Collaborative Leadership: Foundation for Success
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Agenda

- About Optum

- What is Collaborative Leadership?

- What are the skills, competencies and capacities needed to do it well?

- Examples of how it is being practiced successfully in different settings

- Common barriers and potential solutions

- Q and A

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- **Community and State**
- **Medicare and Retirement**

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Helping people live healthier lives

- Diverse benefits business
- Ensuring 37 million individuals get the best care
- Positioned well for post health care reform

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- **Technology solutions**
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- **Health management and interventions**
- **Administrative and financial services**
- **Pharmacy solutions**

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Helping to make the health system work better for everyone

- Independent businesses providing services to:
- 6,200 hospital facilities
- 246,000 health care professionals or groups
- nearly 60 million individuals

What Is Collaborative Leadership?

- The term **Collaborative Leadership** describes an emerging body of theory and management practice which is focused on the leadership skills and attributes needed to deliver results across organizational boundaries*

"A collaboration is a purposeful relationship in which all parties strategically choose to cooperate in order to accomplish a shared outcome." Basic task of the collaborative leader is "the delivery of results across boundaries between different organizations."

Hank Rubin, author and President of the Institute of Collaborative Leadership

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Toward a New Operating System for Leaders

- Old vs. new models of leadership

Ego System	Eco System
• "It's about me"	• "It's about us"
• Top-down control	• Influence of all
• Command and control	• Hosting community conversations
• Independent silos	• Cross boundary functionality
• Territoriality	• Partnership
• Power struggles	• Mutual empowerment
• Self interest	• Mutual support
• Withholding information	• Joint knowledge development
• Blaming	• Mutual accountability

Source: Adapted from Oxford Leadership Academy Limited 2011.

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Leading Through Conversation

- The collaborative leader:

    - Creates a climate for discovery and emergence

    - Evokes and honors diverse perspectives

    - Asks powerful questions

    - Suspends premature judgment

    - Explores assumptions and beliefs

    - Embraces ambiguity and not-knowing

    - Articulates emergent patterns and solutions

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From Hero to Host

Hero Characteristics

- Leaders have answers; they know what to do

- People do what they're told; they just need good plans and instructions

- High risk requires high control; as situations grow more complex and challenging, power needs to shift to the top (command and control)

Host Characteristics

- Know people willingly support what they have helped create

- Invest in meaningful conversations with diverse participants

- Provide conditions and group processes for people to work together

- Offer unequivocal support; people know the leader is there for them

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Host Characteristics *cont.*

- Keep bureaucracy at bay

- Play defense with other leaders who want to take back control

- Reflect back on a regular basis how they're doing, what they've accomplished, how far they've journeyed

- Work with people to develop relevant measures of progress to make their achievements visible

- Need to be skilled conveners and facilitators

  - Tolerance for and understanding how to use conflict

  - Ability to involve everyone and make sure all voices are heard

  - Capacity to restate arguments, ideas, issues so everyone is clear; includes gift for reframing debate to disarm or enlist as allies many who otherwise would be opponents

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Core Practices of Collaborative Leadership

- Forging a shared purpose that inspires all participants
  - What can we only do together that we can't do alone?

- Crafting shared agreements for engagement and accountability
  - Create scorecard that group can use to monitor its performance after each meeting

- Clarifying roles and decision rights
  - Size and geographic proximity impact decision making

- Creating systems and structures for communication and coordination
  - Transparency is critical

- Harnessing collective intelligence
  - Use social media to solicit ideas

- Ensuring accountability for results
  - Be clear what mutual accountability means; share credit generously

Source: Margaret Wheatley and Debbie Frieze. Leadership in the Age of Complexity: From Hero to Host, 2010

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Case Study #1:
Rocky Mountain Health Plan Accountable Care Collaborative

- Catalysts for Change:

  - Major problem facing State of Colorado Health Care Policy and Financing was that FFS expenditures on the medical side were "burning the house down"

  - Passage of the Accountable Care Act and a democratic governor

- Actions:

  - HCPF issued an RFP for seven Regional Care Collaborative Organizations; program implemented in May 2011

  - RCCOs

    - Connect Medicaid clients to Medicaid providers

    - Help Medicaid clients find community/social services in their area

    - Assist providers communicate with Medicaid clients and with each other, so Medicaid clients receive coordinated care

    - Assist with level of care transitions

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RCCO Primary Responsibilities

Network Development	• Develop a formal contracted network of primary care providers and an informal network of specialists and ancillary providers • This addresses the core program goal of ensuring access to primary care
Provider Support	• Support the PCMPs in providing efficient, high-quality care through activities such as providing clinical tools, client materials, administrative support, practice redesign, etc. • This responsibility ties to the core program goal of ensuring a positive provider experience
Medical Management and Care Coordination	• The RCCOs must ensure that every client receives an appropriate level of medical management and care coordination • This links to the program goal of ensuring a positive provider experience as well as a positive member experience • RCCOs can assist providers with addressing the non-medical needs of their clients that they may not have the in-house capacity to address
Accountability and Reporting	• The RCCOs are responsible for reporting to the state on the region's progress

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Key Performance Indicators (KPIs)

- The Department identified three key performance indicators (KPIs) to target initial improvement efforts and gauge the program's impact on promoting cost-effective and clinically appropriate utilization of services

  - Inpatient Hospital Readmissions

  - Emergency Room (ER) Visits

  - High-cost Imaging Services

- These metrics were adopted because they are strongly correlated with the total cost of care and may be measured using existing claims data

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Year One Results

- Extensive analysis of the program's performance demonstrates:

  – Reduced utilization rates for emergency room (ER) visits, hospital readmissions, and high-cost imaging services

  – Lower rates of aggravated chronic health conditions such as asthma and diabetes

  – Reduced total cost of care for clients enrolled in the ACC Program

Creating a Role for Colorado West Inc. (now Mind Springs Health, Inc.)

- Colorado West initiated conversation with Rocky Mountain HMO in 2010

- Met with their CEO and started conversation about a common vision for the communities they serve and ways they could work together in the future

  - Shared success stories prior to RFP release in 2011

  - Agreed Rocky Mountain HMO would be the lead organization

    - Numerous conversations re: partnership opportunities

    - Stressed experience managing risk as the BHO for the region

    - Initiated a series of community conversations that included Rocky Mountain HMO, Colorado West, St. Mary's Hospital, and a local IPA

    - Looked for ways to continue to engage

    - Beacon Communities grant provided first opportunity to demonstrate impact

    - Rocky Mountain HMO was awarded grant in 2009; overlap with counties served by Colorado West

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Mind Springs Health, Inc. *cont.*

- Requirement of Beacon Communities grant was to administer depression screenings in primary care settings
  - Rocky Mountain HMO using own instrument and shared patient concern about always having to answer the same four questions
  - Colorado West CEO suggested problem might be a workflow issue
    - Recommended changing to a standardized screening tool (PHQ 2) and having nurse administer the questions when taking the patient's blood pressure
    - Patients loved the change
    - Patient satisfaction started to increase
    - CEO now had a seat at the table

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Mind Springs Health, Inc. *cont.*

- First real opportunity for collaboration was the CMS Innovations grant opportunity
  - Proposal included an integrated global budget
    - Required that Rocky Mountain HMO and Colorado West be able to integrate claims to create integrated budget
    - Developed set of principles on sharing BH claims data
    - Hired actuary who used summary data
  - Also included funding more BH clinicians who would be embedded in primary care
  - Also proposed using Hot Spotter technology and hiring change drivers

Mind Springs Health, Inc. *cont.*

- Outcomes:
  - Application disqualified due to budget spacing error, **however…**
  - Relationships had been cemented; core partners moved from devastation to recommitment
  - RMHMO proposed a Steamboat Springs pilot and hiring two BH staff
    - One as a "Hot Spotter"; the second was embedded in a PC practice
    - Project funded by primary care doctors willingness to "give up" the $3.00 pmpm they received from the RCCO to fund positions
    - Went live summer 2011
    - Colorado Health Foundation funded part of a third BH position; RMHMO funded the rest

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Mind Springs Health, Inc. *cont.*

- Hot Spotter Program requires that any patient referred to the program by a hospital or physician will receive home visits including follow up on patients who have just had surgery

- Metrics to be collected included:

  - Readmissions

  - ER Use

  - Pharmacological use

  - Hot Spotter patients linkage to physicians and tracking visits

Developing the Accountable Care Collaborative

- A core leadership council formed in Mesa County that met monthly
    - Membership included CEO of Rocky Mountain HMO, CEO of Colorado West, Inc., CEO of St. Mary's Hospital, and CEO of the IPA
    - Core leadership council has morphed into a group of 20: including DHS, Health Department, two other hospitals, nursing homes, public health, hospice, developmental disabilities
    - Council studies issues (i.e., payment reform)
    - Currently discussing that there is no FQHC in Mesa County; do they need one as there are access problems in the community
- HCPF required by 2012 Legislature to do payment reform pilot
    - RFP released in February 2013
    - Steamboat Springs pilot has provided proof of concept
    - Have dusted off CMS Innovations grant
    - Global budget now based on real claims data vs. summary data

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Collaborative Leadership: Forging a System in Pierce County

Cheri Dolezal, RN, MBA

Executive Director, Optum Pierce Regional Support Network

September 19, 2013

MISSION, VISION, & CORE PRINCIPLES

- We help people live their lives to the fullest

- Optum Pierce strategic vision

- To be a "FIRE STARTER" of a recovery driven mental health system of care and a constructive and transformation force in the Pierce County community of care

OUR Pillars of Success for Collaborative Leadership

Central focus: consumers & recovery

Engage the community: *What can we accomplish together?*

Provide best value to our community and State stakeholders

Use the power of collaborative leaders to maximize our impact

Foster innovation in the service of excellence

Model leadership in all of our work

Maintain discipline to execute & fulfill commitments to the community

Develop & maintain the tools to address healthcare challenges

Barriers to Collaboration and Solutions

TURF WARS → Emphasis on collaboration benefits

UNFORTUNATE COMMUNITY HISTORY → Emphasis on transparency

POOR LINKS TO COMMUNITY → Forged new links

LITTLE ORGANIZATIONAL CAPACITY → Offered assistance

Source: http://ctb.ku.edu

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Optum's Collaborative Leadership Process

- Optum held first Community Conversation in Pierce

- Representatives from all the *silos* attended including City, County officials, Jail, Sheriff, Judges, Hospitals Administrators, Legislators, State officials, Community Mental Health Clinics, Primary Care Clinics, FQHC's, consumers & family

Community Strategic Conversation Outcomes

DESIGNATED CRISIS LINE	• Created Single 24/7 Crisis Line • One line ensuring immediate access • *3073* average calls per month
WARM LINE	• Opportunity to speak to a peer when in need of support • Decreasing non emergent crisis calls to the centralized crisis line • Operated by Certified Peers • *180* Average Calls per month
MOBILE OUTREACH CRISIS TEAMS	Children Team and Adult Team (24/7) • Certified Peer, Youth & Family supports on all teams • Adult Crisis Diversion beds—*33* throughout the County • Children Crisis Stabilization beds--*20* throughout the County
CRISIS TRIAGE CENTER	Opened 16 bed "Recovery Response Center" Only Certified Center in WA State—12 hour police holds • **50%** of staff are Certified Peers • **220** average guests per month
EVALUATION & TREATMENT CENTERS	Opened two 16 bed Evaluation & Treatment Centers • Engagement Sanctuary Model • Certified Peers on all shifts • Involuntary detainments are primary guests

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Community Strategic Conversation Outcomes

SYSTEM OF CARE	Consumer empowerment and involvement at all levels • Mental Health Advisory Board over **50%** consumers • Governing Board **43%** consumers
TRAINING CERTIFIED PEER SUPPORT	July 2009: **Zero (0)** Certified Peer Supports Employed July 2012: • **266** individuals trained • **248** employed • **90** wait listed to be trained
PEER INTERNSHIP	Mental Health Resource Center created to provide Wellness Education and Internship Programs for newly certified Peers
PEER BRIDGER PROGRAM	• Assist individuals discharging from E&T's and community hospitals back into community life • Receive 67+ referrals a month • Significantly decreased readmissions

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Medical Integration

EMERGENCY ROOM DIVERSIONS	• Team of Certified Peers and Mental Health Professionals placed in the busiest Emergency Department to meet with people who seek assistance with a mental health presenting issue • Focus on diversions for individuals seeking psychiatric services • **565** individuals seen in 7 months resulting in only **29 hospitalizations**
MEDICAL INTEGRATION	• Co-locating mental health professionals at Primary Care/Community Health Care Clinics. • Effort started Oct, 2011 • **In 6 primary clinics, 2 community clinics and 1 children's clinic**
MOBILE INTEGRATED HEALTH CLINIC	• Integrated primary & mental health care • Utilization of a specially equipped mobile clinic that travels around the County at specific sites weekly • Certified Peers provide engagement & wellness groups • **564** unique individuals being served

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Integrated Health Clinic

The mobile integrated health clinic is a 38-foot mobile unit

- Two fully functional treatment rooms
- Staffed by an advanced registered nurse practitioner supervised by an offsite physician, nursing coordinator and wellness peer-support coach

Independent Housing

RECOVERY CENTERED HOUSING	Partnering with WA State, on a SAMSHA Grant for Permanent Options for Recovery Centered Housing (PORCH). Awarded to Optum Pierce RSN September 2010. Formed three-way partnership with Washington State Division of Behavioral Health and Recovery and Greater Lakes Mental Healthcare (in-network provider) Live: January 2011 • 50% of team are Certified Peers • **74** unique individuals served with **48** in housing
COMMUNITY BUILDERS	Transition of care moving individuals from long term institutional care to independent housing • Majority of staff are Certified Peer Support Specialists • Operational July 2012 • **21** individuals now in housing, **37** in training
HOMELESS OUTREACH	A team of Certified Peers and a Mental Health Professional in 3 Homeless shelters during high traffic periods (lunch/dinner) to provide engagement and linkage to Medicaid & mental health services • Operational June 2012 -- **28** individuals receiving services

Public Safety

JUVENILE DETENTION SERVICES

- At intake, certified youth mentors engage with detainees on arrest and mental health issues.
- Focus on linking youth and families to needed mental health services upon release from detention.
- Family support specialists establish relationships & ongoing plan of care with the family/relatives of the child using the WRAP Model of Care
- After 10 months: **221** individuals have been served and engaged

COMMUNITY RE-ENTRY

- Partnership between County Sheriff's Office/Jail & Optum
- identified 55 high recidivism users of jail services
- Measured recidivism & engagement
- Program designed like a 24/7 Forensic PACT program
- Have seen about half of the 55 and enrolled about 20 in services

JAIL TRANSITION SERVICES

- Daily jail bookings are reviewed for individuals with a past mental health service
- Immediate contact made while the individual is in jail to link them to Medicaid benefits and mental health services
- After 10 months: **2421** individuals served

Collaborative Leadership Performance Outcomes

ACCOMPLISHMENTS: served 26.52% more people and reduced hospitalization rates even in an environment of decreased funding. Due to the use of Peer Support, a redesigned crisis system, partnerships with law enforcement & Emergency Services, and consumers/family members we are able to achieve these outcomes:

Three Year Summary Compared to FY 2009	Prior Year FY 2009	OptumHealth FY 2010	OptumHealth FY 2011	OptumHealth FY 2012
Individuals Served • **32.04% increase in individuals served annually**	12,121	15,262	15,410	16,005
Reductions in Hospitalization Admissions • **33.2% reduction in hospitalizations** • **$7,328624 million est. 3 year savings**	123 monthly	99 monthly	79.25 monthly	71.6 monthly
Involuntary Treatment Act (ITA) Reduction • **32.15% reduction in ITA** • **$4,958,738 million est. 3 year savings**	83.6 monthly	56.8 monthly	55.8 monthly	57.58
Hospital Re-admission Rate / 30 days • **26.4% reduction in re-admission rate** • **$516,510 est. 3 year savings**	12.6%	8.6%	10.75%	8.45%
Inpatient Bed Days / 1,000 • **35.0% below state average** • **$11,980,622 million est. 3 year savings**	19.60	12.13	12.37	13.73

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Community Leadership Signatures of Support

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Thank you.

For more information, please contact:
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