DY6 RHP Annual Report

The Program Funding and Mechanics Protocol (paragraph 25) requires that each RHP Anchoring Entity submit an annual report by December 15 following the end of Demonstration Years. 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 DY6 (October 1, 2016 – September 30, 2017). 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 DY6 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. 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 DY6 RHP Annual Report Form by December 15, 2017, to HHSC (TXHealthcareTransformation@hhsc.state.tx.us).

RHP	10
Contact name	Shelly Corporon
Contact number	817-702-6294

1. Describe your RHP's progress during DY6.

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 DY6, including updates to the RHP's website. Information can also be provided on administrative activities, such as reporting.
- any other relevant progress updates from DY6.

RHP 10 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.

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.

During DY 6 we worked with Health resources in Action to update our Community Heath Needs Assessment. In comparison to the 2012 CHNA, we found that most of the needs in RHP 10 have not changed. A high level summary of the needs identified in the 2017 CHNA were as follows (additional detail is found in the full report):

• Social Determinants of Health

o Poverty - Quantitative data illustrates the economic diversity of the region. In Texas, 14.5% of adults had incomes below the 100% poverty line; at the county level, this proportion was generally lower for most of the counties within the region. However, the proportions of adults living in poverty were higher in Navarro County (16.9%) and Erath County (24.6%).

o Transportation - Concerns about transportation were discussed in nearly every focus group and interview. While buses exist in some counties and Tarrant County has a small light rail system, these services were viewed as inadequate for the region's communities.

o Housing - About one in five homeowners in Texas spent 35% or more of their income on their mortgage (21.3%), while nearly two in five renters in Texas spent 35% or more of their income on rent (39.5%). Somervell County had higher proportions of homeowners that were cost burdened (25.6%) than the state and the other counties in the region. Erath and Hood counties had higher proportions of renters that were cost burdened (48.8% and 43.0%, respectively) than the state and other counties in the region.

o Access to Healthy Food - Across the region, rates of food insecurity varied within a narrow range of 15 to 16% for most counties (Ellis, Hood, Johnson, Parker, Somervell, and Wise) but were higher in Navarro County (19.4%), Erath County (19.3%), and Tarrant County (18.1%), compared to 17% of residents statewide.

• Health Conditions

o Chronic Disease Prevention and Management - High rates of chronic diseases – especially diabetes, obesity, hypertension, and heart disease—were identified as a concern for the region in interviews and focus groups.

o Cancer (Lung) - While cancer is the second leading cause of death in the region, it did not emerge as a community concern among interview and focus group participants. Notably, in 2013, every county for which data were available in the region exceeded the statewide age-adjusted rate of 52.7 incident cases of lung cancer per 100,000 population.

o Behavioral Health - mental health and substance use concerns—were identified in nearly every focus group and interview as a concern for the region. Lack of behavioral health services is a substantial challenge in the region according to numerous participants who shared that the region has insufficient numbers of behavioral health providers of all kinds. As a result, participants reported, there are long wait lists for services and many untreated residents.

o Maternal and Child Health - Most of the counties in the region reported a proportion of 2014 births with no prenatal care during any trimester that was lower than that reported statewide (5.2%). High rates of smoking during pregnancy, infant mortality in the region is high, especially for lower income and African American women.

• Access to Health Care

o Insurance coverage/cost - One in every five Texas residents reported to have no health insurance in 2015. This was largely consistent across the region as well, which ranged from 15.6% of residents uninsured in Parker County to 21.6% of residents uninsured in Erath County.

o Lack of primary and specialty care providers (mental health, substance abuse, dental, etc.)

o Care coordination and integration - The 2017 provider surveys also explored perceptions of care coordination and co-management for low-income patients in the region. In 2017, a majority of survey respondents perceived the co-management of patients with both mental health and medical conditions between primary care physicians and mental health professionals to be very/somewhat ineffective.

The region as a whole reported achievement of 93% of the total DSRIP dollars available during DY 6. 67% of all RHP 10 participating providers have reported achievement of 90% or greater success in meeting all DY 6 milestone and metrics. The implementation of the RHP 10 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, DY6 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, PCMH, 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 provided 4 webinars on the topics of HIE, sustainability planning and Value Based Purchasing. In addition, the Anchor was able to design, create and share a pertinent "Project Evaluation" tool/template that was not only used by our participating providers but also shared with other Anchors across the state to support sustainability planning efforts. The Anchor office participated in RHP12's learning collaborative to provide a demonstration and training on the tool, as well as presented multiple webinars on the topic.

As the Anchor, we continued anchor site visits to each performing provider's local area in DY 6 to gather valuable insight as to how to better serve our partners. 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 7 learning collaborative jointly as well. This success has reduced administrative burdens, lowered costs, and improved our participation rate in our learning collaborative events.

2. Describe lessons learned.

This section should include lessons learned, both from regional governance perspective and learning collaborative/continuous quality improvement activities.

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 RHP 10 call/webinar 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 yearly site visits to each provider.

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.

3. Describe other challenges within your RHP during DY6.

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 new challenges surfaced for RHP10. 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 dependent on data from community partners is a challenge because priorities shift over time and it is difficult to ensure data integrity. Also MLSC audits are difficult when dependent on community partners as providers do not have access to their systems for the required documentation and screen shots.

RHP 10 also had challenges with ambiguity around the next phase of the Waiver. Not having the Waiver renewed by the end of DY 6, lack of final specifications and requirements has left the Region with a sense of angst, which has delayed many providers ability to take action on planning efforts. Providers have expressed concerns that delays in CMS decisions will have negative consequence in their ability to execute timely which will ultimately delay achievement of DSRIP outcomes and flow of funds.

As the 1115 Waiver moves into DY 7, it is becoming increasingly difficult for providers to retain staff due to uncertainty of the renewal of the 1115 Waiver and sustainability of existing programs. Anchors and providers seek to understand the complexities of shifting to an outcomes based model, aligning with Managed Care Organizations, and alternate payment models such as Value Based Purchasing, MACRA and other funding sources.

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.

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.

4. Describe any other pertinent findings from your RHP during DY6.

Lack of a region wide 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.