DY5 RHP Annual Report

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.

Please summarize the progress of the RHP during DY5 (October 1, 2015 – September 30, 2016). Information can include 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 DY5 based on the information available prior to annual report submission.

For the questions below, HHSC indicates specific information that should be included, but otherwise each anchor may report as appropriate for the RHP. The RHP annual report is an opportunity to share 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. HHSC will share this information with CMS, as well as the data elements on the second tab of this document.

Your answers 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 or project information, particularly if there are themes across multiple providers or projects in an RHP.

Each anchor should submit its annual report on the DY5 RHP Annual Report Form by December 15, 2016 to HHSC (TXHealthcareTransformation@hhsc.state.tx.us).

RHP	10
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1. Describe your RHP's progress during DY5.

This section must include:

- a summary of the regional implementation of the RHP plan, progress on meeting community needs included in the community needs assessment, and changes in DSRIP performing providers and other key stakeholders. Project specific highlights may also be included, including sustainability planning.
- major activities conducted by the RHP during DY5, including updates to the RHP's website. Information can also be provided on administrative activities, such as reporting.
- any other relevant progress updates from DY5.

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 125 active projects. Common threads shared across projects in the region focus on behavioral healthcare, access to primary and specialty care, chronic care management, health promotion and disease prevention, as well as, helping patients with complex needs navigate the healthcare system.

The region as a whole reported achievement of 82% of the total DSRIP dollars available during the October DY 5 Reporting Period. 38% of all RHP10 participating providers have reported achievement of 90% or greater success in meeting all DY5 milestone and metrics. The implementation of the RHP10 plan had the most significant impact on care coordination, ED overuse, lack of provider capacity, and access to Behavioral Health resources as the highest concentration of the region's DSRIP projects are focused on these unique community needs.

RHP 10 Providers benefited from the strong relationships forged over the course of the waiver. Particularly, DY5 demonstrated the advancement of specialized cohorts allowing our providers to come together and share best practices and lessons learned. Key topics such as Palliative Care, Patient Navigation, Sepsis, HbA1c Safety Expertise, and Preterm Birthrate became areas of targeted focus in our region facilitated by the Anchor. Sustainability planning for our providers included looking for innovative ways to partner with community resources, managed care organizations and other healthcare service providers to heighten awareness of available resources, shared resources, and services to provide "the right care, in the right setting" for the population in our region. In addition to cohorts, as the Anchor, we were able to facilitate a summit with the AETNA MCO to collaborate on projects related to Moms and Babies. The relationship continues to strengthen by fostering an environment of transparency and willingness to share data and service offerings.

Additional major activities conducted by the Anchor in DY5 included a "technical support" onsite training session focused on reporting for RHP 10. This session provided an opportunity for providers in our region to share best practices, lessons learned, share standard templates and an opportunity as the anchor to assist with technical questions and requirement interpretations.

As the Anchor, we continued anchor site visits to each performing provider's local area in DY 5 to gather valuable insight as to how to better serve our customers. We asked for specific feedback on what's going well, what's not going well, what we as the anchor could do better in the future and how could we enhance communication and website information.

We found that many of our providers cross multiple regions and would benefit from streamlined communication and learning opportunities. Region 9, our sister anchor in Dallas shared many of the same performing providers creating a unique opportunity to band together to deliver a much more meaningful joint learning collaborative event. The success of this partnership has prompted us to plan our DY 6 learning collaborative jointly as well. This success has reduced administrative burdens, lowered costs, and improved our participation rate in our learning collaborative events.

Lastly, in DY 5, the anchor hosted the annual Clinical Quality Committee meeting to conduct a year in review of the effectiveness of our learning collaborative activities, topics, and measurement results with a heightened focus on sustainability planning into DY 6.

2. Describe lessons learned.

This section should include lessons learned, both from regional governance perspective and learning collaborative/continuous quality improvement activities. Please include updates to the RHP learning collaborative plan, which can be provided as an attachment, and any RHP-wide learning collaborative events, including activities with other RHP's learning collaboratives.

The role of the anchor in regional governance is becoming increasingly important to synthesize, disseminate, and coordinate information in a concise effective manner. We've learned that in such a diverse environment in terms of geographic location, size, type and scale of providers there is no one size fits all. To better serve our providers, we began facilitating a monthly RHP10 call so that lead providers could respond to the HHSC Anchor Notes and provide us valuable feedback that we share on the Anchor calls with HHSC. Also, we've learned that our providers enjoy and appreciated the monthly webinars provided as part of our learning collaborative plan but have requested that we reduce the frequency to quarterly to accommodate their demanding schedules.

Although we have made no formal changes to our learning collaborative plan, we've learned that our providers need more than a learning collaborative that is focused on two specific tracks, Care Transitions and Behavioral Health. Our providers look to the anchor to be the conduit to connect them with other providers that share similar outcomes whether that is internal to our region or external across the state. As a result, we have provided opportunities to form focused cohorts based on the demand to share best practices and lessons learned. The MLSC audits, although challenging, created many learning opportunities for our providers to gauge their effectiveness in documentation. As a result, the lesson learned is to insure all decisions, assumptions, changes, and processes are clearly documented and stored in a way that key participants have access.

RHP 10-wide Learning Collaborative Events hosted by the Anchor:

- **o RHP 10 Clinical Quality Meeting (Women's Center of Tarrant County)**
- **o RHP 10 Clinical Quality Meeting (Lena Pope Event Center)**
- **o Monthly stakeholder calls (2016 - May 17, June 21, July 19, August 16, September 27)**
- **o Joint Webinar- January 21st, 2016 BH Integration**
- **o Feb 9-10th RHP 9 & RHP 10 Joint Learning Collaborative Event**
- **o May 19th,2016- RHP 1's Integrated Learning Collaborative Webinar**
- **o May 19th,2016- National Transition of Care Perspective Webinar**
- **o June 30th, 2016- RHP 10 Learning Collaborative-Theme of sustainability**
- **o July 21st, 2016- An Integrative Approach to the Management of Chronic Pain and Addiction Webinar**
- **o August 18th, 2016- Joint Webinar- Sustaining your project**
- **o September 15th, 2016- Peer providers/peer support specialists on integrated behavioral health care teams Webinar**
- **o September 15th, 2016- Mobile Healthcare Webinar**
- **o September 15th, 2016-Palliative Care Cohort**
- **o January 13, 2016- ED Navigation Cohort**
- **o December 3, 2015- Sepsis Cohort**
- **o April 7, 2016- Sepsis Cohort**
- **o January 26, 2016-HbA1c Safety Net Expertise Cohort**
- **o December 7, 2015- Preterm Birthrate Cohort**
- **o August 26, 2016- Preterm Birthrate Cohort**

3. How many learning collaborative events did your RHP host during DY5 (October 1, 2015 - September 30, 2016)?

Please enter the number of events that took place for the following types. *Not applicable to Tier 4 RHPs not conducting their own learning collaborative.*

- in person events
- teleconferences/webinars
- other, please list the number held and describe the type of event

RHP 10 Anchor facilitated 11 in person events (includes face to face learning collaboratives and cohorts) and 9 webinars.

4. Which quality improvement topics were included in your RHP's learning collaborative(s) in DY5? Please select all that apply. For Tier 4 RHPs not conducting their own learning collaborative, please indicate the focus areas of the learning collaborative(s) your RHP members participated in through other RHPs, if known.

- [x] Access to primary care
- [x] All-cause 30-day readmission rates
- [x] Behavioral health access and/or integration
- [x] Care navigation
- [x] Care transitions
- [x] Chronic care prevention and management
- [x] Diabetes in adult patients
- [x] DSRIP project implementation, strategic planning, and/or reporting
- [x] Emergency department utilization
- [x] Health promotion and disease prevention
- [x] Improve patient and community engagement
- [x] Measurement strategies
- [x] Medical homes
- [x] Palliative care
- [x] Potentially preventable readmissions
- [x] Primary care expansion
- [x] Right care, right setting
- [ ] Specialty care access
- [x] Telehealth/telepsychiatry
- [ ] Other, please describe:

5. Describe how your RHP's learning collaborative(s) used the Plan-Do-Study-Act (PDSA), Plan-Do-Check-Act (PDCA), or other selected quality improvement process.

Indicate how the learning collaborative(s) were facilitated throughout the cycle(s); the tools participants used to establish a plan, set expectations, and monitor progress (e.g., the Institute for Healthcare Improvement's PDSA form; how fidelity to the plan was measured; who evaluated outcomes of the process and how). *Not applicable to Tier 4 RHPs not conducting their own Learning Collaborative.*

The learning collaborative methodology is primarily based on the widely adopted IHI Breakthrough Series, with some modifications to meet the learning collaborative requirements outlined for Texas' 1115 Waiver requirements. The key to this model is to combine subject matter experts in specific clinical areas with application experts who can help organizations select, test, and implement changes on the front lines of care.

The Breakthrough Series methodology alternates between gathering organizations to learn together and participants returning to their institutions to test and then implement effective changes in the clinical setting. Earlier convening's focus on theory, middle ones on reporting methods and initial results, and later ones allow collective reflection on lessons learned and planning for next steps. The ongoing direct access to others implementing similar changes facilitates dissemination of replicable practices and avoidance of others' mistakes. A key piece of the learning is access to experts and mentoring.

Based on IHI's Breakthrough Series and the Model for Improvement, the Region 10 Learning Collaboratives will bring together organizations testing similar innovations, clinical interventions, or process improvements so that the organizations can learn from each other and share best practices. In addition to data, participants will share successes and challenges, as well as identify best practices. As a result, all participants can benefit from the collective development of an effective and proven solution that can be widely replicated and more rapidly adopted as a result of the collaborative.

6. List the specific measures your RHP monitors through its Learning Collaborative(s).

Please list the measures and summarize any changes observed since the learning collaborative began. *Not applicable to Tier 4 RHPs not conducting their own Learning Collaborative.*

RHP10's Learning Collaborative has shared measures related to both the care transitions and behavioral health tracks.

There are five teams that report monthly on the care transition inpatient measures and 2 teams that report monthly on the care transitions outpatient measures:

- **Measurement 1 – Care Transitions - Inpatient: "Percentage discharged patients who received written discharge summary"**
- **Measurement 2 – Care Transitions - Inpatient: "Percentage discharged patients whose follow-up provider received summary within 7 days"**
- **Measurement 3 – Care Transitions - Inpatient: "Percentage discharged patients with community provider contact within 7 days"**
- **Measurement 4 – Care Transitions - Outpatient: "Percentage who are provided health education materials related to health condition"**
- **Measurement 5 – Care Transitions – Outpatient: "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."**

Summary for Care Transitions wins:

Total interventions achieved for 2015 and 2016

- **Care Transition - Inpatient: 59,195**
- **Care Transition - Outpatient: 2,585**

Intervention rate for 2015 and 2016

- **Care Transition - Inpatient: – Increase from 70% to 85%**
- **Care Transition - Outpatient:– Increase from 81% to 86%**

There are four teams that report monthly on the behavioral health shared measures:

• Measurement 1 – Behavioral Health "Percentage patients screened with cross-specialty tool"

• Measurement 2 – Behavioral Health "Percentage of patients who received integrated care intervention in past 12 months"

• Measurement 3 – Behavioral Health "Percentage patients whose condition improved with intervention"

Summary for Behavioral Health wins:

Total interventions achieved for 2015 and 2016

• Behavioral Health: 265,090

Intervention rate for 2015 and 2016 YTD

• Behavioral Health: – Increase from 48% to 53%

7. Describe any challenges in administering, facilitating, or participating in a learning collaborative.
For Tier 4 RHPs not conducting their own learning collaborative(s), please respond from the perspective of participating in other RHP's learning collaborative or the Statewide Learning Collaborative, if known.

The size and breadth of RHP 10 consisting of 125 DSRIP projects, 29 providers across 9 counties, in itself, creates significant challenges to facilitate a learning collaborative that meets the needs of all its participants. Although Behavioral Health and Care Transitions are very broad topics, we learned early on that narrowing the focus to 2 tracks limited participation from some providers. Without a standard mechanism to share data our learning collaboratives became limited to sharing best practices, subject matter expertise, lessons learned, and the introduction of improvement tools and sustainability planning tools. In many ways, it seemed as though providers were looking for more guidance and leadership on the actual execution of their unique DSRIP projects which made it difficult to please everyone. The diversity of the providers created unique challenges as well, relative to the rural versus urban perspective.

8. Describe strengths and challenges of the learning collaborative model as a tool for quality improvement within or for your RHP.

Strengths of the IHI's Breakthrough Series and the Model for Improvement provides opportunities for participants to access subject matter experts, mentors, share best practices, lessons learned and avoid mistakes already incurred by others with similar experiences. Based on IHI's Breakthrough Series and the Model for Improvement, the Region 10 learning collaborative will bring together organizations testing similar innovations, clinical interventions, or process improvements so that the organizations can learn from each other and share best practices. In addition to data, participants will share successes and challenges, as well as identify best practices. As a result, all participants can benefit from the collective development of an effective and proven solution that can be widely replicated and more rapidly adopted as a result of the collaborative.
The challenge with this model is that it is less structured than other continuous improvement models and may not produce specific measureable results as with PDSA cycles or DMAIC process improvement methodologies.
Additional ideas:
o LC is very broad and trying to include everyone is difficult

o Cannot achieve measures for providers
o LC's create understanding of Waiver and what is the most current information
o Allows providers to have their voice heard

9. Describe your participation in the Statewide Learning Collaborative and any recommendations for the next Statewide Learning Collaborative.

RHP 10 finds great value in the Statewide Learning Collaborative in bringing the unique perspective from across the state together and was proud to have projects highlighted. Feedback we've received on recommendations moving forward include:
Use the statewide LC to deliver consistent messaging so that all anchors and lead providers are on the same page and hear information during a common venue.
Providers and Anchors are looking to the statewide LC for leadership and guidance on specific "how to" on the topics of partnering with MCO's, Value Based Purchasing, and Sustainability Planning.
Allow for more stretch breaks.
Equally distribute the speakers and breakout sessions for a better representation of the diversity of the regions.

10. Describe other challenges within your RHP during DY5.
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.

Each demonstration year in DSRIP has brought with it a unique set of challenges. As the region has shifted focus from project implementation to sustainability planning the challenges faced by RHP 10 have also shifted. Some Lead Providers have expressed challenges in operationalizing and integrating the work of the individual projects into a cohesive strategic plan that creates synergies across projects as not to duplicate efforts, exhaust resources and negate the work of parallel efforts. Achieving some category 3 outcome measures such as Readmissions and Ambulatory Care Sensitive Conditions in the Emergency Department is exceedingly challenging. The compendium and required data specifications as designed created an inherent problem because of the current coding practices for billing. Also projects working or contracted with 3rd party community resources have challenges because priorities and sense of urgency shifts.

Relationship building with project leaders and Managed Care Organizations is underway, but providers are struggling to determine the next logical steps in alignment aside from information sharing.

As the 1115 Waiver moves into DY6 and the transition year, it is becoming increasingly difficult for providers to retain staff due to ambiguity and uncertainty of the renewal of the 1115 Waiver. Burn out is high and wading through the ambiguity of sustainability planning has left providers feeling

fearful of what the future holds. Anchors and providers are trying to understanding the complexities of aligning with Managed Care Organizations, and alternate payment models such as Value Based Purchasing, MACRA and other funding sources.

Managing the responses to Meyers and Stauffer compliance monitoring was equally challenging as their data, in some cases was outdated and created extra work to find the corrected information that had already been submitted and approved by HHSC. Managing MLSC deadlines in tandem with HHSC deadlines was a significant challenge to maintain without missing any specific project requests or deadlines. This was particularly challenging for providers in multiple regions.

11. Describe any other pertinent findings from your RHP during DY5.

Lack of a regionwide HIE to share data hinders provider's ability to effectively collaborate with other healthcare systems and community partners.
Also rural providers have expressed a need for cohorts that address their unique perspective. There is a significant difference between the needs of the rural provider versus the urban provider.