Collaborative Leadership: Forging a System in Pierce County

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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

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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

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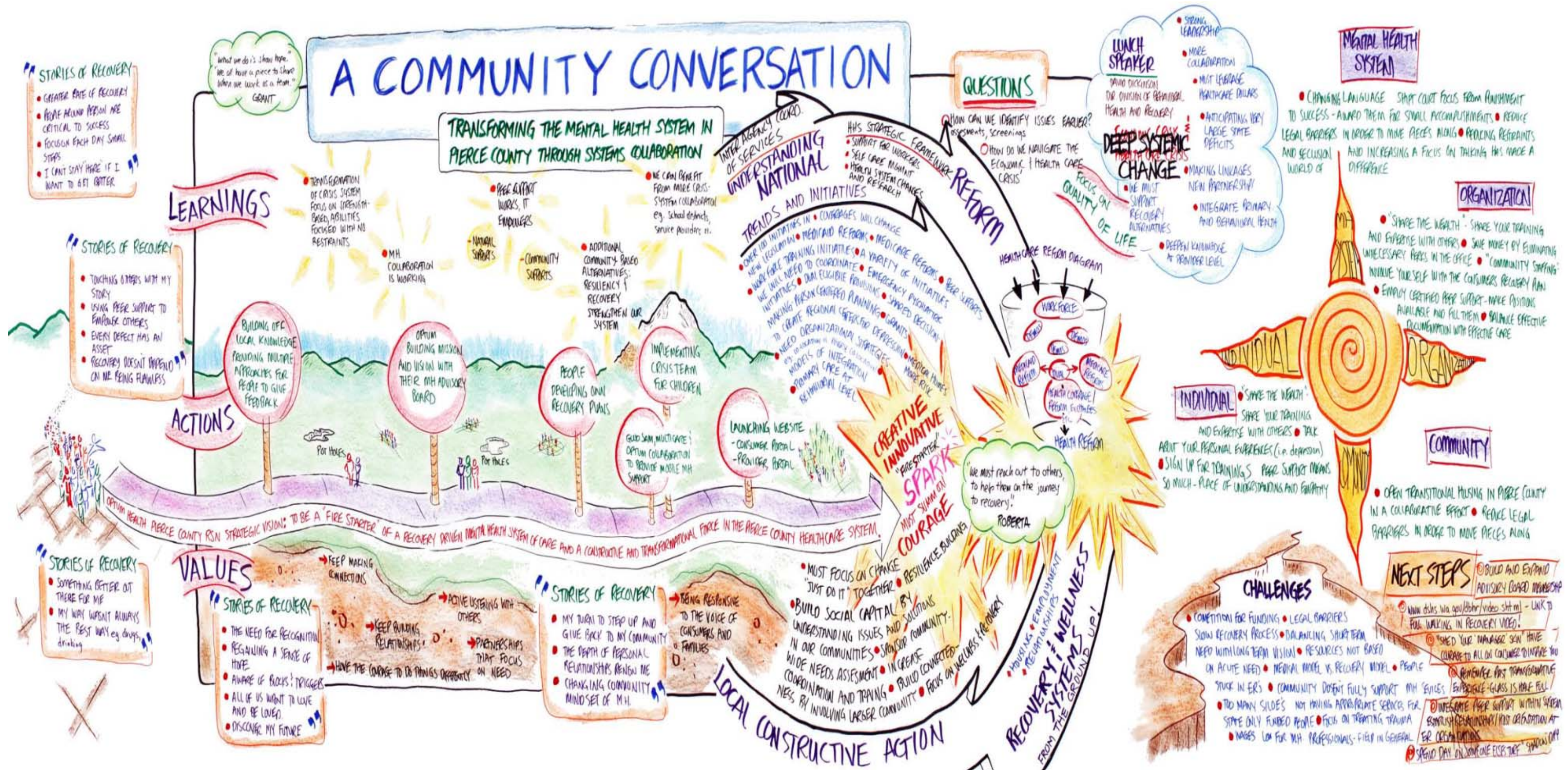
Optum's Collaborative Leadership Process

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



Barriers to Collaboration and Solutions

Barrier	Solution
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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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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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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Documenting Measured Success- Our Passion

Whatever gets measured

- Gets attention
- Gets done

If you don't measure it, you cannot manage it

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Optum Pierce Regional Support Network Outcomes

Serving 32% more people and reducing hospitalization rates even in an environment of reduced funding

- ✓ Use of peer support
- ✓ Redesigned crisis system
- ✓ Partnerships with the County, City of Lakewood, Public Health, City of Tacoma, law enforcement, emergency services and consumers/family members

		Benchmark (prior to Optum)	Optum Year 1	Optum Year 2	Optum Year 3
32.0%	increase in individuals served annually	12,121	15,262	15,410	16,005
32.3%	reduction in hospitalizations, *$7.3 million estimated cumulative 3-year savings*	123 monthly	99.0 monthly	79.3 monthly	71.6 monthly
31.1%	reduction in Involuntary Treatment Act admissions, *$5.0 million estimated cumulative 3-year savings*	83.6 monthly	56.8 monthly	55.8 monthly	57.58 monthly
26.5%	reduction in 30-day readmission rate *$0.5 million estimated cumulative 3-year savings*	12.6%	8.6%	10.75%	8.45%
35.0%	below state average for inpatient bed days/1,000, *$12.0 million estimated cumulative 3-year savings*	19.60	12.13	12.37	13.73

•Source: Optum analysis of redesigned regional support network, G. Dolezal and F. Motz, 8/1/13. Reduction in hospitalizations, ITS reductions, and reduction in 30-day readmission rate percentages are calculated as the average reduction over the 3-year period compared to the prior year benchmark. Bed days per 1,000 is calculated as bed days divided by total covered county population. Average length of stay and daily unit cost based upon the base period experience.

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$12,800,000

Performance Measure Outcome Savings

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Mobile 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

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Medical Integration: Community Strategic Conversation Outcome

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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Public Safety: Community Strategic Conversation Outcome

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

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Independent Housing: Community Strategic Conversation Outcome

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

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Healthcare transformation requires…

Integration instead of Silos

Care Coordination instead of Fragmentation

Person-Centered instead of Medical Model

Community Leadership

New Federal and State legislative directions

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OPTUM WA QUALIFIED HEALTH HOME LEAD ENTITY

OPTUM WA LEAD ENTITY

Broad-based regional provider networks

Contracted to the State as a Qualified Health Home

Subcontract with local/regional organizations that provide all Health Home coordination services

HIGH COST / HIGH RISK POPULATIONS

Medicaid Managed Care
Amerigroup and Molina

Medicare/ Medicaid-Fee for Service (DUALs)

Medicaid-Fee for Service

19 CARE COORDINATION ORGANIZATIONS IN 4 AREAS

62 STAFF

49 Care Coordinators

13 Wellness Coaches

SERVICE DELIVERY SYSTEMS

- Primary Care
- Mental Health
- Chemical Dependency
- Hospitals
- Long Term Care

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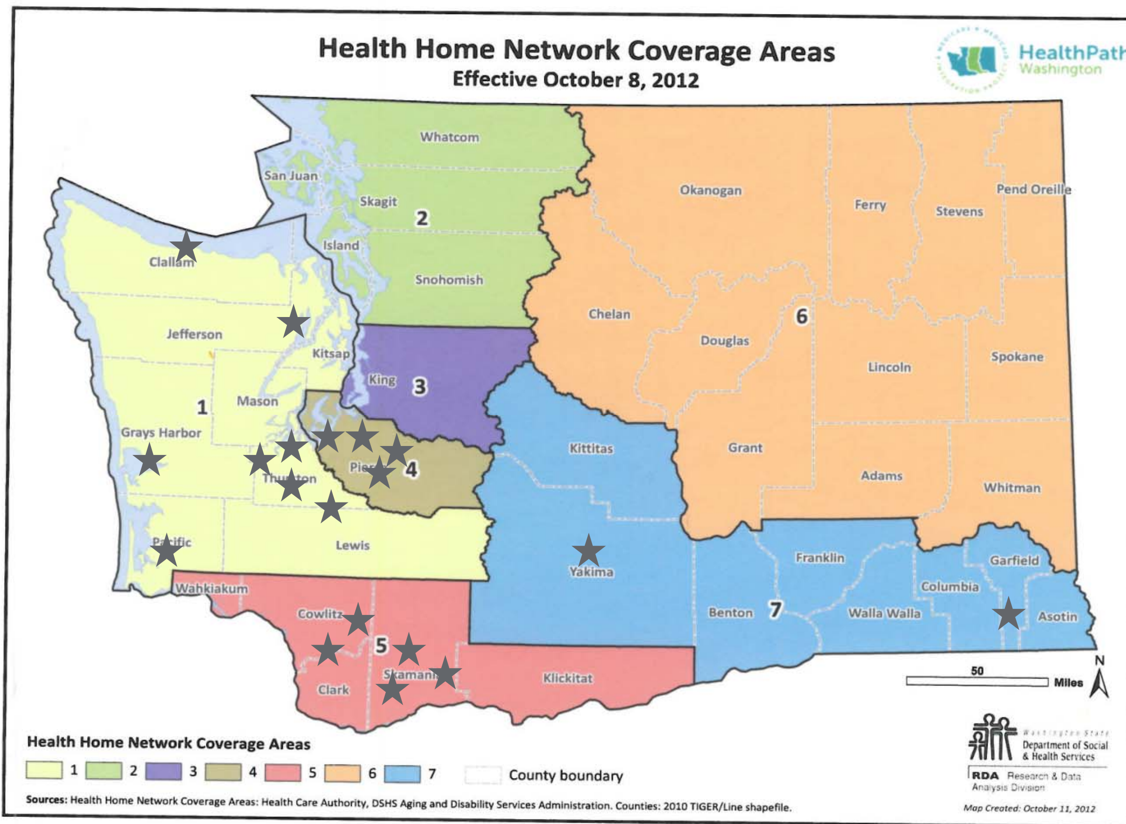

Health Home in Pierce County

Estimated number of beneficiaries : **13, 214**

Duals: 5,100

Non-Duals: 8,114

Four Care Coordination Organizations

MultiCare Good Samaritan Outreach Services

Greater Lakes Mental Healthcare

Catholic Community Services of Western Washington

Pierce County Community Connections Aging and Disability (AAA)

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Defining Health Home Services

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Individual and Family Support
- Transitional Care
- Referral to community and social support services

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HEALTH HOME SERVICES

Primary Care
Community Services
Managed Care
Community Integration
Chemical Dependency
Long Term Services and Supports
Mental Health
Acute Care
ME

LEAD ENTITY
LONG TERM SERVICES & SUPPORTS
COMMUNITY INTEGRATION
CHEMICAL DEPENDENCY
PRIMARY CARE
ACUTE CARE
MENTAL HEALTH
MANAGED CARE
COMMUNITY SERVICES
ME
My Health Home Coordinator

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Engaging Everyone!

Hospice

Long-term Care

Home Care

Post-Acute Care

Hospitals

Primary Care

Public Health Agencies

Ancillary Providers

Specialists

Pharmacies

Continuum of Care

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NOTIFICATION SYSTEM – *PreManage*

(by Collective Medical Technology)

Optum: Care Manager

CareManager

820 File

CMT

Care Coordination Organization

Health Home Beneficiaries

Care Coordinator

Other

Transmitted Information

Patient Health Information

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HEALTH HOME: Joint Outcomes

1. Access to the right care at the right time and place

2. Increase beneficiary engagement level

3. Improve health outcomes

5. Reduce avoidable costs

6. Reduce preventable hospital admissions & re-admissions

7. Reduce avoidable emergency room use

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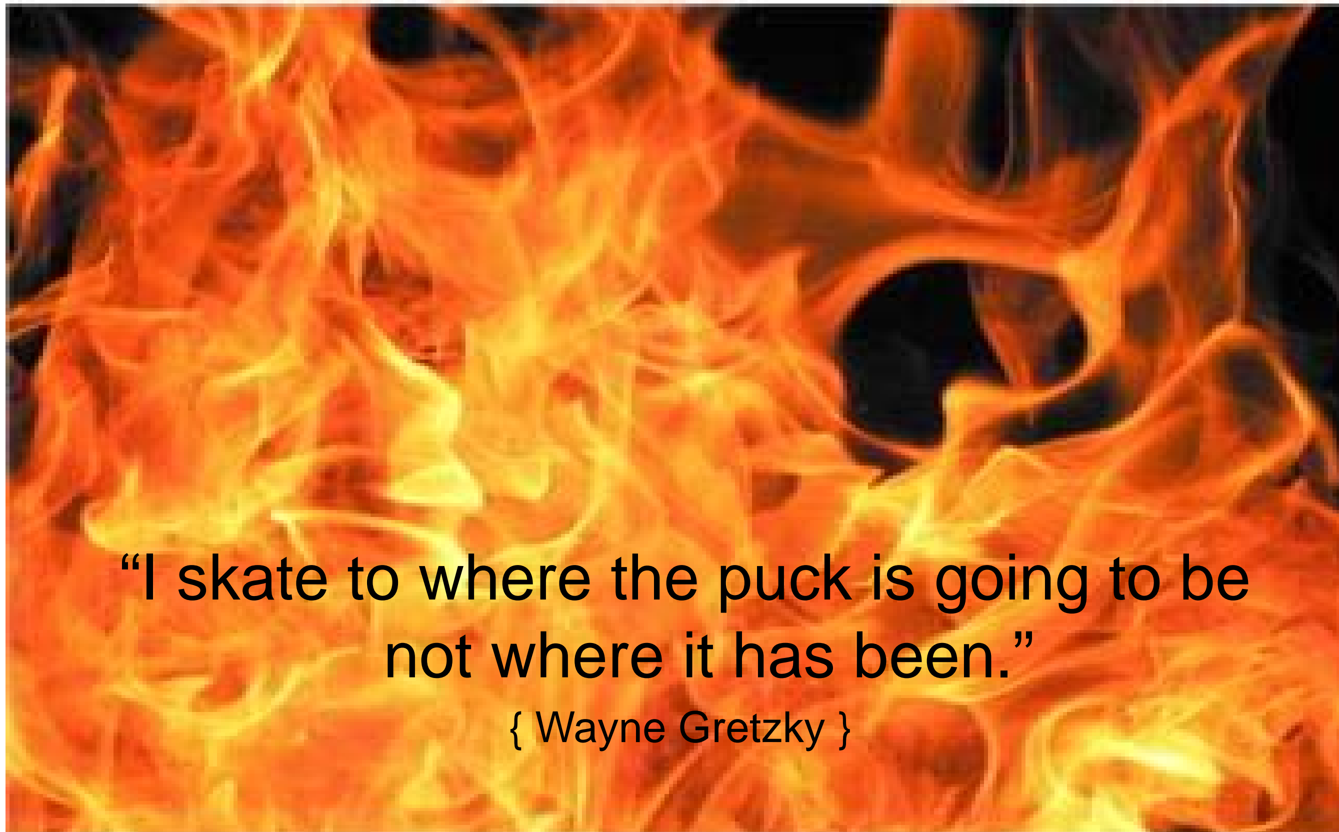
Fire Starter



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Thank you

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