Instructions and Form for RHP Annual Report due December 15, 2013

The Program Funding and Mechanics Protocol (paragraph 23) 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 DY2 RHP annual report is to summarize the progress of the RHP during DY2 (October 1, 2012 – September 30, 2013). While each RHP does not need to duplicate the information already submitted to HHSC and CMS in DY2 (e.g., the RHP Plan, learning collaborative plan, prioritized list for potential new three-year projects), it is appropriate to summarize key information from these documents in the annual report. The annual report also will summarize information for each RHP regarding metrics reporting and achievement in DY2 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 extension beyond the initial five-year waiver term.

The narrative portions should address RHP governance issues (how the RHP came together and is working together), 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 DY2 RHP Annual Report Form by December 15, 2013 to HHSC (TXHealthcareTransformation@hhsc.state.tx.us). HHSC will submit these reports to CMS and also will use them to help inform the statewide annual DSRIP report for DY2 that HHSC is required to submit to CMS by January 2014.

Anchor Information

RHP Number:	10
Anchor's Name:	David Salsberry & Mallory Johnson
Anchor's Phone Number:	817-920-1611 & 817-702-2204

1. **Data on the progress made for all metrics (summary of information previously submitted for the DY)**

	# of Providers Reporting Achievement	# of Providers with Payment Approved	Total # of Metrics (Cat 1 & 2) and Milestones (Cat 3) reported as achieved	Total # of Metrics (Cat 1 & 2) and Milestones (Cat 3) approved	Payment Amount Approved
August Reporting Period	16	16	159	146	$62,874,197
Cat 1 & 2	16	16	73	69	$55,383,125
Cat 3	15	8	78	70	$1,849,332
Cat 4	8	7	8	7	$5,641,740
October Reporting Period	To be completed by HHSC	To be completed by HHSC	To be completed by HHSC	To be completed by HHSC	To be completed by HHSC
Cat 1 & 2	To be completed by HHSC		To be completed by HHSC		
Cat 3	To be completed by HHSC		To be completed by HHSC		
Cat 4	To be completed by HHSC		To be completed by HHSC		
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.

To fill in the above table, the Anchor should reflect the summary information that HHSC provides for August and October reporting. For August, the anchor will have the results of the HHSC/CMS review. For October, the anchor will only have the information regarding what was reported, not what was approved.

Each Anchoring Entity will be able generate the information for the table above using the summary reports provided by HHSC. HHSC also will plan to make available by early December information in the

summary format above. An Anchor may either use the HHSC-provided summary information for the table above or may use the HHSC information to crosscheck the summary information the Anchor already has generated for the table.

The Anchor also may provide supporting narrative to support or give context to the information in the table.

Supporting Information Regarding Metrics/Milestone Achievement

Region 10 saw a great deal of achievement throughout DY2. Region 10 origionally submitted $218,316,696 for DY2 in the RHP Plan sent to CMS in March of 2013. After Phase 1 valuation reductions, RHP 10 had a total of $188,716,539 potentially reportable for DY2. After the first reporting period in August, $62,874,197 was reported and approved for payment across 16 unique providers. In the second reporting opportunity for the deomonstration year, 25 providers reported achievement of $107,268,450. The combined total for reporting between August and October for Region 10 was $170,142,647, or 90% of the potential funds to be achieved.

2. Narrative Description of Progress Made

This section should at a minimum include the following:

--Summary information on development of the RHP Plan, community needs assessment, description of DSRIP performing providers and other key stakeholders, etc.

--Major activities conducted by the RHP during DY2 including required public meetings prior to project submission (PFM Protocol, paragraph 10.d), the post-award implementation forum with stakeholders (PFM Protocol paragraph 16), and any RHP-wide learning collaborative events.

--Any other progress updates from DY2 that the Anchor thinks are important to provide.

Progress Update Summary for the RHP for DY2

As reflected in our RHP plan, Region 10's vision and goals for Delivery System Transformation Include transparency, collaboration, and accountability; our shared vision is a transformed Regional delivery system that actively collaborates across all nine counties to provide integrated and coordinated care. In developing the RHP plan during 2012, Region 10 conducted stakeholder surveys, assessed provider readiness, collected and analyzed relevant data about the Region, and engaged in exploratory dconversations with a wide range of Regional stakeholders to inform its decision-making activities. This information was synthesized into a community health needs assessment shared with all RHP participants and the public through open-access committee meetings, online postings, webinars, and County Visioning sessions. The CHNA reflects 22 unique community needs throughout Region 10 which were used as the foundation for selecting DSRIP projects by performing providers. The four most serious

community needs identified were: (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.

While developing the RHP 10 plan, the region felt it necessary to have a strong structural oversight and support system that represented DSRIP performing providers and other key stakeholders. This was achieved by creating five committees that met regularly throughout the development and approval of the RHP 10 plan. These committees were: 1) The RHP Steering Committee, made up of all the CEOs of performing providers and elected officials, which had final review and approval of key initiatives; 2) the RHP Elected Officials committee, consisting of elected County Judges or their designee, who maintained ongoing communication/engagement with counties and county stakeholders in Region 10; 3) RHP Finance Committee made up of finance leaders across performing providers, their role was to review of DSRIP projects, UC pool and IGT capacity, and lead the development of valuation methodology; 4) RHP Planning Committee consisting of planning officers of performing providers, who provided overall strategic planning and development of RHP plan, including stakeholder engagement; and 5) RHP Clinical Quality Committee, made up of Quality/Medical officers of performing providers, who led the development/review for quality metrics for DSRIP projects, as well as for learning collaboratives. The Clinical quality Committee has been charged with the role of being the official oversight of the Region 10 Learning Collaboratives, focused on Care Transitions and Behavioral Health. The fully revised Learning Collaborative Plan is found as Appendix A.

Region 10 is a diverse region consisting of nine counties (Tarrant, Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, and Wise) in north Texas. We have a variety of performing providers participating in DSRIP; there are a total of 27 organizations represented. The anchor is Tarrant County Hospital District, dba JPS Health Network, the tax-supported county hospital of Tarrant County. We have four mental health agencies represented (MHMR of Tarrant County, Lakes Regional MHMR, Helen Farabee MHMR, and Pecan Valley MHMR), two children's hospitals (Cook Children's of Fort Worth and Dallas Children's of Dallas), one academic health science center (UNT Health), one public health department (Tarrant County Public Health), two physician groups (JPS Physician Group and Wise Clinical Care Associates) and 16 other acute care hospitals of various sizes and types (Glen Rose, Methodist Mansfield, Baylor, 3 HCA facilities, 8 Texas Health Resource facilities, and Wise Regional). We believe the variety of performers represented in Region 10 will lead to strong improvement in the coordination of care across the continuum.

As noted in our shared vision and goals, transparency is important to the success of Region 10. The Planning Committee released the Region 10 RHP Pass 1 plan for public comment on November 2, 2012. The final RHP plan was posted online on December 6, 2012. Both plans were made publicly available on the Anchor's website and were shared via email with all of Region 10's county elected officials, other participating IGT entities and performing providers. Region 10 also conducted two open public meetings with webinars on November 7, 2012 and December 12, 2012 to provide the public with an opportunity to engage in a dialogue around the RHP plan. These webinars included an overview of the 1115 Waiver,

a description of the RHP development process and a presentation of projects with their associated outcomes. Public comments were accepted until December 14, 2012 and incorporated into the final plan.

After receiving the Initial Approval letter from CMS in April of 2013, the RHP held post-award forums with various stakeholders. The first was held on May 8, 2013 where a review of the contents of the letter was held and known next-steps were communicated regarding the upcoming four-phased revision process. This meeting was posted on-line on the Region 10 website so interested public stakeholders were aware. The meeting was largely attended by representatives of the performing providers in the Region. A second post-award forum was held on June 24, 2013 with a joint-meeting of the Region 10 Elected Officials and Steering Committee meeting. The content of each of these meetings was made available on the Region 10 website, including the official letter from CMS. As a follow up, a review of the contents of the second CMS Review letter (received on September 9, 2013) was provided during the public meeting for 3-year projects. The September letter from CMS was distributed to the Region 10 distribution list and posted online upon receipt for public review.

The Region 10 Learning Collaborative plan was revised, as required by the CMS Initial Review Letter, and resubmitted to HHSC in October of 2013. Performing providers were engaged throughout the revision process in order to structure the learning collaboratives in such a way that allowed for broad participation and encouraged shared learning across the Region. A large joint-meeting of the Clinical and Quality Committee as well as providers participating in the learning collaboratives and other interested stakeholders gathered on September 4 as the first official kick-off meeting for the Region 10 Learning Collabroatives. A follow-up public call and webinar was hosted on September 20th to engage providers and interested stakeholders in the final revised plan and accept feedback and comment. The feedback received on this webinar was also included in the final submission of the Learning Collaborative plan.

Stakeholder Engagement including Required Public Meetings

Stakeholder Engagement is important to the Anchor and Performing Providers in Region 10. A number of meetings (in-person, conference calls, and webinars) were held throughout DY2. The Region 10 website is continually updated with information, frequently asked questions, HHSC and Region 10 documents, and other items important for successful transparency in Region 10. Each of the following meetings were announced to the Region 10 email distribution list as well as listed on the public website prior to being held. Providers and other stakeholders are also aware they are able to contact to contact the Anchor at any point to ask questions, seek information, or assistance to be successful within the DSRIP program.

Below is an overview of the Stakeholder Engagement that took place between October 1, 2012 and September 30, 2013. ** Denotes required public meetings

Date	Meeting Format	Meeting Overview
**November 2, 2012	Public Comment	RHP 10 Pass 1 Plan posted and open for public comment

**November 7, 2012	Public meeting and webinar	RHP 10 overview of Pass 1 Plan
**December, 6, 2012	Public Comment	RHP 10 Pass 1-3 Plan posted and open for public comment
**December 12, 2012	Public meeting and webinar	RHP10 overview of Pass 1-3 Plan (Public comments accepted until 12/14/12 and incorporated into final RHP plan)
December 21, 2012	Submission and posting	Final RHP plan submitted to HHSC; posted online and made available to RHP and public stakeholders; communication of submission sent out
January 29, 2013	Conference Call	Overview of HHSC feedback regarding RHP plan – content and next steps
February 12, 2013	Submission and posting	RHP plan, post HHSC comments and revisions, submitted and posted online
February 14, 2013	Presentation	RHP 10 update to Texas House Committee on County Affairs
March 13, 2013	Conference Call	Review of next steps after RHP Plan submission to CMS
April 8, 2013	Meeting	Meeting with Elected Officials of Tarrant County – Navigating the 1115 Waiver presentation
April 10, 2013	Conference Call	Call with IGT providers regarding IGT commitments
**May 8, 2013	Meeting	Post-award forum, review of CMS initial letter and next steps (See Appendix C for sign in sheet & presentation)
May 30, 2013	Conference Call	Engaged RHP 10 providers and HHSC with technical assistance for Phase 1 / CMS Initial letter
June 6, 2013	Conference Call	Review of Phase 3 Revisions requirements and deadlines
June 20, 2013	Presentation	Presented a Region 10 overview to the Fort Worth Medicaid Regional Advisory Committee
**June 24, 2013	Meeting	Joint meeting of the Elected Officials and Steering Committee (Post Award Forum) (See Appendix D for sign in sheet & presentation)
July 15, 2013	Presentation	Presentation to Texas Society of Public Accountants regarding the financial aspects of the 1115 Waiver and elements of the RHP 10 plan
July 26, 2013	Presentation	Presentation on 1115 Waiver/ Region 10 and impacts on technology (EHRs) at Texas Epic collaboration Meeting
August 6, 2013	Webinar	RHP & public webinar/ conference call regarding the process for 3-year projects (See Appendix E for sign in sheets and presentation)
September 4, 2013	Meeting	Clinical and Quality Committee Meeting, At large Learning Collaborative Meeting 1
September 17, 2013	Presentation	Presentation over 1115 Waiver and Region 10 Plan at North Texas HFMA Chapter Meeting
September 20, 2013	Conference Call/ Webinar	At large Learning Collaborative Meeting 2
September 23-24, 2013	Symposium	Large symposium providing overview of the Texas 1115 Waiver & Population Health. Attended by providers and public stakeholders. Presentations by SMEs, HHSC, & Region 10 Providers

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.

Description of Lessons Learned

DY2 provided many opportunities for lessons learned regarding the Waiver. A main lesson learned at the anchor level, and noted by a number of providers in both August and October reporting, is the importance of flexibility. There is a clear need for flexibility in responding to plan implementation and development, such as the four-phased revision process that was implemented across the state following the initial review of RHP plans by CMS.

Consistent communication has always been important to the anchor of Region 10, as well as our stakeholders, but lessons in communication were also learned throughout the year. As an anchor, we learned how important it is to be in contact with both HHSC and other anchors, in order to achieve a consistent message to providers across the state, especially those providers who may be participating in multiple regions. A variety of communication methodologies at the regional governance level is important. Each provider has a particular method of communication that works best for their organization, and it has been important to understand how each provider best receives and understands important messages, especially messages regarding new elements of the Waiver and what is expected of them. One aspect of communication that was noted by multiple providers in their October reporting templates was the communication of new models of care to both front line staff and clinical staff as the implementation of DSRIP projects will change their daily work practices. One provider noted that "*communication of new models of care that attempt to set a new level of integraded services requires both patience and time*". This statement reflects what a number of providers encountered, with how to communicate the downstream effects the implementation of DSRIP projects may have on clinic or hospital operations.

Effective planning, both at the regional governance level and individual performing provider level, has been noted as a critical lesson learned in order to be successful in the DSRIP program. Performing providers have had to learn to balance plan revisions versus needed efforts to implement successful projects. From the regional anchor perspective, it has been important to plan around a 30-60-90 day time-frame. With multiple deadlines and phases to work through during DY2 it was important to keep focused and plan around what was important in the short term, while not losing focus on the long-term impacts of the regional DSRIP projects. Throughout DY2 it seemed that about every 6 weeks there was a new important phase to focus on with HHSC and CMS, this made effective planning critical to ensure that all deadlines were met and providers felt comfortable with the changes and expectations that were taking place. One provider noted in reporting the importance of effective planning at the provider project level "*Key lessons learned during planning and implementation phases across all initiatives included the development of a comprehensive project plan early during the process; identification of engagement of national experts; and early identification of technology needs and solutions for data collection, monitoring, and reporting*". This statement clearly summarizes what a number of providers learned throughout the year regarding the importance of definitive planning and communication for the success of DSRIP project implementation.

From a learning collaborative point of view, important lessons learned have been focused on how to have successful broad provider participation in the learning collaboratives and how to structure the

collaboratives in such a way that there is the greatest opportunity for shared learning and behavior change throughout the remainder of the Waiver. It was important for the team leading the learning collaborative to understand how different and unique each provider in Region 10 is and how each will contribute and take away something different throughout the development and implementation of the two learning collaboratives we have committed to as a region. The majority of shared learning from raise the floor initiatives and project implementation will take place in DYs 3-5 throughout the Waiver.

Stakeholder engagement, understanding how to keep providers in the game, has taken time to learn. Due to the comprehensive nature and torrid pace of plan revisions providers have had to exert extensive work efforts to modify the plan accordingly. It has been important to understand how and when providers want to be communicated with, and how vital the continued flow of information to them is to the success of plan revisions, implementation, and ultimately approval. Region 10 uses a variety of methods to communicate with providers and continues to make regional engagement a priority.

Numerous lessons have been learned regarding the discipline of business planning and bringing new skills into an organizations with regards to business planning, project management , lean management, six sigma, resource budgeting and risk management. With the delayed nature of full plan approval, providers worked diligently to deploy invest in resources to accomplish milestones on time while balancing the risk of delayed plan approval. From a performing provider perspective within JPS Health Network specifically, JPS can now deploy these new skills in a discipline manner to positively impact other areas of the hospital.

Data and information continues to be an area of learning for the region. Extensive data reports will be required in the future years of the Waiver, and providers have learned the criticality of data definitions. Providers are continually learning how to mine the data needed for project reporting, or are building the data systems necessary to show project impact. Through learning collaborative efforts and individual project reporting, Region 10 is looking forward to the great deal of learning that can be had and shared through the data of the DSRIP projects.

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 the RHP.

Challenges Faced

The most prevalent challenge faced throughout DY2 at the regional governance level, and individual provider/ project level, was the continual development of DSRIP requirements by HHSC and CMS, along with compressed deadlines and time for achievement of milestones and metrics due to the delay in project approval. Some providers, in an effort to protect financial standing, did not invest resources on the development of infrastructure due to the delay in approval of projects. One provider states the downstream impact delayed in DY2 achievement will have on later years of the waiver, "*The biggest challenge has been completing milestones on a compressed timeline. Although some projects will be*

able to recover quicker than others, the effect will be prolonged into DY3 and possibly DY4", due to the carry forward policy".

Region 10 is a large region, with nearly 30 DSRIP providers and over 100 DSRIP projects. Management of these projects across the multi-phased submission, revision, and approval process has been a challenge. One of the biggest challenges has been the management of the phases and information control. For some phases and reporting, there have been different expectations of submission. Some items have been submitted by anchors on behalf of the entire region, and others providers have submitted directly to HHSC. When providers submit directly to HHSC it is difficult at the regional anchor level to verify that all providers have met required deadlines and documenting important information regarding project changes are noted at the anchor level. It is important to know the changes providers have made to projects throughout the revision process in order to incorporate all of them in the upcoming full RHP submission in March of 2014.

Project implementation, and the various elements that impact successful implementation, has been noted by a number of providers. One provider noted that "*each project brings its own set of challenges, and each has its own challenges ahead".* This is a clear summary of a challenge many providers are facing, as each project is unique in its content and implementation needs; some projects have required more work throughout the revision process than others, creating a challenge for providers and the anchor, to ensure that each project is in the best position it can be for success over the life of the Waiver. Many providers, especially those of smaller size, have started from scratch in terms of personnel and infrastructure, to implement DSRIP projects, which has required a multitude of planning and coordination. One provider noted the primary challenge of integration of their multiple DSRIP initiatives from a workface development perspective (medical providers, RNs, social workers, etc.) and addressing the technology needs for data collection have been difficult.

One important challenge not to overlook at the project level is the importance of the patient. One provider reported "*Each community or specific population targeted for a DSRIP project has different needs and the resources needed were different based on those needs and the resources available. This is both a challenge and an opportunity. Each new project has brought a new delivery method of health care into the community. The community and specific population responses have been varied but overall very positive. It is an ongoing challenge trying to change behaviors that are multi-generation for many families. Some of the challenges with each project includes patients finding transportation to appointments, appointment no shows, patient awareness, systems integration of our projects while we our completing our migration to a new enterprise EMR*". Patient engagement and participation in these projects will be an essential element and challenge in order to fully achieve population health changes throughout the Waiver. Without proper patient engagement, the health systems participating in DSRIP will only be able to do so much to achieve the promised health outcomes by DY5.

Data has been a common challenge faced among providers. From the anchor perspective, there is a large amount of data management required in keeping the RHP plan together. The success of this data management will be seen when the final RHP plan is resubmitted. Managing the data across the multiple submission and revision process has been a challenge. At the provider and project level, many

providers have expressed challenges in determining final baselines and on-going tracking of data and outcomes. Region 10 is comprised of both rural and urban providers of varying sizes, which have different abilities and systems to manage data and information at the patient and project level. Sharing of data, in a meaningful and lawful way, is also a challenge between providers. There is not a regional HIE in Region 10 that allows providers to clearly communicate data at the patient level across provider systems. Many providers who have Electronic Medical Records have been faced with the challenge of making changes and improvements to their systems in response to DSRIP project and the need for heightened data management.

Leveraging personnel, or hiring new employees, has been a challenge faced by a number of providers. At the regional governance level our Waiver team is small, this makes for a challenge at times in balancing the needs of all providers with the needs and deadlines provided by HHSC and CMS. Many providers have had to hire a number of staff to see their DSRIP projects implemented successfully. Other providers that have not had the resources to hire additional staff have seen more challenges in meeting regional and state deadlines, and ultimately this was seen in their lower reported achievement throughout August and October reporting periods. One provider summarized "*finding the appropriate skilled resources to implement the project as designed has been an organizational challenge*".

Specialty providers in Region 10 that are not acute care facilities have faced unique challenges under the Waiver thus far. These providers have noted how the Waiver and projects on the menu were not originally designed for their (i.e. academic health science centers, public health departments) participation. One provider facing these challenges summarized them in their October reporting as challenges faced included "*contract requirements for State agencies had to be considered when entering into the Affiliation Agreement provided through the 1115 Waiver process. Gaining agreement among hospital partners to facilitate data sharing regarding admissions and patient outcomes also presented a challenge. Additionally, the evolution of the approval process has presented challenges to ensuring project success while minimizing [our] risk should projects not be approved as written in DY4 and DY5. Changing requirements sometimes meant short timelines, especially for the hiring of personnel necessary for successful project implementation. However, these challenges either have been or are being addressed and both HHSC and CMS have shown great availability to help answer questions and assist with concerns*".

5. Narrative Description of Other Pertinent Findings

Other Pertinent Findings Narrative

Each provider within Region 10 has created a governance system within their organization or system unique to themselves and organizational needs, which will allow them the most opportunity within their respective systems to be successful within the DSRIP program. While each performing provider has taken a different approach, there are many similarities across providers. For example, high level senior leadership is involved in some way within each performing provider, regardless of organizational type or structure, providing oversight for DSRIP projects. Many providers have dedicated project directors or managers that oversee the implementation and progression of DSRIP projects. Some have involved clinical and operational personnel at different levels that focus on the logistics and operations of

ensuring successful execution of the projects. Most providers have regular project implementation meetings, some weekly, others monthly, where multidisciplinary teams discuss the operational impacts of the program, resources needed, barriers being faced, and possible solutions. Nearly all providers are using the milestones and metrics as a guiding focal point to ensure the interventions are successful and the projects being implemented will impact the patients they are intended to serve and see the health outcomes they are intended to produce.

Most providers have encountered opportunities to educate employees not directly involved in the Waiver on the structure of the program and the importance of successful implementation of projects to the organization. The most notable departments that are indirectly impacted by DSRIP projects are Finance, Human Resource, Quality, and Information Technology/ Electronic Medical Records. All providers in the Region have found the opportunity to build relationships across departments within their own organization, and across providers in the region, to open up the most opportunities for success.

Providers have discovered other opportunities within their organization for greater transparency or efficiency as they have begun to implement DSRIP projects. One provider noted their realization of a positive experience through participating in the 1115 Waiver, "*The 1115 Waiver projects have provided a good opportunity to reevaluate efficiencies and utilize systems already in place in different ways. As a result, the approach of [our organization] in the oversight of all DSRIP projects reflects a Plan Do Study Act (PDSA) methodology. An 1115 Waiver steering committee has been formed to address key processes common to all projects and to identify best practices. The evaluation and resulting improvements of some processes have led to better integration of DSRIP projects into standard operations and will allow for project learning to be applied across the Institution*".

In September of 2013 JPS Health Network, as the anchor of Region 10, hosted a Symposium on the Waiver. The target audience of this event was professionals, within and outside of healthcare, who had a strong interest in gaining a deeper understanding of the Waiver and its impact on healthcare in Texas. The day-and-a-half event provided an engaging overview of the Waiver, technically and theoretically, with presentations provided by subject matter experts, Texas Health and Human Services Commission, and performing providers in the field. The event proved there is a strong need in the community to further understand the intricacies of the 1115 Waiver in Texas as it was attended by over 350 individuals comprised of performing providers across the state representing numerous regions, other anchor organizations, healthcare professionals not directly involved with the Waiver, finance professionals, and local and state government representatives.

Overall we believe the regional health partnerships is an effective vehicle that could be leveraged for other purposes outside of UC and DSRIP as healthcare in Texas continues to evolve. Region 10 has been able to achieve success and new relationships forged through the regional health partnership model and are looking forward to continuing to be successful as the Waiver continues to develop.

Most importantly, we have found that in all DSRIP work, it is vital that the patient is always kept in the forefront of everyone's focus. Ultimately, each project is being implemented to improve the patients' experience, quality of care, and health outcomes. JPS Health Network is implementing a number of Behavioral Health projects, attached in Appendix B are some examples of patients that have already been positively impacted by DSRIP projects implemented within Region 10.