Texas Healthcare Transformation Waiver

Instructions and Form for DY3 RHP Annual Report due December 15, 2014

The Program Funding and Mechanics Protocol (paragraph 24) requires that each RHP Anchoring Entity submit an annual report by December 15 following the end of Demonstration Years (DY) 2-5. The annual report is to be prepared and submitted using the standardized reporting form approved by HHSC. The report will include information provided in the interim reports previously submitted for the DY, including data on the progress made for all metrics. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings.

Instructions

The purpose of the DY3 RHP annual report is to summarize the progress of the RHP during DY3 (October 1, 2013 – September 30, 2014). Information can include key region-wide progress of DSRIP, cross region collaboration and project-specific highlights. The annual report also will summarize information for each RHP regarding metrics reporting and achievement in DY3 based on the information available prior to annual report submission.

For the narrative portions of the report below, HHSC indicates specific information that should be included, but otherwise each RHP Anchoring Entity may report as appropriate for its RHP. The RHP annual report is a key opportunity to "tell the story" of the RHP's successes, challenges and lessons learned for the year, which HHSC believes will be important information as the State works with CMS for waiver renewal beyond the initial five-year waiver term.

The narrative portions should address RHP governance issues (how the RHP is working together and has continued to develop over time), learning collaborative activities, and also may include individual provider/project progress/lessons/challenges, particularly if there are themes across multiple providers or projects in an RHP.

Each anchor should submit its annual report on the DY3 RHP Annual Report Form by December 15, 2014 to HHSC (TXHealthcareTransformation@hhsc.state.tx.us).

Anchor Information

RHP Number	10
Anchor's Name:	Wayne Young and Shelly Corporon
Anchor's Phone Number:	817-702-3639 & 817-702-6294

1. **For information provided in the interim reports previously submitted in the DY, including data on the progress made for all metrics**

	# of Cat 1-2 Projects, Cat 3 outcomes and Cat 4 hospitals eligible to report in DY 3	**Total # of Metrics (Cat 1 & 2), Milestones (Cat 3), and Reporting Domains (Cat 4)**	**Total # (Cat 1-4) Reported as Achieved**	**Total # (Cat 1-4) Approved**	**Payment Amount Approved**
April Reporting Period	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Cat 1 & 2	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Cat 3	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Cat 4	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
October Reporting Period	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Cat 1 & 2	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Cat 3	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Cat 4	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Totals	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

HHSC will provide information to fill in the above table.

2. Narrative Description of Progress Made

This section should at a minimum include the following:

--Summary information on Regional DSRIP implementation of the RHP plan, progress on meeting community needs included in the RHP plan community needs assessment, changes in DSRIP performing providers and other key stakeholders, etc. Project specific highlights may also be included.

--Major activities conducted by the RHP during DY3 including updates to the RHP's website and opportunities for public comment (PFM Protocol paragraph 16) for 3-year projects, any RHP-wide learning collaborative events and participation in the Statewide learning collaborative. Please include updates to the RHP learning collaborative plan (can be provided as an attachment), including activities with other RHPs' learning collaboratives. Please also include any quality, health and cost measures that are part of learning collaborative activities.

--Any other progress updates from DY3 that the Anchor thinks are important to provide.

Summary Information on Regional DSRIP Implementation of the RHP plan
Regional Health Partnership (RHP) 10's implementation plan is focused on delivery reform in the following key areas as evident in the community health needs assessment: • Connect providers across the Region for improved coordination and communication; • Empower individuals and families to manage and improve their health; • Provide a robust and comprehensive set of services improving the physical health, behavioral health and general well-being of Region 10 residents at an affordable cost; • Expand access to primary care and ambulatory care to serve more patients, particularly through medical homes offering ongoing routine care in a timely manner; and, • Expand access to behavioral health services. RHP10 represents nine counties in north Texas (Tarrant, Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, and Wise) and 29 providers across the care continuum. Inclusively, the region is responsible for the implementation of 102 approved four year projects and 24 approved three year projects. Common threads shared across projects in the region focus on behavioral healthcare, access to primary care, chronic care management and helping patients with complex needs navigate the healthcare system, access to specialty care, and health promotion and disease prevention. RHP 10 anticipates achievement of 86% of the total dollars available upon HHSC's approval of DY3 milestone submitted in the October reporting period. Compared to 88% of the dollars achieved in DY2, a 2% downward trend seems minimal factoring in the complexity of the changing environment in DY3. Despite changing scope mid-stream with new selections of Category 3 outcomes, plan modifications, technical changes and the inclusion quantifiable patient impact targets, the region performed exceedingly well! In fact, several participating providers including MHMR Tarrant County, Wise Clinical Care Associates, Columbia HCA North Hills Hospital, Methodist Mansfield Medical Center, Texas Health Harris Methodist Hospital Cleburne, UTSW Moncrief Cancer Institute, and Ennis Regional Medical Center, in spite of moving targets and stringent deadlines, were able to submit 100% of their milestones for HHSC approval this demonstration year. An incredible achievement!

In addition, many providers exceeded the ninety percentile in potential dollars achieved, Texas Health Arlington Memorial Hospital 99%, and Huguley Memorial Medical Center 99%, Baylor Medical Center at Southwest Fort Worth 98%, Lakes Regional 97%, Test Health Harris Methodist Hospital Stephenville 97%, Texas Health Harris Methodist Hospital Hurst-Euless-Bedford 95% and JPS Health Network at 90%.

75% of Region 10's 29 performing providers upon HHSC approval will achieve greater than 80% of the total DSRIP dollars available to our region. The region's achievement, on average, in DY3 was 83%.

In summary, it is evident that he region is making great progress on their implementation plans as the majority of the regional provider's metric submissions to HHSC exceeded more than 83% for approval. This is a significant achievement as we move from the planning phases of project implementation into the more challenging phase of execution and achieving outcome improvement targets. The success is dependent on building internal and external relationships, breaking down silos, removing barriers, mitigating risks, architecting new processes that close the gaps and transforms the healthcare delivery system.

RHP 10 is a high performing team continuously seeking opportunities to share knowledge and best practices across projects, engage and leverage community stakeholders, as well as continues to provide leadership that enables project teams to be nimble in response to changing requirements during project execution. Meeting the region's vision and goals for delivery system transformation will require transparency, collaboration and accountability at all levels in order to meet DY4 improvement targets, quantifiable patient impact targets, and category 3 improvement outcomes.

Progress on Meeting Community Needs Included in the RHP Plan Community Needs Assessment

The community needs of RHP 10 surfaced 22 unique findings which culminated in addressing four critical areas: (1) access to primary and specialty care, particularly in underserved areas of the Region and for low-income residents; (2) access to behavioral health resources and integration of behavioral and physical health care services; (3) improved primary care management and self-management of chronic care conditions; and (4) better overall coordination and service integration across the Region's providers.

All project's category 1, 2 and 3 milestone and metrics are aligned to the meet the community needs in the RHP 10 Plan. The performance rates of metric submissions described above is a telling story that the projects are performing well in addressing community needs, as well as the project highlights and patient impact stories outlined below.

During demonstration year 3, RHP 10 selected 224 category 3 outcome measures focused on the community needs of the region, obtained CMS approval, and submitted baseline measures. Progress on meeting community needs relative to category 3 measures is too early to assess as baseline measures were established during DY3 and improvement activities are currently underway. Achieving outcomes of improvement efforts are targeted for demonstration year 4 and 5.

DY3 metrics submitted for approval in October is indicative of progress in many areas such as enhanced behavioral health discharge management, integration of behavioral health and primary care services, access to virtual psychiatric services, meeting patient needs where they are through mobile care services, improving access to behavioral health, specialty care and primary care through

the opening of new clinics and expanding hours, as well as enhanced care transitions through patient navigation and referrals to new programs, education and training relative to chronic disease management especially in the areas of diabetes care.

Additional project specific highlights are included below.

Changes in DSRIP Performing Providers & Other Key Stakeholders

As a testament to the value of participating in the 1115 Waiver, we gained two additional participating providers in the RHP 10 Health Partnership, Texas Health Harris Methodist Alliance and UT Southwestern Moncrief Cancer Institute, as well as 24 additional 3 year DSRIP projects.

Project Specific Highlights

The Anchor distributed a survey to the performing providers in RHP 10 to solicit feedback on project specific highlights. The full survey and responses along with patient impact stories is attached in the appendices, however, a few of the key highlights are categorized into the top community needs are reflected below:

<u>Behavioral Healthcare</u> (Addresses CN.4 Lack of access to mental health services, CN.5 Insufficient integration of mental health care in primary care medical care system):

- **Helen Farabee Centers**

Initiated expanded substance abuse services via waiver projects in four RHPs. Increasing coverage from 2 counties to all 19 counties in the service area. Successfully implemented open access for psychiatric evaluations rather than relying on scheduled appointments. This increased evaluation capacity from 657 evaluations in 2012 to 1472 in 2013-14. The IDD Crisis Respite unit (Haven House) was launched and served 21 individuals (some with multiple admissions) to divert from state hospitalization.

- **MHMR Of Tarrant County**

EXPAND BEHAVIORAL HEALTH (081599501.1.1) – In DY3, MHMRTC's new behavioral health services site, Western Hills Clinic, expanded to include additional space designed for optimal clinic layout design and patient flow. Opening of the new behavioral health clinic site and expanding hours at an existing site resulted in increased service capacity and access to psychiatric care for 408 individuals in Tarrant County. For individuals needing behavioral health care, this expansion has allowed for more timely access to care by decreasing wait time for services from up to 6 months to 2 weeks or less.

CRISIS STABILIZATION (081599501.1.2) – In DY3, Program staff implemented the Systematic, Therapeutic, Assessment, Respite Treatment (START) model and delivered crisis avoidance and stabilization services to 70 unique individuals in the Tarrant County area. Program procured and is finalizing renovations of a short-term therapeutic respite home set to begin providing services in early DY4. With the provision of the program's new services, individual access to appropriate treatment settings unique to the IDD population is improved.

RN CARE MANAGEMENT (081599501.2.3) – In DY3, the RN Care Management project implemented several system changes to provide effective team care; planned interactions; patient self-management support; access to community resources; integrated decision support for 134 unique individuals. Program individuals with co-occurring Intellectual developmental disability and other chronic diseases, were identified and entered into the newly developed Chronic Disease Registry

(CDR). Clinical team developed best practice procedures /nursing assessments and provided care coordination services using the Wagner Chronic Care model.

INTEGRATED HEALTH CARE (081599501.2.2) – In DY3, MHMRTC and JPS Health Network partnered to establish a level 4 integration of behavioral health and primary care services at the MHMRTC Homeless Services Clinic (HSC). Level 4 integration includes close collaboration onsite with some system integration. Co-location of providers has allowed for the development of a medical home for the target population with enhanced and increased access to primary care and behavioral health services. The success of the work done to this point heavily relies on communication, collaboration and coordination among the MHMRTC and JPS integrated team staff.

DETOXIFICATION UNIT AND SERVICE EXPANSION (081599501.2.1) – In DY3, the program successfully expanded MHMRTC's Bill Gregory Detoxification unit from 12 to 20 beds, serving 642 unique individuals in Tarrant County with enhanced addiction services. New services provided to individuals served include: 1) the provision of physical health services in a behavioral health setting; 2) Implementing post-discharge interventions by integrating peer support services to offer practical coaching and support in order to maintain sobriety and ensure continuity of care; and 3) Connecting program individuals to more intensive community services as needed by utilizing benefit specialist services in the program. As a result of the expansion, the initiative has implemented an emergency room diversion agreement with the local county hospital's psychiatric emergency center (John Peter Smith Hospital) to transfer and transport individuals in need of detoxification services to our MMHMRTC detoxification unit for appropriate substance use disorder services.

SUBSTANCE USE DISORDER (SUD) OUTPATIENT INTEGRATION (081599501.2.4) – In DY3, the SUD Outpatient Integration program was successfully integrated at 6 existing MHMRTC clinics and served 320 unique individuals within the Tarrant County area. Using the Integrated Dual Diagnosis Treatment model, both internal and external providers were cross-trained with mental health (MH) and Substance Use Disorder (SUD) practices providing seamless service and co-currently addressing an individual's identified MH and SUD conditions. New interventions include: Primary 1) a multidisciplinary team approach, 2) stage-wise interventions, 3) access to comprehensive services, 4) peer support services, 5) substance abuse counseling, group treatment, family psycho-education and 6) participation in alcohol/drug self-help groups. Additionally, the program successfully launched a functional registry to record and monitor individual progress and outcomes.

CHILDREN'S TRAUMA CARE (081599501.2.100) – In DY3, the Children's Trauma Care Initiative staff coordinated a community-wide training in the Attachment, Self-Regulation and Competency (ARC) trauma-informed treatment model. Project staff and over 150 community members from local schools, child services agencies and mental health organizations attended the two-day training on treating complex childhood trauma which was presented by experts from The Trauma Center at Justice Research Institute. In addition, project staff, with input from consultants from The Trauma Center, developed a project plan to prepare for implementation of services that will provide evidence-based and culturally competent trauma-informed care for children and adolescents in Tarrant County.

<u>Access to Primary & Specialty Care:</u> (Addresses CN.3 Shortage of specialty care, CN.10 Overuse of emergency department (ED) services, CN:6 Lack of access to dental care)

- **Texas Health Cleburne Hospital (THC)**

- Many patients who have been utilizing the ED for their primary care, are now able to be seen in the Johnson County HOPE clinic as a result of hiring 2 full time mid-level providers, open a transitional care clinic, and develop relationships with the community providers.

- **UNTHSC**

138980111.1.2 Community-Based Primary Care for the Elderly- the establishment of two community clinics in underserved areas, partnerships with 5 community sites (4 in Tarrant County and 1 in Parker County) to establish mobile clinics, and hosting numerous outreach activities, such as health education events and free flu shot clinics.

138980111.1.7 Expansion of PLAZA/UNTHSC/TCOM Family Medicine Residency Program- hiring of two additional faculty preceptors, successful matching of two additional family medicine residents, and implementing the quality assessment and improvement curriculum for the residents.

138980111.2.5 Discharge Planning for Medicaid-eligible Elders- The establishment of four new hospital partners in RHP 10, bringing the total to seven hospital partners overall and the reconnection of patients with their primary care physicians (PCP) or finding a PCP for 100% of all patients enrolled in this project.

- **Cook Children's Health Care System (Addresses CN:6 Lack of access to dental care)**

In the first month of operations in the dental clinic there were 171 separate encounters, out of which there were 7 (4.09%) extractions, 11 (6.43%) fillings, 20 (11.70%) sealants applied, and 4 (2.34%) crowns applied. During DY 3 the Urgent Care Center provided 28,117 encounters, 26,589 of which were patients between birth and 14 years of age. Out of the 26,589 encounters of patients between birth and 14 years of age, 22,161 (83.35%) of them were covered by Medicaid, CHIP, STAR or were self-pay patients. In the first month of operations for the neighborhood clinic there were 1,852 encounters (856 distinct patients). The goal is to see 8,000 patients within the first year of operations, and should be accomplished based on the volume of patients that have been seen in the new Neighborhood Clinic since September 30, 2014.

<u>Chronic Care Management & Patient Navigation</u>: (Addresses CN.11 Need for more care coordination, CN.13 Necessity of patient education programs, CN.15 Need for more education, resources and promotion of healthy lifestyles, CN19 need for more and earlier onset of prenatal care)

- **Methodist Health System (Mansfield)**

42 year old female patient with a history of chronic pain was seen in the ED 25 times in the 8 months prior to intervention by our DSRIP patient navigator. Due to the patient's extremely high ED utilization, the patient was enrolled in the Methodist Mansfield ED navigation program. After meeting with the Mansfield ED navigator, the navigator contacted the patient's primary care provider and facilitated a referral to a pain management specialist. The patient has not had any additional ED visits since her PCP and specialist appointments in August.

- **JPS Health Network**

All of the women who receive prenatal care at JPS are offered either Centering Pregnancy or the Maternity Medical Home which includes Healthcare Coaching and/or navigation of resources internally and externally to JPS.

A patient had been non-compliant with care and taking her medication. Through Centering Pregnancy, she formed relationships that kept her coming back so she was compliant with care and her medication. She stopped doing drugs and drinking and had a healthy baby.

<u>Health Promotion & Disease Prevention:</u> (Addresses CN.11 Need for more care coordination, CN.13 Necessity of patient education programs, CN.15 Need for more education, resources and promotion of healthy lifestyles, CN19 need for more and earlier onset of prenatal care)

- **Texas Health Harris Methodist Hospital Fort Worth - Mobile Health**

Established mobile health services in rural communities reaching people that have not had preventive health.

Established the role of the Patient Nurse Navigator to ensure timely follow-up of patients that had an abnormal screening for breast, cervical or colon. Established a network of organizations for follow-up care and referral to a more permanent medical home (local clinics and Federally Qualified Health Centers).

- **JPS Health Network**

Implemented outpatient lactation services across 8 clinics. Provided education and support to breastfeeding moms to extend breastfeeding duration among mothers and babies. JPS has been able to help mothers' breastfeed babies with congestive heart failure, babies born with jaundice, babies with significant weight loss, and babies with failure to thrive.

<u>Patient Impact Stories:</u>

- **Baylor All Saints Behavioral Health Project 135036506.2.1**

I am the Licensed Clinical Social Worker at Baylor Community Care at Fort Worth. Since the Behavioral Health program launched, I have screened over 140 patients for depression or anxiety. 24 patients of those patients have enrolled in the Behavioral Health program, but more important for this clinic is the number of high acuity patients that disclose their suicidal ideation to me during the assessment process, and the crisis intervention that is able to take place.
I would like to share one such success story with you, and how this program can give you a glimpse of how the social worker is able to assess, educate and provide key intervention and resources that can help improve and even save these patients' lives at such a critical time. This patient is a XX year old X X who lives in the Region 10 area, and has two young grade-school children; [their] medical issues include headache and gastro esophageal reflux. When I initially assessed [them] in mid-November, 20XX, [their] PHQ score was 21 and [they] were having suicidal thoughts in the previous two weeks. Not only did I provide educational resources to [the patient] about depression, but most importantly, I did crisis intervention with [them] and provided all the vital crisis emergency resources needed in the event [they] had any more suicidal thoughts, and I established a safety plan.
[The patient] started counseling in the Behavioral Health program, and received counseling services every two weeks in the program, where [they] discussed [their] goals and activities; and in between counseling sessions [they] worked on and accomplished those goals and activities. This patient also discussed the option of starting a low dose anti-depressant medication, with [their] physician, and the patient decided to pursue this option for a period of four months. On 12/XX/1X, six weeks after starting the Behavioral Health program, patient's PHQ score had

decreased from a 21 to a 6. [They] continued counseling, because [they] felt it really helped [them] to work on [their] goals and activities, and it has helped improve [their] self-esteem, emotional well-being, and physical well-being. [The patient] feels better overall, and has now weaned off the anti-depressant medication (after discussing this with [their] physician). At [their] last counseling appointment, the patient's PHQ score was a 3 on 2/XX/1X, and is now in the maintenance phase of counseling, where [they] does not need to come in for counseling as often and can contact me when [they] feel the "warning signs" of anxiety or depression coming on. Thank you for giving us the opportunity to help improve these patients' lives!

Major activities conducted by the RHP during DY3

RHP10 website updates and opportunities for public comment (PFM Protocol paragraph 16) for 3-year projects

The RHP 10 website address is www.rhp10txwaiver.com and is continuously updated with information to insure transparency with performing providers as well as serves as central repository for important deadlines, regional and statewide events, and a knowledge store of documentation, announcements, and success stories.

During DY3 the website has been updated to include new website pages:

Anchor Report
Document Library
Anchor Call Notes
Information & Resources

The Anchor office will continue to enhance, optimize and continually improve the website throughout the term of the 1115 Waiver to serve and meet the needs of the region and all those seeking to learn more information about the interworking of the Region 10 Health Partnership.

In compliance with Texas State Rule 1 Texas Administrative Code §354.1635 for the addition of new 3-year DSRIP projects to an RHP Plan, the Anchor (JPS Health Network) proposed a 3-step process to evaluate, score and prioritize additional 3-year projects.

A public hearing was hosted by the Anchor of RHP 10 on October 29, prior to the submission of the prioritized project list to HHSC. In this hearing the process to engage stakeholders and solicit projects was reviewed, along with the process used to create the prioritized list of projects.

During the public hearing an overview of new 3-year projects submitted to the Region was reviewed as well as the results of the evaluation process and the prioritized list of projects.

An opportunity to provide feedback on project scores, the evaluation process, and the prioritized list of projects was given during the public hearing.

Information related to the public hearing for 3-year projects is posted on the RHP 10 website.

RHP-wide learning collaborative events and participation in the Statewide learning collaborative.

RHP 10 hosted two region wide face-to-face learning collaboratives in DY 3. The first learning collaborative was held on January 29th and 30th, 2014. This two day event was split by learning

collaborative tracks, care transitions and behavioral health. The first day was focused on care transitions and the second on behavioral health. During both of these sessions, an opportunity for providers to represent their projects with storyboard was provided enabling participants to share information about their projects, best practices, and any lessons they had learned. The region was also provided with information on PDSA's and motivational interviewing. The plan to collect region wide data was presented to all collaborative participants during this time as well.

The second region wide learning collaborative session took place on September 25th, 2014. This face-to face meeting was combined into one day with separate break out session for the different groups. There was a review of the data that had been collected region wide. A time for provider spotlight on certain projects and a poster session to share projects lessons learned. In the afternoon the two groups came together to listen to a panel of both behavioral health and care transitions experts. The groups then received updates from other regions and updates on RHP 10. In addition to the two face-to-face session RHP 10 held monthly webinars for each group. These webinars had focused topics that allow regional providers to share their projects and progress. At the end of each webinar the monthly data collected from the Region was shared with the providers. Region 10 Providers are engaged regularly in the learning collaborative activities and in providing data.

In addition, to two face to face Learning Collaboratives, a series of topics were presented either by webinar or site visit by the Behavioral Health and Care Transitions Learning Collaborative Leaders, January 2014 through September 2014:

Behavioral Health Topics:

- The Case for Integrated Behavioral Health and Primary Care (JPS)
- Motivational Interviewing (S. Walters, Ph.D.)
- Defining and Measuring Integration (Dr. Miller)
- Operationalizing Integration (Dr. Miller)
- Role of Integrated Care – Making a Collective Impact (Dr. Miller)
- Site Visit – Integrating BH and PC – JPS Experience (JPS)
- Risk Stratification (JPS)
- Site Visit – Behavioral Health and Primary Care (MHMR)

Care Transition and Navigation Topics:

- Using The Patient's Voice To Guide Our Work (Panel Patients & JPS)
- Motivational Interviewing (S. Walters, Ph.D.)
- Community Based Primary Care For the Elderly (UNTHSC)
- Self Determination in Healthcare Services (MHMR-IDD)
- Healthy Lifestyles Program (THR)
- Primary Care Connection (Baylor)
- Closing the Gap-Personalized Care Transitions(JPS)
- Evolution of Population Management At JPS (JPS)
- Risk Stratification (JPS)
- The Discharge Alternative – A "STEP" in The Right Direction (UNTHSC)

RHP 10 was proud to have several of their providers take part in the Statewide Learning Collaborative. In the Highlights of DSRIP Projects panel Sid O' Bryant, PhD from University of North Texas Health Science Center shared information on their primary care for the elderly project. Paul Aslin the COO of Wise Clinical Care Associates, Wise Regional health System served on the panel for Integrated

Delivery of Care. Region 10 was also proud to have MHMR of Tarrant County present their project on RN Care Management during the poster session. A majority of Region 10 sent at least one representative to attend the Statewide Learning Collaborative. This event was particularly helpful to many of our providers. It allowed the opportunity for providers to understand upcoming happenings with HHSC. The Statewide Learning Collaborative also allowed providers to interact with other providers across the state.

Updates to the RHP Learning Collaborative Plan

No modifications to the current RHP Learning Collaborative Plan were submitted in DY3, however, many opportunities for improvement and lessons learned are reflected in the lessons learned section.

Activities with other RHPs' Learning Collaboratives

Recognizing the importance of sharing knowledge and learning best practices, the Anchor representatives across the state of Texas have begun to build a cohesive team to improve the structure and delivery of the face-to-face Learning Collaboratives. To foster statewide collaboration and build relationships, on November 21, 2013, the RHP 10 anchor office hosted the Inter-Anchor Group Meeting in Fort Worth.

In addition, the RHP10 Anchor Office attended the RHP 9 learning collaborative and speaker series and multiple RHP 18 Learning Collaboratives, as well as, traveled to Learning Collaboratives in regions 3, 12, 2 and 7. Each of these events is a learning opportunity to bring back information to Region 10 and provide visibility to the transformational changes underway across the state.

Summary Event Dates:
November 21, 2013- Inter-Anchor Group Meeting (Fort Worth)
December 4, 2013- RHP 3 Learning Collaborative (Houston)
January 14, 2014- RHP 9 Learning Collaborative (Dallas)
April 16, 2014- RHP 12 Learning Collaborative (Lubbock)
May 16, 2014- RHP 18 Learning Collaborative (Plano)
May 21-22, 2014- RHP 6 Learning Collaborative (San Antonio)
June 5, 2014- RHP 3 Learning Collaborative (Houston)
July 11, 2014- RHP 2 Category3 BH Learning Collaborative (Galveston)
August 27, 2014- RHP 18 Learning Collaborative (Plano)
September 9-11, 2014 Statewide Learning Collaborative & Inter-Anchor Meeting (Austin)
September 16, 2014- RHP 7 Learning Collaborative

Quality, health and cost measures that are part of learning collaborative activities

Both tracks of the learning collaborative have defined measures to support telling the story of improvements as a result of the collaborative work across the region relative to care transitions and behavioral health:

Care Transition – Outpatient

Measure 1: **Percentage of individuals who are provided health education materials related to health condition.**

Measure 2: **Percentage of individuals who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.**

Care Transition

Collaborative (2 of 5 Teams): Percentage discharged patients who received written discharge summary

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	99.2%	99.1%	95.1%	92.7%	94.8%	94.0%	93.3%	94.1%				
Median	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	
Goal												
Numerator:	1722	6461	6333	6706	6681	5153	8887	8841				
Denominator:	1736	6520	6660	7236	7049	5482	9525	9400				

Care Transition

Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	6.6%	10.6%	37.8%	49.0%	35.3%	27.5%	49.8%	63.4%				
Median	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%
Goal												
Numerator:	26	52	182	251	135	110	207	298				
Denominator:	391	492	482	513	382	400	416	470				

Care Transition

Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	6.6%	10.6%	37.8%	49.0%	35.5%	27.5%	49.8%	63.4%				
Median	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%
Goal												
Numerator:	26	52	182	251	135	110	207	298				
Denominator:	391	492	482	513	382	400	416	470				

Care Transition

Collaborative (3 of 5 Teams): Percentage discharged patients with community provider contact within 7 days

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	8.4%	3.1%	3.1%	3.7%	3.6%	16.3%	4.6%	5.0%				
Median	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Goal												
Numerator:	150	218	206	268	258	898	443	474				
Denominator:	1778	7011	6694	7257	7074	5514	9595	9468				

Care Transition - Outpatient

Collaborative (3 Teams): Percentage who are provided health education materials related to health condition.

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Value	14%	10%	32%	36%	54%	96%	99%	97%				
Median	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%
Goal												
Numerator	7	4	19	25	29	71	75	62				
Denominator	50	42	59	64	54	74	76	64				

Care Transition - Outpatient

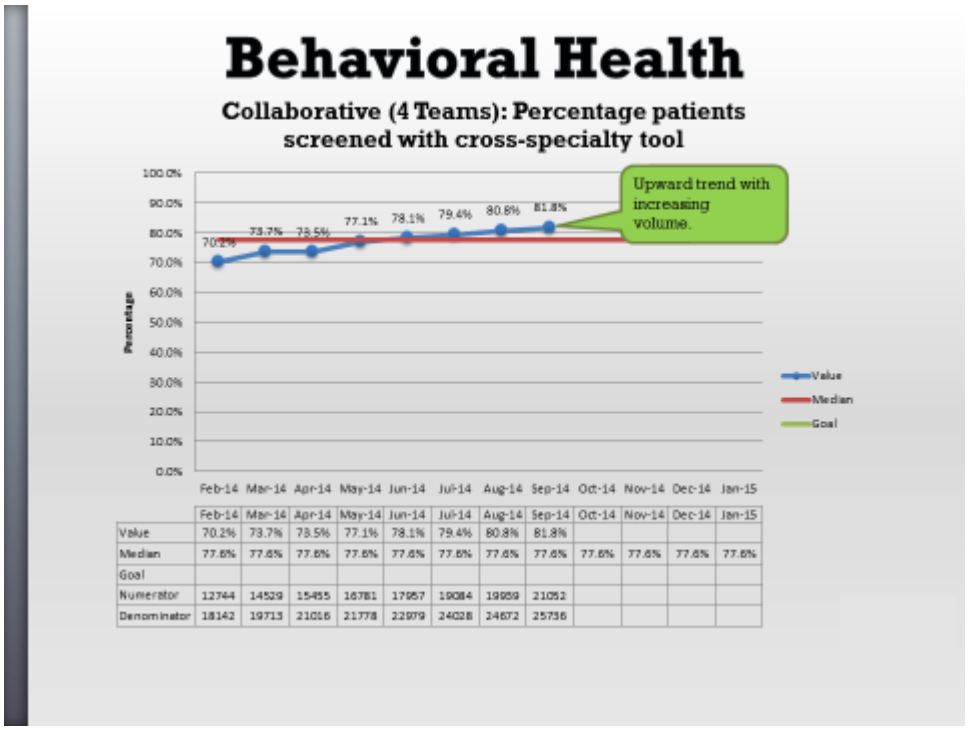
Collaborative (3 Teams): Percentage who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Value	20%	50%	88%	79%	76%	68%	65%	61%				
Median	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	
Goal												
Numerator	1	2	7	11	28	25	34	57				
Denominator	5	4	8	14	37	34	85	94				

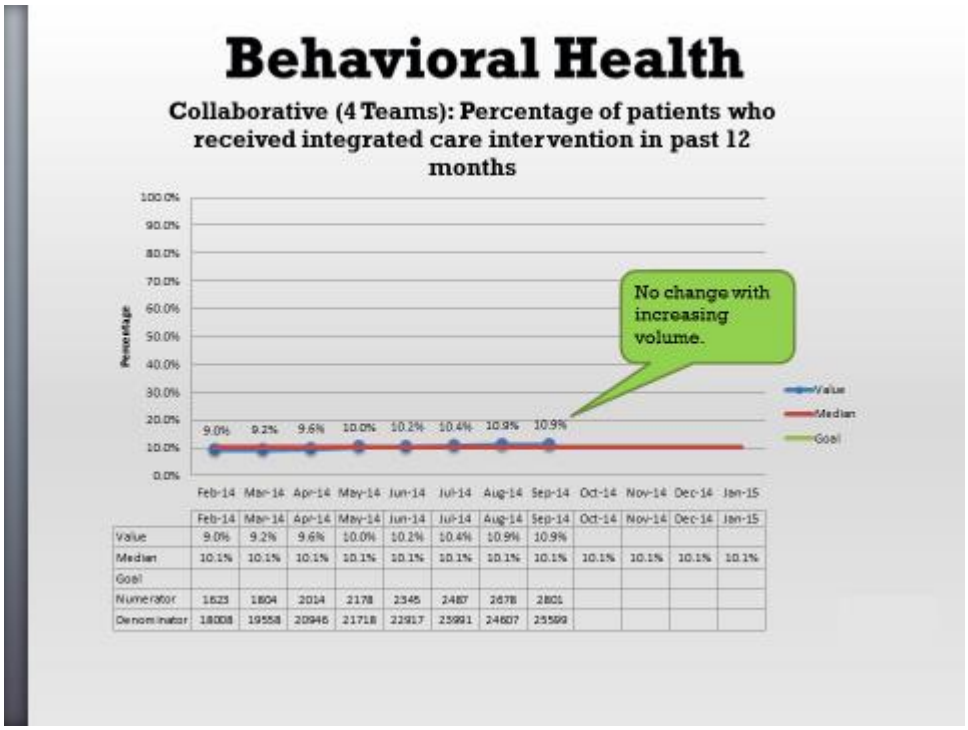
Behavioral Health Measures

Measure 1: **Percentage of patients who received integrated care intervention in past 12 months**

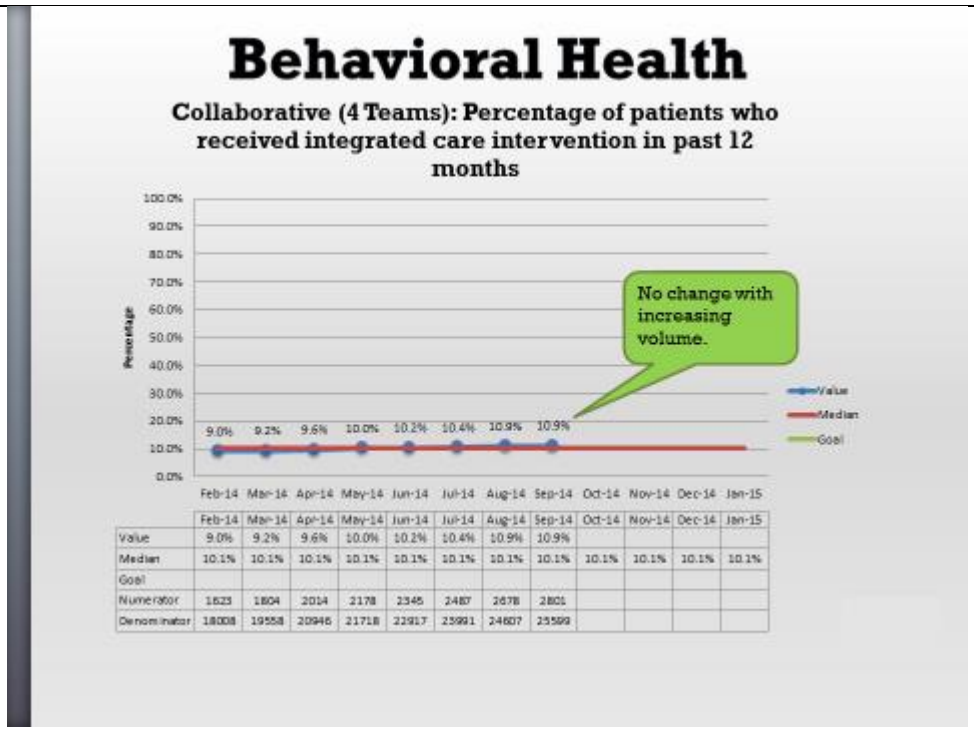
Measure 2: **Percentage of patients whose condition improved with intervention**



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	70.2%	73.7%	73.5%	77.1%	78.1%	79.4%	80.8%	81.8%				
Median	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%
Goal												
Numerator	12744	14529	15455	16781	17957	19084	19959	21052				
Denominator	18142	19713	21016	21778	22979	24028	24672	25736				



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	9.0%	9.2%	9.6%	10.0%	10.2%	10.4%	10.9%	10.9%				
Median	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%
Goal												
Numerator	1623	1804	2014	2178	2345	2487	2678	2801				
Denominator	18008	19558	20946	21718	22917	23991	24607	25599				



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	9.0%	9.2%	9.6%	10.0%	10.2%	10.4%	10.9%	10.9%				
Median	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%
Goal												
Numerator	1623	1804	2014	2178	2345	2487	2678	2801				
Denominator	18008	19558	20946	21718	22917	23991	24607	25599				

A summary recognizing region-wide DY3 wins is outlined below:

Care Transition – Inpatient

- Discharged patients whose follow-up provider received summary within 7 days continue to do well; *going from 27.5% (June) up to 63.4%* in the last 2 months (August and September) as volumes increase during this time frame.

Behavioral Health

- Gradual positive trend for patients screened with cross-specialty tool; going from *70.2% in January to 81.8% for September (11.6% improvement)* as volumes increase (18,142 to 25,736 patients).

3. Narrative Description of Lessons Learned

This may include lessons learned both from regional governance perspective and also from learning collaborative/continuous quality improvement activities. Information can also be provided on administrative activities, including reporting.

Lessons Learned Regional Governance Perspective
Effective communication planning is a continuous theme in terms of lessons learned from a regional governance perspective as well as at all layers of operating within the constructs of the 1115 Waiver. The Anchor Office has learned that our participating providers are often overwhelmed with complex information, multiple deadlines, changing requirements, and version control of documentation. A critical component of effective communication planning moving forward is to take a proactive approach in understanding the flow and timing of information. It is important that we target communications to the appropriate audience at a frequency that is digestible and actionable. It is our goal to synthesize and organize information in such a way that communicates a clear and concise message to the appropriate audience that is timely and meaningful. We also need to consider the most optimal means to communicate delineating when it is appropriate to use phone, website, email, face to face, webinars or events. Preparing for the loss of key subject matter experts is certainly a valuable lesson learned given the complexity of the 1115 Waiver in terms of the time it takes to become productive understanding context, background and DSRIP vernacular. A number of providers expressed the importance of the discipline in documenting processes. DSRIP has a vernacular all its own, therefore, documenting terms, acronyms and establishing an on-boarding process is extremely important to accelerate the learning curve for new participants on DSRIP project teams as well as other key roles. It is essential to onboard staff succinctly to insure productivity in a condensed time frame to meet non-negotiable deadlines. One provider indicated a lesson learned “Flexibility is key to the success of the projects. It is important to plan early and allow ample time to complete milestones and reporting. Preliminary contingency planning is an important part of dealing with ongoing rule changes in a way that allows the projects to adjust and successfully meet milestones.” Another provider shared a valuable lesson learned in the importance of stakeholder engagement stating that “We learned to speak "DSRIP" which is a language all its own and understand how essential it is to attend all webinars and conference calls due to the fluidity of the requirements.”
Lessons Learned Learning Collaborative/Continuous Quality Improvement Activities
The current RHP 10 Learning Collaborative Plan focuses on the following two work streams based on the priority of the community needs in our region: 1. Access to and Capacity for Behavioral Health Care, including Integration with Primary Care; and 2. Care Transitions and Patient Navigation. The primary focus encompasses the following principles and methodologies: • Sharing knowledge, experience, and expertise in content areas and in improvement methods; • Using data-driven analyses to drive performance improvement; • Testing (using Plan-Do-Study-Act (PDSA) cycles) and implementing evidence-based changes in care; and • Improving patient and provider experience.

The two formal learning collaboratives have proven to be an invaluable resource to bring the region together, however we have learned from our providers in the region that focusing solely on these two work streams limit the opportunities for other project leaders with DSRIP projects not focused on Behavioral Health and Care Transitions to collaborate and share learning.

The RHP 10 Anchor office recognized the need to provide additional conduits for regional providers to collaborate and share best practices and is defining a process to enable smaller cohorts to form organically by connecting resources through relationships that have been formed through the Anchor Office.

Lessons Learned Administrative Activities/Reporting

One provider said it best “Flexibility” and “Contingency Planning” is the key to success. The RHP 10 Anchor office has learned the importance of taking a proactive approach in the absence of clarity in order to successfully report milestones and meet the deadlines. For example, with the changes in category 3 selections, plan modifications and technical changes, awaiting final approval before beginning the work was not an option. The work had to be performed in parallel knowing that CMS approval or disapproval would come at a later time. This required flexibility and the ability to adjust course on a moment’s notice. The lesson learned is to invest the time to proactively plan alternative approaches and continuously strive to create standardization in workflow, communications, and gain an in-depth understanding and comprehension of all instructions and guidelines provided by HHSC. Another provider concurred with the common theme amongst providers, “Be flexible. Work out some "what-if" plans ahead of time.”

Transitioning to a new reporting tool introduced another layer of complexity and challenge to overcome during the reporting period. Providers were comfortable using the excel workbooks in previous reporting periods and navigating a new application with a different look and feel slowed down the reporting process slightly. However, the advantages of having a centralized repository has great advantages and over-shadowed any initial concerns. Providers adapted well in a short period of time.

4. Narrative Description of Challenges Faced

This may include challenges both at the RHP governance level and also at the individual provider/project level, particularly if there are themes across multiple providers or projects in an RHP. Information can also be included on discontinued projects, and reasons providers did not continue with a project.

Challenges RHP Governance Level

RHP10 is a very large region encompassing 29 providers and 126 projects. A Clinical Quality Steering Committee, including representatives from all performing providers in the region was established. This forum provides an opportunity for all providers to participate in the decision making process as it relates to the direction and content of the learning collaborative and shared learning across the region.

The Anchor is responsible for organizing, managing and communicating large amounts of data which presents many challenges in terms of identifying the best tools for capturing and communicating "the story" of transformational change across the region. Additionally, in some cases all communication flows through the Anchor and at other times providers communicate directly with HHSC resulting in gaps of understanding or visibility that the Anchor must overcome through other means of communication.

Maintaining achievable deadlines was a challenge while learning the new online reporting tool, as well as getting a head of the learning curve as the Anchors were learning at the same time as the providers. It required staff to become "super users" at an accelerated pace in order to support the region in order to bring them up to speed on the functionality of the tool. Process changes mid-stream was a huge challenge to communicate effectively to all providers.

Challenges at the Individual Provider/Project Level (Themes across multiple providers/projects)

The themes of challenges emerging across the region fall into many broad categories:

Communication/Complexity of Information/ Timeliness of Information/Stringent Deadlines

Some providers indicated that the constant barrage of information makes it a challenge to digest and ascertain its applicability and respond adequately to stringent deadlines.

Interpreting the DSRIP Narrative, milestones, metrics and goals of each project can be a challenge for project leaders as they are often not the original author. Communicating the goals to project teams with clarity to execute the project tasks effectively poses challenges as well.

Any delay in feedback, responses to questions, or required decisions at any point in project execution can be detrimental to timely implementation of DSRIP deliverables.

Visibility/Awareness

Many providers have challenges gaining an adequate number of referrals into their DSRIP programs. One provider indicated that "This would have benefited from more focused marketing efforts to create awareness and generate more referrals. We assumed that creating the service would compel referrals since the services were sorely lacking -- we realized that not all entities in the community may know about what is now available."

Providers and individual project leaders have challenges with visibility or awareness to other projects internally or externally with similar outcomes and miss opportunities to work in collaboration with others to reduce the duplication of effort.

Resource Constraints

Staff turn-over presents many challenges as often times subject matter expertise around DSRIP and historical knowledge goes with them. On-boarding new staff is a challenge from a learning curve perspective due to the complexity of the 1115 Waiver and all of the moving parts.

Many providers expressed challenges given the limited number of resources and competing priorities.

Although providers have approved budgets for additional staff and positions are posted, it has been a challenge to identify, recruit and on-board the talent needed to fully implement programs resulting in carrying forward metrics and delayed DSRIP payments.

Barriers

Access to and the interpretation of data continues to be a challenge across almost all providers. Transparency in sharing data and information from community partners and providers across the region is critical to the success in transformational change of the healthcare delivery system.

Reliance on external partners, or cross departmental dependencies prove to be challenging at times to meet DSRIP goals. It is common for providers to align DSRIP goals with their strategic plan, however, the timing of execution of the DSRIP project plan may conflict with the priorities of external partners, consultants, and other department's internal plan.

Lack of engagement or buy-in

"We need to be well integrated into the rural community before we can effectively deliver services in those communities in order to build trust. Consistency is vitally important. In general, the uninsured in rural areas do not seek preventive care presumably because services are not accessed until there is an acute need and limited preventive health resources are available. We need to use every opportunity to educate regarding the benefits of preventive health, even if it is one patient at a time."

Discontinued Project Information

Although, in May of 2013, two providers discontinued projects for legitimate reason, those dollars were not lost on RHP10. The dollars retracted as a result of the discontinued projects, enabled two new providers to write DSRIP projects and additional funding became available for new 3-year projects addressing the region's community needs.

Provider Helen Farabee Center withdrew a project titled "Virtual Psychiatric Consultation" as it was identified as a project duplicative of a project submitted by JPS Health Network and would have created redundant work for the region.

University of North Texas Health Science Center originally submitted 16 projects, but after extensive analysis of the return on investment, resources and capacity the provider discontinued the following projects:

Unique Number	Project Title	Reason for removal
138980111.1.1	Telemedicine for children recovering from severe burns	Due to the change in CMS approval to 2-year increments creating uncertainty about DY4-5 milestones, UNT Health Science Center is withdrawing this project.
138980111.1.3	Expand existing primary care capacity (Expanding geriatric primary care and consultative services to Medicaid-eligible elders)	Project was flagged by the state and confirmed by CMS with a lower value of "TBD**." Due to the change in CMS approval to 2-year increments creating uncertainty about DY4-5 milestones, UNT Health Science Center is withdrawing this project.
138980111.1.5	Community Health Worker Network	Due to the change in CMS approval to 2-year increments creating uncertainty about DY4-5 milestones, UNT Health Science Center is withdrawing this project.
138980111.1.6	Community-based behavioral healthcare for depressed Medicaid elders and near elders	CMS did not approve this project.
138980111.2.1	Promoting physical and mental health among at-risk, underserved African-American pre-teen girls in Tarrant County	CMS did not approve this project.
138980111.2.2	Improving primary care clinical processes to reduce hospitalization risk	Due to the change in CMS approval to 2-year increments creating uncertainty about DY4-5 milestones, UNT Health Science Center is withdrawing this project.
138980111.2.3	Asthma 411	Due to the change in CMS approval to 2-year increments creating uncertainty about DY4-5 milestones, UNT Health Science Center is withdrawing this project.
138980111.2.4	Tarrant County preconception and perinatal health promotion initiative	Due to the change in CMS approval to 2-year increments creating uncertainty about DY4-5 milestones, UNT Health Science Center is withdrawing this project.

5. **For purposes of waiver renewal planning, please provide a high level description of the regional system of healthcare that was in place prior to the implementation of DSRIP, the evolution of the system with the implementation of DSRIP, and potential next steps for the evolution of the system in your RHP.**

Waiver Renewal Planning
Regional System of Healthcare Prior to DSRIP Implementation
Prior to DSRIP implementation, the region was a much more fragmented delivery system working in silos that lacked care coordination focused on the needs of the patient. Competing partners at all levels of the community were reluctant to communicate, share best practices, or provide a level of transparency that enabled collaboration nor improvements in the health outcomes of the patients in our population.
The Evolution of the System with the Implementation of DSRIP
The healthcare delivery system is evolving by leveraging the DSRIP projects as tool to engage community partners in collaboration to improve the health outcomes of the population. Having common goals and incentives creates a platform to share information and collaborate to improve performance. It is evident that the healthcare system culture is changing. DSRIP projects have enables teams to think outside of the box and implement innovative changes that are proving to be making a difference in the lives of the people in our communities.
Potential Next Steps for the Evolution of the System in RHP10
Currently projects across the state share common improvement targets or similar outcomes but are completely autonomous in execution. Future considerations might be to create projects that require participation from multiple providers or community partners with dedicated participants into one project team with shared goals and incentives.

6. **Narrative Description of Other Pertinent Findings.**

Other Pertinent Findings