommendations at this time.	**Technical Change:** Update the Baseline/Goal section of Metric I-22.1 in the Phase 4 Master Summary for DY 2 - DY 5 to better reflect the project's intended goals. For example, the baseline in I-22.1 in DY 2 appears to be 1, as it states to increase from existing one to three; however, the provider states the Pre-DSRIP baseline is 5, not 1.	N/A	MSLC recommended updating the Baseline/Goal section of Metric I-22.1 in the Phase 4 Master Summary for DY2-DY5 to better reflect the project's intended goals. HHSC updated DY4 and DY5 goals based on the provider's clarification. In DY4 the provider will increase the number of neurologist and /or neurology physician extenders employed in the department to seven, and in DY5 to nine. Goals of 40% increase in each year remained unchanged.
Sierra Providence East Medical Center 196829901.1.3	2	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. The project narrative states different goals for number of providers that will be hired and clinics that will be established or expanded.	No recommendations at this time.	**Technical Change:** Update the project narrative, as one part states, "Sierra East expects that recruiting two additional providers and establishing or expanding two specialty clinics will increase patient visits by about 672 visits in DY 5" but the rest of the project narrative and the metrics state that the goals are to hire 1 specialist and create/expand 1 specialty clinic.	N/A	MSLC recommended updating project narrative to reflect that the intent is to hire 1 specialist and create/expand 1 specialty clinic, since this is what is stated in parts of the narrative and also included in the project's metrics. HHSC updated the narrative and shared with the provider.
City of El Paso Department of Public Health 065086301.2.1	2	2 of 2 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 starts in DY 4. Metric I-7.1 in DY 5 does not express a percentage of the target population as indicated in the metric description.	No recommendations at this time.	**Technical Change:** Update the goal for metric I-7.1 in DY 5 to reflect a percentage increase, as the metric description states.	N/A	MSLC recommended updating a QPI metric I-7.1 in DY5 to reflect a percentage increase, as the metric description states. Since provider has this QPI metric in DY5 only, another option is to change this metric to a customizable so provider does not have to report on increase since the metric is included in DY5 only. HHSC working through addressing this recommendation with the provider and will complete the work in the very near future.
University Medical Center of El Paso 138951211.2.8	3	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-11.1 reports 5,736 out of 4,900 encounters as of April DY 3. HHSC did not accept this metric as completed. The project submitted a response during the NMI period, but it is unclear if the project will be able to meet this metric during DY 3. Unclear baseline for DY 5 metric I-14.1.	No recommendations at this time.	**Technical Change:** Update the Phase 4 Master Summary to clarify the baseline (starting point) in the Baseline/Goal section of metric I-14.1 in DY 5.	N/A	MSLC recommended a technical change to a non- QPI I-14.1 in DY5: provider should clarify the baseline. HHSC did not require provider to update the baseline, since this information will have to be provided during the reporting. Provider will need to show a baseline as well as the percent improvement over the starting point.

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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
University Medical Center of El Paso 138951211.2.9	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 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.	No recommendations at this time.	**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.	N/A	MSLC 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 DY5. The goal states 10,000 encounters over DY4, which could mean the DY5 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.
El Paso Children's Hospital 291854201.2.1	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. Provider appears to be on track to meet their DY 3 metrics. QPI metric starts in DY 4. 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 5 metric states the same amount of additional patients seen in the clinic as the DY 4 metric goal which is inconsistent with the project narrative.	HHSC should strengthen supporting documentation requirements as support for DY 2 metric P-2.1 shows that 1941 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. Note: The support document was transferred to an excel document and filtered by the six members of the Hospitalist Team. A similar approach could be done to review such support in the future.	**Technical Change:** Update the Phase 4 Master Summary to reflect the provider's intended potential additional patients seen (16,936) for metric I-13.1 in DY 5. **Technical Change:** Update the Phase 4 Master Summary as the metric chosen for milestone #1: P-3 in DY 3 is metric P-11.1.	HHSC will look into strengthening supporting documentation requirements.	MSLC recommended updating the baseline/Goal section of Metric I-13.1 in the Phase 4 Master Summary for DY 5 to reflect 16,936 patients for DY5 as intended by the provider. HHSC confirmed this change with the provider, and updated I-13.1 to state 16,936. The QPI goal did not change.
University Medical Center of El Paso 138951211.2.3	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. Provider reports to be on track to meet their DY 3 metrics. Although the provider reports only reaching 97 patients out of 350 for their DY 3 QPI metric I-11.1, the provider states the metric is on track for achievement by the end of DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Las Palmas Medical Center 094109802.2.1	1	1 of 1 DY 2 milestone complete. 1 of 1 DY 3 milestone complete. 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
University Medical Center of El Paso 138951211.2.7	2	2 of 2 DY 2 milestones complete. 1 of 3 DY 3 milestones complete. 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).	HHSC should strengthen supporting documentation requirements as support for DY 2 metric P-9.1 shows that 17 separate meeting took place and the goal calls for 2 per month, which implies there should be 24 meetings. 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.	No recommendations at this time.	HHSC will review its policies regarding supporting documentation.	MSLC did not have any recommendations for the project.

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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
Emergence Health Network 127376505.2.2	4	1 of 1 DY 2 milestone complete. 0 of 3 DY 3 milestones complete. The provider will have to make some significant changes in order to catch up and not fall behind on their metrics. 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 providers stated 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 JDP.	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 decreasing QPI goal in metric 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.	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 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.

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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
Central Counties Services 081771001.1.1	3	2 of 3 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. Although the achievement of the DY 3 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Central Counties Services 081771001.1.3	2	3 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. No major risks/shortcomings identified that would impede the progress of the project.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Goodall-Witcher Healthcare Foundation 137075109.1.4	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. No major risks/shortcomings identified that would impede the progress of the project. HHSC 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-DY 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Hamilton General Hospital 121792903.1.4	3	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 telemedicine in June 2014. With full implementation of telemedicine, 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider updating metric I-17.3, as it does not clearly depict the intent per the Cat 1 menu. The metric is intended to measure the "number of real time multidisciplinary conferences with health care providers, including e-consultations, family and/or other non-clinical parties." The provider has not mentioned this as a goal in project narrative, Phase 4 Master Summary, or QPI Summary. The following metric is suggested for consideration: Metric I-18.2 - Number of telemedicine/telehealth visits. This milestone clearly correlates to the goal stated by the provider "Increase telehealth encounter provided by QPI in DY. Total impact of TPI."	NA	MSLC recommended the provider consider replacing metric I-17.3, as it does not clearly depict the intent per the Cat 1 menu. HHSC worked with the provider and replaced metric I-17.3 with I-12.1. The goals from I-17.3 were used for the replacement metric and I-17.2 remained unchanged. The reporting system was updated accordingly.
Hamilton General Hospital 121792903.1.3	2	1 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. No major risk or shortcomings identified. It appears the project is on track. The baseline and goals for QPI metric I-12.1 are not consistent between the project narrative, Phase 4 Master Summary, and the semi-annual report. Note: A plan modification has been submitted to HHSC regarding baselines.	No recommendations at this time.	**Technical Change:** Ensure baseline and goals are consistent for QPI metric I-12.1 on Phase 4 Master Summary, semi-annual report, and the project narrative. For example, the narrative and the Phase 4 Master Summary states the baseline of 29,716 for DY 1 was used. The April DY 3 Semi-Annual Report lists the baseline as 28,977 for DY 2.	NA	MSLC recommended the provider ensure baseline and goals are consistent for QPI metric I-12.1 on Phase 4 Master Summary, semi-annual report, and the project narrative. HHSC found that this issue was addressed through the plan modification process and did not contact the provider on this recommendation.
Heart of Texas Region MHMR Center 084859002.2.1	4	1 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Delays 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 than 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 metric I-8.1 in DY 4 and DY 5. The provider stated they were able to enroll and serve 264 individuals from 7/1/14 - 9/30/14. The QPI goal for I-8.1 in DY 3 was 250.	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 the provider increase goals for QPI metric I-8.1 in DY4 and DY5. HHSC contacted the provider, who agreed to an increase in the DY5 goal. HHSC updated the reporting system to reflect the new, increased QPI goal.

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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
Coryell Memorial Hospital 134772611.2.7	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The milestones/metrics on the Phase 4 Master Summary and the DY 3 sign-off summary do not appear to be preventing the progress of the project. During April DY 3 reporting, the provider stated they do not intend to start selecting participants until 09/2014, which is the end of DY 3. They will most likely need to carry forward metric #1: P-2.1. Because the project is designed during the school year, the reporting may be behind; however, the project could get back and remain on track. The project narrative differs from the Phase 4 Master Summary in regards to QPI metric goal. The provider stated that the QPI goal was increased to 400 participants and the project narrative has been updated to reflect this.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Goodall-Witcher Healthcare Foundation 137075109.2.1	4	0 of 1 DY 2 milestone complete. 0 of 2 DY 3 milestones complete. The metrics were not started because the project was not approved by CMS. Although this project does need significant changes to get back on track, it is not evident the project will not get back on track because the achievement of the only DY 2 milestone appears possible during the second half of the carry forward period, and now that the project is approved, the carry forward option is available for any DY 3 metrics not met. The provider stated they received CMS approval in March 2014 and the program has been implemented.	Consideration should be given to possible impact on project valuation if plan modification to decrease QPI 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.	HHSC does not consider changes to the valuation based on QPI changes unless the project is outside of valuation ranges.	MSLC recommended the provider consider decreasing QPI goal in Metric 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 DY5 goals are still achievable. The provider indicated that they are on track to meet their stated QPI goal for DY5. No changes were made to this project.
Limestone Medical Center 140714001.2.1	3	1 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. This project remains at risk due to the provider reporting DY 2 metric P-3.1 as incomplete during the carry forward reporting period as well as having a high valuation. With complete and updated documentation, the outcome of the project could change these results and the project could get back on track. It is noted that the provider stated the intended QPI goal for DY 3 is 40, not 75. Being that the project reported seeing 50 patients as of April DY 3; the project was on track to exceed their QPI goal.	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 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. **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.	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 the project narrative be updated to reflect the removal of I-21 in DY5. HHSC did not feel this change was needed since the actual metrics considered for payment are in the milestones and metrics table. HHSC did not contact the provider with this recommendation. 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 DY3 is 40. HHSC contacted the provider to clarify the QPI goals and updated the reporting system to reflect a DY4 goal of 120 and a DY5 goal of 170 for QPI metric P-3.2.
Goodall-Witcher Healthcare Foundation 137075109.1.5	4	0 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. The project poses a high risk because it is not on track and is not clear if it will be able to get on track. The project reported they have begun credentialing of identified provider, which takes a minimum of 6 months. Once the telehealth equipment is received they should be able to begin seeing patients. The provider would still have the option to request carry forward for DY 3 to establish baseline needed for DY 4 and DY 5. It is unclear if the provider is reporting by encounters as stated in DY 3 baseline or individuals stated as goals for DY 4 and DY 5. The provider stated the QPI measurement type is individuals, and the telemedicine equipment was purchased and fully implemented on 9/29/2014.	Consideration should be given to possible impact on project valuation if plan modification to decrease QPI and update QPI measurement approach (individuals instead of encounters) is approved.	**Possible Plan Modification:** Provider should consider aligning metric I-17.2, as stated in the Phase 4 Master Summary, with metric I-17.2 as stated in the Cat 1 Menu. Per the Cat 1 Menu, I-17.2 numerator is the number of 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. **Possible Plan Modification:** The provider should consider decreasing QPI goal to a more achievable value due to the delayed implementation of the telemedicine equipment. **Technical Change:** Update the Phase 4 Master Summary to reflect the QPI measurement to be individuals for metric I-17.2 in DY 4. **Technical Change:** Establish the baseline for measurement of QPI metrics.	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 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-18.1 to more accurately reflect the intent of the project. HHSC worked with the provider and replaced I-17.2 with I.101 and changed the language from encounters to individuals in DY4. MSLC recommended the provider establish the baseline for measurement of QPI metrics. HHSC found that the pre-DSRIP baseline for was 0. HHSC did not follow-up with the provider on this recommendation. MSLC recommended the provider consider decreasing QPI goal to 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, DY5 20, the per individual incentive amount is high at $29,210. If allowed to decrease, they could only decrease by 1 individual over DY4-5 to stay within range. HHSC did not contact the provider on this recommendation.

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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
Hamilton General Hospital 121792903.2.10	3	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.	No recommendations at this time.	**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 = 23%).	NA	MSLC recommended the provider update the wording in goal for metric I-18.1 in DY4 and DY5 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.

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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
Texas A&M Physicians 198523601.2.3	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Metric P-2.3 in DY 3 reported 157 of the 200 encounters as of April DY 3. Project milestones and metrics appear to be on track as of April DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Brazos County Health District 130982504.1.1	3	1 of 1 DY 2 milestone complete. 0 of 3 DY 3 milestones complete. The provider's DY 2 Oct report was not approved and required additional information This caused a delay in funding in which the provider did not receive until January 2014 for this project. The delay in funding has put the project off track because the provider was not able to purchase an EHR system. Being that the new system was being planned to be purchased in August 2014, the project may end up carrying forward DY 3 metrics. However, once the EHR system is purchased, the project could get back on track. The provider stated that it is unclear when a system will actually be purchased, although they will need to have the system implemented by 09/30/2015 to receive funding.	Consideration should be given to project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider reducing QPI metrics in DY 4-DY 5 should there be a continued delay in purchasing the EHR system.	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.	MSCL recommended adjusting DY4-5 goals if there are continued delays regarding system purchasing. Provider confirmed that the delays continued, but their plan is not to meet DY3 QPI but to meet and report DY4 and DY5 QPI goals. Based on this, provider is stating that the adjustments are not necessary.
Scott & White Hospital 135226205.2.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project milestones and metrics appear to be on track for DY 3. The provider stated that they calculated the QPI baseline incorrectly; thus, over-estimating the unique individuals served; however, they anticipate the difference to be minimal.	Consideration should be given to project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** 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. **Technical Change:** Update narrative to include Medicaid/Uninsured percentage.	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 updating project narrative to reflect MLIU percent. HHSC is not requiring providers to update narratives for this purpose since HHSC uses one file QPI and MLIU percent with a record of all MLIU percentages. MSLC also recommended to review provider's baseline and recalculate if necessary. HHSC included this project on the list of technical assistance for QPI and will review the baseline when QPI information is reported.
Conroe Regional Medical Center 020841501.1.2	4	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. As of April DY 3 reporting, the project is not on track due to the medical staff not being on-board with the hospital goals; however, it continues to make progress and with significant changes, it can get on track. The provider stated that specialists have been recruited and more efficient processes and increased training have been put in place.	Consideration should be given to project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** The provider should consider decreasing the QPI for metric I-23.1 should the delay in establishing a new/expanded specialty trauma care clinic cause the project not to be able to use the full pre-DSRIP baseline in their QPI. **Technical Change:** The provider should include the baseline that was established in DY 2 and the expected increase in specialist providers for the goal in DY 4 Metric I-22.1. **Technical Change:** The provider should include the baseline that was established in DY 2 and the expected increase in specialist providers, clinic hours and/or procedure hours in targeted specialties for the goal in DY 5 Metric I-22.1.	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 provider include the baseline that was established in DY2 and the expected increase in specialist providers for the goal in DY4 Metric I-22.1. HHSC updated the baseline for I-21.1 in DY4 and DY5. MSLC also recommended to revisit QPI goals if the project continues to experience delays. HHSC contacted provider, and based on the response of the provider, the project is on track and does not need goals adjustments.
Huntsville Memorial Hospital 189791001.1.1	4	1 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has only served 248 of the 2000 patients needed for DY 3 metrics and will need to make significant adjustments to get the project back on track. The provider stated that in October 2014, they reported seeing 2,109 Medicaid/Uninsured only patients which exceeded their goal of serving 2,000 patients.	No recommendations at this time.	**Possible Plan Modification:** 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."	N/A	MSLC recommended provider updates the project narrative to reflect the measurement of QPI metric I-101.1 being specialty Cardiac Services. HHSC reviewed the narrative and determined that current narrative does not contradict what is stated in I-101.1. Therefore, HHSC determined that no further updates are necessary, since project narrative and workbook summary give full picture of project activities.
Huntsville Memorial Hospital 189791001.1.2	3	2 of 3 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. HHSC requested more information for DY 2 metric P-12.1 and DY 3 metric I-101.1 to show achievement of the metric. The provider stated that in October 2014, they reported for metric I-101.1 seeing 411 Medicaid/Uninsured only patients which exceeded their goal of 390 encounters.	No recommendations at this time.	**Technical Change**: The provider should update the goal for QPI metric I-101.1 to clarify that the nephrology services are provided to Medicaid/Uninsured dialysis patients.	N/A	MSLC recommended updating the goal for QPI metric I-101.1 to clarify that the nephrology services are provided to Medicaid/uninsured dialysis patients. HHSC updated DSRIP system to state in metric I-101.1 in DY4 and DY5the following: Increase number of specialty care services (nephrology services) supplied to Medicaid and uninsured dialysis patients. HHSC informed provider about this change.

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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
Huntsville Memorial Hospital 189791001.1.4	3	0 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestone complete. The provider carried forward DY 2 metrics. The provider reported seeing 225 of the 450 patients for QPI metric I-12.1 in DY 3. DY 3 metric is on track as of April DY 3. The goal for Metric P-5.1 in DY 4 needs to be clarified to include the provider's intent to hire staff.	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. 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.	N/A	MSLC recommended updating the goal in Metric P-5.1 in DY4 to include the provider's intent to hire more staff. The provider should also clarify the baseline and numerical goal for this metric. HHSC 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 to show increase in staff during reporting process.
Huntsville Memorial Hospital 189791001.1.100	4	This is a 3-year project therefore it does not have DY 2 milestones. 0 of 4 DY 3 milestones complete. The 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 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 size/location 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.	Consideration should be given to possible impact on project valuation if plan modification is submitted and approved.	**Possible Plan Modification:** Provider should consider updating the project narrative and Phase 4 Master Summary to reflect the clinic location change. DY 4 metric P-1.1 still referenced the DY 3 clinic being in Bedias. **Possible Plan Modification:** Provider should consider reducing QPI metrics should there be a continued delay in establishing a clinic in DY 4.	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.	MSCL recommended updating the project narrative and Phase 4 Master Summary to reflect the clinic location change. HHSC 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. Metric P-1.1 in DY4 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. 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 DY5 QPI goal is not achievable, they can submit a request to adjust the DY5 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 DY5. HHSC has recommended to the provider that they review the status of the project and request adjustments for DY5 if needed. For any requested adjustments, they should provide a thorough explanation of the reason for the requested adjustment.
St. Joseph Regional Health Center 127267603.2.1	2	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. 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.	**Technical Change:** Update the goal in metric I-7.1 in DY 5 to show the provider's intent to measure a reduction of ED visits. The provider should also add the baseline to this goal once it is established.	N/A	MSLC recommended updating the goal in Metric I-7.1 in DY5 to show the provider's intent to measure a reduction of ED visits. HHSC updated DSRIP system to reflect that and informed the provider. Provider can submit the baseline during reporting of this metric. supporting documentation will need to show 10% reduction.
MHMR Authority of Brazos Valley 136366507.2.1	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Milestones and metrics appear to be on track as of April DY 3. The provider stated in April DY 3 reporting that the baseline has been updated to 621 for metric P-3.1 in DY 3.	No recommendations at this time.	**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.	N/A	MSCL recommended updating the project narrative and Phase 4 Master Summary to reflect the change in baseline mentioned during April DY3 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 baselines. Based on this, HHSC will not be updating QPI baselines in the system.
Texas A&M Physicians 198523601.1.2	2	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. In April DY 3, the provider reported they received inquiries pertaining to the fellowship position required for metric P-3.3 in DY 3. Note: A Plan Modification was submitted to HHSC to reduce the QPI goals in DY 4 and DY 5 due to delay in recruiting a fellow. Myers and Stauffer agrees with HHSC's approval.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Texas A&M Physicians 198523601.2.4	1	1 of 1 DY 2 milestone complete. 0 of 1 DY 3 milestone complete. As of April DY 3, the provider reported 108 consultations to date and is on track to meet its goal of 250 consultations by the end of the year.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

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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
Texas A&M Physicians 198523601.2.2	2	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.	Consideration should be given to possible impact on project valuation if plan modification is submitted and approved.	**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.	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 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.
Montgomery County Public Health District 311035501.2.100	2	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 that 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
College Station Medical Center 020860501.2.1	2	2 of 2 DY 2 milestones complete. 0 of 2 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

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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
Life Path Systems 084001901.1.1	2	2 of 2 DY 2 milestones complete 1 of 2 DY 3 milestones complete There is a material change in the location of the new clinic.	No recommendations at this time.	**Potential Plan Modification:** Provider should consider updating the narrative to reflect the change in the location of the 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	4	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. While the problems have been identified by the provider, the nature of the behavioral health population has made it difficult for the provider to meet its goals. The behavioral health population often experiences high no-show rates and longer than average appointment times which would result in a lower QPI.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider decreasing the QPI goal. However, if QPI is decreased, then 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.
Life Path Systems 084001901.2.2	1	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is on track to complete remaining DY 3 milestones by the end of DY 3.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Life Path Systems 084001901.2.3	5	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider is behind on their goals for DY 3 metric I-17.1, citing the inability to hire and train the appropriate peer support specialists with the needed diagnosis of mental illness. Also, the peer support specialist project option incorporates whole health support and measurement of receipt of recommended preventative services. The provider is an LMHA and does not provide physical health services. While the provider can refer clients for physical health assessments, it does not actually perform those services and therefore cannot guarantee that the client actually receives the preventative health services. The provider relies on the client to self-report whether or not he/she has received the recommended preventative services.	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. **Possible Plan Modification:** Provider should consider reporting its QPI goal for the unique number of individuals receiving services in a milestone separate from I-17. Milestone P-6 is an option to include in DY 4 and DY 5. QPI reduction is also an option based on the number of specialists that provider was able to hire and train. The number of clients served is dependent on the number of peer support specialists that can be hired and trained. **Possible Plan Modification:** Provider should consider submitting a plan modification to Milestone P-3 to account for the availability of the peer support specialist training. The plan modification could include a change that the peer support specialist will receive the internal training and achieve certification within one year.	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-17.1 QPI measure with two measures: P-6 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.
Texoma Community Center 084434201.1.4	3	1 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, such as reducing Emergency Department visits.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Texoma Community Center 084434201.2.2	4	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider has not been able to enroll patients in the program due to the availability of credentialed staff and building renovation/zoning and code compliance issues.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider a possible reduction in the number of patients enrolled for P-3. Also, provider could limit the scope of the project, including the number of interventions it mentions in its narrative. However, the number of interventions is not a specific milestone but is instead part of the provider's comprehensive plan for treatment.	N/A	MSLC recommended to consider possible reduction in the number of patients enrolled for P-3. Also, provider could limit the scope of the project, including the number of interventions it mentions in its narrative. HHSC checked on subsequent reporting. Provider carried forward its DY3 QPI metric (P-3) even thought the QPI template showed that the metric is achieved. With the goal of 750, provider served 789. HHSC does not believe that the reduction in QPI is needed. HHSC believes that no further actions for this project are necessary, since the provider appear to be on track after initial project delays.

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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
Texoma Community Center 084434201.2.3	2	1 of 2 DY 2 milestones have been met. Provider requested carryforward for both. 0 of 2 DY 3 milestones complete. Provider has included a goal for the number of patients, which is not required by I-18.3, but instead could be measured with I-18.4.	No recommendations at this time.	**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.	N/A	MSLC recommended to update project's QPI metric by either deleting the number of patients stated in the I-18.3 goal or including the number of patients served in a new metric, such as I-18.4. Provider agreed with these recommendation, and split existing metric into I-18.3 and I-18.4. In addition, provider requested some changes to the QPI goals, which were approved by HHSC. HHSC changed designation of QPI from I-18.3 to I-18.4 since initially provider was going to report in QPI number of visits available for so many people (QPI target) but actual number of people served would be lower. New goals are I-18.4 250 in DY4 and 300 in DY5.
Lakes Regional MHMR Center 121988304.2.1	3	2 of 2 DY 2 milestones complete. 1 of 2 DY 3 milestones complete. There is a concern with potential measurability of QPI metric I-3.1 in DY 4 and DY 5. Provider has exceeded its goal at mid-point for DY 3 metric P-3.1.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider deleting the unique number of individuals for I-3 in DY 4 and DY 5 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 P-3.	N/A	MSLC recommended to consider deletion of the unique number of individuals for I-3 in DY4 and DY5 and only report a percentage based on the number of individuals enrolled. HHSC does not support removal of the number goal since this metric is used as QPI. Provider will report on both: the QPI goal and the percent as stated in the baseline/goal. Provider has stated that the percentage (adherence) will be obtained by using the number of individuals enrolled in DY3.
Children's Medical Center of Dallas 138910807.1.1	4	1 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider indicated facility closure as reason for lack of progress on the DY 3 milestones and noted that all patients are being seen at a clinic in a different RHP.	No recommendations at this time.	**Technical Change:** Metric I-12.2 in DY 4: goal on Phase 4 Master Summary should specify patients and not visits. Possible Plan Modification: Provider should consider adjusting its baseline for metric I-12.1 and reduce QPI goals in DY 4 and DY 5.	N/A	MSLC recommended clarifying the goal for I-12.2 metric in DY4. The metric should be measuring increased number of unique patients, while provider appear to be measuring visits. Provider agreed with the recommendation. HHSC deleted I-12.2 from the project's metrics, leaving I-12.1 as the QPI metric for the project. Goals did not change.
Children's Medical Center of Dallas 138910807.1.3	3	1 of 1 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The measurement for Metric I-15.1 needs revision in order for the provider to report a valid figure.	No recommendations at this time.	**Technical Change:** Provider is measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the current percentage target and the calculation. The provider can include a percent increase figure as a way to show improvements from DY 3 through DY 5, but the current percentage shows a calculation measuring patients in the registry vs. total patients. Not all patients will be eligible for the registry.	N/A	MSLC recommended updating project's QPI metric, since provider is measuring the absolute number of patients in the registry for metric I-15.1 and therefore should delete the current percentage target and the calculation. Provider agreed with this recommendation. HHSC changed I-15.1 in DY4 and DY5 to a I-15.2 (from a 3 year project menu) and will only measure the number of individuals and not the percent.
Children's Medical Center of Dallas 138910807.2.1	3	2 of 2 DY 2 milestones complete. 0 of 3 DY 3 milestones complete. The measure used by the provider for metric I-12.1 is not specified in the menu. See recommendation.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider deleting Metric I-12 in DY 4 and DY 5. 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.	N/A	MSLC recommended considering deleting I-12 metric in DY4 and DY5 since provider's measurement for this metric differed from the protocol intent. The provider is measuring number of individuals receiving care, not number assigned to home, which I-12 is supposed to measure. HHSC recommended changing this metric into a customizable one and provider agreed with this recommendation. Provider agreed with this recommendation. HHSC changed in DY4 metric I-12.1 (metric #2 - QPI) into a customizable milestone I-101. Goals stayed the same. In DY5 we changed I-12.1 (metric #1) into a customizable milestone I-101. Goals stayed the same
Tenet Frisco, Ltd d/b/a Centennial Medical Center 169553801.1.1	3	5 of 5 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. In order to meet its QPI goals, provider is including all visits in its primary care expansion therefore metric I-15.2 is not related to a specific diagnosis.	No recommendations at this time.	**Technical Change:** DY 5 Metric I-15.2 - Delete metric language "Increase number of diabetes and HTN care patients being served by another 10% over Year 4. Provide urgent care. Maintain and track current patient load." in manual description field on the Phase 4 Master Summary.	N/A	MSLC recommended deleting some language from DY5 Metric I-15.2. HHSC checked DSRIP reporting system and did not identify this language. The project does not need further changes.
Texoma Medical Center 194997601.1.1	2	2 of 2 DY 2 Milestones complete. 0 of 4 DY 3 milestones complete. The goal for I-12 is not specified as measuring visits per day on the Phase 4 Master Summary. If the provider is measuring visits per day, this changes the valuation amount.	No recommendations at this time.	**Technical Change:** Milestone I-12.1 - Provider needs to specify on the Phase 4 Master Summary that the goal measurement is per day. If the provider is reporting the number of visits per day, the valuation should be reassessed based on the annualized number of visits. Otherwise, the provider should report the goal as the number of encounters for each DY in order to assess the valuation consistently across all DSRIP projects.	N/A	MSLC recommended updating Milestone I-12.1 by specifying on the Phase 4 Master Summary that the goal measurement is per day. HHSC verified Phase 4 Master Summary - the metric also includes annual goals. In DY4 provider selected to have 2 metrics - one for daily goals, and one annual. Since the provider has annual number of visits in both DY4 and DY5, HHSC will not be recommending any further changes to the project.

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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
Texoma Community Center 084434201.1.1	2	1 of 1 DY 2 milestones complete. 1 of 2 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-18.1 are incorrect. Total for DY 5 should be 140 encounters, not 240. The 240 figure is the total for DY 4 and DY 5.	**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. (% 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 to DY. 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.	Agree with MSLC that the 240 figure is a cumulative figure and not the DY5 annual goal.	MSLC recommended a technical change to metric P-11.1, since percent increase on the Phase 4 Master Summary should be corrected. The percent increase from DY4 to DY5 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 metric from I-18.2 to I-101.1 in DY4 and DY5 and cleaned the language to eliminate individuals and 40 patients using telemedecine services. Goals (in encounters) stayed the same.
Texoma Community Center 084434201.1.4	3	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, such as improving performance to enhance service availability at a lower cost.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Texoma Community Center 084434201.2.1	3	1 of 1 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. Provider has incorrectly calculated its percent increase for I-25.1 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.	**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."	N/A	MSLC recommended updates to Milestone I-25.1 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 with this recommendation. HHSC changed QPI metric from I-25.1 (deleted this one) and replaced with I-101.1. Goals stayed the same.
Hamilton Hospital 110856504.2.2	4	1 of 1 DY 2 milestones complete. 0 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. referrals from physicians, etc.). The provider's target population is unclear and the QPI numbers are extremely low.	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 including enrollees in the wellness center and/or health education classes, not just those who complete a pre-health self-assessment. Currently, the provider is measuring QPI by the number of individuals 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 DY5.	MSLC recommended updates to 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 DY5. MSLC 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 (DY5 metric). MSLC also recommended updating narrative to reflect MLIU. HHSC ddes not require providers to reflect that in the narrative, since a separate QPI and MLIU summary file is used for these purposes.
Wilbarger General Hospital 112707803.1.1	4	0 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider did not submit the appropriate provider contracts as requested by HHSC for DY 2 milestone. Additionally, the supporting documentation that was submitted by provider for DY 2 was dated from before DSRIP project approval. Provider did not report any progress as of mid-point DY 3. This project is dependent on the provider hiring a new family practice physician in order to increase the number of patients in DY 4 and DY 5. The incorrect metric is used on the Phase 4 Master Summary in DY 4 and DY 5.	No recommendations at this time.	**Technical Change:** I-12.1 (DY 4 and DY 5): Provider is measuring the number of patients for its metric and therefore the metric number should be changed to I-12.2. The provider is currently using metric I-12.1 on the Phase 4 Master Summary which is specific to the number of visits.	N/A	MSLC recommended a technical change to : I-12.1 (DY4 and DY5): Provider is measuring the number of patients for its metric and therefore the metric number should be changed to I-12.2. HHSC replaced I-12.1 with I-12.2 in DY4 and DY5 since the provider is measuring number of individuals instead of visits. Providers QPI was already in individuals, so no change rather than metric ID. HHSC informed provider about this change.

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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
Faith Community Hospital 119874904.2.2	1	4 of 4 DY 2 milestones complete. 1 of 5 DY 3 milestones complete. 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Faith Community Hospital 119874904.2.3	3	3 of 3 DY 2 milestones complete. 1 of 4 DY 3 milestones complete. We determined that the provider has incorrectly reported completion of the milestone I-101. (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.	On the provider's DY 3 April report for Milestone #3 (I-8.1), the goal progress is incorrect. The provider is reporting progress of 40 percent of its goal. This calculation should show the actual percentage completed, not the percentage of the goal completed. As it's currently written, it looks as though the provider completed achieved 40 percent, greatly exceeding its goal of 13 percent. Provider has incorrectly reported completion of metric for I-101.1 on the April DY 3 report. Provider reported a goal of 35 patients with a goal completion of 207 patients, for a total of 242 patients. On this report, the provider is using a baseline of zero. However, this metric is simply the absolute number calculation of Metric I-8.1. The baseline is 561 as established in DY 2 with a goal of 35 over baseline for a total of 596 patients. The provider has not yet achieved its goal. It first needs to reach its baseline before it can report its increase over baseline.	**Possible Plan Modification:** Provider should consider updating its narrative if it has only implemented five the seven Health Promotion programs for DY 2 P-2.1. **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."	1) The goal progress was not used to make or deny payment so there is no need to change this information. 2) HHSC NMI'd this metric and requested that the provider submit additional information to support achievement.	MSLC recommended updating project narrative since provider addressed only five of the seven Health Promotion programs in P-2.1 in DY2. The most recent narrative HHSC has on file (Feb. 2015) states that four of the program have been implemented and three are in development. Based on this, HHSC does not believe further revisions to the narrative are needed at this time. MSLC also recommended updating typo in I-101 (DY5): goal currently states "05" as the goal and should state "105." HHSC checked the master summary and the summary currently shows 105 as the goal for DY5. No further changes are needed.
North Texas Medical Center 121777003.2.1	1	3 of 3 DY 2 milestones complete. 3 of 4 DY 3 milestones complete. Provider has reported on recruiting efforts to fill holes in staffing and is on track to meet its QPI milestone.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Nocona General Hospital 127310404.2.1	2	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Project uses customizable milestone to measure "positively impacted individual." There is not a direct intervention relating to improved satisfaction scores but only that surveys of satisfaction are being conducted.	During reporting, HHSC should consider requiring the provider describe the various interventions and improvements that are actually impacting patient satisfaction scores. An example could be discharge instructions and follow-up procedures at the time of discharge.	No recommendations at this time.	HHSC will take this under consideration.	MSLC did not have any recommendations.
Helen Farabee Center 127373205.1.2	2	3 of 3 DY 2 milestones complete. 3 of 3 DY 3 milestones complete. Provider also reported exceeding its goal of patient encounters in the new/expanded clinic by 118 encounters (Goal = 459 encounters; Actual achieved at mid-point = 577 encounters)	No recommendations at this time.	**Possible Plan Modification:** Provider should consider increasing QPI goals in DY 4 and DY 5 proportionately based on the results of the DY 3 October reporting for P-11.1. The increase in QPI goal could potentially increase project valuation. Provider reporting overachieving for P-11.1 at mid-point and could potentially reach more patients in subsequent years.	N/A	MSCL recommended increasing goals for P-11.1 because provider reporting overachieving at mid-point and could potentially reach more patients in subsequent years. HHSC followed up with the provider, and as a result increased QPI goals to 758 from 505 in DY5. HHSC also updated percent increase resulting from change in the numbers.
Graham Regional Medical Center 130613604.1.2	5	0 of 2 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Project is not on track. Provider states they will fulfill DY 2 carryovers on the last possible day, but have not provided any update on progress towards goals. DY 3 metrics are at risk of not being met due to failure to build new space or hire additional personnel. The provider is not clear on how it intends to increase the number of visits between DY 3 and DY 5.	This is a project that could possible need to withdraw as provider was not clear on how they would increase visits. The concern is greater as none of the milestone have been met from both DY 2 and DY 3 at this point.	**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.	HHSC considered MSLC suggestion regarding project's withdrawal. However, based on the most recent reporting by the provider, the clinic is on track to attain DY3 and DY4 targets at the end of DY4 period. The staffing model appear to be stable.	MSCL recommended considering withdrawal for the project. HHSC checked subsequent reporting by the provider. At the end of DY3 provider got approval for one of the DY2 metrics. Provider did, however, indicate that they do not have space for additional providers. 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.

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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
Electra Memorial Hospital 135034009.1.4	2	2 of 2 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Project is well on track to meet its 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Electra Memorial Hospital 135034009.1.5	3	4 of 5 DY 2 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC recommendation was already resolved through the plan mod process. No further changes are needed.
Electra Memorial Hospital 135034009.2.2	2	3 of 3 DY 2 milestones complete. 3 of 4 DY 3 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.	No recommendations at this time.	**Possible Plan Modification:** Provider should consider including a milestone to measure a comparison. This is a Category 2 project option and is aimed at showing effectiveness of intervention. Measurement could consist of number of patients receiving transition care protocols vs. the total number of patients eligible for service or discharged from the hospital.	N/A	MSLC recommended adding another milestones to DY5 that would show effectiveness 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.
United Regional Health Care System 135237906.2.1	3	1 of 1 DY 2 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.	No recommendations at this time.	**Technical Change:** Metric I-7 (DY 4 and DY 5): Delete the additional measure of "number of patients" in metric I-7.1. This metric should be measuring cost savings only. Provider is already including a measure of the number of patients benefiting from the project (I-101.1). **Possible Plan Modification:** Provider should consider revising metric I-101.1 in DY 4 and DY 5 to record the number of patients experiencing a reduction in per episode cost of care. The current metric is not specific and how the patient actually benefits is not clearly defined.	N/A	MSLC recommended that provider adjusts its QPI metric I-101.1 to record the number of patients experiencing a reduction in per episode cost of care, and clean language in I-7.1. Provider had another metric where the number of patients with cost information was reported. HHSC worked with the provider to clean project's metrics. As a result, project's QPI I-101.1 reflects now the number of chest pain observation patients benefits from the intervention - admission to Clinical Decision Unit. Another metric I-7.1 measures reduction in cost per chest pain observation. This addresses MSLC recommendations.
United Regional Health Care System 135237906.2.4	1	1 of 1 DY 2 milestones complete. 0 of 1 DY 3 milestones complete. Provider has reported progress on DY 3 milestone and is on track to meet its goal.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Seymour Hospital 138353107.1.2	2	1 of 1 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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.
Seymour Hospital 138353107.2.3	2	0 of 1 DY 2 milestones complete. 0 of 2 DY 3 milestones complete. Provider reported completion of all milestones on the DY 2 carryforward report. However, HHSC requested additional information for one of the three metrics for milestone P-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.	No recommendations at this time.	No recommendations at this time.	N/A	MSLC did not have any recommendations.

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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
University of Texas Health Science Center at San Antonio 085144601.1.1	3	1 of 3 DY 2 milestones complete 0 of 1 DY 3 milestones complete 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.1.100	2	This is a 3-year project therefore it does not have DY 2 milestones. 0 of 3 DY 3 milestones complete Provider is on track to complete the remaining DY 3 metrics by the end of DY 3. Provider is making progress on their milestones. They have given 431 of 1280 dental education and fluoride varnish treatments and have expanded preventative dental services.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Border Region Behavioral Health Center 121989102.1.2	3	1 of 3 DY 2 milestones complete 0 of 4 DY 3 milestones complete Provider is delayed in initial planning stages, but has drafts developed for the GAP analysis and Plan, Do, Study, Act (PDSA). Once this is finalized, the provider should be able to get back on track.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.
Maverick County Hospital District 137908303.1.1	1	1 of 1 DY 2 milestones complete 0 of 2 DY 3 milestones complete Provider appears to be progressing well and is on track with project milestones. DY 3 milestones will be in the October reporting period.	No recommendations at this time.	No recommendations at this time.	Provider carried forward all DY3 milestones	MSLC did not have any recommendations.
Driscoll Children's Hospital 132812205.1.1	3	5 of 5 DY 2 milestones complete 2 of 4 DY 3 milestones complete Provider is overachieving their DY 3 milestones, which is considered a moderate risk. Provider has submitted a plan modification to increase their goals for these milestones.	Consideration should be given to potential impact on project valuation if plan modification to increase QPI is approved.	No recommendations at this time.	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. Although the provider increased QPI for fetal anatomy scans (2nd I-23.1), the updated DY4-5 goals are still lower than DY3 achievement of 448. Provider did not increase QPI goal for 1st QPI metric of fetal echocardiogram procedures when DY3 achievement of 80 exceeds DY5 goal of 60.	MSLC recommended consideration should be given to potential impact on project valuation if plan modification to increase QPI is approved. HHSC does not change valuation based on QPI changes, unless the project is outside the valuation ranges, and HHSC can decrease the valuation in this case. Although the provider increased QPI for fetal anatomy scans (2nd I-23.1), the updated DY4-5 goals are still lower than DY3 achievement of 448. Provider did not increase QPI goal for 1st QPI metric of fetal echocardiogram procedures when DY3 achievement of 80 exceeds DY5 goal of 60. HHSC will follow-up with the provider in May 2015 with proposed increases in QPI.
Border Region Behavioral Health Center 121989102.2.1	4	0 of 4 DY 2 milestones complete 0 of 3 DY 3 milestones complete Core Components have not been adequately addressed. Provider is delayed in hiring staff, but has since hired 5 needed staff and therefore completing this milestone by carrying them forward. Since the project hired an additional physician, there is a potential need to increase their QPI going forward.	Consideration should be given to potential impact on project valuation if plan modification to increase QPI is approved.	**Potential Plan Modification:** Provider should consider increasing QPI for DY 5 since they hired an additional physician. **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.	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 the provider consider increasing QPI for DY5 since they hired an additional physician. HHSC did not agree with this recommendation since the 5th provider may be counted for DY4 P-6.1 goal of 6 providers. DY5 P-6.1 has goal of 7 providers. After further discussion with the provider, they requested, who agreed that an increase was needed, HHSC updated the reporting system with the new, increased DY5 QPI goal to 250. MSLC recommended the provider 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. HHSC agreed that P-6.1 may be clarified by possibly splitting out the QPI goal from the number of providers achieving level 4 interaction. HHSC worked with the provider and updated the reporting system by creating a new QPI milestone (I-101.1) and revising P-6.1 to reflect the number of providers achieving level 4 interaction.

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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
Driscoll Children's Hospital 132812205.2.100	1	This is a 3-year project and therefore did not have DY 2 milestones. DY 3: 1 of 4 DY 3 milestones complete 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 I-102.1.	HHSC should clarify how the provider should report on DY 3 milestone I-102.1. The 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.	No recommendations at this time.	Provider had to update DY3 baseline so M&S 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 I-102.1. The 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.
Laredo Medical Center 162033801.2.1	3	4 of 4 DY 2 milestones complete 0 of 6 DY 3 milestones complete Project is operating with an interim CEO. Provider states in the April sign-off summary "due to questions regarding IGT funding we have hit delays in some of our metrics/milestone". QPI metric P-10 is looking for patients included in an inquiry (survey), in DY 2 this milestone was met. DY 3 P-10 states they have not completed any surveys from October - March. Provider states "We are committed to continue to participate in the 1115 Waiver project and are working towards meeting are DY 3 metrics and milestones by year end." Provider has the remainder of the year to complete their milestones and is making progress, but it has been slow. Provider may want to request a QPI reduction to get back on track if the provider has not accomplished this prior to the end of DY 3.	Consideration should be given to potential impact on project valuation if plan modification to increase QPI is approved.	**Possible Plan Modification:** Recommend 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.	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 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.
Border Region Behavioral Health Center 121989102.2.2	2	1 of 1 DY 2 milestones complete 0 of 2 DY 3 milestones complete 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 I-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.	No recommendations at this time.	**Technical Change:** Provider should clarify DY 4 milestone I-5 baseline goals. Clarification is needed to state whether the baseline should be based on a fiscal year or a demonstration year.	NA	MSLC recommended the provider clarify DY4 milestone I-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 I-5, so due to timing, no system changes were made.
City of Laredo Health Department 137917402.2.1	4	1 of 1 DY 2 milestones complete 1 of 1 DY 3 milestones complete 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 mention of changing the requirement for "at risks patients" 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. This project was selected as a benchmark project because of their community outreach efforts and utilization network in order to meet their QPI goals.	No recommendations at this time.	**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. **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.	NA	MSLC recommended the provider should update their narrative to state their various programs and should include an explanation on the supporting documentation to state DSM is the same as DSME. HHSC followed up with the provider on these recommendations and the narrative was updated accordingly. MSLC recommended the provider should 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 DY3 reporting and additional changes were not needed. HHSC did not contact the provider on this recommendation.
Border Region Behavioral Health Center 121989102.1.3	2	2 of 2 DY 2 milestones complete 0 of 4 DY 3 milestones complete 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.	No recommendations at this time.	No recommendations at this time.	NA	MSLC did not have any recommendations.