M-10 RHP Structure Post-DSRIP: Provider Survey Responses

In February 2020, HHSC requested feedback from DSRIP providers on the existing Regional Healthcare Partnership (RHP) structure as part of the transition to post-DSRIP programs. This task is directly tied to Milestone 10: RHP Structure Post-DSRIP which seeks to assess the benefits of having a formal RHP structure post-DSRIP to advance regional collaboration and continued delivery system reform. HHSC appreciates providers who took time to respond to the survey. HHSC will consider all responses below as the agency continues to develop post-DSRIP programs and operations.

Eighty-six out of 290 providers responded to the survey, with all twenty regions having at least one submission. Responses were generally in support of retaining an RHP structure, with most respondents agreeing the structure and Anchoring entities have had a positive impact on their organizations and regions. The RHP structure's positive impact on developing regional relationships and sharing of information and best practices were widely cited as successes of the structure. Most providers agreed that Anchoring entities were beneficial within DSRIP due to provision of technical assistance for reporting, having a single point of contact with HHSC, development of their Community Needs Assessment (CNA), and coordination of regional learning collaboratives. Although most providers saw the benefit of the current RHP functions, the majority of providers agreed that alignment with Service Delivery Areas (SDAs) would be beneficial.

The most common responses to the provider survey are included below.

How has your organization benefitted from a formal RHP structure?

- Majority of providers agreed that their organization benefitted from a formal RHP Structure (79/86). Providers stated various ways they have benefitted, and the most common responses are listed here by theme:
  - The development of regional CNAs has helped providers to better understand the scope of the health issues affecting their region through data and helped to identify pressing needs in their community.
  - The RHP Anchors helped disseminate reporting procedures from HHSC, acted as a go between with HHSC, and clarified any information and/or deadlines from HHSC.
  - The RHP formal structure made it easier to coordinate or collaborate with other providers, develop best practices, standardize processes for continuous quality improvement (CQI), and improve decision making for patient outcomes.
  - The RHP formal structure helped facilitate the regional learning collaboratives, where providers shared lessons learned/best practices, helped each other navigate DSRIP and reporting, provided opportunities for networking, and in some cases, acted as a neutral resource to clarify processes between the performing provider organization and IGT entity.
- Five providers did not agree, stating that their organization did not benefit from having a formal RHP structure.

How has your region benefitted from a formal RHP structure?

- Majority of providers agreed that their region benefitted from a formal RHP Structure (78/86 responders). Providers stated various benefits to their regions, listed here by theme:
  - Some providers stated that providers in their regions were able to build strong partnerships which have shown positive impacts on the MLIU populations.

- Some providers stated their region benefitted from Anchor facilitated communication with HHSC, facilitated communication between providers, easier resolutions for troubleshooting, and Anchor guidance as changes occurred, especially to smaller providers who lacked the staff.
- Many providers thought that learning collaboratives helped providers obtain specific information for that region (i.e., presentations/information relevant to extensive rural areas and comparatively smaller urban areas), provided technical assistance related to reporting, and had workshops that offered one-on-one and group opportunities for providers.
- Several providers stated that the RHP structure created more opportunities for collaboration and coordination, with a focus on best practices (i.e., increasing access to care for MLIU, coordination of services, insights to work flows/processes, data analysis, and overcoming challenges), networking, connecting providers with the same projects/programs to compare outcomes, developing formal partnerships, and addressing how to best serve the community health needs.

- Four providers did not agree and stated their regions did not benefit from a formal RHP structure.

Please describe the most valuable activities performed by your RHP Anchor

- The most common provider response regarding their Anchor's most valuable activities was providing updates about the DSRIP program through periodic calls, emails, or meetings (39/86 respondents)
- The second most common response was coordination of regional learning collaboratives.
- Many providers appreciated their Anchors answering questions, and providing advice, advocacy and technical assistance (i.e., DSRIP reporting, IGT questions, healthcare funding).
- Some providers responded that the coordination of local providers to facilitate sharing of lessons learned, experiences, and opportunities, and/or data exchanges were valuable activities.
- Some providers most appreciated that Anchors led the regional Community Needs Assessment (CNA) process.
- Several providers responded their Anchor helped providers interface with HHSC, including issues related to reporting, audit responses, and NMI requests.
- A few providers valued that their Anchor takes on administrative burden from providers.

What additional support would you have liked from your Anchor?

- About half of respondents indicated they needed no additional support from their Anchor.
- Several providers indicated they would have liked more sharing of information or resources within their region (i.e., data and information sharing, sustainability planning, tracking regional outcomes).
- Some providers wanted more resources shared across regions and increased connectivity to other regions in the state for further understanding and collaboration. Additionally, a few providers wished their Anchor facilitated more collaborative projects, not specifying whether this was within their region or across the state.
- Several providers wanted more help from their Anchor with DSRIP reporting.
- A few providers would have preferred their Anchor share information more frequently or quicker, while one provider wished the information was more detailed.
- Several providers wanted information sharing or workshops regarding quality improvement, value-based payment projects, and connecting with managed care organizations.

Should the RHP structure continue post-DSRIP? If you selected 'Yes' or 'No' on continuing the RHP structure, please explain why. If 'Unsure', what additional information would you need to make a decision?

- Majority of respondents agree that the RHP Structure should continue (50/86 respondents).
  - Providers in support of continuing the RHP structure state that the RHPs allow for support to providers in terms of technical resources and the ability to serve as a liaison between providers and HHSC.
  - Several providers agree that the RHPs allow for the opportunity to collaborate and network between participating organizations.
  - Providers that identify as "low-volume" or "rural" discussed the importance of RHPs advocating for smaller providers.
  - Several providers mentioned that the most valuable aspect of the RHP structure is the support received from their Anchor team.
- Some respondents suggested that they were unsure if the RHP Structure should continue (26/86 respondents).
  - Providers who responded that they were unsure of the need to continue the RHP structure stated that they were unable to answer this question without further definition of a potential replacement for the existing RHP structure and the associated reporting requirements.
- Ten respondents suggested that the RHP Structure should not continue.
  - Providers that did not support the continuation of the RHP structure stated that they did not communicate with other participating providers in their region or the RHP structure was only beneficial for HHSC in terms of ease of communication to providers.
  - Of the 10 providers suggesting discontinuation of the RHP structure, six providers are supportive of a new structure aligned with the Service Delivery Areas (SDAs).

Would any valuable activities be discontinued without the RHP structure? Why would or wouldn't these activities be difficult to coordinate?

- Majority of providers responded that valuable activities would be discontinued without the RHP structure (57/86 respondents) and cited the following reasons:
  - Many respondents indicated that a lack of financial and staffing resources would restrict their ability to continue valuable activities in the absence of an existing RHP structure.
  - Several providers suggested that valuable activities would be discontinued due to the absence of an RHP structure to facilitate communication and coordination among providers. Many providers cited the lack of support from an Anchor team as an explanation for the difficulties that would arise in coordinating activities without a formal RHP structure.
- A third of the respondents selected "No" and cited the following reasons why the valuable activities would not be discontinued (29/86 respondents):
  - Several providers stated that they had committed to the essential activities and would continue despite the possible financial hardships caused by the elimination of a formal RHP structure.
  - Several providers suggested that the activities could continue if an alternative to the RHP structure was implemented.

DSRIP RHPs are not currently aligned with HHS administrative regions or service delivery areas (SDAs). If an RHP structure is required post-DSRIP, would you like the regions to align with SDAs? Please explain why you would or wouldn't like the regions to align with SDAs.

- Approximately two-thirds of providers (51/86) were in favor of a regional structure by Medicaid managed care service delivery areas (SDA). One common reason for favoring regionalization by SDA was to promote strategic alignment between providers and HHS and Medicaid managed care organizations (MCOs). However, a few of these providers, even in favoring regionalization by SDA, were concerned about the disproportionate sizes of some SDA regions, particularly across rural counties and geographically widespread counties in Texas.
- Several providers were in favor of maintaining a regional structure by DSRIP RHP regions (18/86). One common reason for favoring regionalization by RHP was to continue the existing RHP working relationships. Another common reason was concern over the disproportionate sizes of some SDA regions, particularly across rural counties and geographically widespread counties in Texas.
- Several providers (17/86) were unclear about the SDA regional structure to offer input or did not provide any explanation.

Additional Comments

- A few providers expressed additional favor for the continuation of the DSRIP RHP regional structure.
- A few providers emphasized consideration for the unique perspective of rural regions and rural providers in any regional structure.
- One provider particularly expressed the importance of a bridge entity between local providers and HHSC, regardless of the regional structure.