



**MEETING NOTICE**  
**INVITATION TO NEGOTIATE COMMITTEE**  
**FRIDAY, JUNE 22, 2012**  
**1:00 p.m.**  
**COUNTY – CITY BUILDING – 555 S 10<sup>TH</sup> ST**  
**ROOM 113**

**AGENDA**

1. Integration of Behavioral Health and Primary Health Care -  
Kathy Reynolds, Director, SAMHSA/HRSA, Center for Integrated  
Health Solutions, Vice President Health Integration and Wellness  
Promotion National Council for Community Behavioral  
Healthcare

**MINUTES  
COMMUNITY MENTAL HEALTH CENTER (CMHC)  
INVITATION TO NEGOTIATE (ITN) COMMITTEE  
FRIDAY, JUNE 22, 2012  
COUNTY-CITY BUILDING, ROOM 113  
1:00 P.M.**

**Committee Members Present:** Ron Sorensen, Community Mental Health Center (CMHC); Lori Seibel, Community Health Endowment (CHE); C.J. Johnson, Region V Systems; Judy Halstead, Lincoln-Lancaster County Health Department (LLCHD); Cpt. Joe Wright, Lincoln Police Department (LPD); Gary Lorenzen, Mental Health Foundation; Jane Raybould, County Commissioners; Gail Anderson, CMHC Advisory Committee; J Rock Johnson, consumer advocate; Kerry Eagan, County Chief Administrative Officer (Ex-Officio); Vince Mejer, City-County Purchasing Department (Ex-Officio); and Wendy Andorf, CMHC (Ex-Officio)

**Committee Members Absent:** Brent Smoyer, County Commissioner; Scott Etherton, CMHC (Ex-Officio)

**Others Present:** Kathy Reynolds and Jeff Capobianco, National Council for Community Behavioral Healthcare; Deb Shoemaker, People's Health Center; Christine McCollister, CenterPointe; Pat Kant, City-County Personnel Department; and Cori Beattie, County Clerk's Office

*(Note: Pat Talbott previously resigned from the ITN Committee.)*

Sorensen called the meeting to order at 1:00 p.m.

## **1 INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY HEALTH CARE**

Introductions were made by those in attendance.

Sorensen provided a brief overview of the Community Mental Health Center transition process noting that a basic principle is to integrate primary healthcare with behavioral healthcare. Eagan explained the relationship between Lancaster County and Region V. He said the County plans to retain the Crisis Center and possibly some other programs. Seibel added the Invitation to Negotiate (ITN) language was derived from the Health Management Associates report.

In response to Reynolds' inquiry, Sorensen said the ITN Committee will be reviewing whether a Request for Proposal (RFP) or Request for Agreement (RFA) will be part of the process. Sorensen said the Committee is to make its recommendation to the County Board and the Region V Governing Board by the end of September.

Reynolds said she and Capobianco have been involved in similar movements whereby a Michigan county divested of its community mental health center and moved to a contracted system of care with private providers. She said she could provide some information on that process. She explained that an integrated healthcare delivery system was created through a partnership with a local primary care organization allowing for mental health, substance abuse

and primary care services to all be provided. Reynolds said this was done for a number of reasons. She noted Medicaid statistics showed that those in the public mental health system had a shorter life expectancy. It was also discovered that this population was not receiving adequate physical healthcare, thus, partnerships were formed with various primary care organizations to address these needs.

Reynolds noted the four-quadrant model was done with integrated care. Interventions and financing were identified for each quadrant and this information was then used as a basic conversation tool when organizations were considering who they will serve. She added that an effort was made to work with primary care providers and clinics to have those established in a recovery lifestyle to be able to leave the system and move to primary care for services.

Seibel questioned the primary care providers' receptiveness in taking on Medicaid patients. Reynolds said it varied. She noted there was a training component involved which helped providers get used to the new model. Another key piece of the transition was assigning community mental health center staff (a full-time social worker and a consulting psychiatrist) to every primary care office. Capobianco added the integration included a lot of coordination and workflow analysis between agencies and staff. He stressed the importance of getting providers involved early with the ITN process so everyone is clear about what model is desired once the RFP is released. Halstead felt it was important for primary care providers to know that psychiatric consult support will be built into the system before they begin taking patients with chronic and persistent mental illness.

Reynolds said many felt there were some patients who would not be able to adapt to the integrated model. She said some of the most successful cases were patients with chronic mental health issues as they oftentimes did better in their recovery plan in primary care as opposed to the community mental health center. Capobianco added this integration allows patients to step up or down their care accordingly and with that comes potential cost savings.

Raybould asked how the initial clinics were chosen. Capobianco said they started with physicians who were willing to get involved. Staff then engaged other providers including a homeless shelter with a primary care component. He noted after the demand was created among the consumer population, additional primary care providers were quickly added.

Seibel questioned crisis services. Reynolds said they were maintained by the local mental health center, although, primary care staff was considered part of the crisis team. She added the short-term solution focus therapy model is being used which includes a meeting with a mental health professional while the patient is in the primary care exam room.

Lorenzen asked about funding for the Michigan model. Reynolds said it was predominantly Medicaid (65%). She said few State general fund dollars were used. Additionally, counties were required to indefinitely maintain their level of support at the time the integrated model began. Reynolds estimated that amount to be less than 10% of the total budget.

With regard to provider incentives, Reynolds said Medicaid is a good pay source in Michigan. Another incentive was the huge demand for behavioral health services in primary care as the partnership increased the productivity of primary care staff.

Sorensen noted Nebraska's Medicaid system is stricter. Reynolds said they were able to increase Medicaid eligibles by leveraging local and state match dollars. For those not Medicaid eligible, some state general funds were still available. She added the rate parity is key.

Eagan said another factor to consider when discussing integration is County general assistance. Reynolds said Michigan turned the indigent health plan into outpatient care. The savings realized from fewer hospitalizations was used to fund it.

Seibel asked how consumers responded to the shift in care and how outcomes were tracked. Capobianco said patients liked the new model. He added satisfaction surveys were performed with consumers and primary care staff. Reynolds said they also had a robust database to track healthcare utilization throughout the project.

Eagan said there has been feedback that consumers won't be able to adjust if services are not offered at one location. Capobianco said it is unrealistic to think all the services will be in one building. He felt the bigger issues are transportation and building a strong team network approach between mental health and primary care.

With regard to core services, Reynolds said there are primary care and mental health services which should be co-located and recommended these be defined by consumers.

Reynold noted that from 2001-2003 there was a 20% reduction in primary healthcare costs for those in the integrated model. She added the healthcare system(hospitals) will also see a return on investment. It was suggested the process be tied to reimbursement methodologies. Reynolds noted there are at least two dozen business models related to clinical integration which are available for the Committee's review. She reiterated the importance of involving providers and consumers in the ITN process from the beginning.

Sorensen said he was not sure if the current timeline allows for the business model approach. He questioned how to incorporate a process into a contract that allows for evolvment over time. Reynolds said there are certain core things which need to be included from day one and business models are available which address payer mix. She said they opted for the outcome based approach for providers and stated the objectives need to be clearly stated in the RFP.

Reynolds said various resources related to integration are available at [www.integration.samhsa.gov](http://www.integration.samhsa.gov).

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 2:15 p.m.

Submitted by,

Cori Beattie  
County Clerk's Office