The Process of Partnership Development Between a Colorado Accountable Care Collaborative and a Behavioral Health Provider

Introduction

Recent major health policy reforms, along with increased concern about controlling costs, improving quality of a care, and enhancing access, have increased pressures for various entities in the health system to form partnerships. As a result, important questions include how successful partnerships are formed and maintained over the long-term and what kind of leadership is required for these initiatives to be successful.[1] The following case study examines two Colorado organizations that have built a successful partnership. A cross-sector framework (depicted on page 4) developed from research evidence on cross-sector collaboration is applied to the partnership as a method for conceptualizing the process of system change.

The ultimate goal of health care reform is often defined as the Triple Aim—improving the experience of care, improving the health of populations, and reducing per capita costs of health care.[2] Achievement of these goals will require major changes in the way care is delivered and major reorganization of many components of the health care system. New kinds of partnerships and collaboration among previously disconnected parts of the health care system are increasingly necessary. Cross-sector collaboration is "more likely to form in turbulent environments"[3] as a way to decrease complexity and uncertainty caused by these environmental pressures and to create stability and sustainability.[4] In times of disruption, organizations often recognize that single sector/single organization efforts to solve a public problem are more likely to fail, and thus sectors come together and "fail into collaboration."[5]

This paper examines collaboration within the larger Colorado health reform efforts to demonstrate the interplay between context and partnership development.

Regional Care Collaborative Organization and Behavioral Health Organization Context

As part of health reform efforts, Colorado, and specifically the Department of Health Care Policy and Financing (HCPF, Colorado's Medicaid Department), embraced infrastructure and system changes that have altered the care delivery system to improve care and outcomes and to control costs. A primary part

[1] Rodgers, P. (2015). The dawn of system leadership. *Stanford Social Innovation Review, Winter,* 27-33.
[2] Berwick, D.W., Thomas W. Nolan, T.W., & Whittington, J. (2008). *Health Affairs* 27(3) 759–69.
[3] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006). The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature, *Public Administration Review* Special Issue, 44-55, p. 46.
[4] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006).
[5] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006), p. 46.

of this change was the 2011 implementation of the Accountable Care Collaborative (ACC) program, which acknowledged that the state is composed of regions with unique characteristics and needs. The response was to create seven accountable care organizations, called Regional Care Collaborative Organizations (RCCOs),[6] to serve seven distinct regions of the state. The primary goals of the RCCOs are to improve member health, improve the member and provider experience, and contain costs.[7] The RCCOs are tasked with developing a network of providers, delivering administrative support to providers, assisting with coordination of care across the network of care, reporting on costs, and providing a utilization management function—ensuring funds are utilized to maximize population health goals.[8] The approach also requires medical providers to adopt a Primary Care Medical Provider model (PCMP) to serve as a medical home for the Medicaid members.

The payment structure of the ACC model is multi-layered. The RCCOs receive a per-member-per-month (PMPM) payment for each member enrolled to assist with care coordination and administration of the network of providers. Medical services delivered by the PCMP medical homes are paid for through a managed fee-for-service structure with the medical homes paid directly by the State Medicaid department (HCPF). In addition, the ACC program has performance-based incentives built in for the RCCO and the network of providers. The RCCOs and PCMPs receive these incentive or value-based payments for reaching Key Performance Indicators (KPIs) such as reduction of emergency department visits, increased post-partum visits, and well-child visits for children. To encourage RCCOs to have members sign up with a medical home, the RCCOs also receive a PMPM payment for members who have chosen a medical home within their region within six months of enrolling in the ACC.[9] HCPF plans to gradually add additional payment structures that reward providers for producing high quality care. [10]

[6] Colorado Department of Health Care Policy and Financing, Creating a culture of change: Accountable Care Collaborative, 2014 Annual Report.

[7] Colorado Department of Health Care Policy and Financing, "Creating a culture of change: Accountable Care Collaborative, 2014 Annual Report," *Colorado Department of Health Care Policy and Financing* (2014): 1-20

[8] Colorado Department of Health Care Policy and Financing, "Creating a culture of change: Accountable Care Collaborative, 2014 Annual Report"

[9] Colorado Department of Health Care Policy and Financing, "Creating a culture of change: Accountable Care Collaborative, 2014 Annual Report"

[10] Colorado Department of Health Care Policy and Financing, "Creating a culture of change: Accountable Care Collaborative, 2014 Annual Report"

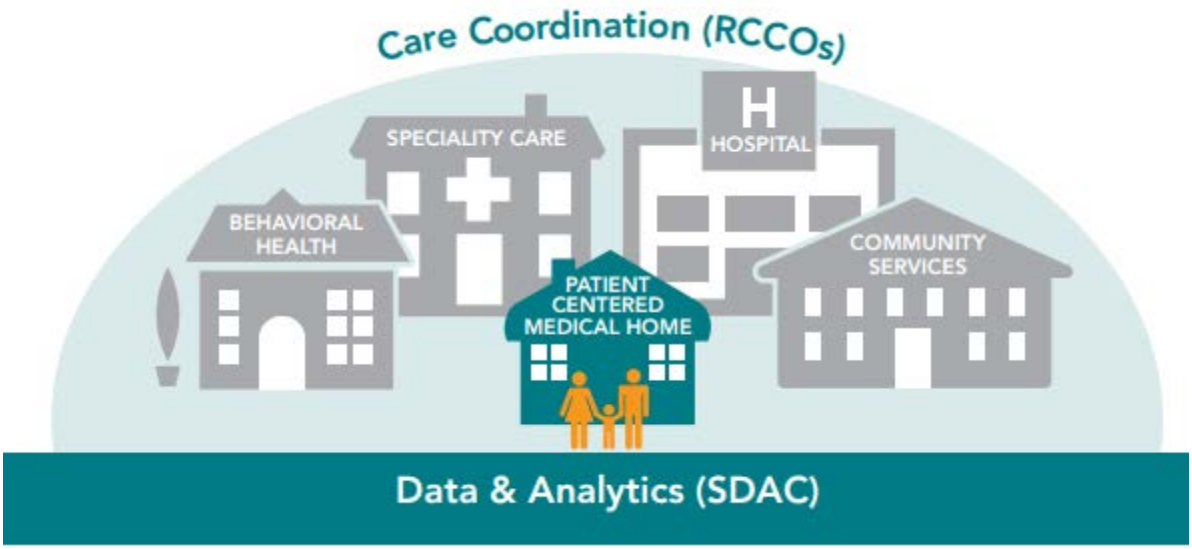


Figure 1. RCCO Model and Graphic from the Colorado Department of Health Care Policy and Financing (HCPF) ACC Annual Report. [11]

Behavioral Health Organizations (BHOs) are an integral component of the Colorado health care landscape. BHOs contract with HCPF to manage all of the Medicaid-reimbursed mental health services and many of the substance use disorder treatment services provided to Medicaid members. BHOs are at full risk for the behavioral health needs and costs of the Medicaid members in their regions. They contract with HCPF and receive a capitated payment (PMPM) for delivering Medicaid services. The program is statewide, with five BHOs serving specific regions of the state.[12] BHOs contract with community-based mental health and substance use providers (large and small organizations) in each region to provide direct care.

BHOs are paid on a capitation basis, with each BHO receiving a PMPM payment for each Medicaid member in the BHO's region. The payment is the same regardless of the amount of services an enrollee uses. Thus the BHO risk and payment structure is meaningfully different from the ACC model: the BHO contract employs a full-risk structure; the ACC model does not.[13]

[11] Colorado Department of Health Care Policy and Financing, "Creating a culture of change: Accountable Care Collaborative, 2014 Annual Report" Reprinted with permission from HCPF.

[12] Colorado also has Managed Service Organizations which have historically provided a management and administrative role for substance use services. MSOs are contracted through the Department of Human Services. In many cases, the BHO has partnered with the regional MSO or contracts with the MSO to integrate services where possible. In Western Colorado, the BHO is one such example of BHO/MSO partnership called Colorado Health Partnership—which is a partnership owned by Pikes Peak Medicaid LLC, SyCare LLC, and West Slope Casa (the MSO).

[13] In October of 2015, The Colorado Department of Health Care Policy and Financing released the Accountable Care Collaborative Phase II Concept Paper outlining ideas and concepts for the next phase of the ACC program. The paper has outlined both finance and governance changes particularly for the behavioral health services in the State. Because the final changes to the ACC model in the next phase are not finalized, we based the information on the existing model and the model that was present during the formation of the partnership which is the focus of this document. Although changes to the ACC model are important, they do not change the process or important lessons learned from this example of partnership.

Case Study

The partnership explored here is between a Community Behavioral Health Center (CBHC) that is a member of a BHO and a health plan that is also a RCCO for one region of the state. In addition to being an example of cross-sector collaboration, the case provides an example of partnership development between a RCCO and a behavioral health provider organization at a pivotal moment.

HCPF recently announced that, in the future, the ACC and BHO contract will be a single contract, rather than two separate contracts.[14] This requires the ACCs and BHOs to consider more formal partnerships. The process that aspiring partners use to develop a shared network and a shared governance structure to maintain that network will have an important effect on the long-term success of the state's ACC model of accountable integrated health care. This case provides insight into how two organizations built a successful network of care for a shared population and, in so doing, share responsibility for integrating service delivery implementation, outcomes, accountability, financial success, and, ultimately, population health management.

LEARN MORE ABOUT THE PARTNERS

Rocky Mountain Health Plans

Mind Springs Health

Sharon Raggio, Chief Executive Officer of Mind Springs Health (MSH, a CBHC) and Patrick Gordon, Associate Vice President of Rocky Mountain Health Plans (RMHP, a health plan) worked together to create a unique collaboration to serve individuals in Western Colorado. The partnership took advantage of disruption in the environment, policy change, and organizational flexibility. In addition, both organizations have leaders that exemplify the system leadership required for successful system change.[15]

The development of this collaboration occurred in three phases: Relationship Building, Model Design and Strategy, and Implementation and Merging of Organizational Activities. This collaboration brings to life some of the theoretical literature on collaborative partnerships—particularly cross-sector partnerships. For example, the partnership fits within Bryson et al. cross-sector framework (depicted below), which is a model other health care organizations can use as a foundation in pursuing partnerships.[16]

[14] Colorado Department of Health Care Policy and Financing, "ACC Model Details and Policy Decisions," *Memo, April 21, 2015.*

[15] Rodgers, P. (2015). The dawn of system leadership. *Stanford Social Innovation Review, Winter,* 27-33.

[16] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006). p. 46.

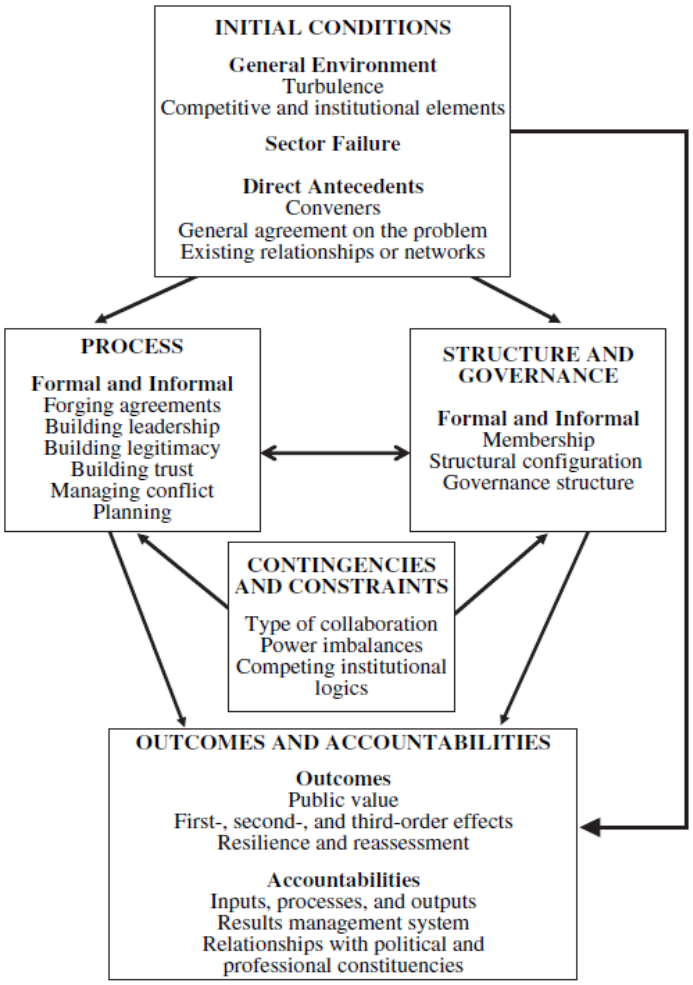


Figure 2. Framework for Multi-Sector Collaboration (Bryson, J.M., Crosby, B.C., & Middleton Stone, M., 2006).[17]

Methodology

We chose the case study approach for this research because we wanted to explore a partnership within the specific environment of Colorado's health care landscape and because we thought the approach would yield some valuable "real world" lessons. A primary assumption of the project was that exploring the context of the partnership was integral to understanding the lessons that the case provides.[18] Health care is seeing an increasing number of partnerships, and yet many of these efforts are failing to see the desired outcomes in the short term, often as a result of failing "to develop a viable and durable basis for

[17] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006).

[18] Yin, R.K., (2012). A (Very) Brief Refresher on the Case Study Method. In *Applications of case study research (3rd ed.).* Washington D.C.: SAGE Publications, Inc.

collective action."[19] This case provided an opportunity to explore how two organizations focused on capacity building and structure of the partnership were able to obtain successful results.

The primary sources for the investigation were interviews with Sharon Raggio and Patrick Gordon, as well as a review of presentations and written materials produced for stakeholders, and research on cross-sector collaboration and Colorado health care reform. Literature on cross-sector collaboration and partnership development provided the theoretical background for the case and influenced the design and findings.

Phase 1. Relationship Building Leading to Partnership Formation (Bryson Framework: Initial Conditions and Process)

Prior to 2011, when Colorado formally initiated health care reform, Patrick and Sharon foresaw the early indications of policy change on the horizon and anticipated a need for a new model of care. Independently, they were looking at new service models, and both had particular interest in the integration of physical and behavioral health care. In addition, both organizations were starting to identify the environmental shifts and complexity ahead, such as an emphasis on truly holistic care, improved population health, and a well-coordinated system of care. More importantly, both leaders became increasingly aware that, working alone, they could not achieve the goals of the Triple Aim or even improved local health outcomes.

For Sharon, some of the environmental cues underlined the importance of getting behavioral health "at the table" and sharing her organization's expertise. Rather than waiting to be invited, she took the imitative because she knew that her organization had important elements of care for future models and that many health leaders might not fully understand the role of behavioral health or exactly what she and MSH could offer. In a collaborative and patient manner, she reached out to Patrick to expand the network and to participate in any of the convenings occurring locally. Sharon reported that she spent a lot of time early on simply listening and being present to understand what RMHP needed and to think about how she and MSH could assist or provide information. Over time, greater trust was established along with an increasing sense that, as a behavioral health leader, she had important information and expertise to share. Researchers note that "system leaders," such as Sharon, "build relationships based on deep listening, and networks of trust and collaboration start to flourish."[20]

Another important element of system leadership for Sharon was to address openly some of the "past battles" between the behavioral health center and key stakeholders. As a new CEO of the behavioral health center, Sharon was deliberate and transparent in addressing internal challenges as well as attending to relationships in the community. Two such examples were fixing and stabilizing the finances of the center—demonstrating financial sustainability internally and externally—and improving communication and rapport with the primary care providers in the community.

[19] Alexander, J.A., Christianson, J.B., Hearld, L.R., Hurley, R., & Scanlon, D.P. (2010). Challenges of capacity building in multisector community health alliances. *Health Education & Behavior, 37*(5), 645-644, p. 646.

[20] Senge, P., Hamilton, H., & Kania, J. (2015). The dawn of system leadership. *Stanford Social Innovation Review,* Winter, 27-33, p. 28.

In this early phase, the leaders got to know one another, shared ideas, and listened to the challenges and barriers each of them were encountering in their independent spheres of the system. Both organizations offered their individual expertise on important elements of the system and started to prove to one another that they were trustworthy and important resources for one another. Over time, both partners had the opportunity to demonstrate that they could follow through with initial tasks, which allowed each of them to prove their credibility—and in, essence, their ability to lead.[21] As the process continued, Sharon and Patrick started to share conceptualization of the specific problems in the system and to define shared goals. In Sharon's own words, "building trust generated the ability to define shared goals and place the focus on shared outcomes rather than any turf or division in purpose."

As these conversations evolved, MSH and RMHP recognized shared goals, a shared vision of a community health system, and a shared leadership approach. They also recognized that they had complementary strengths and knowledge and started to think about how they could work together to reach the population and produce outcomes. As Patrick stated, "The mission became to fill in each other's gaps in terms of knowledge, competencies, data, and services." This acknowledged self-interest *and* interdependence have been found to be "necessary preconditions for collaboration formation" and are essential for governing by network (a key underlying goal of the ACC model). [22] An essential factor of the interdependence was a firm belief that behavioral health and behavior change drive health outcomes—both good health and poor health. MSP and RMHP believed that strong integration of behavioral health with physical health was the only way to make the financial and clinical model successful.

Figure 3. MSH and RMHP Shared Vision

Shared Vision	Population Health—Whole person care that is integrated and improves the health of the community while achieving the Triple Aim.
Shared Goals	Shift state policy away from fee-for-service models that silo care and demonstrate that models of full risk result in improved outcomes.
Shared Philosophy	Focus on the payment structure and health plan first, not the individual different primary care practices; focus on the research; work on philosophy that community providers can impact cost and quality more so than the health plan alone.
Shared Leadership Approach	Collaborative, system leaders with commitment to transparency, community engagement, and foundations of trust.

For both Sharon and Patrick, there was also a bigger goal: not simply local success but demonstration of an improved financial and clinical model that could support changes to state policy, which they believed would ultimately improve care statewide. System leaders are known for re-conceptualizing self-interest and recognizing that "their organizational success depends on creating well-being within the larger system of which they are a part."[23]

[21] Kouzes, J. & Posner, B. (2007). *The leadership challenge*. San Francisco: Jossey-Bass.

[22] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006). p. 46.

[23] Senge, P., Hamilton, H., & Kania, J. (2015).

Other process components of partnership development included regular communication, including meeting four hours a month (on a weekly phone call), and beginning to hold each other accountable for specific goals and action items. Continued testing of the partnership's strength required both leaders to demonstrate that they could address barriers within their own realm and that they could count on one another. One important skill was to demonstrate to one another that they had the ability to "build bridges rather than walls."

Another important process element in the first phase of the partnership was to extend the trust and rapport built between these two leaders to others in their respective organizations, particularly among organizational leaders who would also need to commit to the collaboration. Additional organizational "buy in" would be essential to gaining authority to carry the process forward into a formal partnership. For example, Patrick described going to lunch with Arnold Salazar, the Executive Director of Colorado Health Partnerships, the BHO for MSH. It was essential that Patrick build rapport at the BHO level, and Patrick wanted to demonstrate a genuine commitment to the partnership, to shared values, and to the promise of transparency and trust. In this way, Sharon and Patrick carefully and successfully managed the interactions of the partnership development—an essential component of collaborative leadership.

Phase 2. Model Design and Strategy: Network Opportunity (Bryson Framework: Structure and Governance)

Despite the strong leadership across organizations and a commitment to a new model of care, both organizations acknowledge that a formal partnership would not have occurred without the environmental context of health reform in Colorado and in particular the Medicaid RCCO (ACC) opportunity.

The next phase became development of a more formal partnership, including more formal binding of the two organizations in their commitment to bring to the state a new integrated model with an innovative partnership and payment structure.

Health Care Policy Environment[24,25]
• State started exploring new models of managed care. • Increases in Medicaid enrollment and the economic recession strained the state budget and created a focus on identifying a change from traditional fee-for-service payments for health care. • Colorado passed Colorado Health Care Affordability Act of 2009, enabling the state to enroll an additional 130,000 low-income children and adults into public insurance programs. • Colorado's Governor and Medicaid health policy leadership placed emphasis on payment reform. • RCCO contracts were initially awarded in 2011, with an expectation of a rebid in 2016. • BHO contract was rebid in 2013, with a new contract set for 2014. • Anticipation of the state slowly carving in behavioral health into physical health, with the RCCO construct and governance being the primary delivery model statewide.

[24] Implementing health care reform: A roadmap for Colorado. State of Colorado, Office of the Governor. Retrieved from http://www.colorado.gov/GovernorsHealthReform/pdf/QL-4Ex6Fi90.pdf

[25] Rodin, D. & Silow-Carroll, S. (2013). Medicaid payment and delivery reform in Colorado: ACO's at the Regional Level. *The Commonwealth Fund Publication, 11.*

- Significant development at the grass roots level of models integrating physical and behavioral health across the state.

The existing policy climate left the partners with three important realizations that informed their development of governance structure in a formal partnership:

1. A recognition that the fragmented, volume-oriented basis of the Medicaid model was unsustainable and that neither partner could achieve the desired goals alone; collaboration was essential.
2. A shared view that the policy framework of the ACC model was "directionally correct" in placing an emphasis on community rather than corporate forms of integration; however, there was a need for considerable advocacy to make the case for experimentation with a full-risk model of delivery. The partners found that they were vastly more powerful in advocacy efforts as partners than as individual organizations.
3. A conviction that it is important to ground decisions about design in evidence and practical learning. The partners shared their knowledge of the research that demonstrated that behavior and social determinants of health are more meaningful drivers of health outcomes than health processes themselves. As a result, they embraced behavioral and community integration as a strategy because they knew they needed to "win the war for health, not merely the battle for health care."

As a result of this convergence of views, the partners developed a shared vision of a fully integrated community system characterized by total shared accountability for the cost of physical health, mental health, and substance use. Financial burdens and benefits would be shared (through upside and downside risk sharing) at a level that is proportional to each partners' respective shares of the total global budget and capitalization. They wanted to adopt the full-risk payment approach on the physical health side similar to what existed in the state within the capitated and full-risk behavioral health carve out. They wanted to demonstrate full integration of physical and behavioral health and be able to demonstrate a positive return on investment. This was the foundation of the partnership despite clear recognition that the initial ACC opportunity would not support this full vision. There would be need for a

MEDICAID PRIME

In 2012, the Colorado legislation passed House Bill 1281, requiring payment reform, including global payment reform pilots within the ACC program. This opportunity facilitated the partnership's ability to implement a more full version of the foundational vision. The partnerhsip proposed a payment reform pilot (called the Medicaid PRIME) that combined payment reform, population health management, and whole person care along with with community-based service delivery. HCPF approved this plan for Western Colorado. PRIME allows the partnership to engage in the kinds of shared risk and shared savings that they wanted to test and demonstrate for the state.

stepwise iteration of the model based on policy evolution. Ultimately, it took five years and statutory changes to make the full vision a reality.

Despite the fact that the full model was not implemented in the initial phases of the RCCO, from the beginning, the partnership developed their model as if the full opportunity existed. The design and governance structure were created to be compatible with the long-term vision. They then implemented the model components that were possible within the policy initiatives while advocating for change at the policy level that would allow implementation of the next layer.

Because their focus was on the long term, the process of model development described below is for the full vision. Planning started at the top—examining total cost and the creation of a "real budget with real targets" and a plan to create an integrated care model with tangible and realistic outcome measures including quality and cost metrics. Determining the financial model more specifically required an extensive period of data-sharing, including sharing of claims data and an actuarial assessment. According to Patrick, "The primary goal initially was to improve quality of care with the belief that this would result in cost savings. The design phase was figuring out the nuts and bolts of how we would do the cost savings and the program."

Based on the actuarial projections, the proposed model could be expected to realize a reduction in costs of 1% to 2% out of a $150 million budget, and this reduction was enough to suggest that the model would be sustainable with the service delivery components the partnership believed were required to meet the desired quality of care outcomes. Examining the financial model in this way was an essential step in the partnership process because the financial modeling validated the theoretical model assumptions underlying the partnership. With a strong financial model as a foundation, the partners could then begin to stratify the population by risk and need and begin to scale interventions for the community-based model they had envisioned.

Figure 4. Model Details

MODEL COMPONENTS

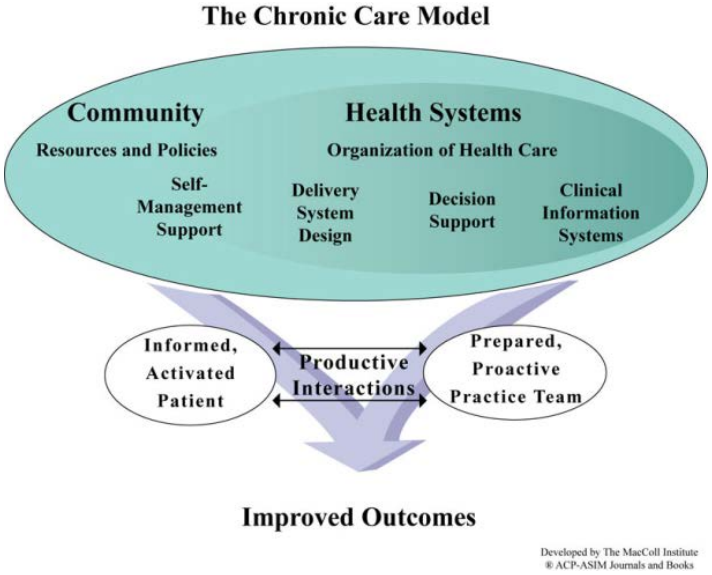
Partnership Model

- **Shared claims data**
- **Developed a logic model and associated global budget**
- **Scaling small tests of change with targeted populations and partners to drive broader transformation**
- **Developing governance**
- **Meet weekly by phone with longer face to face meetings monthly**

Population-Vulnerable Populations Focus

- **Medicaid – Low-income Adults**
- **Medicaid – Individuals Living with Disabilities**
- **Medicare – Low-income Seniors**
- **Medicare – Individuals Eligible for Medicare and Medicaid**
- **Uninsured – Adults without Dependent Children Income ≤ 133% FPL (Medicaid Expansion)**

Chronic Care Community Based Model



To more formally describe the model, the partnership also developed a logic model to demonstrate the model of care with the stratification of the population into the four quadrants (outlined below Figure 5). Patrick and Sharon shared the view that the traditional models of physical and behavioral health were unidimensional and unbending, and they wanted instead to create a flexible network that could take whatever shape was necessary to be responsive to community and individual need. In this way, integrated care moved far beyond putting behavioral health providers into primary care. As the Community Behavioral Health Center (CBHC), MSH works to fulfill the broader role of convener in order

to support, enhance, and develop community-based interventions. As Patrick stated, “This is a significant leg of the stool—community interventions beyond any walls of organizations.”

Since a primary goal of the partnership was to leverage the CBHC training, network, and expertise in community-based services, the CBHC became the pivotal point of integration of services into the community. Utilizing community partners, behavioral health infrastructure, and CBHC clinicians, as well as community health workers and peer specialists, MSH created a community service network. The partners believed in the power of networks and the goal of developing a value base in the community—rather than focusing on specific organizational positioning or market presence. They believed that the real opportunity to improve care was by engaging the non-traditional partners in the community—health and human services, adult protective services, long-term services and supports, and the local public health agency. Rather than compete, the partners served as conveners and network developers to leverage the expertise across the community.

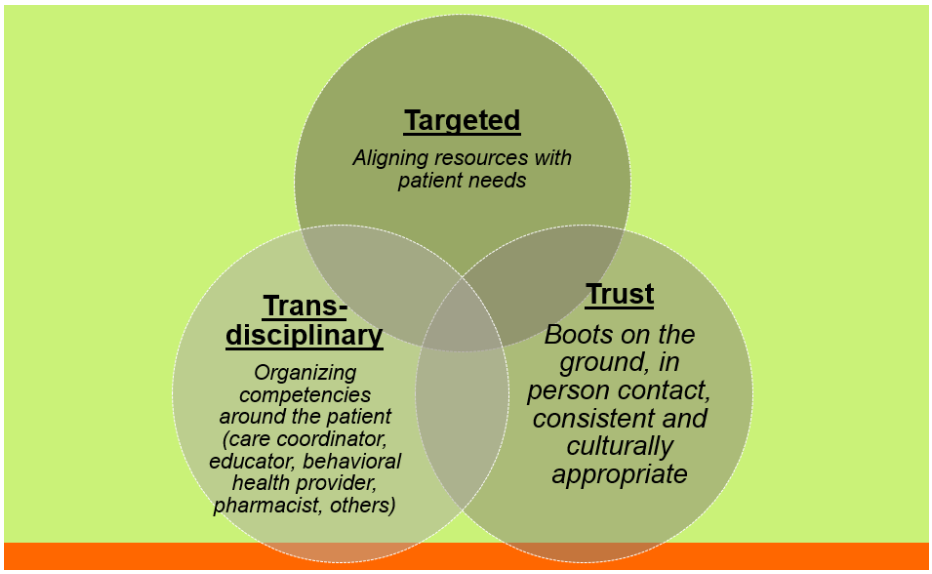
Not only does MSH provide services for behavioral health; they also provide the network infrastructure and function as communicators between numerous organizations to advance a model of care that is truly community-based, not within their organizational walls. Figure 5 describes the theory of the “three Ts” of community integration used by MSH and RMHP to facilitate the networked community. The development of strong relationships with non-traditional partners was as intense a focus for the partners as developing the network of primary care providers within the RCCO model.

Figure 5. Logic Model and Major Components of Care

Logic Model

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Diagnostic Complexity	Low Physical / Low Behavioral	Low Physical / High Behavioral	High Physical / Low Behavioral	High Physical / High Behavioral
Heightened Risks	Accident, Disease, Disability	Accident, Disease, Disability, Major Event / Mortality	Major Event / Mortality	Major Event / Mortality
Patient Characteristics	Not Diagnostically Complex Higher Functional Ability	Major Psych Diagnosis Lower Functional Ability	Major Physical Diagnosis Lower Functional Ability	Major Physical and Psych Co-Morbidities, Lowest Functional Ability
Frequent Confounding Factors	Unhealthy Behavior Lower-Scale Depression Chronic Pain Substance Abuse	Unhealthy Behavior Chronic Pain Substance Abuse Isolation Difficulty Utilizing Primary Care	Unhealthy Behavior Lower-Scale Depression Chronic Pain Substance Abuse	Unhealthy Behavior Chronic Pain Substance Abuse Isolation Difficulty Utilizing Primary Care
Clinical Focus	Behavior Change Pain Management Addiction Disorder	Care Coordination Medication Adherence Behavior Change Pain Management Addiction Disorder Primary Care Access	Care Coordination Medication Adherence Behavior Change Pain Management Addiction Disorder	Care Coordination Medication Adherence Behavior Change Pain Management Addiction Disorder Primary Care Access
Time Horizon for Outcomes	Longer Term	Longer Term	Near Term	Near Term
Planned Interventions	Depression Screening Substance Abuse Screening Motivational Interviewing Patient Coaching Pain Protocols	Trans-disciplinary Case Mgt Substance Abuse Screening Patient Coaching Navigator Services Pain Protocols	Trans-disciplinary Case Mgt Depression Screening Substance Abuse Screening Motivational Interviewing Patient Coaching Pain Protocols	Trans-disciplinary Case Mgt Substance Abuse Screening Motivational Interviewing Patient Coaching Navigator Services Pain Protocols
Additional Coordinated Therapy (When Necessary)	Substance Abuse Treatment Short-Term Therapy	Substance Abuse Treatment	Substance Abuse Treatment Short-Term Therapy	Substance Abuse Treatment
Diagnostic Complexity	Low Physical / Low Behavioral	Low Physical / High Behavioral	High Physical / Low Behavioral	High Physical / High Behavioral

The Three Ts of Community Integration



Similar to Phase 1, Phase 2 of this partnership highlights the important role of leaders and specific leadership capacity, particularly an ability to coordinate efforts in working with stakeholders at the state and the community level. In numerous ways, the two leaders demonstrated the "four forces that provide the primary power for strategic cross-sector collaboration—alignment of strategy, mission, and values; personal connection and relationships; value generation and shared visioning; and continual learning."[26]

Key Leadership Lessons

1. Sharon and Patrick worked together to create solutions to system challenges, including overcoming historical reputations, past battles, and community member fatigue. As discussed in the framework above, the shared destination and the commitment to the partnership grounded in the foundation of a strong relationship allowed the partnership to move together rather than having challenges separate them back into isolated operation or create conflict.

2. Patrick and Sharon were also acutely mindful that they were not working in a vacuum—that the community network of care they envisioned encompassed many additional partners and key stakeholders. The principles that were the foundation for their partnership development were then expanded to those additional partners. Sharon as the CEO of MSH had a particularly important role to play. She knew that there was an historic gulf between MSH and the primary care providers in the community, as a result of some poor experiences prior to her tenure. Sharon worked to build new relationships with the primary care providers—improve trust through relationship building and by being transparent in communication while demonstrating accountability. It was important to prove that MSH could be useful and a credible partner to the providers. A key element of her success was her willingness to acknowledge past mistakes or challenges as a way to move beyond those "past battles" and set the stage for new, improved relationships. Similarly, both partners needed to demonstrate to the external partners and stakeholders that the two organizations were capable of meeting the financial, community, and leadership needs required of the network. As Sharon described it, both MSH and RMHP needed to "demonstrate that 'your house' is in order first." The community needed to see and not simply hear the progress of each organization and to view them as stable and well run.

3. For RMHP and Patrick it was important to communicate and illustrate that RMHP would behave "differently than other health plans." For Patrick this meant a particular focus on transparent communication with community partners. As he described it, "Secrecy is a recipe for disaster."

4. Finally, for both Sharon and Patrick, it was important to acknowledge with external partners and stakeholders that MSH and RMHP were not perfect entities, not finished in development or improvements, and that both leaders and organizations were committed to the new approach of a community-based network and that it would take time to build the model. Both leaders shared their vision for community providers and worked to inspire confidence as partners. They also wanted to illustrate to the community that as key partners they were firmly committed to the collaboration

[26] Austin, J.E. (2000). Strategic Collaboration Between Nonprofits and Business. *Nonprofit and Voluntary Sector Quarterly* 29, 69-97, p. 71.

and that their collaboration would not dissolve into turf battles. Patrick put it this way: "[At] each step of the process, we [the partnership] needed to be candid, demonstrate that it was a rational approach—no games with transparency, no victimizing of each other. We worked together-not individually."

Phase 3. Merging Activities-Implementation and Maintenance (Bryson Framework Outcomes and Accountability)

The partnership today is in the "integrative stage of collaboration"—where missions, workforces, and activities begin to "merge into more collective action and organizational integration."[27] RMHP and MSH have continued to refine the partnership as well as enhance the model of care. In this later phase of partnership development, the focus moves to relationship management—refining the effectiveness and the efficiencies of the shared work, attending to communication, and solidifying mutual expectations and accountability.

Continued attention to mutual expectations and accountability[28] is essential to maintain the progress made and to continue to advance the model and meet expectations of individuals receiving care and the community partners. Both leaders have needed to be patient with the process, as well as to mark and celebrate milestones. Both leaders report being both patient and impatient as they make accommodations to current real world requirements while trying to prepare to meet a new world. This push-pull experience is a consistent challenge for health care partnerships as they try to build capacity that allows the effort to be better equipped for the long term while being held accountable to short-term standards from funding and policy initiatives.[29]

At this phase of the process the partners are able to point to clear markers of success while they continue to set the stage for the next level of change.

Sharon and Patrick articulated *five markers of early success* that signify both process and health outcomes:

1. Designing and utilizing a shared training curriculum
2. Analysis and risk stratification of individuals who experience the highest rates of emergency department use to examine both medical and social factors that drive emergency department use. Risk stratification occurred at two levels of the system:
    a. Health plan
    b. Primary care practice
3. Operationalizing the process for face-to-face and close care coordination (i.e., "warm hand-offs") between distinct parts of the network and then measuring the success of that process
    a. For example, examining the percentage of providers who accept community health worker involvement

[27] Austin (2009).
[28] Austin (2009).
[29] Alexander, J.A., Christianson, J.B., Hearld, L.R., Hurley, R., & Scanlon, D.P. (2010). Challenges of capacity building in multisector community health alliances. *Health Education & Behavior, 37*(5), 645-644.

4. Tracking and reducing emergency department usage
5. Operationalizing the concept of the community health worker and the community framework through routine measurement and review of specific factors such as
    a. the number of community health worker contacts (including face-to-face contacts and phone contacts);
    b. rates of engagement compared to community health worker coaching/intervention; member data points such as the percentage of individuals with behavioral health comorbidity;
    c. contributing factors to use of emergency department; progress toward behavior change; patient satisfaction with the program, etc.

Patrick and Sharon acknowledged that the system needs to have a better process for anticipating the medical, behavioral, or social risk factors that give rise to episodic utilization of the emergency department. This is an example of the importance of the fundamental learning process the partners engage in and how the lessons inform strategy and further development of a "better community-based intervention." The community health worker model and community framework provide the partnership an opportunity to address these issues systemically.

These early successes have resulted in broader significant markers of success as the partnership has entered the maintenance phase. These include:

1. Primary care provider satisfaction
2. Cost savings at multiple levels
    a. Individual member
    b. Cohort
    c. Health Plan

    As Patrick described this early success: "Regarding financial outcomes – I would candidly say that 'off to a good start' means 'more lucky than good,' but we are currently operating within our fixed budget, will be able to reinvest gains in systems and sustain a well aligned model over time if we persist and strengthen all systems – clinical, operational, financial, data sharing and measurement and governance – as we move forward."
3. Deeper provider and system understanding of physical and behavioral health comorbidity, which has resulted in richer organizational integration between the community behavioral health center and the primary care providers.
4. The more complex understanding of why individuals use the emergency department has led to a community systems integration and reduction of silos and duplicity of efforts focusing attention on "coordinating the coordinators."

Both Patrick and Sharon believe that the specific model could be replicated anywhere—that their efforts and success are not unique to Western Colorado. Such depends on leadership, shared vision of what the model could be, sharing goals, and working hard to share data and work together. However, they both agree that the partnership success depends on having the right the policy context. Having a policy environment that allows people to take advantage of opportunities is vital to the success of new health

care models; as has been found in other industries "for partnerships focused on public policy or public problem solving, the institutional environment is especially important because it includes broad systems of relationship across public jurisdictional areas."[30]

Conclusion

Donald Kettl makes a compelling argument that the government's tool chest is out of sync with the new problems and challenges it is tasked with addressing; "the growing complexity of the service delivery systems make it increasingly difficult to ensure the public programs work effectively and efficiently….As more public programs are delivered by private and nonprofit actors, and as many more public programs rely on intricate public-private-partnerships, it is ever harder to make sure the right dots are connected well."[31] The partnership between MSH and RMHP is an example of this complexity and an example of how at the grass roots level the dots need to be connected through a foundation of strong cross-sector partnership. As this case highlights, these organizations spent a significant amount of time building the foundation of trust and shared vision, and this was vital to the long-term success of both the process and the outcomes. The ACO/ACC model is an example of government (both federal and state levels) trying to adapt the tool chest with innovation in policy and accountability structures aimed at creation of collaborative networks with effective partnerships.

Disruptive innovation such as the ACO/ACC model is rarely precisely "right" the first time around. Instead it takes continuous innovation over time to refine the approach and identify the key elements. The partnership between MSH and RMHP exemplifies the role of cross-sector collaboration embedded within these larger networks of government service delivery. The ACO/ACC model will be effective only if the participants seeking to form partnerships are fully committed to developing a more coordinated service for the population being served.

Far too often when the environment in which an industry is operating becomes uncertain, chaotic, and disrupted, leaders and organizations respond defensively, becoming more insular, turf oriented, and adversarial—fighting for what is perceived as shrinking resources. The challenges to the status quo produce fear and anxiety rather than sparking creativity and change. RMHP and MSH's partnership highlights the power of doing the reverse—of reaching out to non-traditional partners and being open to organizational change to take advantage of the changing environment. Partnership and collaboration can often be the answer when organizations can no longer accomplish their goals alone. As broader changes within the health care space focus attention on new goals—obtaining population health, curbing epidemic levels of chronic disease, and bringing health into the community—organizations need to consider collaboration as an essential tool for the "new world."

There are always limitations in drawing conclusions for a case study. However, the purpose of this project was to explore a partnership within Colorado with a clear record of success—focusing on the process of collaboration and leadership. Although some could argue that the specific lessons of the case

[30] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006), p.45.

[31] Kettl, D.F. (2009). *The Next Generation of the United States: Why our institutions fail us and how to fix them*. New York: W.W. Norton & Company, p. 30-31.

apply only to other similar entities in Colorado, the hope is that lessons learned from this one experience can be generalized to other similar situations. Every partnership is unique; however, the experience of this partnership can provide some guidance to other organizations seeking to form new partnerships and collaborative efforts. This is not the only model, and there is no one "right solution" for all collaborative efforts; however, this case study offers an example of how theory can work in practice.

Summary of Lessons by Framework[32] Phases
Initial Conditions
• Federal and state policy changes pushed the status quo and provided opportunity • Growing awareness that single-sector efforts would fail to reach desired goals • Agreement on the problem and solutions (e.g., integration of behavioral health and medical care) • Willingness to reach out towards others in partnership rather than withdrawal
Process
• Investment of time and resources to build trust (informal initially and eventually formal) • Transparent communication (informal initially and eventually formal) • Neither partner had a "set" or "hidden agenda" and remained open to finding solutions collaboratively (informal initially and eventually formal) • Identified challenges—organization-specific as well as shared (informal initially and eventually formal) • Tested and demonstrated accountability and credibility to one another (informal initially and eventually formal) • Defined shared goals, vision, and outcomes (formal) • Defined and engaged shared leadership approach (formal) • Explored each other's value and strengths to identify areas of inter-dependence (e.g., behavioral health drives good health) (informal initially and eventually formal) • Held each other accountable (formal) • Continued testing of partnership strength (formal) • Built rapport together with other stakeholders (formal)
Structure/Governance
• Capitalized on policy opportunity • Created shared governance of the network—everyone has risk and everyone shares in savings • Engaged financial modeling to identify "real budget with real targets" • Testing the financial model required engaging in shared actuarial assessment • Designed and defined specific model components (financial components as well as service delivery model) • Formalized the model and the metrics that would be used to measure success • Extended the relationship building process between the partners to community stakeholders (e.g., worked together to demonstrate partnership, provide transparent communication, etc.)
Outcomes/Accountability
• Remained patient with the process

[32] Bryson, J.M., Crosby, B.C., & Middleton Stone, M. (2006).

Summary of Lessons by Framework[32] Phases
• Remained impatient, understanding the need for continued refinement and improvement • Celebrated milestones • Created clear outcomes for assessing the process and the ultimate outcomes • Routinely reviewed both process and health outcomes to inform design improvements • Maintained focus on the vision • Maintained the shared governance approach • Maintained formal communication processes initiated in Phase 1