

# Evaluation of the Texas Healthcare Transformation and Quality Improvement Program: 1115(a) Medicaid Demonstration Waiver

Statewide Learning Collaborative Summit  
Austin, Texas  
September 10, 2014

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# Waiver Evaluation Goals

## Goals 1-4

- Measure the effect of Medicaid Managed Care Expansion on access, coordination, quality, and cost

## Goal 5

- Measure the effect on Uncompensated Care (UC) claims based on service type

## Goals 6-8

- Measure changes to quality, health outcomes, and cost as a result of DSRIP

## Goal 9

- Measure changes in collaboration among organizations as a result of DSRIP

## Goals 10-11

- Assess stakeholder perceptions and recommendations

# Presentation Outline

- This presentation will include preliminary findings for Evaluation Goals 9-11
  - Goal 9: Examines collaboration among organizations
  - Goals 10-11: Assesses stakeholder perceptions and recommendations
    - RHP Participants' experience with the planning and implementation process
    - Perceptions of the benefits and challenges of the waiver, DSRIP specifically
- Questions and Comments

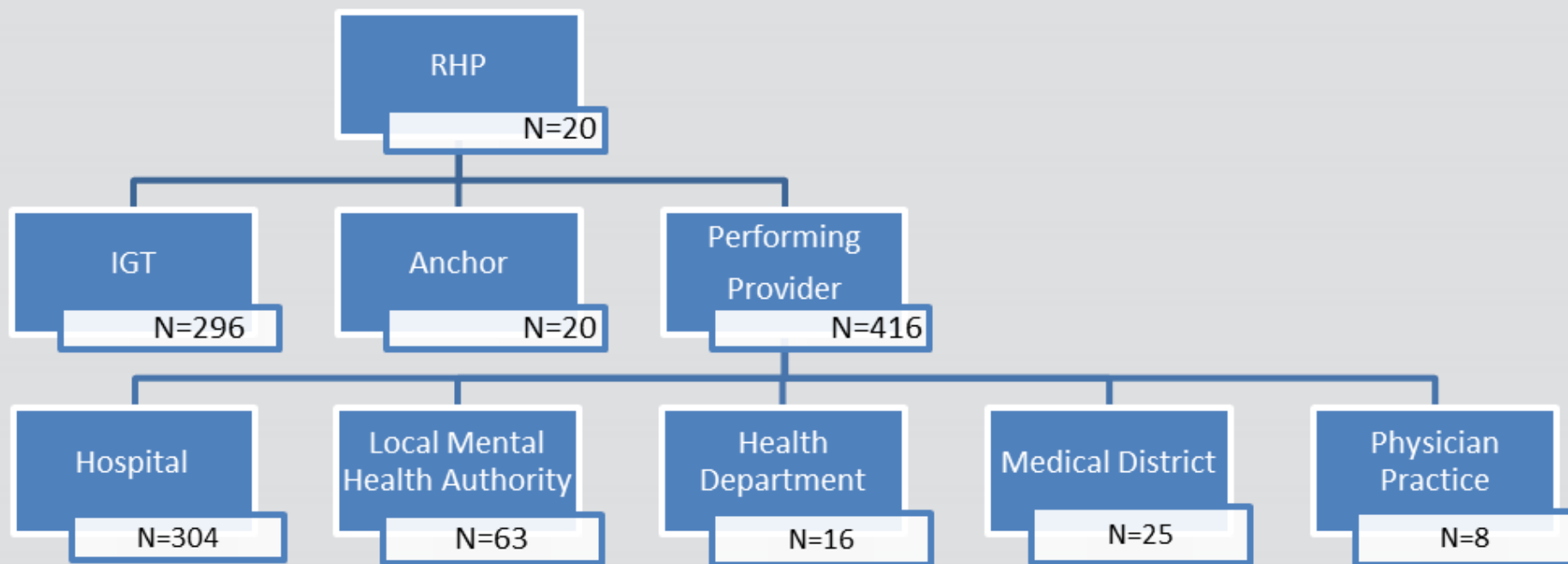


Evaluation Goal 9

# **EXAMINING COLLABORATION AMONG ORGANIZATIONS**

# Changes in Collaboration

- Evaluation Goal 9 focuses on changes in collaboration among organizations within each Regional Healthcare Partnership (RHP)



# Methods and Measures

- Use network analysis to map and measure relationships and flows between organizations
- Assessed through a network survey
- Uses organization-level information
- Examines change over time
  - Prior to the Waiver Program
  - During Demonstration Year 2
  - During Demonstration Year 4 (data collection to begin Winter 2015)

# Methods and Measures

- Participants included representatives from organizations participating in DSRIP
- Telephone-based survey asking about collaboration with other organizations in RHP

## Current Collaboration

- Joint services / programs
- Shared resources
- Data sharing

## Potential for future collaboration

## Prior Collaboration

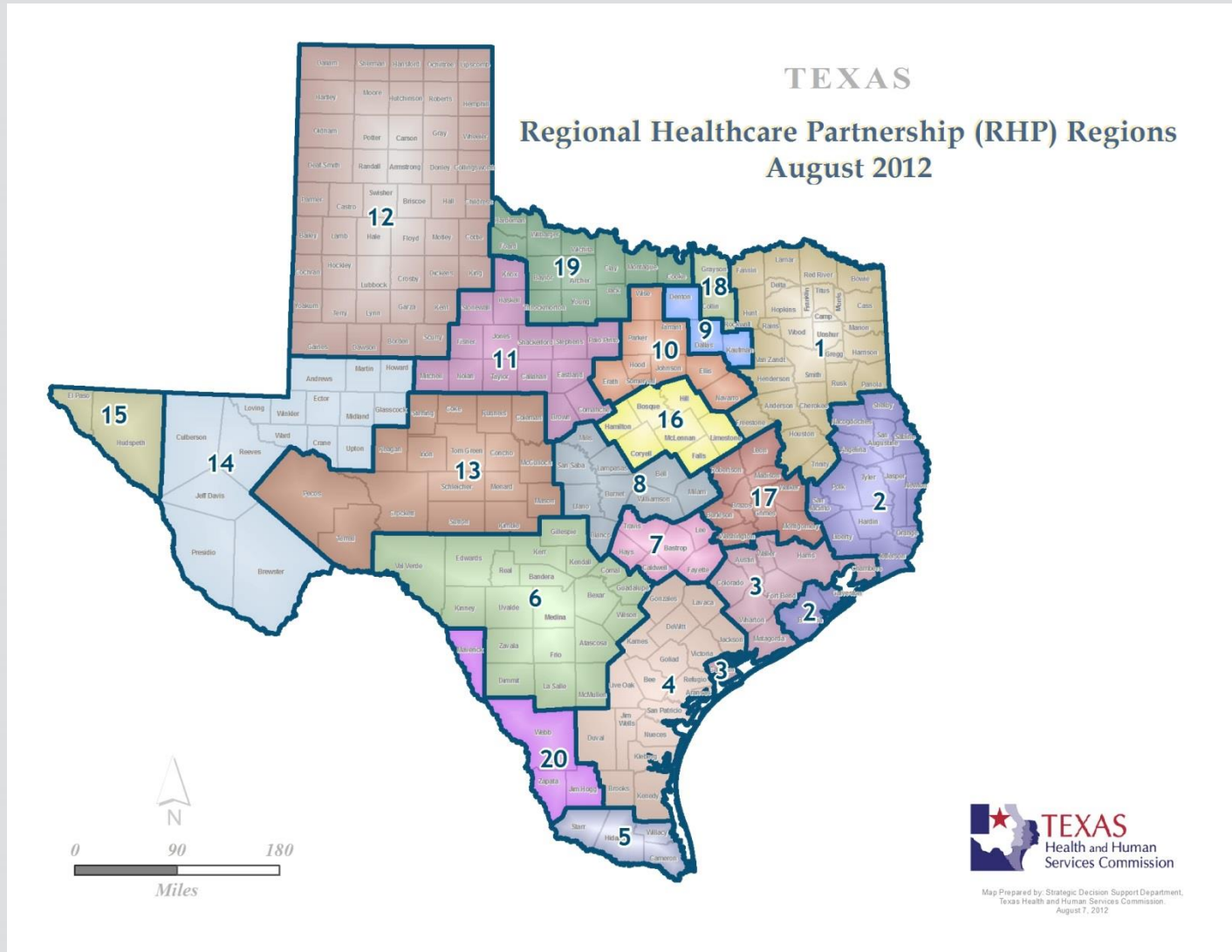
- Joint services / programs
- Shared resources
- Data sharing

# Methods and Measures

- Looking for change in several factors:
  - Density: # of collaborative relationships that exist within an RHP
  - Centralization: degree to which collaboration in an RHP is focused around a few central organizations
  - Relationship strength: # of collaborative relationships between organizations in the RHP



# Respondents



Map Prepared by: Strategic Decision Support Department,  
Texas Health and Human Services Commission,  
August 7, 2012

# Overview of Respondents

- # of organizations participating in DSRIP ranges from 8 to 38 in each RHP
- Overall response rate for survey was 84%
- Response rate ranged from 67% - 100% across RHPs

## Overall collaboration on activities that target improved access or services for the underserved

- Density: proportion of total possible relationships that are present in an RHP
- 2011: 36% (range: 14%-61%)
- 2013: 47% (range: 24%-89%)

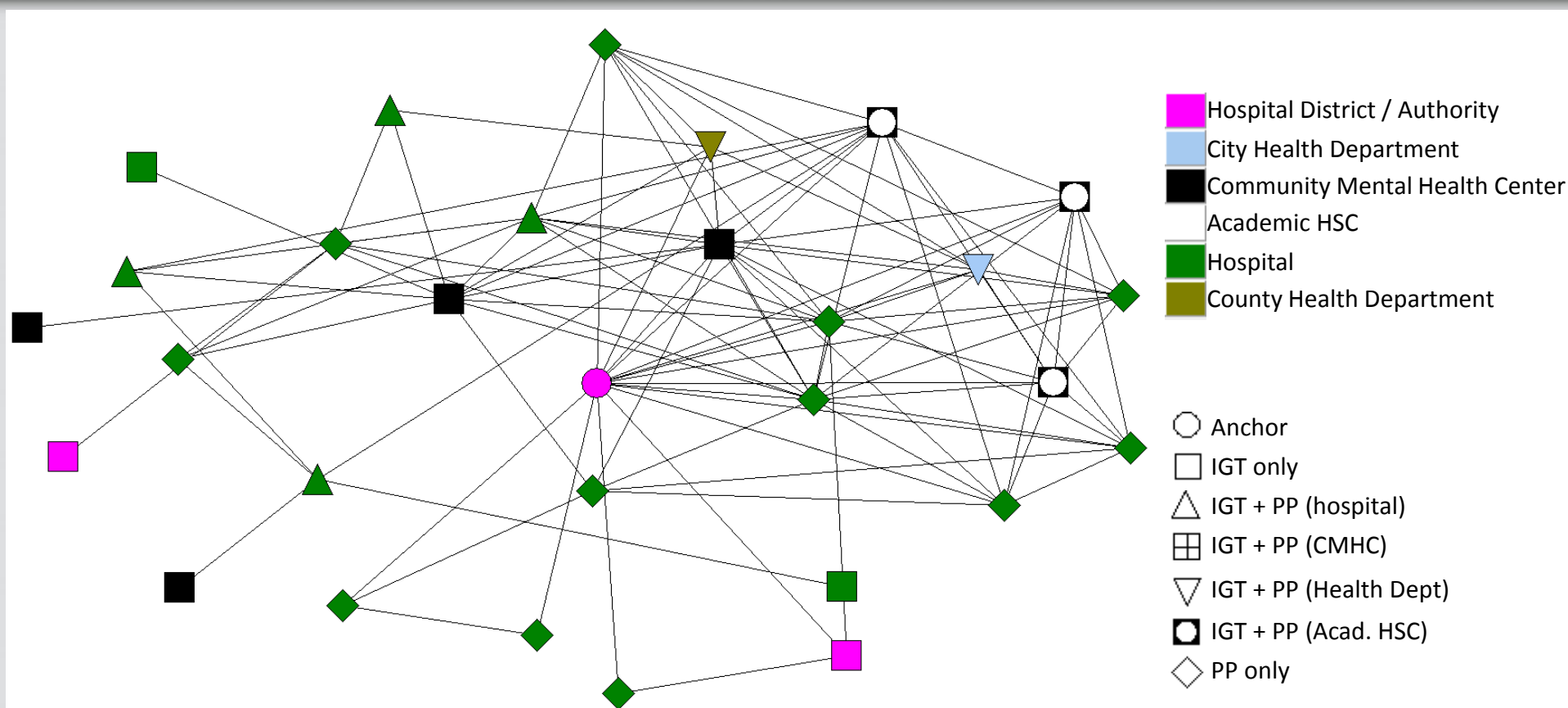
## Overall collaboration on activities that target improved access or services for the underserved

- Centralization: the degree to which collaboration in an RHP is focused around a few central organizations
- 2011: 34% (range: 11%-65%)
- 2013: 55% (range: 14%-81%)

# Additional Planned Analysis

- Relationship strength: the different ways organizations are collaborating (i.e., sharing data, joint programming, sharing resources, or combinations of those).
- 2011: *analysis in progress*
- 2013: *analysis in progress*

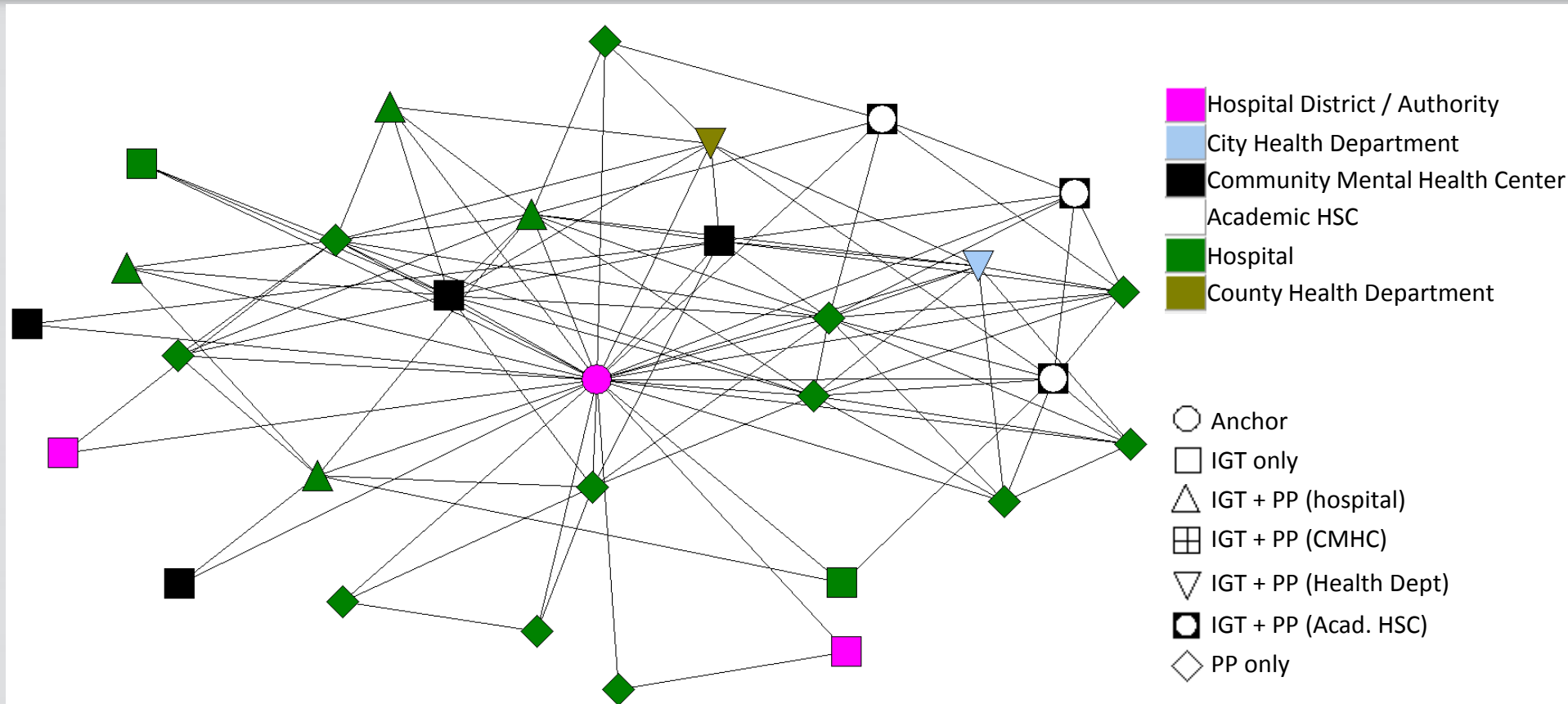
# Urban Example: 2011 (baseline)



Density: 22%

Centralization: 35%

# Urban Example: 2013



Density: 24%

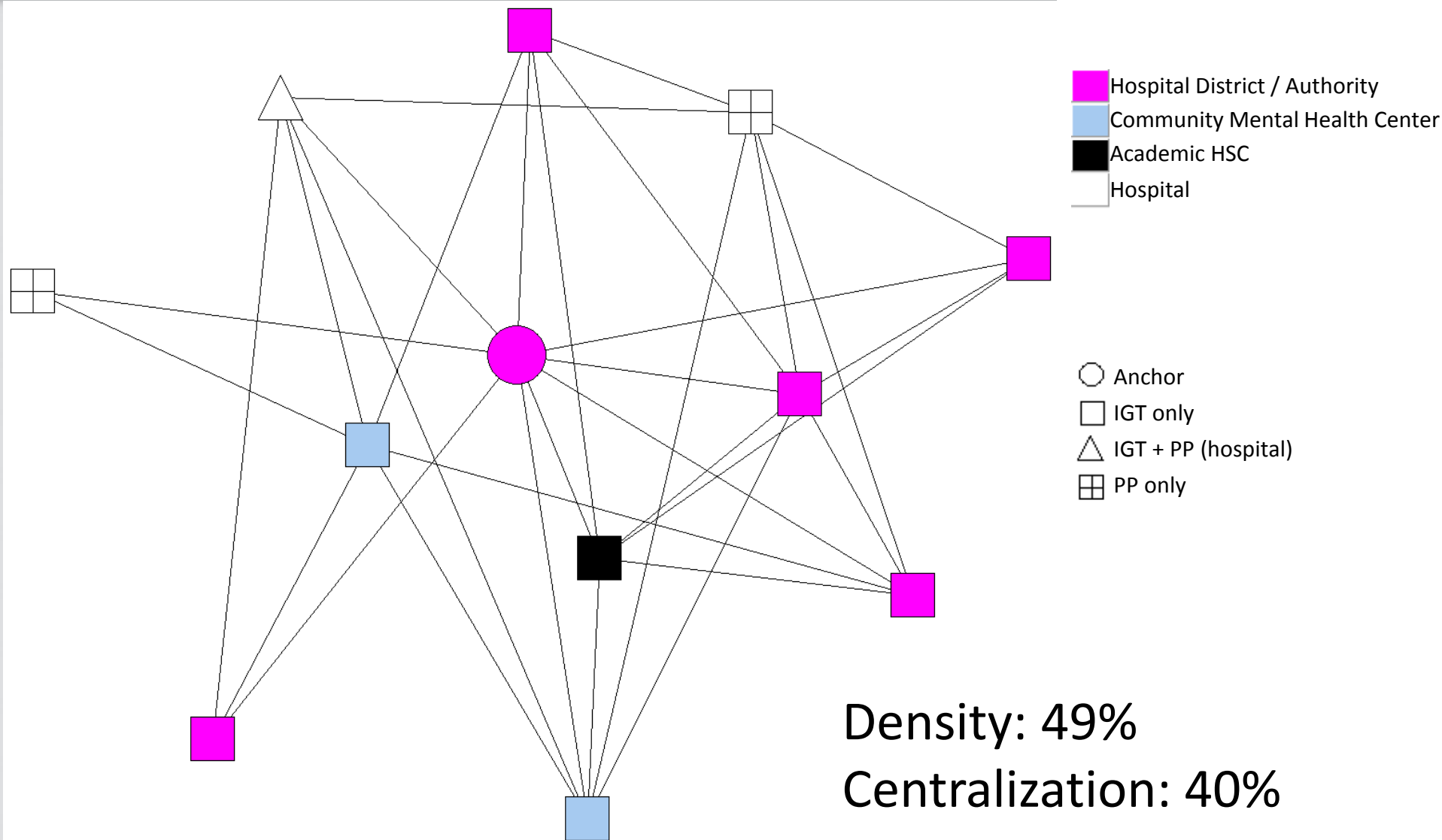
Centralization: 81%

# Urban Example: Interpretation

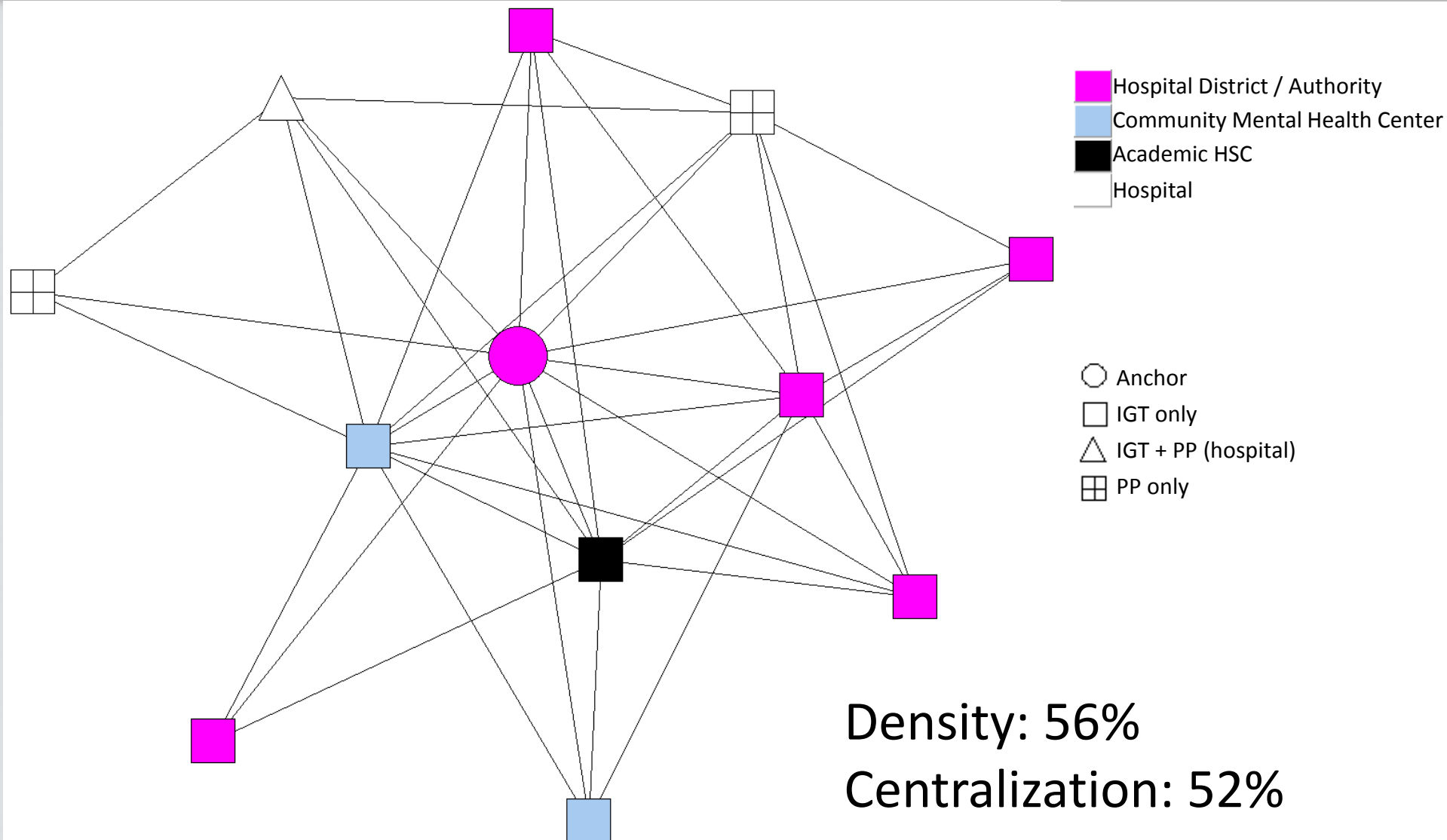
- In this RHP, there are 30 organizations, so 435 possible relationships. They experienced a slight increase in density, from 22% to 24%.
  - The number of collaborative relationships in the RHP is increasing.
  - By 2013, nearly one quarter of all possible relationships in the RHP actually existed.
- Centralization in this example increases from 35% to 81%, indicating that the RHP is becoming more centralized around particular organizations.



# Rural Example: 2011 (baseline)



# Rural Example: 2013



# Rural Example: Interpretation

- In this RHP, there are 12 organizations, so 66 possible relationships. They experienced a slight increase in density, from 49% to 56%.
  - The number of collaborative relationships in the RHP is increasing.
  - By 2013, over one half of all possible relationships in the RHP actually exist.
- Centralization in this example increases from 40% to 52%, indicating that the RHP is becoming more centralized around particular organizations.

# Planned Comparisons

- Urban vs. rural RHPs
- RHP governance structure
- Geographic spread
- Existing infrastructure
- Availability of IGT
- Number of service providers / services available
- Historical relationships / partnerships / competition

Evaluation Goals 10 & 11

# **ASSESSING STAKEHOLDER PERCEPTIONS AND RECOMMENDATIONS**

# Stakeholder Experience

- Evaluation Goals 10 & 11 focus on stakeholders' experience:
  - With the Waiver implementation process, their RHP, and the waiver overall;
  - Identification of successes and challenges; and
  - Recommendations for future changes

# Stakeholder Survey

- Identification of stakeholder groups
  - RHP Participants
  - RHP Other Stakeholders
  - Medicaid Managed Care Organizations
  - State Associations
  - Advocacy Groups
- Web-based survey deployed to 6,679 individuals by email, as identified through RHP Plans and other lists of interested stakeholders
- Survey responses collected April-May 2014
- Response rate = 10% (708 responses)

# Stakeholder Survey

- Survey was designed to understand:
  - Participants' experience with the planning and implementation process used within their RHP
  - Perceptions of the benefits and challenges of the waiver
  - Experience and perceptions of stakeholder organizations **not** participating in the waiver



# Respondent Profile

Organization Type	Frequency	Percent
Private hospital	88	12%
Hospital district / hospital authority	85	12%
Community mental health center	67	9%
Advocacy group / statewide association	45	6%
Academic health science center	34	5%
County government	28	4%
Physician group	22	3%
Health department	19	3%
Health plan	18	3%
Public hospital	13	2%
School district	8	1%
City government	7	1%
Health district	7	1%
<i>Other</i>	92	13%
<i>Unknown</i>	175	25%
<b>Total</b>	<b>708</b>	<b>100%</b>



Evaluation Goals 10 & 11

# **RHP PARTICIPANTS' EXPERIENCE WITH THE PLANNING AND IMPLEMENTATION PROCESS**

# RHP Experience - Summary

- Respondent perceptions:
  - Positive about anchor leadership
  - Communication between anchor and RHP members, and amongst RHP members, was frequent and productive
  - Their voice was heard and they were involved
  - Their community's needs were being addressed
  - Collaboration was increasing within their RHP

# RHP Experience

- Anchor Leadership

	Yes or Yes, but limited	Min.	Max.
Provides <u>leadership</u> in ongoing RHP operations	88%	74%	100%
Provides <u>guidance</u> in ongoing RHP operations	88%	72%	100%
Provides <u>accurate information</u> about Waiver Activities	88%	74%	100%
Provides <u>timely information</u> about Waiver Activities	89%	74%	100%
Provides <u>accurate technical assistance</u>	84%	58%	100%
Provides <u>timely technical assistance</u>	84%	58%	100%

# RHP Experience

- RHP Functioning
  - Modes of Communication
    - Mailed, emailed, or faxed written materials most important
    - Group discussions, RHP websites, and webinars also important
    - Social media least important

	Overall	Min.	Max.
<b>Communication <i>between</i> Anchor and RHP Members</b>			
communication <u><i>very frequent</i></u> or <u><i>somewhat frequent</i></u>	94%	78%	100%
communication <u><i>very productive</i></u> or <u><i>somewhat productive</i></u>	98%	67%	100%
<b>Communication <i>among</i> RHP Members</b>			
communication <u><i>very frequent</i></u> or <u><i>somewhat frequent</i></u>	72%	50%	100%
communication <u><i>very productive</i></u> or <u><i>somewhat productive</i></u>	88%	73%	100%

# RHP Experience

- Satisfaction with RHP

	Very Satisfied or Somewhat Satisfied	Min.	Max.
RHP's progress toward <u>addressing community needs</u>	95%	56%	100%
RHP's level of <u>commitment to all partners having an opportunity to participate</u>	94%	44%	100%
RHP leadership's level of <u>commitment to listen to the ideas and opinions</u> of people/organizations involved in the RHP	95%	67%	100%

# RHP Experience

- RHP Impact and Outcomes

	Overall	Min.	Max.
RHP is <b><u>increasing collaboration</u></b> among organizations in the region to increase access to health services	<b>94%</b> (agree or somewhat agree)	78%	100%
Extent to which Waiver activities implemented by RHP are <b><u>beneficial for the residents of their community</u></b>	<b>98%</b> (beneficial or somewhat beneficial)	80%	100%



Evaluation Goals 10 & 11

# **PERCEPTIONS OF THE BENEFITS AND CHALLENGES OF THE WAIVER**



# DSRIP Strengths

- Top identified strengths of DSRIP
  - Resources to serve more patients/clients
  - Opportunity to design innovative projects
  - Collaboration with other organizations in the area/community
  - Access to health services programs
  - Opportunity for system reform

# DSRIP Strengths

General

Investment in  
Healthcare

Innovations

Improved  
Access and  
Patient Care

Collaboration

# DSRIP Weaknesses

- Top identified weaknesses of DSRIP
  - Unclear expectations/changing expectations
  - Project limitations
  - Reporting
  - Timeliness in funding
- Identified weaknesses tie closely with recommendations and are presented in the following slides as Areas for Improvement

# DSRIP Recommendations

Implementation  
Processes

Outcomes

Sensitivity to  
Context

## Implementation Processes

- Minimize changes
- Clearly define expectations to reduce ambiguity
- Simplify rules and reporting to reduce administrative burden
- Provide less-compressed timelines for providers
- Provide timely feedback and guidance for decision making
- Provide timely release of funds
- Involve new providers to meet community needs
- Expand DSRIP menu to facilitate innovation
- Improve communication and collaboration, especially by improving technical assistance

## Outcome Measures

- Improve Category 3 outcome measures by accommodating differences in providers and projects
- Align metrics across categories
- Reduce changes to outcome measures

# DSRIP Recommendations

## Sensitivity to Context

- Recognize and accommodate rural-urban differences
- Recognize and accommodate hospital differences

# DSRIP – Other Insights

- Concern about sustainability of the projects after the Waiver ends
- Mention of external factors that may impact project outcomes
- Stakeholders want time for project maturation and stabilization to better understand effectiveness
- Stakeholders encouraged learning from the process and addressing problem areas



# Summary

- Overall, stakeholders expressed:
  - satisfaction with their RHP functionality
  - agreement that their RHP was meeting community needs
  - optimism about the DSRIP program
- Although there were identified DSRIP weaknesses, stakeholders provided thoughtful recommendations for improvement

# Next Steps

- Network Analysis
  - Continue analysis and conduct relevant comparisons
  - Initiate and complete next portion of data collection (Winter 2015)
- Stakeholder Perceptions and Recommendations
  - Analyze results of Stakeholder Survey related to Uncompensated Care and Medicaid Managed Care Expansion
  - Analyze non-participant feedback, including opportunities and challenges for the Program



**QUESTIONS? COMMENTS?**

# Contact Information

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