

**Instructions and Form for
RHP Annual Report due December 15, 2013**

The Program Funding and Mechanics Protocol (paragraph 23) 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 DY2 RHP annual report is to summarize the progress of the RHP during DY2 (October 1, 2012 – September 30, 2013). While each RHP does not need to duplicate the information already submitted to HHSC and CMS in DY2 (e.g., the RHP Plan, learning collaborative plan, prioritized list for potential new three-year projects), it is appropriate to summarize key information from these documents in the annual report. The annual report also will summarize information for each RHP regarding metrics reporting and achievement in DY2 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 extension beyond the initial five-year waiver term.

The narrative portions should address RHP governance issues (how the RHP came together and is working together), 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 DY2 RHP Annual Report Form by December 15, 2013 to HHSC (TXHealthcareTransformation@hhsc.state.tx.us). HHSC will submit these reports to CMS and also will use them to help inform the statewide annual DSRIP report for DY2 that HHSC is required to submit to CMS by January 2014.

Anchor Information

RHP Number:	9
Anchor's Name:	Christina Mintner
Anchor's Phone Number:	214-590-4605

1. Data on the progress made for all metrics (summary of information previously submitted for the DY)

	# of Providers Reporting Achievement	# of Providers with Payment Approved	Total # of Metrics (Cat 1 & 2) and Milestones (Cat 3) reported as achieved	Total # of Metrics (Cat 1 & 2) and Milestones (Cat 3) approved	Payment Amount Approved
August Reporting Period	17	16	161	130	\$61,951,359
Cat 1 & 2	17	15	78	67	\$48,129,352
Cat 3	16	9	75	55	\$5,612,580
Cat 4	8	8	8	8	\$8,209,427
October Reporting Period	To be completed by HHSC	To be completed by HHSC	To be completed by HHSC	To be completed by HHSC	To be completed by HHSC
Cat 1 & 2	To be completed by HHSC		To be completed by HHSC		
Cat 3	To be completed by HHSC		To be completed by HHSC		
Cat 4	To be completed by HHSC		To be completed by HHSC		
Totals	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.

To fill in the above table, the Anchor should reflect the summary information that HHSC provides for August and October reporting. For August, the anchor will have the results of the HHSC/CMS review. For October, the anchor will only have the information regarding what was reported, not what was approved.

Each Anchoring Entity will be able generate the information for the table above using the summary reports provided by HHSC. HHSC also will plan to make available by early December information in the

summary format above. An Anchor may either use the HHSC-provided summary information for the table above or may use the HHSC information to crosscheck the summary information the Anchor already has generated for the table.

The Anchor also may provide supporting narrative to support or give context to the information in the table.

Supporting Information Regarding Metrics/Milestone Achievement

The achievement of each DY2 milestone brought Regional Healthcare Partnership for Region Nine (RHP9) closer to our goal of transforming the health care delivery system for our three counties Dallas, Denton and Kaufman. Collectively our projects support RHP9 priorities of:

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

The achieved milestones of DY2 focused on:

1. Program Development and Design

- “Plan to integrate primary care to the outpatient psychiatric clinic has been completed. We have identified clinic space (leased signed 10/10/13) and recruited physicians to provide the services. We have provider agreements in place, and identified EMR resource.” – Medical City Dallas Hospital
- “For DY2, we have researched licensure requirements, operational needs and developed a project plan for our behavioral health program. We have hired our multidisciplinary behavioral health team who are taking referrals from MyChildren’s clinicians for visits with our child and adolescent psychiatrist or clinical psychologist. We have set up a referral process with how patients will "flow" through the MyChildren's clinics and if any need to be referred to an external community resource as appropriate. We have initiated our goal of increasing behavioral health visits in the primary care center and transitioning appropriate patients from specialty mental health care to primary care.” – Children’s Medical Center

2. Program Implementation

- “A Diabetes Chronic Care Management Program (DCCMP) was developed utilizing Wagner's Chronic Care Model. The goal is to provide support and assistance in self-care management to low income, uninsured and/or under-insured individuals with diabetes and pre-diabetes in the following areas: disease process; medications; self-management; diet; complications and risk factors; exercise; and emotional support. The program includes self-assessment and goal-setting to determine individual needs as well as group visits and education by various medical professionals including a pharmacist, clinical dietician, certified diabetes educator and physical therapy technician. A baseline

and program completion HbA1c is provided as well as follow up and connections to community resources. The program is overseen by a multidisciplinary committee that reports up to the hospital quality management committee with an identified physician champion. 264 individuals were enrolled.” – Texas Health Presbyterian Hospital Kaufman

- “The Registry has been expanded to encase patient case management files in addition to the initial data set that houses all diabetic patients in DCHD clinics. The registry houses more than 740 diabetic patients. In addition, each patient enrolled in education and case management services has a case management form where information is recorded and updated throughout the case management process. There are 28 patients enrolled in case management, with more being added each week. As DCHD clinics receive new patients with diabetes or existing patients are diagnosed, a referral is sent from the clinical staff to the case management staff for entry into the registry. Each of those patients are assessed to determine their color code to determine eligibility for the education and case management program.” – Denton County HHS

3. Add / Expand Clinics

- “The goal of increasing the number of hours at dental care clinics or offices to 150 hours per month has been achieved. Clinic hours were increased by an average of 103 hours each month, and a total of 215 hours per month was achieved. These additional hours were achieved through a combination of an increase in coverage at the local nonprofit organization's locations and Dallas County's Juvenile Detention Center.” – TAMU Baylor Denistry
- “We opened eight MyChildren's Primary Care Clinics before September 30, 2013. We are doing individualized outreach activities by clinic locations (open houses and partnering with local community entities to market the clinics to our target population.” – Children’s Medical Center

4. Policy / Protocol Review and Revision

- “We have completely developed this chronic disease management program to include curricula and protocols around education and management of chronic heart failure, asthma, COPD, tobacco cessation and diabetes. Training manuals, clinical protocols and E.H.R documentation forms have been completed.” – Baylor Medical Center at Irving
- “Doctor’s Hospital White Rock Lake has created and implemented a standardized care transitions assessment for use on all patients.” - Doctor’s Hospital White Rock Lake

5. Hiring and Training of Staff

- “The navigator roles and responsibilities, training, and orientation were defined and a job description developed. In addition, the team developed workflow, policy/procedures, patient navigator education curriculum, patient assessments and enrollment and documentation guidelines for the navigator program. Initial referral

networks for medical, social, and financial needs of the patients were identified as well as patient follow-up post intervention. In July/August, the first patient navigator was hired, trained, and oriented to the program. Patient enrollment began in September and as of September 30th 10 patients were enrolled in the navigation program.”

– Methodist Charlton Medical Center

- “We reviewed current research on the supply and demand for CHWs. The reports indicated a need, significant benefit, and local resources to do the training for us. We conducted an assessment of how many Medicaid and Indigent patients our providers were seeing or will be seeing during the scope of the DSRIP Program. We then determined that there would be a minimum need of 8 CHW staff to serve this population. With a baseline of zero CHW in place, we determined the gap and prepared a plan to recruit, hire and train the additional CHW support.” – UT Southwestern Medical Center Faculty Practice Plan

6. Gap Assessments

- “After engaging stakeholders, brainstorming, and performing data collection on variation of care (gap analysis), the following process were identified as needing focused attention in DY3: 1. Central line insertion, maintenance and removal, 2. Urinary catheter insertion, maintenance and removal, 3. Surgical Site Infection with focus on perioperative interdisciplinary care and perioperative antibiotic prophylaxis, and 4. Sepsis Mortality with focus on Sepsis Protocol and Early ED Warning System.” – Parkland Health and Hospital System
- “We completed a needs assessment of 200 clients who are current users of the public mental health system to determine needs and to establish and appropriate location for the clinic.” – Denton County MHMR

7. Collaboration

- “In DY2, Metrocare reached out to several community healthcare providers, city and county governments, charities, faith-based organizations and other community based organizations regarding the need for integrated behavioral health services in the community. Five organizations have endorsed the program at the Lancaster-Kiest location.” – Dallas County MHMR, dba Metrocare Services
- “Establishment of weekly meetings with Dallas County Public Defender’s Office, referring Judges, and CSP clinical staff to improve program implementation and service delivery.” – Dallas County HHS

2. Narrative Description of Progress Made

This section should at a minimum include the following:

--Summary information on development of the RHP Plan, community needs assessment, description of DSRIP performing providers and other key stakeholders, etc.

--Major activities conducted by the RHP during DY2 including required public meetings prior to project submission (PFM Protocol, paragraph 10.d), the post-award implementation forum with stakeholders (PFM Protocol paragraph 16), and any RHP-wide learning collaborative events.

--Any other progress updates from DY2 that the Anchor thinks are important to provide.

Progress Update Summary for the RHP for DY2

The RHP9 anchor is Parkland Health and Hospital System (Parkland), the tax-supported hospital system of the Dallas County Hospital District. Comprised of Dallas, Denton and Kaufman counties, RHP9 participants include 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.

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 needs assessment.

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.

Stakeholder Engagement including Required Public Meetings

The twenty-five RHP9 performing providers, as well as community and business leaders, are deeply invested in considering the community's needs and challenges, understanding the goals of the 1115 Waiver demonstration, developing system reformation concepts, vetting ideas 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 6th), 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 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 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.

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.

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.

Description of Lessons Learned

RHP9 experienced a variety of lessons learned at the regional and performing provider level.

RHP9 has learned the importance of **Consistent Communication** with HHSC and other Anchors in order to achieve a consistent message both regionally and at the state level. At the performing provider level lessons learned in communication consisted of a variety of topics ranging from competing electronic medical record systems to stakeholder engagement to communicating with the community prior to opening clinics.

- “The need to include significant stakeholders early and often is essential. Identifying and recognizing who are the real and significant stakeholders can be a challenge all by itself ~ so this task is worth handling diplomatically.” – UT Southwestern Medical Center Faculty Practice Plan
- “Stakeholders depending on their role, have very different perspectives and roles in the hospital. We had to have multiple meetings to discuss the scope and purpose of the clinic.” – Baylor Medical Center at Carrollton (Trinity)

The Waiver is continually evolving and we have learned how important it is to be **Adaptable and Flexible** of the changes and requests from HHCS. There are multiple deadlines and moving parts in the Waiver which creates challenges for our performing providers. The Anchor’s ability to adapt and be flexible impacts the overall Region’s ability to do the same. At the performing provider level, adaptability/flexibility was evident through lessons learned that required refocus, realignment, or engagement of resources and ideas that were not previously identified in the beginning their projects.

- “We have learned that facilities will need to add in their bylaws psychiatric telemedicine. This process takes a few months for completion. We know moving forward with facilities this topic will need to be addressed from the start.” – Medical City Dallas Hospital

- “Enrollment: In the beginning, the navigators attempted to enroll patients via telephonic enrollment but found that face to face or engagement with community based case managements on the acute care side helped build the trust and relationship with the defined population thus increasing the number of patients who were willing to enroll.” – Methodist Charlton Medical Center
- “Taking the program out into the community instead of expecting the participants to come to the facility has had the greatest impact and has been the most significant lesson learned.” – Texas Health Presbyterian Hospital Kaufman

There is a focus in RHP9 to accurately and consistently **Collect, Validate, and Document Data** for the best outcomes and easier data comparison both locally and across the region.

- “The main lesson learned with this project (still underway) is determining consistent and appropriate methodologies for data collection for various metrics.” – Baylor Medical Center at Irving
- “Obtaining documentation supporting the planning that has taken place to support milestone achievement.” – Medical Center of Lewisville
- “Data collection was not standardized and clarification was necessary for inclusion and exclusion for targeted population”. – Denton Regional Medical Center
- “We have learned that there is a lot of information needed to make decisions in the criminal justice system; however, not all information needed to make a decision is housed in a central location. This has presented challenges for developing CSP data systems.” – Dallas County HHS
- “Internal data analysis of utilization patterns has been an effective proxy to standardized risk-stratification tools to identify the highest risk patients.” – Children’s Medical Center

Education lessons learned focused on the development of training that was targeted for the needs of the diverse medical staff and performing providers. In order for many of the projects to be successful it was necessary to provide education on population management, medical processes, scripting, access, care coordination, motivational interviewing, patient self-management, and goal setting to address the challenges of practice transformation needed.

- “. . . ensuring the project was culturally appropriate for the Medicaid/indigent population.” – Baylor University Medical Center
- “There are significant practice transformations that need to occur and training is vital for medical home program implementation success. Appropriate departments are providing trainings which will include population management, medical processes, scripting, access, care coordination, motivational interviewing, patient self-management, and goal setting.” – Parkland Health Hospital System

Building Partnerships is a key component of transforming the delivery of care. Monthly Performing Provider Meetings is an opportunity for the providers to interact and assists in building relationships across the region. Multiple performing providers indicated the importance of building partnerships

ranging from collaboration between different disciplines within their own systems to working with other regional resources.

- “We have found that a collaborative approach including case management, social work, dietitian, and ECI staff is essential in meeting the needs of this population.” – Texas Health Presbyterian Hospital Denton
- “There were bureaucratic challenges in 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.” – TAMU Baylor College of Dentistry
- “Visiting a like program, started three months prior, was valuable in program initiation tips and setting-up collaborative relations.” – Lakes Regional MHMR Center
- “The biggest lesson learned thus far has been that while parents, service coordinators, or providers may believe the patient needs services, obtaining team consensus is not always an easy task.” – Dallas County MHMR dba Metrocare Services

Patient Feedback is essential to the success of a project.

- “Many of the patients assessed have communicated a lack of nutrition knowledge as it relates to their overall health. A Nutrition Workshop is currently being planned in response, for the end of October 2013. This will be followed by Dietician appointments with those individuals needing additional support. Underlying mental health issues have also been found; which shows how vitally important community resources are to this program. Mental health referrals have been added to the list of services provided by case managers. Lastly, "thank you" notes provided to the patient following the initial appointment have been appreciated and seems to have increased patient buy-in.” – Denton County Health and Human Services
- “The CCAM has learned to be flexible with scheduling. A consumer can benefit from 1 hour sessions multiple times a week. 1:2 sessions and groups can be beneficial to the consumers who are ready for that level of service.” – Dallas County MHMR dba Metrocare Services

Finally, many performing providers identified several lessons learned in **Overall Process and Resource Management**. Underestimation of resource needs associated with the waiver projects was identified almost unanimously by performing providers as a huge lesson learned.

- “Because this is new territory for the Baylor Clinics, things such as crisis protocols, authorization so that physicians can view patient's records for behavioral health issues, storage of paper health records with psychotherapy notes were all items that were very time consuming and deterred overall project development. Perhaps partnering with a facility/entity that is well versed in behavioral health could have helped these issues.” – Baylor Medical Center at Irving
- “IT Interface design and implementation has taken longer than anticipated.” – Doctor's Hospital at White Rock Lake
- “Start recruiting even earlier than you think you need to start because there will be unforeseen delays in hiring. Start orienting new physicians and staff on the main campus before the clinic opens whenever possible. The people that oriented on campus before the clinic opened

functioned much more effectively after the clinic opened, making productivity for those individuals much higher. We were afraid to market the clinic before it opened, which was probably not in our best interests.” – UT Southwestern Medical Center Faculty Practice Plan

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 the RHP.

Challenges Faced

RHP9 faced 4 major challenges.

Continuing Development of 1115 Waiver DSRIP Program Requirements Throughout DY2 was the most prevalent challenge faced by providers, along with compressed deadlines and time for achievement of milestones and metrics due to the delay in project approval. As noted by one provider, “Because this was flagged as a Phase I project, the revision and iteration process caused a delay in our ability to implement and operationalize the project.” Many providers did not invest financial and programmatic resources on the development of infrastructure to support the implementation of their DY2 DSRIP projects due to the delay in their project approval and the uncertainty of program requirements. The reoccurring theme in the provider feedback is that due to the delay in approval, they have had difficulty identifying and procuring the necessary infrastructure (staff, equipment, clinic space) to meet their DY2 metrics and milestone.

Due to the high influx of new healthcare projects, many providers **Lacked Experienced Project Management Staff** to manage the large number of complex programmatic and infrastructure projects with existing staff. One provider commented that “Lack of a designated project manager greatly hampered the timely completion of tasks as the project leaders were also responsible for their primary roles as well as overseeing the project.” Their efforts at obtaining this expertise through internal or external sources were difficult. One positive development is that RHP9 implemented a regional Project Management Solution that will assist in mitigating the issue.

The **Ability to Recruit Qualified Health Care Professionals** needed for the successful completion of approved projects is an ongoing obstacle. In many instances providers are competing for the same type of individual to meet their project metrics. There is a critical shortage of bilingual healthcare providers which is impacting providers’ ability to obtain specialized staff. Additionally, “Finding physicians that are willing and competent at working with the Medicaid and uninsured populations has been difficult.”

The ability for providers to **Develop the Processes and Infrastructure to Collect and Report the Required Data** has been challenging. From the anchor perspective, there is a large amount of data management required in compiling the RHP Plan. Overseeing the data across multiple submission and revision processes has been laborious. At the project level many providers expressed challenges in determining final baselines and the on-going tracking of data and outcomes. Many providers with electronic medical records have been faced with making changes and improvements to their systems in response to DSRIP project and the need for heightened data management. One provider stated, “We have had several challenges around DSRIP data collection. Some of the data points we need to collect

require manual work from staff which has been a challenge to incorporate into their workflows. We are working on automating these processes so that it is not so labor intensive.”

5. Narrative Description of Other Pertinent Findings

Other Pertinent Findings Narrative

None.