Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP)

PLAN

November 14, 2012

RHP#3 HIV Service Linkage Expansion Project

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Narrative for Category 2 Project Title: HIV Service Linkage Project

Project Option 2.9.1- Establish/Expand a Patient Care Navigation Program

**Unique Project ID:** 0937740-08.2.3  
**Performing Provider Name/TOI:** City of Houston Department of Health and Human Services / 0937740-08

**Project Description:**

This Program will expand service linkage to provide navigation services to targeted patients with HIV who are at high risk of disconnect from institutionalized health care.

This project will use patient navigators to connect at risk HIV diagnosed individuals to appropriate care. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.

The Houston Area has placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts. For example, a unique local service category within the Ryan White HIV/AIDS Program for linking the newly diagnosed into HIV clinical care (e.g., Service Linkage Workers) was created in 2008. Current estimates of those linked to care in the Houston Area are as follows:

1. Of newly diagnosed HIV infected individuals diagnosed in the Houston Area, 65.1 percent linked to HIV clinical care within the national standard of three months following diagnosis. The Houston area rate falls below the average for the state of Texas as a whole (68.6 percent) as well as the national target (85.0 percent).

2. Certain demographic groups in the Houston Area have lower than community-wide aggregate linkage to care rates. Known at risk groups such as males, blacks/African Americans, and Injection drug users (IDU) all have linkage to care rates below the Houston area average. Those in the age category of 13 to 24 years also have a lower than average linkage to care rate.

The Houston Area has adapted the Case Management (Non-Medical) service category for the purpose of linking the newly-diagnosed into primary HIV medical care. Defined locally as Community-Based (Non-Medical) Case Management, services provided under this adapted category are called Service Linkage. Service Linkage Workers (SLW) or patient navigators are often co-located at HIV testing sites.

The Houston area places a high priority on widespread access to HIV testing in both targeted and routine settings, using all available technologies. The Expanded Testing Initiative (ETI) supports routine opt-out HIV RHP Plan for City of Houston Health and Human Services
screening at local emergency rooms; and community-based organizations provide targeted counseling and testing to those at high risk. Of all publicly-funded HIV tests offered in the Houston Area in 2010, 1.2 percent were positive, which translates into almost 600 HIV+ individuals who became aware of their status in that year alone. The Ryan White HIV/AIDS Program Part A contracts with the HDHHS to place service linkage workers at HDHHS locations where individuals are newly-diagnosed, including routine HIV testing sites at local emergency rooms and medical institutions and public STD clinics, for the purpose of linking these individuals to HIV care, treatment, and support services. The Service Linkage Worker Outcome Measure requires each newly-diagnosed client to be linked to a Ryan White HIV/AIDS Program-funded primary medical care or case management provider within 120 days of contact.

The Houston Department of Health and Human Services (HDHHS) is funded by the Ryan White HIV/AIDS Program to employ Service Linkage Workers (SLW) who connect newly-diagnosed individuals to Ryan White HIV/AIDS Program-funded primary HIV medical care. SLWs at the HDHHS are also cross-trained in disease investigation and can provide partner services for the newly-diagnosed. SLWs also provide referrals to non-HIV related services such as those for co-morbid conditions, behavioral health concerns, and social support services including housing, food, employment, transportation, and child care.

**Goals and Relationship to Regional Goals**

The goal of this project is to utilize patient navigators (called Service linkage workers) to provide targeted, non-medical community-based case management, including active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing for newly diagnosed HIV patients in a geographic area with low rates of linkage to care for the target population.

**Project Goals:**

The overall goal of the project is to help and support HIV patients through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. The project will expand access to the existing care management program for individuals who are HIV positive.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces
unnecessary or duplicative services, and builds on the accomplishments of our existing health care system,

Challenges

The program anticipates some challenges in implementation of the program. Some of these challenges are successful hiring and training of new staff for the program, maintaining ongoing collaboration with primary care providers and ensuring clients have access to immediate medical care when necessary to avoid hospitalization and developing a system that will ensure ongoing retention into care after the required time allotted to Service Linkage workers has expired. These challenges will be met by ongoing training and workforce development efforts. Additionally a strong follow up component will be added to the project so that referrals are followed up and receive appropriate care.

5- Year Expected Outcome for Provider and Patients:

Goals from the Joint Comprehensive Plan:

1. Target linkage to care efforts to vulnerable points in the HIV system (e.g., at initial diagnosis, before the first medical visit, after the initial visit, etc.) where individuals are more likely to not seek care or to fall out of care, particularly newly-diagnosed Persons living with HIV or AIDS (PLWHA).
2. Intensify retention and engagement activities with currently in-care PLWHA, focusing on community education, system enhancements, and health literacy
3. Adopt strategies to re-engage out-of-care PLWHA and other “prior positives” to return to care

Starting Point/Baseline:

Baseline data on navigation program after implementation will be collected in Year 2 of the project.

Rationale:

HIV related hospitalizations account for a significant portion of national health care costs every year. Many of these visits occur when patients are not receiving continuous care to manage their infections. By increasing the number of newly diagnosed HIV positive patients who are linked to clinical care within three months, and increasing the number of patients who receive continuous clinical care, the number of HIV related hospitalizations can be greatly reduced, resulting in significant cost savings.

Project Components: This project will address all the components of a navigation program. Required core project components:
a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. – We plan to work with hospital ED and Expanded Testing Initiative (community based testing) to assist newly diagnosed HIV patients navigate through the health care system. Our navigators (service linkage workers) will be trained in cultural competency to reflect the diverse population in Houston.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. – Our navigators will use a non-medical case management model to address the needs to the patients.

c) Connecting patients to primary and preventive care - Our navigators will ensure that the patients are connected to primary and preventive care so that they are better equipped to manage their conditions with a specified time period after their diagnosis and entry into the Service Linkage Program..

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management – Our navigators will also provide information and instruction on chronic disease care and self management.

e) 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 - Our navigation program will conduct continuous quality improvements and share lessons learned.

**Unique community need identification numbers the project addresses**

The HIV Service Linkage Expansion Program also addresses the issues addressed in the following community needs assessments:

- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including AIDS/HIV 1,2
- CN.23 Lack of patient navigation, patient and family education and information programs 1,2

**How the project represents a new initiative or significantly enhances existing delivery systems reform initiative:**

This project is an expansion of an existing HIV Service Linkage program which is funded by federal dollars. The project will add additional service linkage workers to serve more HIV positive individuals who are at risk from being disconnected from the health care system.
**Related Category 3 Outcome Measures:**

**OD- 9 Right Care, Right Setting**

IT-9.4 Other Outcome Improvement (ED Appropriate Use)

Numerator: Number of HIV patients that are in Service Linkage Program that were admitted to a hospital in the past 6 months.

Denominator: Total number of HIV patients enrolled in Service Linkage Program during the same time period.

Data Source: Service Linkage Database, Patient electronic records

**Reasons/rationale for selecting the outcome measures:**

We chose “Other Outcome Improvement” under Outcome Domain 9 (Right Care Right Setting) due to the high ED utilization for newly diagnosed HIV patients who may suffer from multiple comorbidities. Providing navigation services to HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients. The Houston Area has placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts.

**Relationship to other Projects:**

**Relationship to Other Performing Provider’s Project and Plan for Learning Collaborative:**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4)Cost Avoidance 5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs

RHP Plan for City of Houston Health and Human Services
and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The HIV Service Linkage Expansion received a composite Prioritization score of 6.5 and a Public Health Impact score of 6.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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### Process Milestones and Metrics

**Milestone 1 [P – X1]:** Plan scope, range, current capacity and needed resources for the Service Linkage Expansion Program.

Metric 1: Service Linkage Program Planning Materials, Meeting minutes, Sign-in sheets, Staff Qualifications, Staffing Plan

Goal: Provide report documenting all process measures listed above

Data Source: Program Documentation

Milestone 1 Estimated Incentive Payment: $ 819,513.66

**Milestone 2 [P – 2]:** Establish a health care navigation program to provide support to HIV populations who are most at risk of receiving disconnected and

**Milestone 4 [P-3]:** Provide care management/navigation services to targeted patients.

P-3.1. Metric: Increase in the number or percent of targeted patients enrolled in the program

a. Numerator: Number of targeted patients enrolled in the program

b. Denominator: Total number of targeted patients identified

Goal: Implement program as per plan

c. Data Source: Enrollment reports

Milestone 4 Estimated Incentive Payment: $ 778,327

**Milestone 7 [I-6]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.

I-6.4. Metric: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment

Goal: Increase PCP referrals by 5% over baseline

Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program

Milestone 7 Estimated Incentive Payment: $ 2,323,307

**Milestone 8 [I-6]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.

I-6.4. Metric: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment

Goal: Increase PCP referrals by 10% over Baseline

Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.

Milestone 8 Estimated Incentive Payment: $ 2,069,313
<table>
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<th>Year 2</th>
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### Outcome Measures:

**Related Category 3**

<table>
<thead>
<tr>
<th>Unique Identifier: 0937740-08.2.3</th>
<th>RHP PP Reference Number: 2.9.1</th>
<th>Project Components: 2.9.1 (a-e)</th>
<th>Project Title: HIV Service Linkage Expansion Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: City of Houston Department of Health and Human Services</td>
<td>HDHHS -0937740-08</td>
<td>IT-9.4 Milestone: ED appropriate utilization (Stand-alone measure)</td>
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**P-2.1.** Metric: Establish optimum number of people that should be trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.

- a. Workforce development plan for patient navigator recruitment, training and education
- b. Goal: Provide report documenting workforce development for patient navigators (service linkage workers)
- Data Source: Program Documentation

**Milestone 2 Estimated Incentive Payment:** $819,513.66

**Milestone 5 [P-5]:** Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care.

- P-5.1. Metric: Collect and report on all the types of patient navigator services provided.
- Goal: Report on types of navigation services provided for different sub-populations in the target population to understand service usage.
- Data Source: Program documentation

**Milestone 5 Estimated Incentive Payment:** $778,327

**Milestone 6 [P-X]:** Establish baseline for number of PCP referrals for patients without a medical home who use the ED.

RHP Plan for City of Houston Health and Human Services
**Unique Identifier:** 0937740-08.2.3  
**RHP PP Reference Number:** 2.9.1  
**Project Components:** 2.9.1 (a-e)  
**Project Title:** HIV Service Linkage Expansion Program

**Performing Provider Name:** City of Houston Department of Health and Human Services  
**Related Category 3**  
**Outcome Measures:** 0937740-08.3.09  
**IT-9.4 Milestone:** ED appropriate utilization (Stand-alone measure)

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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Milestone 3 [P-X2]:</strong> Develop and test database created for HIV Service Linkage navigation program</td>
<td><strong>Metric 1:</strong> Determine and provide documentation of type of system and IT resources needed.</td>
<td><strong>Goal:</strong> Establish baseline for connecting program enrollees to primary care</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2:</strong> Select, install and test navigation data system</td>
<td><strong>Goal:</strong> Database that has capacity for efficient reporting of project outcomes and processes</td>
<td>c. <strong>Data Source:</strong> Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.</td>
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<tr>
<td><strong>Goal:</strong> Database that has capacity for efficient reporting of project outcomes and processes</td>
<td><strong>Data Source:</strong> Program documentation</td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $819,513.68</td>
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<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> $2,458,541</td>
<td><strong>Year 3 Estimated Incentive Payment:</strong> $778,327</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $2,323,307</td>
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<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $2,069,313</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundles amounts over DYs 2-5):* $9,186,142

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RHP Plan for City of Houston Health and Human Services
Narrative for Category 3 Outcome Measure 1 Associated with Category 2 Project Title:

**HIV Service Linkage Expansion**

**Title of Outcome Measure (Improvement Target):** IT-9.4 Other Outcome Improvement Target(ED appropriate utilization )(Stand-alone measure)

**Unique RHP Outcome identification number(s):** 0937740-08.3.9

**Outcome Measure Description:**
IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)

The performing provider proposes to provide navigation services to targeted HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients. Providing navigation services to targeted HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients.

Numerator: Number of HIV patients enrolled in program that used ER in past 6 months

Denominator: Total number of HIV patients enrolled in Service Linkage Program during the same time period

Data Source: Service Linkage Database and follow up data

**Process Milestones:**

- **DY2:**
  - P-X1 Development of Outreach and Education Plan

- **DY 3:**
  - P-4 Metric: Conduct Plan-Do-Study-Act
  - P-5 Milestone: Disseminate findings, lessons learned and best practices

**Outcome Improvement Targets for each year:**

- **DY 4:**
  - IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)Reduce rate of ER visits that are non emergent among HIV patients enrolled in Service Linkage program in past 6 months by 3% over baseline

- **DY 5:**
  - IT-9.4 Other Outcome Improvement Target (ED appropriate utilization) Reduce rate of ER visits that are non emergent among HIV patients enrolled in Service Linkage program in past 6 months by 6% over baseline.

**Rationale:**
Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatient and outpatient care can help integrate RHP Plan for City of Houston Health and Human Services
inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. This service linkage expansion will provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others).

**Outcome Measure Valuation:**
The Outcome measure was valued at 10.71% of the overall assigned project value for the associated Category 2 project in year 3, 10.71% in Year 4 and 10.71% in Year 5. HDHHS utilized the following method to determine the Category 2 project value.

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RHP Plan for City of Houston Health and Human Services
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<tr>
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<tbody>
<tr>
<td><strong>Process Milestone 1 [P-X1]:</strong> Development of Outreach and Education Plan to Target population</td>
<td><strong>Process Milestone 2 [P-4]:</strong> Conduct Plan Do Study Act cycle to continually improve</td>
<td><strong>Outcome Improvement Target 2 [IT-9.4]:</strong> Other Outcome Improvement Target (ED appropriate utilization)</td>
<td><strong>Outcome Improvement Target 4 [IT-9.4]:</strong> Other Outcome Improvement Target (ED appropriate utilization)</td>
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<tr>
<td>Metric: Written report on Outreach Education Plan for Service Linkage Program</td>
<td>Metric: Document use of PDSA in planning process</td>
<td>Numerator: Number of HIV patients enrolled in program that used ER in past 6 months</td>
<td>Numerator: Number of HIV patients enrolled in program that used ER in past 6 months</td>
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<tr>
<td>Goal: To disseminate information about program in Target Population</td>
<td>Goal: Utilize a cyclical quality improvement process</td>
<td>Denominator: Total number of HIV patients enrolled in Service Linkage Program.</td>
<td>Denominator: Total number of HIV patients enrolled in Service Linkage Program.</td>
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<tr>
<td>Data Source: Program Documentation</td>
<td>Milestone 2 Estimated Incentive Payment: $ 129,721</td>
<td>Goal: Reduce number of ED visits in Program enrollees by 3% in 6 months over Baseline</td>
<td>Goal: Reduce number of ED visits in Program enrollees by 6% over Baseline</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $ 129,397</td>
<td><strong>Process Milestone 3 [P-5]:</strong> Disseminate lessons learned and best practices</td>
<td>Data Source: Service Linkage Database and follow up data</td>
<td>Data Source: Service Linkage Database and follow up data</td>
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<tr>
<td>Metric: Documentation of best practices and lessons learned</td>
<td>Goal: Share lessons</td>
<td>Outcome Improvement 4 Estimated Incentive Payment: $ 258,145</td>
<td>Outcome Improvement 5 Estimated Incentive Payment: $ 517,329</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Starting Point/Baseline</th>
<th>Data</th>
<th>Incentive Payment</th>
<th>Estimated Outcome Amount</th>
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<td>Year 5</td>
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<td>Year 5 Estimated Outcome Amount: $517,329</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5):$1,164,313*