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REGIONAL PLANNING CONSORTIUMS (RPCs): *Local Oversight of the Behavioral Health System*

ROLE OF REGIONAL PLANNING CONSORTIUMS (RPCS)

New York State is four years into the implementation of its Medicaid Redesign Team (MRT) objectives to; rebalance New York State's healthcare system from an institutional to a community-based system, integrate the fragmented behavioral and physical health care systems and provide care management for all individuals enrolled in the Medicaid program. The DSRIP program is adding tremendous momentum to all efforts to transform the healthcare system in New York.

For behavioral health, the most significant component of the Medicaid redesign is the move to Medicaid managed care and health homes for adults and children. Other State operations initiatives including the downsizing of the OMH psychiatric center footprint and the OASAS redesign of residential treatment services are intertwined with the Medicaid redesign and will impact the behavioral health system. The State's focus on services for individuals with mental illness, serious emotional disturbance and substance use disorders is a huge leap forward toward true integration of physical and behavioral health services and reaching the goals of DSRIP.

However, as we move to develop an integrated services system, it is important to recognize that the behavioral health treatment system is not starting from a position of strength. In fact, the opposite is true.

STABILIZING THE FRAGILE COMMUNITY BEHAVIORAL HEALTH SYSTEM

Not unlike other states, New York's mental health and addiction treatment services systems are imbalanced with more resources going to higher intensity services and less to the mid to lower intensity early interventions and community based services. Now is the opportunity re-balance the system and ensure that prevention, support and treatment services are available for New York State's growing need.

In the last 2 years, a large portion of the pent-up demand for behavioral health services has been translated into actual demand as over 2 million more New Yorkers have gained insurance through NY State of Health or Medicaid. When placed within the context of a nationwide heroin epidemic, actual demand for behavioral health services is at unprecedented high levels.

Behavioral health is facing other challenges including:

- Adult and children's substance abuse and mental health providers have expressed serious concerns about their ability to remain fiscally viable in a managed care environment
- Significant need for all types of housing
- Closure or downsizing of Article 28 inpatient psychiatric units
- Profound lack of psychiatrists, especially child psychiatrists



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- Minimal access to IT funding
- Shortage of LCSWs and an aging workforce

These factors fall outside the realm of managed care and DSRIP implementation by themselves, but will directly impact the ability of the system to successfully integrate and innovate for the future.

PURPOSE OF THE RPCS

In 2013, the Conference proposed the formation of Regional Planning Consortia (RPC) in 10 regions in the State outside of New York City, to bring together behavioral health, physical health, MCO and other stakeholders to collaborate and problem solve around the issues inherent to the transition to Medicaid managed care. The Conference is pleased that the state supports the RPCs and has incorporated the RPCs into the Request for Qualifications (RFQ) issued to MCOs.

The New York City Department of Health and Mental Hygiene has developed a different structure for its Regional Planning Consortium to adapt to the City's mental hygiene system and to integrate with the Population Health Improvement Program (PHIP) efforts, since NYC DOHMH is the PHIP for NYC. Therefore, the function and governance outlined in this paper do not apply to NYC's RPC.

Since our initial RPC proposal, New York State has introduced multiple initiatives that are driving sweeping and rapid changes to the behavioral and physical health delivery systems. DSRIP is the largest of the projects for Medicaid enrollees, along with NY-SHIP which puts forward a roadmap to expand integrated primary care practices via Patient Centered Medical Home (PCMH) and Advance Primary Care (APC) models, the State Innovation Models (SIM) testing grant which provides federal funding to implement and test the SHIP, the Prevention Agenda, the Population Health Improvement Program (PHIP) and the ongoing development of community based services needed to successfully transition people from the psychiatric centers to the community.

Transforming a system rooted in decades of silos and fragmentation into an integrated care model that treats the entire person is a goal we must achieve. *How* that implementation impacts the behavioral health system and more importantly, the people and families it serves, requires a community focus and continuous, vigilant attention. This is the purpose of the RPC.

RPC ROLE AND FUNCTION

The RPC is a multi-stakeholder group which reflects natural patterns of access to care and is comprised of: Consumers, Families & Youth; LGUs; MCOs & HARPS; adult and child services and housing providers; hospitals and primary care providers, state agencies, county social services and public health departments, the PPSs and the PHIPs. The RPC will function as the vehicle through which issues are identified, discussed, brainstormed and resolved through a collaborative governance model.

The scope of the RPC will encompass the Medicaid managed care transition for adults and children, the downsizing of State psychiatric centers, behavioral health DSRIP projects, the stability and capacity of the provider system, the interaction with social services and myriad issues which require a specialized focus in order to meet the goals of Medicaid redesign and ensure the many initiatives are in alignment.

The RPC is where collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical healthcare can occur in a way that is data informed, person and family centered, cost efficient and results in improved overall health for adults and children in our communities.

This is the objective of the RPC.

The RPC is the local reconnaissance and early warning system for issues occurring on the ground that the data won't necessarily show. Such as; access to needed services, gaps in services, timeliness of eligibility determinations and engagement or disengagement in care etc.

The primary function of the RPC is to collaborate and problem solve around the issues that rise up from the stakeholders at the table. Below are examples of areas of work.

Improved Services and Outcomes:

- Increase recovery oriented engagement and retention of people, and improve adherence to treatment
- Monitor and improve timeliness of actions throughout the payer, healthcare provider and support system (eligibility determinations for services, access to needed services, enrollment, utilization review, etc.)
- Monitor and improve the collaboration among SPOA, DSS economic support services, adult serving providers, law enforcement and criminal justice, health homes and MCOs to improve outcomes for adults
- Monitor and improve the collaboration among SPOA, DSS foster care, child serving providers, schools, juvenile probation, health home and MCO to improve outcomes for children and families
- Inform the development of the annual MCO & HARP performance improvement projects (PIP) and clinical quality studies required under the RFQ.

Access and Capacity:

- Identify areas of needed housing capacity in the region and expand housing options for people with SMI/SUD *beyond* OMH/OASAS certified or funded housing programs
- Monitor access to inpatient hospital and treatment services in Art. 28 hospitals, including 9.39 hospitals and Comprehensive Psychiatric Evaluation Program (CPEP), Psychiatric Centers (PCs) and Addiction Treatment Centers (ATCs)
- Monitor network capacity for services in the region (HARP/HCBS) for adults and children and identify ways to develop new capacity if necessary
- Monitor the timeliness and effectiveness of outreach/engagement for high-need, high-risk enrollees (discharged from a PC, ATC or released from jail)

Collaboration and System Improvement:

- Monitor and improve communication between consumers, providers and MCOs
- Monitor and improve connections between justice involved adults and youth, jail and prison release, probation, SPOA, HARP/HCBS services, housing and health home
- Standardization of processes and procedures (agree upon data to be collected, forms to be used, etc.) to increase efficiency for consumers, providers and plans
- Transmit success by disseminating best practices to the other RPCs
- Improve process and practice through training and education that is consistent and aligned across RPCs

THE RPC – HOW IT FITS WITH DSRIP, PHIP, PREVENTION AGENDA

Achieving the DSRIP goals and metrics will be contingent upon establishing a closer collaboration with the community and the performance metrics can be directly linked to issues and solutions in the community. We have specifically included representatives from the Performing Provider Systems (PPSs) and the Population Health Improvement Projects (PHIPs) on the RPC Board of Directors.

The PPSs will bring together parts of the health and behavioral health systems which have historically worked in parallel worlds. Developing collaboration across the institutional and community services systems will take time and effort. In mental hygiene, the cross system collaboration already exists with the LGU which has a legal mandate under Article 41 MHL to:

- Assure that under the goals of the annual Local Services Plan (LSP);
 - the needs of all population groups (MH/SA/DD) are adequately addressed,
 - the Local Services Plan is integrated and coordinated with other community OMH/OASAS & OPWDD programs, and
- Make policy and exercise general supervisory authority over local services and facilities including responsibility for proper performance of services

The LGU has community connections with:

- Hospitals (community hospitals and State-operated psychiatric centers & addiction treatment centers)
- Child and adult services providers (including adult & child rehabilitation services, schools)
- Housing & shelter systems
- Social services (foster care, adult and child protective services)
- Juvenile and adult probation/community supervision
- County jail & county/municipal law enforcement
- Criminal & family courts & district attorney's office

The LGUs oversee, prioritize, plan for and fund services in their counties across the mental health, substance abuse and developmental disability systems. By virtue of its responsibility and authority for the three disabilities, the LGU is intertwined with other local services and has the relationships in place that come from being embedded in the community. The cross-system structure of the LGU is the groundwork for the RPCs to problem solve through collaboration.

RPCs AND PPSs

We see the RPCs and PPS as symbiotic partners. The PPSs will need to invest in behavioral health services in the community to meet the DSRIP performance metrics since behavioral health conditions underlie many of the poor health outcomes and avoidable hospital admissions for the high-risk, high-cost Medicaid enrollees. These community investments will facilitate the RPC's goal of a stable, integrated, quality behavioral healthcare system.

The PPSs have hundreds of providers and thousands of programs in their networks and some counties have more than one PPS. The RPCs brings together the behavioral healthcare expertise and the healthcare system in the region to provide the focus necessary to guide and refine the system transformation and PPSs project planning.

The role of the RPC and the LGU is to create as much continuity and efficiency as possible across multiple MCOs and PPSs projects serving the counties and the regions. This coordinated approach will help Medicaid managed care roll out and the DSRIP projects meet the transformation goals.

RPC s and PHIPs

The Population Health Improvement Program (PHIP) was created to promote the Triple Aim of better care, better population health and lower health care costs. The PHIP's will convene a very broad range of healthcare and consumer stakeholders including the business community, unions, disability rights organizations, local transportation authorities and institutions of higher education to establish neutral forums to support strategic planning for identifying, sharing, disseminating and helping to implement best practices and local strategies to promote population health and reduce

health disparities. PHIP's are focusing on advancing ongoing activities related to the New York State Prevention Agenda 2013-2017 and the State Health Innovation Plan.

The counties that comprise the RPC and PHIP regions are identical and mirror the regions adopted by the DOH Public Health and Health Planning Council (PHHPC). The regions reflect the natural patterns of where people access care. While the geographic regions overlap, the focus of the RPCs and the PHIPs differ. The RPCs membership and charge will focus on the behavioral health specialty and predominantly for the Medicaid population. The PHIPs have a broader membership and is looking at ways to reduce health disparities for all populations and all payers to advance the SHIP priorities to developed Advanced Primary Care models and implement the Prevention Agenda. That said, there are many opportunities for the RPCs and the PHIPs to share expertise and collaborate on issues in the regions.

JUSTICE-INVOLVED MEDICAID ENROLLEES

Justice-involved adults and children in the community with serious mental illness/emotional disturbance and substance use disorder who have Medicaid coverage and are likely eligible for state plan, HARP and care coordination services. The RFQ included specific requirements for MCO collaboration with the LGU for this population.

In fulfilling their existing responsibilities (e.g. AOT, 730 CPL exams, 9.37 MHL orders, jail mental health services, etc.), the LGUs have formal and informal relationships with local law enforcement, County jails and correctional facilities, the County District Attorney's office, County and City courts, County probation (adult and juvenile), State Parole and other Criminal Justice Advisory Boards. There is regular and frequent interaction between the LGU and the local criminal justice system on behalf of justice-involved adults and children with behavioral health issues.

In every jail, there are individuals with behavioral health issues whose untreated mental illness or addiction is implicated in the behavior that resulted in criminal charges. Addressing the complexity of this issue requires comprehensive approach to developing better and cost effective alternatives. One of the best models for transforming and improving how justice-involved individuals with mental health needs move through the criminal justice system is the Sequential Intercept Model (SIM). The model looks at 5 points in the criminal justice process (sequence) where a person with mental illness could be re-directed (intercepted) out of the criminal justice system and into appropriate treatment or prevented from progressing further into the criminal justice system. The SIM mapping process brings together dispatch/911, law enforcement, courts, jail administration, probation/parole, LGU, DSS, behavioral health providers, 9.39 hospitals and other stakeholders in the community to map the current process and identify opportunities for improvement and redesign. The State Division of Criminal Justice Services (DCJS) was awarded a federal grant to provide SIM technical assistance to several counties in the state which is currently underway.

The Conference sees the LGU as the convener and connector between the RPC and stakeholders in the local criminal justice system. This collaboration would focus on areas such as, facilitating new or expanded jail diversion programs or more seamless re-entry programs. A connection among the LGUs, the RPC and the local criminal justice system holds promise for new options to link justice-involved Medicaid enrollees with care management and treatment in the community to deliver the right care and supports at the right time.

RPC ESTABLISHMENT AND GOVERNANCE

Through its board of directors, committee structure and staff support, the RPC will function as the vehicle through which issues are identified, discussed, brainstormed and resolved through a collaborative governance model. The RPC will use data – local, state and MCO - to inform the process, review measures, identify gaps in services and develop opportunities for improved services.

The effectiveness of the RPC is based in its multi-stakeholder, regional membership under a Collaborative Governance with Consensus Decision Making model.

The goal of the group is not to vote on every issue. The goal of the group is to collaborate and reach decisions by consensus. A properly structured formal decision making structure will facilitate reaching consensus.

The Conference developed the membership and voting of the board with the following considerations in mind:

- Board size must be large enough to represent stakeholder voices, yet small enough to reach consensus. The RPC boards will include 25 voting representatives
- Ensure that all components of behavioral healthcare specialty are represented
- Ensure hospital and primary care are represented
- Ensure the children’s system is integrated at the Board of Director’s level and provided the needed additional focus and expanded membership through a required Standing Children and Families Committee
- Ensure substance abuse and children’s providers and family members are prominently represented
- Voting groups are based on representatives that are likely to have similar interests
- Block voting as a group fosters collaboration
- Equalizing the weighted vote establishes a level playing field among the voting groups
- Weighted voting is structured such that success only occurs through collaboration

Board Co-Chairs:

- LGU – Selected by LGU members
- Other – Selected by majority vote of the individual Board members, excluding LGUs

Committee Chairs:

- Selected from Board membership & approved by majority vote of the individual Board members

Standing Committees: Additional members from the region included & no size limit

- Children & Families (Add foster care, schools, family court, juvenile justice etc.)
- Data and metrics
- Access and integration
- Training and education

Ad Hoc Committees:

- Created to respond to regional priorities

RPC BOARD OF DIRECTORS GOVERNANCE STRUCTURE
Collaborative Governance with Consensus Decision Making

Board Representative(s)	Stakeholder Role	# of Reps.	% of vote
LGU Group	Local Gov't., Mental Hygiene System Oversight & Planning, Payer	Up to 5 DCSSs	20%
Institutional Providers Group <ul style="list-style-type: none"> ▪ Hospital ▪ Primary Care/FQHC ▪ Health Home - Adult ▪ Health Home - Children 	Care delivery & coordination Regional services providers	Up to 5 reps.	20%
Community Based Providers Group <ul style="list-style-type: none"> ▪ Mental Health ▪ SUD ▪ Housing ▪ Children & Youth ▪ Rehab HCBS 	Community services and supports provider	Up to 5 reps. At least 1 rep. from child/youth serving agency	20%
Peer/Family/Youth Group	Advocacy & client voice for programs & services	Up to 5 reps. At least 1 rep. from each: MH, SA, and Youth	20%
MCO/HARP Group	Service authorization & payment Reinvestment (i.e. demonstration programs under RFQ) Quality and process measures	Up to 5 reps.	20%
Non-voting			
State Government	OMH/OASAS/DOH/OCFS	1 from each agency	0%
Other stakeholders	PHIP, PPS, LHD, LDSS	At least 1 from each PHIP(s) & PPS(s) in the region	0%
Total		25 Voting + 8 others	100%

RPC BOARD OF DIRECTORS: MEMBERSHIP SELECTION

A Regional Planning Consortium Board of Directors is expected to operate like any other Board of Directors. The RPC Board will adopt by-laws, largely standardized among the RPCs but with room for some regional variations, which will provide for the purpose and mission of the RPC, the terms of membership, and procedures to guide the RPC operations. Board training is a high priority as well as agreement on communication values for effective collaboration. (e.g., issues are raised in an open and authentic manner and at the table).

SELECTION OF RPC BOARD MEMBERS & CO-CHAIRS

The selection of the RPC Board of Directors is a ground-up, local process. The RPC is a regional, community entity. No one knows the region better than the people who spend every day living and working in their community. The RPC Board membership must be decided by the voting groups representing the community.

It is the responsibility of each group in the region to come together and collaborate to identify those individuals to sit on the RPC Board. Each of the governance groupings (LGUs,) Providers (Institutional), Providers (Community Based), MCO/HARP, Peer/Family/Youth, and Children's Providers, will appoint up to 5 members to the Board of Directors to represent the group.

The groupings were selected based on representatives that are likely to have similar interests. It is expected that in its selection, the governance groups will place a high priority on identifying representatives who are committed to building and fostering relationships among the Board members, whose leadership style is goal focused and collaborative and who represents the diversity of the stakeholder group within the region (e.g. urban/suburban/rural).

The Board of Directors will have two Co-Chairs.

- In recognition of the LGU statutory responsibility for oversight of the local mental hygiene system as a whole (OMH/OASAS/OPWDD), one Co-Chair will be an LGU representative selected by the LGU Board Members.
- The other Co-Chair will be approved by a majority vote of the individual members of the Board, excluding the LGUs.

Committee Chairs will be selected from the Board of Director's membership and approved by a majority vote of the individual board members. Each RPC is expected to form a standing committee on Children and Families, and other committees such as Data and Metrics, Access and Integration and Training and Education may be created as well. RPCs are encouraged to establish Ad Hoc Committees to address needs specific to their region.

COLLABORATIVE GOVERNANCE WITH CONSENSUS DECISION MAKING

The governance structure and consensus decision making process will use the collaborative governance model which is built on the following foundation.

Collaborative Governance is an internationally accepted and replicated form of governance which is based on the premise that through collaborative governance, leaders engage with all sectors – public, private, non-profit, citizens, and others - to develop effective, lasting solutions to public problems that go beyond what any one sector could achieve on its own.

Perhaps the most notable success of collaborative governance with consensus decision making is the National Quality Forum (NQF), which brings together working groups from the public and private sectors to endorse consensus standards for healthcare performance measurement which are evidence-based and valid. The result is high-quality performance information that is publicly available and recognized as the gold-standard for healthcare quality.

Collaborative governance creates the structure and rules under which the RPC will function and carry out its mission.

The consensus decision making process is critical because if the group is engaging in collaborative problem solving, the need to invoke a formal vote is minimal if not eliminated. The operative word is collaboration.

There are several critical factors for successful collaboration and consensus building:

- 1. Face to face dialogue*
- 2. Trust building*
- 3. Development and commitment to shared understanding of the interests of other parties*
- 4. Shared goals*
- 5. Leadership*

The ability of the RPC to successfully collaborate, reach consensus and perform as a group is based on establishing relationships, identifying regional needs and working on collaborative problem solving to meet the objectives of the RPC, and the transformation of Medicaid.

RPC COLLABORATION WITH EACH OTHER & OMH/OASAS/DOH/OCFS

The RPCs across the state will encounter similar issues yet will develop different solutions. Multiple factors will influence how regions problem solve including what tools the RPC has at its disposal. Local resources, services capacity, proximity to a state psychiatric center or addiction treatment center, primary care capacity, PPS projects, transportation, poverty, homelessness etc. will affect how RPCs address systems challenge.

RPC TO RPC COLLABORATION

Trading experiences among the RPCs about what is working and what isn't working is critical to the RPCs as they develop into well-performing groups. We are envisioning multiple opportunities for collaboration among the RPCs including,

- In-person meetings of RPC leadership representatives (e.g. Board Co-Chairs and Chair of C&F Committee)
- Webinars/conference calls among the RPC staff in the regions, Albany and field office state agency staff and CLMHD staff
- Website development

RPC TO STATE COMMUNICATION

A communication and information feedback loop between the RPCs, Medicaid and the state agencies central office staff in Albany is critical to ensure communication between the regions and the state. In the first year of operation we recommend quarterly meetings in Albany of a Statewide RPC group, the membership to be determined. Regular updates to the Behavioral Health Services Advisory Council (BHSAC) and the Public Health and Health Planning Council (PHHPC) on the progress of the RPCs are expected.

DATA AND METRICS: CLMHD BEHAVIORAL HEALTH PORTAL

The work of the RPC will be informed by data and performance measures collected and reported from the MCOs, OMH/OASAS/DOH and the LGUs. The data will become actionable at different time frames. For example, HEDIS/QARR data is reported annually and will become available in 2016 at the earliest. Medicaid claims data through Salient will be available much sooner, some MCO/HARP utilization data will be real-time data and the LGU collects data from many sources including adult/children's services contracted providers (across disabilities), the jail, their county-operated MH/SA clinics and other non-Medicaid, LGU funded programs.

As part of the LGU's oversight of the local mental hygiene system, each LGU develops and annual comprehensive Local Services Plans (LSPs) which is data informed and identifies local priorities and needs in the community. The Conference's Mental Hygiene Planning Committee (MHP) collaborates with OASAS, OMH and OPWDD to develop the LSP guidelines provided to county planners.

Through the MHP Committee, the Conference contracted with Coordinated Care Services, Inc. (CCSI) to develop a CLMHD Behavioral Health Portal which pulls in data from many sources to provide an efficient, integrated, uniform behavioral health planning tool that identifies and quantifies current and emerging needs to support local services management. This is a multi-year effort and the Planning Committee is exploring additional data the RPC will need to monitor the system including physical healthcare data.

CLMHD Behavioral Health Portal

Key Features:

- Data views can be created by county or in most cases, by region (data can roll up & roll down)
- Active data views can also be exported to Excel for additional analysis and formatting
- Links to descriptive information about the data sources and data field definitions are provided on each page
- Data export instructions and other tools are found in the Video Tutorials link on the CLMHD Behavioral Health Portal landing page

The CLMHD Behavioral Health Portal includes data from several systems:

- Local Prevalence: These data provide county and regional estimates of the use of alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health issues (National Survey on Drug Use & Health)
- County and regional estimates of the number of Medicaid FFS and Managed Care recipients with a potential need for behavioral health or developmental disability services and selected demographic characteristics (Salient, no PHI, Medicaid Data System)
- Continuity of Care: Engagement in Care, and Continuity of Medication for Fee-for-Service Medicaid consumers discharged from inpatient mental health treatment (NYS OMH BHO Portal)
- County and regional adult inpatient admissions data (all-payer) as reported in the Statewide Planning and Research Cooperative System (SPARCS)
- County and regional Medicaid FFS and managed care service utilization summaries for priority populations, including behavioral health and developmental disability service recipients (SPARCS)
- Local estimates of the number of homeless individuals and households including special subpopulations such as individuals with serious mental illness (U.S. Department of Housing and Urban Development, Annual Continuum of Care Homeless Populations and Subpopulations Reports)
- Overall service use and characteristics of the Juvenile Justice population admitted to detention including length of stay, family court petition dispositions resulting in Juvenile Delinquent findings, and data on the overrepresentation of minority youth in the juvenile justice system. (NYS DCJS, County Juvenile Justice Profiles)

STAFFING AND SUPPORT FOR RPCs

Support needs for the RPCs include a Regional Coordinator, Project Manager and staff with needed policy and administrative skills, depending upon the population and geographic size of the region or combination of regions. It is anticipated that data support would be provided through a combination of the CLMHD Behavioral Health Portal, reports from MCOs, data analytics through Salient and the Medicaid Analytics Performance Portal (MAPP).

The Conference is strongly recommending that the RPCs meet monthly for *at least* the first year to allow the groups to form relationships and have the time and support necessary to perform the work. In addition to policy support, administrative support is critical for Board meeting minutes, meeting and webinar support and other organizational activities.

A combination of RPC staff for the regions, staff support from the state agencies and CLMHD, and a contract for data needs is one option for ensuring the RPCs have the level of support necessary to get established and develop into well-performing groups.

NEXT STEPS

The Conference looks forward to collaborating with our colleagues and the state agencies to develop and establish the RPCs. Ideally, the RPCs will be in place before the roll out of managed care in the rest of the state and in conjunction with the implementation of DSRIP projects in the regions.

We are encouraged that the State clearly recognizes the critical need to address the social determinants of health (e.g. stable housing, social supports, and employment) to meet the goals of DSRIP and improved population health. The sweeping changes to behavioral healthcare and the healthcare system as a whole, while daunting and unwieldy, are an opportunity to improve the lives of adults and children with mental illness and substance use disorder in our State.

It is the responsibility of all of us to come to the table and collaborate on these complex problems to make better outcomes a reality for the people and families who are counting on us to get it right.