The Hard Work of Soft Skills

Four Takeaways from the Third Delta Center Convening

February 11-12, 2019 | Oakland, CA

the DELTA CENTER for a thriving safety net

Community health centers and community behavioral health organizations exist in a complex ecosystem. There are many types of partnerships that can help these providers to thrive while providing quality care. Building partnerships can also be a challenge. Often, building strong relationships between organizations is less of a challenge with known solutions than an adaptive challenge requiring changes in values and attitudes. "Soft" skills become essential, whether in truly understanding partners' priorities, creating "productive disequilibrium" to bring about change, or reframing requests to get a different result.

The Delta Center for a Thriving Safety Net convened grantees from 12 states at our third Learning & Action Collaborative in Oakland, CA, in February 2019. The first day focused on partnering with state Medicaid directors and Medicaid managed care organizations (MCOs), and the second day focused on building skills in adaptive leadership. Below are five key takeaways from the convening.

1. Medicaid Director is both the best job and the worst job.

Keynote speaker Beth Waldman described her former job as a state Medicaid director as one of the best she's had. Why? Because Medicaid directors can affect real change to promote quality healthcare. That said, she added that the position is incredibly challenging because "everyone wants something from you and you have very little to give." Strikingly, she reflected that most requests that she received focused on providers, rather than the impact of an issue on beneficiaries. Her tips for partnering with Medicaid included:

- Remember that the top priorities of all state Medicaid agencies are to stay on budget and reduce cost growth.
- Work on building long-term relationships with the Medicaid office. Medicaid directors often have short tenures (2-3 years). Are there other staff with whom you can build a relationship?

The Delta Center for a Thriving Safety Net was launched in May of 2018 and brings together PCA and BHSA leaders from 13 states for a two-year learning and action collaborative.

The Delta Center is led by JSI Research & Training Institute, Inc. in partnership with the MacColl Center for Health Care Innovation @ KPWHRI and the Center for Care Innovations, and with national partners the National Association of Community Health Centers and the National Council for Behavioral Health.

One of the primary goals of the Delta Center is to foster collaboration between primary care and behavioral health at the state level.

Email: deltacenter@jsi.com
Web: deltacenter.jsi.com

Support for this program was provided by the Robert Wood Johnson Foundation (RWJF). The views expressed here do not necessarily reflect the views of RWJF. Funding stipulations from RWJF prohibited the use of Delta Center funds for engaging in direct or grassroots lobbying.

"We need to try some new things. We love pilots. Maybe they don't work right the first time, but we tweak it and make it better."

- Kimberley Cox Vice President, Specialty Provider Networks, Optum

- When making a request, try to provide a concrete example, illustrate the issue with data, demonstrate how the issue affects both providers and beneficiaries, and come prepared with possible solutions.

2. Payers can be partners.

MCOs are an important partner for community health centers and community behavioral health providers. Health centers and community behavioral health providers have an opportunity to demonstrate their value proposition and make the case for mutually beneficial partnerships. At the convening, the Delta Center hosted a panel of MCO leaders from a variety of settings ranging from urban centers to rural and frontier communities. The panelists were Kimberley Cox from Optum, Kevin Campbell from Greater Oregon Behavioral Health, Inc., and Patrick Gordon from Rocky Mountain Health Plans. The panelists reminded us that all care is local and that value-based payment arrangements, particularly those involving both primary care and behavioral health, are still emerging.

Common sticking points include approaches to measurement and data sharing. For example, panelists acknowledged the lack of an industry-standard outcome tool for behavioral health. Further, data sharing faces technical barriers—such as privacy concerns for substance use disorder patients—and trust and transparency challenges. As the saying goes, the devil is in the details.

Panelists also highlighted some innovative efforts, such as beginning to think beyond health outcomes to measures like kindergarten readiness, and having weekly meetings between a health plan and providers to track progress toward their mutual goals. Panelists shared that pilots of new care and/or payment models can be an opportunity to try out and refine new approaches, and advance both parties' goals. Local/regional initiatives may be a way forward when state-level initiatives feel too slow and complex.

Both Beth Waldman and MCO panelists recognized the value of providers coming together under independent practice associations (IPAs) and/or Clinically Integrated Networks. Beth cautioned that if IPAs are bearing financial risk, there is a level of data and analytics savvy required. MCO leaders described value in the infrastructure that IPAs offer to support providers in quality improvement and care management activities; such activities can help to achieve a plan's goals of improving HEDIS scores and managing costs.

3. Thinking about different kinds of partnerships matters at the provider and association levels.

Value-based pay and care requires expanded data and quality improvement infrastructure and new ways of thinking about your organizations' business case. Partnerships between primary care, community behavioral health, and others can be helpful in building these infrastructures, rather than each organization developing them on their own. Whether it is partnering with other service providers in the community, linking together into IPAs, or even talking about mergers, membership associations have a role in helping providers navigate new kinds of partnerships. For example, Iowa shared how the health centers and the PCA agreed to form an IPA called Iowa Health Plus that would invest in data analytics and ultimately negotiate collectively with payers. PCA staff play dual roles supporting both organizations. Michigan shared how expanding the idea of partnerships to include both behavioral health providers and payers shaped the work, membership, and structure of their association.

"Ultimately we live and die by trust. That means transparency, data sharing, and sharing the wins and windfalls as equitably as possible."

-Patrick Gordon President & CEO, Rocky Mountain Health Plans

4. Leadership requires prompting others to change at a pace they can handle.

Marc Manashil, who led the Adaptive Leadership Workshop, described adaptive challenges as those that require "changes in values, attitudes, and behaviors," and often involve "loss and resistance in the face of necessary change." Community health centers and community behavioral health providers face an immense adaptive challenge in transitioning to value-based payment and care. There's a reason this topic so often involves the word "transformation."

Adaptive leadership asks leaders to use the concept of productive disequilibrium to guide a change process. What is the rate of change that stakeholders can handle? Are stakeholders uncomfortable enough that they're learning and changing? Are they so uncomfortable that they've been pushed beyond their limits, resulting in a 'jumping ship' of sorts? Or are they feeling too comfortable, resulting in work avoidance and looking the other way? Applying these concepts, grantees identified the level of disequilibrium among their stakeholders and developed plans to move stakeholders back into the "productive ranges of distress."

"Leadership is disrupting your own people at a pace they can handle".

- Marc Manashil Consultant, Leadership Development

5. Progress is not linear.

Twelve grantee teams spent time with panelists, speakers, and each other sharing challenges and offering insights about how to address the hurdles in advancing value-based payment and care in their states. Examples of challenges included:

- Behavioral health providers that had formerly operated BH health plans under a global capitation (a highly advanced form of value-based payment on the HCP-LAN framework) being integrated into MCOs under state reforms and struggling to now operate under fee-for-service contracts, which feels like a step backwards on the continuum of payment reforms.
- Navigating delays and potential course changes in advancing a payment reform proposal, which had been carefully crafted with state and provider stakeholders.
- Recognizing that research is needed to better understand how to operationalize optimal integration and collaboration between primary care and behavioral health in different communities, depending on which community resources already exist and what funding is available (e.g., existence of CCBHC, DSRIP, and/or managed care funding).

Yet for every challenge or setback, there were also stories of progress and excitement about where new partnerships could go, including:

- Supporting the development of regional networks to pursue IPAs.
- Partnering with a MCO to share claims data.
- Facilitating partnerships with community-based organizations, such as domestic violence coalitions or legal aid entities, to help address social determinants of health.

*Funding stipulations from the Robert Wood Johnson Foundation prohibited the use of Delta Center funds for engaging in direct or grassroots lobbying. Grantees used their Delta Center funding to support a broad array of policy activities, including background research, education and training, stakeholder engagement and convening, and building shared policy agendas. As state associations, Delta Center grantees used other non-Delta Center funding sources when they engaged in lobbying and legislative advocacy to advance policy.