DY7 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 DY7 (October 1, 2016 – September 30, 2017). Information can include region wide progress of DSRIP, cross region collaboration and intervention specific highlights. The annual report also will summarize information for each RHP regarding metrics reporting and achievement in DY7 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 information, particularly if there are themes across multiple providers or core activities in an RHP.

Each anchor should submit its annual report on the DY7 RHP Annual Report Form by December 15, 2018, to HHSC (TXHealthcareTransformation@hhsc.state.tx.us).

RHP	10
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1. Describe your RHP's progress during DY7.

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. Provider initiative highlights may also be included, including sustainability planning.
- major activities conducted by the RHP during DY7, including updates to the RHP's website. Information can also be provided on administrative activities, such as reporting.
- any other relevant progress updates from DY7.

RHP 10 represents nine counties in north Texas (Tarrant, Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, and Wise) and 24 providers across the care continuum. During the implementation of DY 7 5 providers from DY 1-6 were realigned to other regions by HHSC. Inclusively, the region is responsible for the implementation of 284 measures. Common threads shared across measures 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

RHP 10 Providers have been striving to meet the needs expressed in the community health needs assessment. One provider utilizes a multidisciplinary care team comprised of CHWs, RN Care Managers, Social Workers, Pharmacists and Pharm Techs along with referral coordinators and front desk support to create a holistic team to handle social, behavioral and clinical components of patients' care. This provider also created integrated care appointments to have patients see multiple care team members in one visit which has helped to decrease no show rates. Another provider has continued their ED navigation work from Waiver 1.0 and has enhanced their activities to actively engage the patient's entire care team and community. One other area of amazing work in RHP 10 is multiple providers developing a comprehensive network of both post-acute providers and social service agencies to address the social determinants of health for their patients.

RHP 10 has benefited from the strong relationships forged over the course of the waiver. Particularly, DY 7 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 and Maternal Care became areas of targeted focus in our region facilitated by the Anchor. During DY 7 the Maternal Care cohort expanded to include providers in several other regions across the state.

As the Anchor, we continued anchor site visits to each performing provider's local area in DY 7 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 and 18, our sister regions share 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 host 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. We are also planning to have two joint cohorts with RHP 9 for DY 8.

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 continued to 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 MSLC 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 to this information.

The successes we have had in previous joint Learning Collaborative events with RHP 9 & 18 compelled us to host our DY 7 learning collaborative jointly as well. The regions share many of the same providers which allows for the opportunity to come together and provider a comprehensive learning environment. The success with this joint event has lowered costs, increased participation and lead us to plan two joint cohorts with RHP 9 for DY 8

3. **Describe other challenges within your RHP during DY7.**
   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 measure achievement new challenges surfaced for RHP 10. The biggest challenge during DY 7 was the transition happened relatively quickly and many providers struggled with the many changes. There was specific challenges with Category C measure specifications. Due to the many updates and changes to the specifications some provider chose not to start writing reports until later in the demonstration year. This led to a tremendous amount of work leading up to October DY 7 reporting.

Several RHP 10 provider transitioned to different EMR system during DY 7. This led to several challenges in acquiring and retaining data. These providers often were pulling data for Category C baseline reporting from at least two EMR systems and combining the data to accurately report their baseline. One of the concerns voiced by a provider was data retention from their previous EMR system and future audits on reported baselines. Many providers also faced challenges with aligning DSRIP measures with current quality measures that do not exactly match the DSRIP Category C specifications. This has created additional work for providers to modify or rewrite their EMR reports in order to acquire the DSRIP specific baseline.

RHP 10 has also faced challenges with ambiguity around DY 9-10 of the Waiver. Not having the protocols by the end of DY 7 and lack of clear requirements has left the Region with a sense of angst, which has delayed many providers ability to take action on planning efforts for DY 9-10. 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.

4. **Describe any other pertinent findings from your RHP during DY7.**

Lack of a region wide HIE to share data hinders provider's ability to effectively collaborate with other healthcare systems and community partners.

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.

RHP 10 providers have found the need for additional clarification on several measure specifications. A group of clinical providers to review and give guidance on measure specification questions would be an appreciated addition to DY 9-10.