

## Texas Healthcare Transformation Waiver

### Instructions and Form for DY3 RHP Annual Report due December 15, 2014

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.

### Instructions

The purpose of the DY3 RHP annual report is to summarize the progress of the RHP during DY3 (October 1, 2013 – September 30, 2014). Information can include key 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 DY3 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 renewal beyond the initial five-year waiver term.

The narrative portions 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/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 DY3 RHP Annual Report Form by December 15, 2014 to HHSC ([TXHealthcareTransformation@hhsc.state.tx.us](mailto:TXHealthcareTransformation@hhsc.state.tx.us)).

### Anchor Information

<b>RHP Number</b>	9
<b>Anchor’s Name:</b>	Christina Mintner
<b>Anchor’s Phone Number:</b>	214-590-4605

1. For information provided in the interim reports previously submitted in the DY, including data on the progress made for all metrics

	# of Cat 1-2 Projects, Cat 3 outcomes and Cat 4 hospitals eligible to report in DY 3	Total# of Metrics (Cat 1 & 2), Milestones (Cat 3), and Reporting Domains (Cat 4)	Total# (Cat 1-4) Reported as Achieved	Total# (Cat 1-4) Approved	Payment Amount Approved
<b>April Reporting Period</b>	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.
<b>Cat 1 &amp; 2</b>	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.
<b>Cat 3</b>	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.
<b>Cat 4</b>	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.
<b>October Reporting Period</b>	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.
<b>Cat 1 &amp; 2</b>	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.
<b>Cat 3</b>	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.
<b>Cat 4</b>	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.
<b>Totals</b>	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.

HHSC will provide information to fill in the above table.

## 2. Narrative Description of Progress Made

*This section should at a minimum include the following:*

*--Summary information on Regional DSRIP implementation of the RHP plan, progress on meeting community needs included in the RHP plan community needs assessment, changes in DSRIP performing providers and other key stakeholders, etc. Project specific highlights may also be included.*

*--Major activities conducted by the RHP during DY3 including updates to the RHP's website and opportunities for public comment (PFM Protocol paragraph 16) for 3-year projects, any RHP-wide learning collaborative events and participation in the Statewide learning collaborative. Please include updates to the RHP learning collaborative plan (can be provided as an attachment), including activities with other RHPs' learning collaboratives. Please also include any quality, health and cost measures that are part of learning collaborative activities.*

*--Any other progress updates from DY3 that the Anchor thinks are important to provide.*

### **Summary of DSRIP Implementation**

Comprised of Dallas, Denton and Kaufman counties, Regional Healthcare Partnership for Region Nine (RHP9) participants include the tax-supported hospital system of the Dallas County Hospital District (Parkland Health & Hospital System, also serving as the anchor), a children's hospital (Children's Medical Center), two local health departments (Dallas County HHS and Denton County HHS), an academic institution (UT Southwestern Medical Center), two physician/dentist practice associated with a health science center (Texas A&M Health Science Center Baylor College of Dentistry and UT Southwestern Medical Center-Faculty Plan), three mental health agencies (Denton County MHMR, Dallas County MHMR, and Lakes Regional MHMR Center), and fourteen private hospitals in the hospital systems of Baylor Scott & White, Tenet, HCA, Methodist Healthcare, and Texas Health Resources. Timberlawn Mental Health System was added as a performing provider in DY3 with a 3-Year project.

In November 2011, the Parkland's leadership requested Dallas Medical Resource's (DMR) assistance in the formation of a Dallas regional healthcare partnership and plan for the Texas Transformation and Quality Improvement Program.

Established in 1989 by the Greater Dallas Chamber of Commerce, DMR is devoted to addressing major issues impacting the health of the Region's citizens and the health care delivery system. It is a partnership between the leaders of the business community and the medical and health care

community. DMR serves as the forum for these groups to work together on such issues as supporting Parkland Health and Hospital System.

On November 22, 2011, DMR responded affirmatively to Parkland's request. In partnership, Parkland and DMR successfully engaged a broad array of stakeholders in the production of the RHP9 plan. From November 2011 to September 2012, a work group and several taskforces produced the plan and ensured stakeholder inclusion and participation.

**The RHP9 Work Group** served as the steering committee and was responsible for the overall direction of plan development and approval of the final draft recommended to the Parkland Board of Managers. It was composed of representatives of Parkland, the performing providers and business leaders. It commissioned three task forces and a plan writing group to develop the required components of the RHP9 plan covering Dallas, Denton and Kaufman counties.

**The Delivery System Redesign Incentive Pool Task Force** (DSRIP Task Force) provided input on statewide protocols and made recommendations for meeting state requirements for the DSRIP projects. It worked with performing providers in the development of DSRIP projects, which became a part of the RHP9 plan.

**The Uncompensated Care Pool Task Force** (UC Task Force) developed recommendations on the creation of the uncompensated care pool and other related state requirements for the RHP9 plan.

**The Community Need Assessment Task Force** in partnership with the Dallas Fort Worth Hospital Council (DFWHC) developed the community health needs assessment (CHNA).

The Task Forces, appointed by the Work Group, were populated with representatives of RHP9 performing providers and other stakeholders. In addition to the appointed members, meetings were open to additional representatives of the stakeholder organizations. There was consistent and regular meeting attendance by all stakeholders.

The DFWHC was commissioned by Parkland to lead and staff the development of the needs assessment because of its extensive data on the region's health and healthcare delivery system. The Community Needs Assessment Task Force served as an advisory committee. It reviewed and identified the regional needs through data analysis, expert presentations, and committee discussions. The major criteria used

to identify and rank regional priorities included population impact, alignment with intervention categories, and whether solutions lent themselves to regional based approaches. The following priorities were identified as the region's major community health needs:

- Capacity - Primary and Specialty Care
- Behavioral Health - Adult, Pediatric and Jail Populations
- Chronic Disease - Adult and Pediatric
- Patient Safety and Hospital Acquired Conditions
- Emergency Department Usage and Readmissions
- Palliative Care
- Oral Health

The community needs assessment was the basis for the selection of DSRIP projects included in the RHP9 plan.

The twenty-six RHP9 performing providers, as well as community and business leaders, are deeply invested in the community's needs, progression of our regional plan, and refining collaborative strategies that will best serve this region.

The formation of RHP9 plan took place over an extended period of time and was finalized in early August 2012. Throughout this formation period, there was considerable interaction with elected officials and other interested parties. It has been the intent and practice for RHP9 to maintain full transparency. The completion of the RHP9 community health needs assessment provided an opportunity to promote public awareness. It was presented to the Parkland Board of Managers in May 2012, resulting in a Dallas Morning News article.

In August 2012, Parkland created a website to provide information on the Waiver and the development of RHP9 plan. It also provides an on-line opportunity for community input.

RHP9 has held three public meetings. On the evening of November 7, 2012, RHP9 hosted a public meeting on the Pass 1 plan at the Dallas County Commissioners Court. An overview of the waiver and its potential impact on the health of Dallas, Kaufman and Denton County residents was presented. The meeting also addressed the waiver's goals to transform the delivery of health care by enhancing access and increasing the quality of care provided. Public comment was invited. In addition, at the regular

Dallas County Commissioners Court meeting the preceding day (November 6<sup>th</sup>), the upcoming public meeting was highlighted, and interested parties were encouraged to attend. They were also encouraged direct questions and comments to the web site.

To provide geographic access, a second public hearing (identical in content to the first public hearing) was held in the Denton County Commissioners Court on December 18, 2012 at 6:30 p.m.

The third public hearing was on October 24, 2013 at 6 p.m. at the Dallas County Commissioners Court. The meeting presented information on the HHSC and CMS review process and on the status of the RHP9 proposed DSRIP projects. Information was provided on the proposed and prioritized New Three-Year DSRIP projects.

It has been the policy and practice of RHP9 to remain open to questions, comments and feedback throughout the plan development process. Comment periods were not restricted and feedback has been and continues to be welcomed.

After submission of the RHP9 plan, the Task Forces used to develop the plan were dissolved. Recognizing a need for ongoing collaboration of RHP9 participants and stakeholders in the implementation of the plan, a new organizational structure was put in place. It provides RHP9 participants with oversight, guidance, monitoring and engagement in the implementation of the RHP9 plan.

**The RHP9 Oversight Board** provides oversight, guidance, and direction in the implementation of the RHP9 plan. It is composed of CEO representatives of Parkland, the performing providers and business community leaders. The Board continued to meet regularly in DY3.

**The Executive Oversight Committee** reports to the Oversight Board. It provides the staff oversight; monitoring and administration of plan implementation of the subcommittees. It also is responsible for developing a stakeholder engagement plan. The Executive Oversight Committee did not meet in DY3.

**The Performing Providers Group** is composed of representatives of all performing providers. The performing providers group meets periodically to receive updates from Parkland in its role as the anchor. It is the forum for discussion and coordination of plan revisions and implementation. And it provides an opportunity to get up dates on HHSC and CMS requirements. In DY3 the Performing

Provider group did not meet as we transitioned to the learning collaborative. Updates were provided at learning collaborative meetings and through routine regional correspondence.

**The Finance Committee** is composed of the performing providers CFOs or their designees. It is the forum for discussion and recommendations on the financial aspects of the plan including but not limited to the IGT funding and processing, and DSRIP project valuations. It also evaluated and made recommendations on the use of a performance-monitoring tool. The Committee continued to meet regularly in DY3.

Biannual reports on RHP9 were presented to the DMR.

Our website is currently under revision to better meet the needs of our providers, provide more comprehensive updates for the community and stakeholders, and document our journey through the wavier. We expect to reveal the updated website in early 2015. A RHP9 newsletter, "Anchor Notes" was also developed in DY3. The newsletter provides an additional outlet to share RHP9 news and updates, project and provider highlights, patient impact stories, and status updates on milestones and metrics.

### **DY3 Achievements**

The achievement of each DY3 milestone brought Regional Healthcare Partnership for Region Nine (RHP9) closer to our goal of transforming the health care delivery system. Collectively our 131 projects support the RHP9 priorities of:

1. Improve Access to Health Care Services
2. Improve Care Coordination and Management
3. Improve Provider Quality, Cost, and Outcome Performance

Our projects align with both our CHNA and the Triple Aim in 8 focus areas:

- Chronic Care Management / Navigation: 32%
- Behavioral Health: 24%
- Access to Primary Care: 20%
- Access to Specialty Care: 9%

- Applied Process Improvement Methodology and Reducing Hospital Acquired Infections: 7%
- Health Promotion and Disease Prevention: 4%
- Improving Patient Experience: 3%
- Cost Containment: 1%

In DY3 our projects moved from the planning stage to implementation. The achievements of DY3 centered on:

### **Expanding Access**

The largest area of growth in DY3 was the **expansion of access** in all areas: primary care, behavioral health care, oral care, and specialty care.

“During DY3, we successfully opened new primary care practices in the Dallas area. One is in the Mill City neighborhood in South Dallas and is in partnership with Habitat for Humanity's redevelopment of neighborhood. The other two practices opened in September on the main Dallas hospital and specialty care location in a large building with pediatric specialty care. One of these practices, Children's Health Pediatric Group Medical District is a primary care practice that will be open approximately 18 hours a day 365 days a year providing an alternative to patients and families who have historically used the Emergency Department for after-hours primary care. The other practice is devoted to children with chronic complex medical needs.” – Children's Medical Center

“Timberlawn has expanded its partial hospitalization program to adolescent and adult medically indigent recipients who are high utilizers of services in order to reduce costly and preventable inpatient utilization for mental health needs.” – Timberlawn Mental Health System

“In DY3 access to primary care in East Dallas was expanded by increasing the hours of operation at the existing East Dallas Health Center. Weekend hours were added beginning in May 2014 resulting in over 100 additional hours of access in DY3. These extended hours of operation, which were offered on Saturdays, provided greater flexibility and convenience to the patients served in the East Dallas community. The center functioned as a walk in clinic which was open and available to patients from 8:00 AM until 12:00 PM, and from 1:00 PM until 5:00 PM each Saturday of operation.” - Parkland Health & Hospital System



“We have added 3 new sites for telemedicine since Oct 2014. We have grown average consults per month from 200 to 300.” - HCA Medical City Dallas

### **Patient Impact**

The waiver is designed to help people. What make an impact are the **patient stories**. Hearing the providers speak on patient’s lives they are transforming and the care they are providing is truly remarkable. In DY3 we exceeded our quantifiable patient impact by 80%. We estimate over 654,500 patient impacts in DY3.

Below are a few examples of the impact of our RHP 9 providers.

In September 2013, 5-year old “Mary” started therapy at the Center for Children with Autism at Metrocare (CCAM). When Mary started therapy, she engaged in inappropriate behaviors often and lasting hours. This included some self-injurious behaviors such as head banging, head hitting, and repeatedly flopping to the floor. Mary was unable to communicate her wants and needs and would engage in severe tantrums by screaming, head butting and scratching others to gain access to her wants and needs. These tantrums would last hours and were difficult for the family to watch and see. Through their waiver project, Metrocare is offering **Applied Behavior Analysis (ABA) services to children on the autism spectrum and/or children with other developmental disabilities**. The goal is to lead each child to his or her potential through evidence based therapy founded on the principles of ABA. The CCAM provides a hands-on approach with assessments, one-to-one therapy, and parent training to maximize progress. Now, one year later, with 4 hours a week of ABA therapy as well as the help of a communicative aid Mary is able to indicate her wants and needs by using the application, signing as well as pairing these with some vocal sounds. Mary has begun to imitate some words including numbers and letters. Moreover, Mary is engaging in fewer tantrums during her sessions at the center, in school, and at home for children with autism.

Baylor Scott & White patient “Nancy” is a 41 year old smoker with morbid obesity, uncontrolled diabetes, hyperlipidemia, and depression. When she started **receiving care management services** through the Baylor Scott & White DSRIP project at the Baylor Community Clinic in Garland her HgA1c was 9.6 and she often forgot to take her insulin. Nancy initially referred to herself as “lazy” and disorganized”. She agreed to

weekly phone calls or clinic visits with her care manager, Sydney. Nancy is now actively engaged in strategizing around problem areas, such as medication adherence and diet. In only 1 month the patient increased her medication adherence by 40% and switched her diet to the “Plate Method” by using smaller plates. Her HgA1c continues to improve and is now at 8.6. She is also currently receiving counseling to treat her depression. The progress is slow but steady. Nancy recently remarked, “I have even amazed myself!” Multiple waiver projects overlap to provide care for Nancy. Access to a behavioral health specialist and pharmacist provide additional needed services for the patients. Depression is common in patients living with a chronic disease. Sydney has the ability to collaborate with the behavioral health specialist and ensure Nancy’s emotional needs are met. Additionally Sydney and the clinic pharmacist review medications and work with the provider to ensure that they are affordable for the patient. Sydney can support the patient’s medication adherence through weekly follow up. The waiver provides the opportunity for team based care – the provider, RN Care Manager, community health worker, social work team, and pharmacy team are all in place to facilitate patient engagement and promote successful self-management.

Denton County Health Department patient “Eddie” is a 28 year-old, Hispanic male, non-smoker who was diagnosed with Type 2 Diabetes in November, 2013. At the time of diagnosis, Eddie’s HgA1c was 13.2%, he also has hyperlipidemia, hypertension and was suffering from tinea cruris. Eddie is a very easy-going young man with an engaging sense of humor. Eddie agreed to enter the **Diabetes Education and Case Management (DECM)** program in March of 2014. He began to follow the “My Plate” method of choosing healthier foods and to control his portion sizes. He also agreed to reduce his consumption of alcoholic beverages. Eddie began a regular blood sugar self-monitoring regimen at home and increased his medication adherence. After 8 months of case management and over 9 hours of Diabetes Self-Management Education (DSME), Eddie has improved his HgA1c to 9.8%. He has also self-identified some problem areas in his diet and has strategized ways to correct these problems to improve his cholesterol levels. The DSRIP project at Denton County Health Department has closed the gaps in Eddie’s health care. He now has access to a glucose meter and testing supplies, can request individual education when the need arises, as well as attend regular DSME or support group meetings, has a case manager to provide regular follow-up, and a social worker who can help him find additional resources outside of health care as necessary. The DECM Team is able to collaborate with the clinicians and outside agencies to improve the level of care that the diabetes patients need. The waiver provides the opportunity to give patients the resources they need to participate actively in their own health care.

Recognizing the need for additional support for patients with a mental disorder and/or substance abuse, Parkland Health and Hospital System implemented a **peer navigation program**. Through care coordination and focused individual support, assistance is provided to this vulnerable population to decrease unnecessary ED visits, increase access to care, enhance self-management skills, as well as increase satisfaction for the patient and family. One patient example, “BB” presented to the emergency room for narcotics withdrawal. She was recognized to be a high risk behavioral health/substance abuse patient and a social worker placed a peer navigator referral. The Peer Navigation program was explained to BB and she decided to enroll in the program. She had several questions for the peer navigator and support was provided regarding groups and transportation near her location. BB called her assigned peer navigator requesting additional information on a local Narcotics Anonymous group and to date has had 6 contacts with her peer navigator. BB has been sober for two months. She has completed all of her paperwork for Metrocare, is compliant with her court ordered meetings, and has been able to reestablish custody of her son.

### **Collaborations**

Collaborations are crucial to the success of impacting delivery system wide changes. Many of our providers **established partnerships** with other DSRIP providers or community organizations to better meet the needs of our patients.

“We developed a relationship with the Texas A&M College of Dentistry to provide dental services in our Baylor Clinic. The clinic opened in July and sees patients five days a week. The community has greatly benefited from this service.” – Baylor Medical Center at Irving

“Collaborating with Texas Health Dallas Emergency Department to create a direct referral process for scheduling frequent flyers and uninsured patients to Healing Hands Ministry (HHM). Collaborating with Texas A&M Baylor School of Dentistry to provide a greater scope of dental care to patients. The Learning Collaborative Meetings focused our attention on additional needs of the community. We built relationships with the Dallas Fire Department at Home Program, behavioral health providers Metrocare, Galaxy Counseling and Pastoral Counseling. As a result of this education, HHM is planning to integrate behavioral health into our primary care practice in DY 4.” – Healing Hands Ministries

“The Crisis Services Project strengthened existing partnerships and collaborations with behavioral health service providers, as well as identified new partners which include mental health hospitals and

community behavioral health clinics.” - Dallas County Health Department

### **Workforce Enhancement**

**The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access.** Workforce enhancement projects are a critical component of bridging this gap. Efforts this year have focused on training existing and new healthcare providers.

“The Altshuler Center for Education & Research (ACER) is continuing to strengthen the collaboration with current staff within Metrocare to ensure available supervision in order to build the number of professional trainees in the following past existing training facilities and schools: UTSW, UTA, UNTD, SMU, TWU, Argosy, Children’s Medical Center, Bellevue, Capella, and CCI Training Center. Within the last 6 months, the center has expanded relations with various training facilities which include: University Texas at Dallas, University of Texas at Austin, Texas Tech University, Texas A&M, Brookhaven DCCC, El Centro DCCC, Midwestern State University, and Abilene College. Most recently, the center has been approached by SMU Counseling Department seeking placement for 24 graduate interns, and UT at Dallas seeking placement for 6 graduate interns.” - Metrocare

“In our three education-oriented projects, we have augmented three of our teaching platforms to specifically include DSRIP-related topics. With the addition of these topics, we are educating and training the current population of primary care providers in RHP9, as well as future providers that will graduate from our medical school and allied health professions school, in Family Medicine and Physician Assistant Studies, with DSRIP-related skills which will enhance community efforts in population health management, chronic disease management, patient-centered medical home development, and process improvement at the practice level.” - UT Southwestern Medical Center at Dallas

### **Chronic Care Management**

Similar to national trends, North Texas is experiencing **increasing rates of many chronic diseases**, including heart disease, cancer and stroke. Also there are increasing rates of asthma and diabetes in adults within RHP9.

“The evidence-based program has shown to help participants make substantial and sustainable gains in functioning on a number of dimensions not the least of which are community engagement and

employability in more normalized settings. Participants graduating in DY3 made remarkable change in their recovery through the year in social cognition, optimism, social engagement, appropriate interactions and self-esteem.” - Lakes Regional MHMR Center

“In DY 3, Doctors Hospital was able to successfully hire a Certified Diabetics Educator to assist with the education needs of newly diagnosed diabetics as well as those who have not traditionally been able to manage their disease due to lack of knowledge on proper dietary/nutritional and exercise needs.” – Doctor’s Hospital at White Rock Lake

“125 patients were enrolled in the Diabetes Chronic Care Management Program for DY3 exceeding the target of 100. All patients were referred or provided additional services based on individual needs and included services such as a referral to a PCP, HbA1c screening, education for additional chronic illnesses, assistance with community resource needs through the ED Navigator program for support for food, transportation, safe shelter, diabetic testing supplies, and medication assistance to name a few. Positive patient satisfaction and active patient participation were noted.” – Texas Health Presbyterian Hospital Denton

### **Patient Navigation**

The goal of patient navigation is to remove the obstacles patients face in accessing or receiving treatment. RHP 9 providers are actively engaging creative and unique ways **to incorporate patient navigation into their operations**, including working with community and healthcare resources.

“Patient navigators have surpassed original DY3 goals and have successfully enrolled over 3600 patients in the Methodist Richardson patient navigation program. Efforts of the program have focused on connecting the targeted patient population with area primary care providers and accessing additional resources (prescription benefits, transportation vouchers, etc.) for this patient population.” – Methodist Richardson

“ED Navigation program at THK has proven to be an asset not only to the hospital in regards to reducing the amount of unnecessary visits by non-emergent patients to the ED, it has also proven to benefit the local community clinic as well as the underserved/underinsured in Kaufman county. A partnership has been formed between the local community clinic. Additionally, a relationship has been formed between

the underinsured in Kaufman county and the Navigators. Patients now ask to speak to a navigator when they are experiencing difficulty with either making an appointment to see their PCP or finding a specialist.” – Texas Health Presbyterian Hospital Kaufman

No projects were withdrawn in DY3.

### **Learning Collaborative Activities**

In DY3 we kicked off our Learning Collaborative (LC). The overarching aim of the RHP9 approach to collaborative learning is to assure that the expertise, tools and resources are organized and deployed in a manner to promote strong collaborative learning and sharing within the region and to produce maximal individual and collective performance in all aspects of the RHP 9 Plan. To achieve this aim, the LC Plan encompasses four main collaborative learning activities:

**Region-Wide Shared Experience and Learning** – designed to convene all performing providers, share experiences, and provide ongoing communication and performance monitoring information during DYs 3-5.

**Shared Implementation Learning (Cohorts)** – focused primarily in DY 3 to share the regional experience and best practices related to groupings of similar Interventional Projects with the aim that all RHP9 providers will successfully launch and complete their Category 1 and 2 Projects meeting associated milestones and metrics.

**Improvement Collaboratives** – initiated in late DY 3 and conducted through the remainder of the Waiver demonstration period, institute 3-5 carefully structured and resourced Improvement Collaboratives through use of the IHI Breakthrough Series Improvement Collaborative model. These collaboratives will be centered on groupings of high impact outcome measures and/or population health status indicators (Category 4).

**Ad Hoc Learning Activities** – conducted throughout DYs 3-5, these activities will be tailored to address specific concerns that would benefit from the application of an improvement model approach. These activities are expected to be of short duration and of reasonably tight scope. Support of the ad hoc improvement functionality will provide adaptive flexibility to the RHP9 Plan implementation.

A Learning Collaborative Committee was formed to guide the above LC activities. The leaders on this committee are actively engaged and have the improvement and transformation of the entire region as their primary interest.

**Region-Wide Shared Experience and Learning** events were held in January and September. Regional project updates were shared at both events.

- **January 2014:** Our learning collaborative kick-off event focused on a history of the Texas Healthcare Transformation and Quality Improvement Program, our CHNAs, a summary of our regional plan, review of our project management tool, and a celebration of our DY2 accomplishments. Project specific highlights and progress were presented on Developing Behavioral Health Crisis Stabilization Services, Enhance Medical Home Model: Healing Hands Ministries, and Chronic Disease Programs. Finally, we introduced the learning collaborative structure and kicked-off the learning collaborative cohorts for Access, Behavioral Health, Chronic Disease, and ED/Readmissions.
- **September 2014:** Keynote speakers presented on: Future of Healthcare: Transformation and the Affordable Care Act; Texas Healthcare Transformation and Quality Improvement Program Waiver; and Population Health through Regional Collaboration. RHP 9 providers shared their highlights, learning's, and experiences through projects updates on Cognitive Enhancement Therapy, Expanding Chronic Care Model, and Patient Transition Program.

In DY3 we launched the **RHP9 Speaker Series**. Events were held in May (DY3) and November (DY4). Subject matter experts were selected based on provider feedback and project focus. Presentations at the May event were:

- **The Need for Wrap-Around Care: Integrating Behavioral Health and Primary Care;** *John W. Burruss, MD, Chief Executive Officer, Metrocare Services*
- **Bringing Care to the Patient: The Mobile Healthcare Program;** *Norman Seals, Assistant Chief, Emergency Medical Rescue Bureau, Dallas Fire-Rescue Department*
- **The Electronic Movement: Improving Healthcare through Data Exchange;** *Christine Killgore-Lannan, Director of Privacy, Parkland Health & Hospital System*
- **Navigating the Patient-Centered Medical Home Model;** *Cliff T. Fullerton, MD, MS, Chief Officer – Population Health and Equity, Baylor Scott and White Health*

Based on the frequency of our projects and the CHNA, four **Cohorts (Shared Implementation Learning)** were formed in DY3: Access, Behavioral Health, ED/Readmission, and Chronic Disease. The cohorts are the essential workgroups that will create and transform change in their respective groups and at the regional level. This arena is where the work actually occurs, ideas are shared, best practices are implemented and collaboration and agreement about changes that need to be made are determined. The cohorts are comprised of the operational people who perform and implement DSRIP projects. The cohorts met 4 times in DY3. Each session included activities for sharing and learning.

- **January 2014:** The cohorts were introduced at the January Shared Experience Event. Providers selected the cohort group that most closely aligned with their project. Breakout sessions were held for each of the 4 cohorts. Providers began the process collaborative sharing, challenges faced in planning/implementation, and goals they would like to achieve from the learning collaborative.
- **February 2014:** This cohort provided an outline of the year's activities, a brief introduction to the IHI Model for Improvement, the use of PDSA, and a description of the projects. Each cohort began the process of goal identification and prioritization through mind mapping and team building activities. Providers agreed to sharing best practices, learning's, and experiences with other RHP9 cohort members, and to test out new ideas within each organizational team that may lead to improvement at both the individual performing levels and the regional level. Providers showed their commitment through the RHP9 LC Cohort Commitment form. Projects were introduced with the "DSRIP News Headline" activity.
- **March 2014:** The focus of this cohort was sharing of best practices, networking and opportunities for collaboration. A summary of possible cohort goals and a regional improvement project was introduced. Providers participated in a "Getting to Know Your Project" activity designed to explain the project interventions and goals.
- **May 2014:** Using a modified IHI Model for improvement, the cohorts were introduced to the performance improvement process of using change packages and driver diagrams to drive change. The Improvement Collaboratives for DYs 4 and 5 were introduced. Based on previous cohort sessions, the CHNA, and project goals, the Improvement Collaboratives will be Behavioral Health and Readmissions. A draft driver diagram was presented for feedback and approval.

In August we began our **Improvement Collaborative**. The Improvement Collaborative Process goal is to share experiences and learning around like processes and topics to achieve improved outcomes in the



areas desired. Although cohorts continued to meet separately, the Access, Chronic Disease, and ED/Readmission cohorts were combined for the Readmissions Improvement Collaborative.

- Readmissions Improvement Collaborative: **RHP9 providers will provide the right care, in the right setting, and the right time for individuals within their target population(s).** The teams will achieve this through a variety of methods such as increasing patient access through new and expanded programs and facilities, evidence based assessment and intervention, creating best practice support systems, and incorporating technology such as telehealth/telemedicine and chronic disease registries for managing complex patient care. This will be accomplished through providers of primary health care, acute care, behavioral health, county health and human services, academic health and dental systems, and the criminal justice system. These providers will change and improve systems of communication, collaboration, and coordination with each other to enhance patient wellness.
- Behavioral Health Improvement Collaborative: **RHP9 providers will achieve better health status, (mental, medical, or both), for individuals within their target population(s).** The teams will focus on improving targeted patient identification through appropriate evidence based assessment, evidence based intervention initiation, creating best practice support systems, and integrating behavioral and primary care services. This will be accomplished by mental health providers, primary care health providers, and the providers in the criminal justice system. These providers will change and improve systems of communication, collaboration, and coordination with each other to enhance patient wellness.

To achieve the goals of the Improvement Collaborative, RHP9 providers will continue to plan, implement, test, and monitor their individual DSRIP projects. In addition, providers will report on one or more improvement collaborative outcome measures related to their DSRIP projects to track regional improvement. A commitment form was distributed. Providers will submit outcomes monthly, or as appropriate, to the Anchor Department through a tracking tool. The Anchor Department will provide status updates on the progress of regional improvement.

Additionally providers shared best practices, PDSA opportunities, driver diagrams, and selection of Category 3 outcome measurement through their project storyboards at the August cohort meetings. At the request of our providers and to further provide guidance and opportunities on continuous quality

improvement, two **Ad Hoc Learning Activities** were conducted in DY3.

- **March 2014:** A webinar was conducted on the **Plan Do Study Act (PDSA)** cycle for performance improvement for use in their projects. The training was provided by the University of Texas Southwestern Medical Center (UTSW) Department of Quality Improvement.
- **August 2014:** One of the goals of the Triple Aim framework is to improve the patient experience of care including quality and satisfaction. The Lean and Six Sigma process improvement methodologies are uniquely suited to facilitate and accomplish such a goal. The **Process Improvement in Healthcare** cohort provides a brief overview of each methodology, the toolsets utilized and case studies from RHP9 providers demonstrating their use. Participants from all skill levels in the quality, clinical and administrative functions were encouraged to attend and learn how these tools can be utilized in their organization. This new cohort was co-chaired by the Operational Excellence team from Parkland Health & Hospital System and the Lean Six Sigma team from UTSW.

We are planning combined learning collaborative activities with RHP10 for DY4.

Representatives from all 26 providers attended the Statewide Learning Collaborative Summit in September.

### 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. Information can also be provided on administrative activities, including reporting.*

The lessons learned below mirror many of the experiences that providers experienced during DY3.

**Patient engagement** was one of the most critical topics throughout the region. There are many reasons a patient might not engage in their own healthcare, however many projects noted that unless the patient's immediate basic needs are met (such as housing, food, transportation, etc.), they will not engage in preventative or ongoing healthcare activities. This is true for both medical and behavioral health providers. Additionally, changing a patient's behavior of using the Emergency Department for

non-emergent care requires more than just making care available.

“If the family is in a housing, food, or domestic relations crisis, healthcare navigation can be unimportant at that time. Successful care navigators have to be able to understand family conditions and assist with current family emergencies (food, housing, paying power bills, etc.) before they can address the health navigation needs.” - Children’s Medical Center

“The use of the ED/hospital to meet social and daily living needs was previously underappreciated. We continue to observe purposeful non-compliance among the frequently sick; many are attention-seeking and lack the capability for self-care. They are dependent upon on the hospital as a source of substance, shelter and compassion. Until such time as other care venues can be offered that do not require co-payment, many of the frequent visitors will continue to use the ED for their primary care”. – UTSW St. Paul University Hospital

“Patients that cannot read or write, in Spanish or English, have little opportunity to improve their health. They cannot understand how to read food labels, ingredients in food products, or education material, leaving little options for them, but one-on-one narrative learning and instruction. The lesson learned for DECM is that narrative learning and instruction is very time intensive”. – Denton County Health Department

“The seemingly short distance between providers (3 Miles) has proven to be more difficult to overcome than anticipated. Providers have worked together to ensure that targeted population has means to reach PCMH. Additionally, even with Mission East Dallas willing to accept patients with no means to pay, we have found there is still a decent sized population that refuses to go there and would rather use ER for primary care needs. ER Case Manager and Referral Coordinator continue to educate patients on reasons that utilizing Mission East Dallas as their PCMH is in their best interest and the most appropriate place for care”. – Doctor’s Hospital at White Rock Lake

Providers have learned that **building community and provider partnerships** are crucial to success.

“Collaboration proved to be a key strategy in the hospital and in the community as resources are defined. We found that there is extreme variability in diabetes management between physician providers. American Diabetes Association recommended measurement and trending of HbA1cs were inconsistently done in this population. Consistent and affordable medications for management of blood sugars were lacking and mostly attributed to the episodic care amongst a variety of providers for any one patient. Next steps will be to leverage community partners in implementing ADA guidelines throughout the community as we meet to agree on what a community plan of care looks like.” – Texas Health Resources Denton Presbyterian Hospital

“Lessons learned have revealed that physician partnerships cannot be understated in implementing an innovative approach of any kind. This level of buy-in is critical for overall success. On a positive note, we were pleased to learn that several of the primary care clinics we talked to embrace the concept of telemedicine as an opportunity to streamline care to their patients rather than the typical referral process and associated scheduling hassles.” – UT Southwestern Medical Center at Dallas

“There were bureaucratic challenges with some of the schools and school districts that were difficult to overcome. By working closely with the school nurses we were able to overcome these barriers in most instances, and add new schools to the program.” – Texas A&M Baylor College of Dentistry

“Understanding the needs of the hospital and surrounding community were important in the development of this clinic. Getting perspectives from ED physicians as well as external family care physicians were important in developing the structure of this Baylor Clinic. Vetting and modeling different clinic scenarios were also important in the development”. – Baylor Medical Center at Carrollton

One of the most valuable lessons learned by providers was to remain **adaptable and flexible to process**

**modifications.** The key for our providers was to know when to make changes and when to hold steady.

“ED navigators have moved their physical location down to the ED allowing for easier access to patients and greater visibility with ED staff. For Golden Cross Clinic referrals, the ED navigators have learned that making the appointment for the patient instead of having the patient make the appointment has led to greater patient satisfaction.” – Methodist Dallas Medical Center

“Rapid Assessment and Prevention (RAP) is succeeding because of the commitment from our leadership to be true to the empirically validated Critical Time Intervention Model and the efforts to resist pressures to overpopulate the program at the expense of the consumer's quality of care and the clinician's ability to serve them at a capacity that is both effective and realistic.”  
– Metrocare Services

“We are also very happy that we elected to deploy telemedicine stations that are mobile (on wheels). Some of our telemedicine studio systems have needed to be moved around, so we've learned that more permanent types of studio systems installations are not a good idea. We learned to unplug the network port data cables during severe storms. The power input to our systems is protected by surge suppression, but we had one of our telemedicine system units damaged by an electrical surge through the network port.” – Lakes Regional MHMR Center

Providers are also diligently working to show their progress through efficient and timely **data collection, measuring, monitoring, and reporting.** Working across multidisciplinary groups, physician networks, community partners, business partners, and varying systems, our providers learned that it takes time and creativity to gather the data needed to evaluate the interventions.

“Some of the lessons learned so far in DY3 include having a robust data collection system in place in order to capture the encounters that occur that could count toward our specialty care project. Because all providers that are in our network are not necessarily on our E.H.R, it is hard to get the data necessary to demonstrate that encounters occurred to count toward our QPI

metric.” – Baylor at Garland

**Resource management** was another key element in implementation and sustainability of the DSRIP projects. Providers learned that in many cases it is taking more time to attain resources or more resources are needed to address the needs than originally identified. Issues included hiring, credentialing, and educating staff, acquiring appropriate space, and finding the right software or hardware for a program. These challenges have taught the project teams the value of contingency planning and working with existing resources.

“The main lessons learned for this project have been around staffing. Finding compassionate staff that can handle the complexities of this population has been a challenge and the project's greatest attribute. Staff must have the ability to interact with all types of patients and also all different types of staff in the ED to be highly effective in their roles.” – Baylor University Medical Center

“Start contracting and credentialing as early as possible with facilities. Working closely with Medical Staff offices to provide them timely with information needed to add tele-psychiatry into bylaws for privileges. Working with the facility med staff to follow the credentialing process closely.” – HCA Medical City Dallas

“Although the dedicated resource of Sepsis Coordinator allows full time focus on Sepsis initiatives, the interdisciplinary team is critical in making the improvements work as they are very reliant on each other to get process done and done timely” – HCA Denton Regional Hospital

#### **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 an RHP. Information can also be included on discontinued projects, and reasons providers did not continue with a project.*

Providers have experienced and overcome many challenges over the last demonstration year.

Challenges materialized from the ongoing administration of the DSRIP project activities and early results of implementation.

Administratively the Anchor received a variety of feedback on the ongoing challenge of planning and implementing the DSRIP project while projects were still in various stages of approval. DY3 brought new challenges to the providers with Category 3 compendium revision, changes to Category 3 selections, QPI reporting, and the new online reporting system. Learning curves for using these various tools along with existing workload provided additional stress.

At the provider level the primary categories of challenge have been:

**Increasing patient involvement** in their plan of care.

“An ongoing challenge for the clinic is a fluctuating no show rate, particularly for initial appointments. Continuing efforts to combat this have included having hospital case managers screening for medication and transportation needs prior to first appointment. The clinic has increased calls to remind patients of upcoming appointments, increased screening for barriers to attending appointments, and will continue to assess any potential areas of improvements.” – THR Presbyterian Hospital of Dallas

“Timberlawn has encountered challenges in engaging this population at the partial hospitalization level of care as many of the unique individuals served do not have resources such as a stable home, family support and are not good historians of demographic information. We have learned that the window to engage this population is small and we must act quickly to engage this population in care. As a result we have begun a Plan, Do, Study, Act to engage this population prior to discharge from inpatient care. We have not seen a large amount of success to date; however, we are continuing to educate our inpatient staff in the importance of the continuum of care and ongoing recovery from chronic mental illness.” – Timberlawn Mental Health System

“Patient Family Advisory committee was been a challenge to gain committed attendance from patient and family. We are a small hospital and a large OB program and meeting commitments have limited participation. We scheduled as best as possible (lunch time) to provide best opportunity for attendance.” – HCA Las Colinas Medical Center

**Resource challenges** ranged from internal challenges to hiring, educating, and credentialing staff to finding physical locations for programs to expand or be built. Additionally, modification of **technology systems**, purchases of new hardware and software systems to allow appropriate data collection and reporting, and ongoing issues with interface across internal and external systems were common in DY3.

“Project obstacles have surfaced in the following area: The time that it took to recruit and onboard/credential providers and maintaining clinic's high volume. Challenges for the project in DY3 included securing Primary Care Physicians and adequate support personnel willing to staff and secure the clinic each Saturday of operation. Hiring physicians in the competitive DFW market has been extremely difficult.” – Parkland Health & Hospital Systems

“Finding area primary care providers who are willing to care for uninsured patients continue to be a challenge. Socioeconomic factors (lack of transportation, housing issues, language barriers, etc.) impacting a large percentage of our patients present an additional challenge when attempting to follow-up and connect patients with the resources that they need. The ED patient tracking system here also lacks the ability to flag navigator patients that enter the ED, allowing ED navigators to quickly identify these patients.” – Methodist Charlton Medical Center

“We have faced challenges in credentialing and contracting providers for Medicaid and Medicare. Learning a new electronic health record has been a challenge as well. We did have some challenges staffing positions early on. Both RN positions and APRN positions have been challenging to fill. We were able to hire and train individuals prior to the end of the grant year as per our metric.” – Denton County MHMR

“We faced significant challenges finding a location for our project. Initially, we struggled to find a place that would accept our project due to zoning regulations. Later, we faced issues with



stigma regarding the individuals we serve keeping us from finding a suitable location for our project. When we found a location, renovations were needed.” – Denton County MHMR

“Trying to find a space has been the biggest challenge faced over the last year. It took extra time with the 2nd location after lease negotiations fell through. For the 3rd location we have yet to identify a space to begin the leasing process.” – Metrocare

“One of the big challenges we have had is around technology and finding a software platform that can interface with our E.H.R. There are rules and regulations around documentation for medication management services and we have been struggling to find a software platform that interfaces with our current E.H.R to avoid double documentation by staff.” – Baylor Medical Center at Irving

Building new programs has created challenges in added **volume of patients/clients**. In many cases, the programs have had outstanding participation which creates the challenge of dealing with a larger than anticipated patient/client load.

“There has been an overwhelming response to the navigation program. Over 700 patients have been presented to the navigators for assistance. Weeding through all of the requests to find the appropriate patients to assist has been a challenge. Tracking and following up with the navigated patients has turned into a full time job for one of the navigators.” – Texas Health Presbyterian Hospital Kaufman

“Managing the increase of OPAT referral notification to additional members of the OPAT multidisciplinary team is needed to facilitate in a timely patient discharge from the hospital . . .”  
– Parkland Health & Hospital System

“While this addition to staff improved our ability to provide services to diverse populations, the challenge to meet the demands of the increase in consumers developed . . .” - Metrocare

“Challenge is now keeping up with increased appointment demand to where we have added a part-time NP position. We have already identified and hired a part-time Nurse Practitioner to start the first week of November. We will be expanding access with this provider to evenings and occasional Saturday hours.” – Baylor Medical Center at Carrollton

Once the technology infrastructure was in place, **measuring, monitoring, and reporting on data** from projects was a challenge.

“Project continues to face challenges with tracking and monitoring patient BP and HgA1c levels following initial DSRIP contact.” – Methodist Richardson Medical Center

“Currently, the Population QI Team’s biggest challenges are the various EMR systems utilized by the UTSCAP Community Clinics posing a data extraction issue, however, the team is working diligently to establish consistency amongst the EMR systems.” - UT Southwestern Medical Center

Finally, one of the biggest challenges was the actual changes in **organizational and system processes** that were necessary to implement the DSRIP project.

“Staffing to complete Post Visit contacts is a challenge as we need to contact many patients and should be within 24/48 hours of discharge so depending on census in hospital/how busy staff is, this can be challenging to complete.” - HCA Lewisville Medical Center

“The challenge with this project has been developing and redeveloping workflows to address the Category 3 changes that have occurred. Because these metrics rely on a diagnosis of a certain condition, we rely on the workflows of physicians to meet these metrics/goals and for some physicians, they are not comfortable with behavioral health and this has been a challenge. We are trying to determine ways to delegate certain tasks to various staff members so that the physicians are not burdened with other workflow issues that contribute to hitting our metrics. Understanding some of the documentation rules and nuances around the Category 3 metrics

has been challenging as well.” - Baylor Medical Center Irving

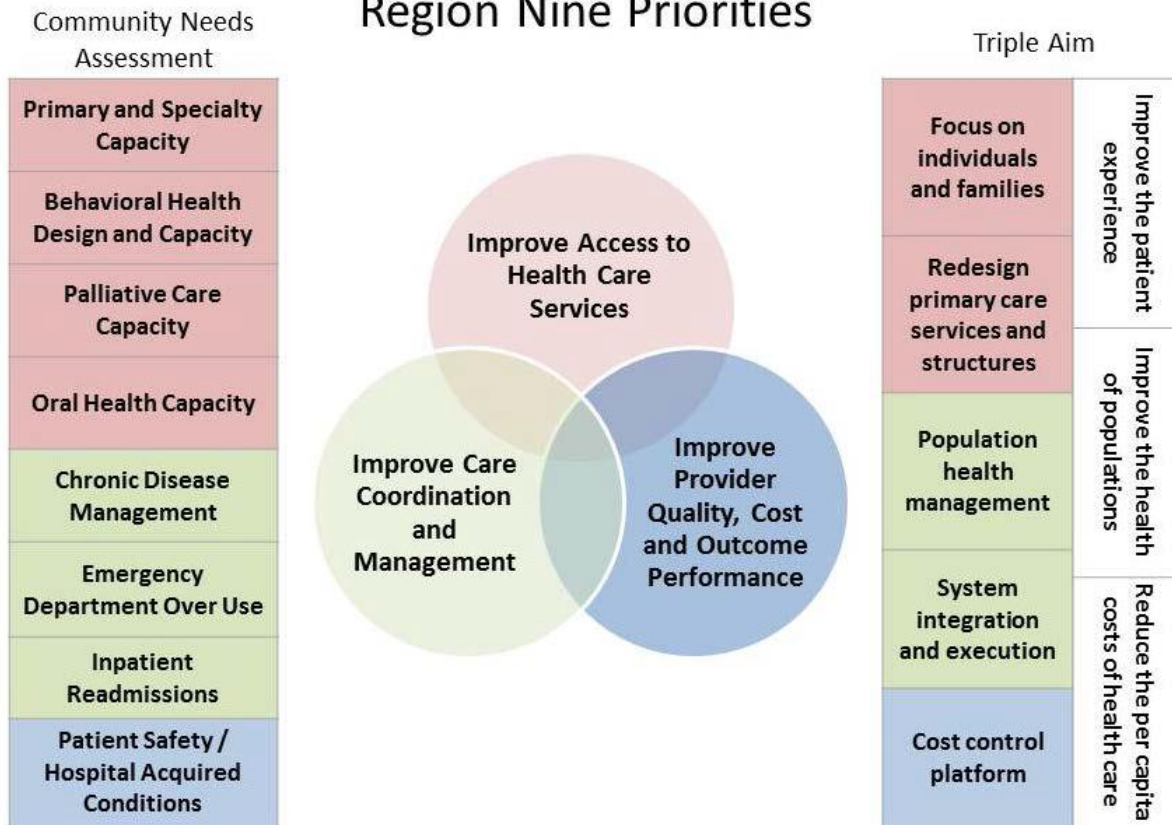
“Converting 2 IT electronic health record modules in 2014 that impacted Sepsis screening and bundle orders. The Sepsis Coordinator was able to monitor compliance daily to follow up one on one with providers and staff for education on new process and mitigate lost productivity in these areas” – HCA Denton Regional

- 5. For purposes of waiver renewal planning, please provide a high level description of the regional system of healthcare that was in place prior to the implementation of DSRIP, the evolution of the system with the implementation of DSRIP, and potential next steps for the evolution of the system in your RHP.**

The North Texas health care delivery market is dominated by several large health systems. While the systems are expanding into growing suburban markets, they maintain major flagship hospitals in Dallas County. These continue to attract a large number of patients from surrounding counties and regions. RHP 9 health care system hospitals and physicians are increasingly working together to address development opportunities as accountable care organizations, prompting greater focus on care coordination and integration across the care continuum. Inclusion of the community mental health centers and local health departments as participants in the RHP 9 plan has yielded greater interface and collaboration among the entire region’s performing providers.

The following schematic presents the factors that frame the Region Nine focus for transformational change. Bracing on one side the challenges that were identified in the Community Needs Assessment and on the other side the intentions of the Texas Healthcare Transformation and Quality Improvement Program embodied by the Triple Aim, RHP 9 has identified three broad priorities for transformation. Each of the region’s DSRIP projects addresses one or more of the priorities. Collectively, the projects that make up our plan will make significant strides in meeting the three priorities.

## Region Nine Priorities



The biggest change we have seen with the implementation of the waiver is the increased access to primary care to the Medicaid and low-income populations. Not only did our safety net hospital and major hospital providers expand primary care, but also two of our community mental health centers (CMHC) integrated primary care in to a behavioral health care setting.

With both our hospital and CMHC providers, there was an increase in behavioral health services. Hospital providers incorporated behavioral health screenings, while our CMHCs expanded interventions for targeted populations and the Dallas County Health Department implemented a crisis stabilization program.

Our projects focus on patient-centeredness. Our providers consider the patients and their families as partners and are encouraged to actively participate in their care. Providers tailored their projects to the unique needs of their patients, while also addressing the CHNA, and working with our regional providers to prevent potential duplication.

As noted in the achievement section of our report, many of our providers executed partnerships with DSRIP providers and community organizations to achieve their project goals.

RHP9 is positioned for ongoing success of their projects to meet the identified community and unique patient needs. Our providers are passionate about transforming the healthcare delivery system. In DY4 we will be working more closely with RHP10. Many of our project initiatives are similar and we have many providers that are in both RHPs 9 and 10. By leveraging the combined resources of RHP9 and RHP10, we will better meet the goals of the Triple Aim. Through discussion with providers and stakeholders, we foresee a stronger system of care in North Texas to improve access and to continue to meet the changing demands of our region.

**6. Narrative Description of Other Pertinent Findings.**

None