



MEETING NOTICE
INVITATION TO NEGOTIATE COMMITTEE
WEDNESDAY, AUGUST 22, 2012
7:30 - 9:30 a.m.
COUNTY – CITY BUILDING – 555 S 10TH ST
ROOM 113

AGENDA

1. Approval of Minutes - August 8, 2012
2. Review of Process Prior to Asking for Proposals
3. Draft ITN, Part Two

**MINUTES
COMMUNITY MENTAL HEALTH CENTER (CMHC)
INVITATION TO NEGOTIATE (ITN) COMMITTEE
WEDNESDAY, AUGUST 22, 2012
COUNTY-CITY BUILDING, ROOM 113
7:30 A.M.**

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

Others Present: Amanda Tyerman-Harper, Region V Systems; and Ann Taylor, County Clerk's Office

Sorensen called the meeting to order at 7:35 a.m.

1 APPROVAL OF THE JULY 25, 2012 MINUTES

MOTION: J Rock Johnson moved and Raybould seconded approval of the minutes. Sorensen, C.J. Johnson, Halstead, Wright, Raybould, Lorenzen, Anderson and J Rock Johnson voted aye. Seibel and Smoyer were absent from voting. Motion carried 8-0.

DRAFT ITN, VERSION TWO

Discussion took place regarding the Lancaster County & Region V Systems Invitation to Negotiate (ITN) Response Package (Exhibit A).

Lorenzen noted the document states total revenue for CMHC is \$10,148,301 (see Page 4). Sorensen said that number reflects the 2011 budget, noting revenues have decreased since then. Lorenzen said he is concerned that potential providers might not understand that some of the revenues will not be made available to them for the services they are bidding on, citing funding for the Crisis Center and General Assistance (GA) as examples. He suggested that a footnote be added for clarification. C.J. Johnson said exact revenue sources will be made available to potential providers at the time the ITN is issued. Sorensen said it might be better to look at it from the standpoint of units of service, given changing rates. Lorenzen said he does not want to

see a situation in which a lot of services are requested with a limited amount of funds. Sorensen said there also needs to be a caveat that revenues are dependent on the services provided.

Raybould said she believes the section relating to a transition/communication plan (Page 11) is weak and should be revised to include benchmarks and time lines. She also felt the document should state that a preliminary transition/communication plan is expected at this time and that time lines for both elements should be incorporated in their proposal.

Sorensen asked whether the Committee wants to recommend that existing employees be given the right to transition to the new provider. Mejer said it is not uncommon to include language to require that existing staff be given an opportunity to interview for employment.

Lorenzen suggested the ITN Committee members be added to the list of entities prospective respondents are prohibited from contacting, with the exception of clarifying questions (see Page 13). Sorensen agreed.

Andorf noted that CMHC does not provide supported employment (see Page 3).

C.J. Johnson said the draft will be presented to the Behavioral Health Advisory Committee (BHAC) on August 29th and said they will be informed of the suggested changes. Mejer said he believes the draft should also be provided to employees. Eagan said it is a public document and will also be made available on the County's website. Sorensen said he, Etherton, Andorf and Dr. Joe Swoboda, a psychologist at CMHC, can serve as contacts for employees.

Sorensen presented a draft timeline of the ITN Process (Exhibit B)

Mejer asked how input on the ITN will be collected from providers, consumers and stakeholders. Suggestions included town hall meetings, a pre-submission conference with potential providers, an on-line survey, and placing materials at places the consumers utilize. Sorensen said he will work on a plan to get CMHC clients together to talk about the ITN, since they are most directly impacted. Lorenzen suggested they be provided a summary of the service elements.

Anderson questioned what demographic is being targeted, noting she was recently contacted by a resident in an assisted living facility who was seeking information regarding mental health services in the community. Sorensen said a substantial portion of the population that CMHC serves is severely, mentally disabled and that is important for potential providers to understand. J Rock Johnson added that population also has a higher than average mortality rate and said that is important to note in the integration with primary care.

Smoyer arrived at the meeting at 8:12 a.m.

C.J. Johnson noted that many of the consumers that attended the focus groups talked about their case managers being their “lifeline” and said one of the challenges will be to not get locked into community support. He felt many could utilize some other type of service coordination such as peer support, which is more cost effective. C.J. Johnson said the State is working on a matrix of services and said the ITN document could list the services to be provided and allow the potential provider to propose alternative services that are equivalent to those components. Wright said it appears that the list of CMHC services shown on Page 3 are the services that are being bid out. Seibel suggested that the current services be reflected in an appendix, rather than imbedded in the document. J Rock Johnson suggested the document reflect an emphasis on well-being, self-determination and individual decision making and developing those skills. She also suggested that it emphasize evidence-based practices and rehabilitation. Wright suggested an overall statement regarding outcomes and performance measures. J Rock Johnson felt there should also be a specific reference to peer support and peer operated services. C.J. Johnson suggested that specific criteria be listed in an attachment and refer to the attachment in certain sections.

Etherton arrived at 8:24 a.m.

Andorf said the service definitions need to be rewritten. She also suggested that potential providers be provided with information regarding the number of clients receiving General Assistance (GA) and primary care. Halstead said examples could be provided but said the GA patients are receiving care for an acute care need, not routine primary care or ongoing needs.

J Rock Johnson asked that quality improvement in the evaluation be included in the Consumer Involvement section on Page 12.

Seibel felt potential providers should be asked to identify their partnerships and collaborations. She also felt cultural and linguistic competency should be included in the evaluation criteria. C.J. Johnson cautioned against listing too many criteria. He said an assurance document that lists significant principals might be more useful.

J Rock Johnson suggested that rights protection and conflict resolution mechanisms be emphasized. C.J. Johnson said those components will be included in the contract.

2 REVIEW OF PROCESS PRIOR TO ASKING FOR PROPOSALS

See discussion of the Draft ITN.

3 DRAFT ITN, VERSION TWO

Item was moved forward on the agenda.

4 ADJOURNMENT

There being no further business, the meeting was adjourned at 8:47 a.m.

Submitted by Ann Taylor, County Clerk's Office.



**Lancaster County & Region V Systems
Intention to Negotiate (ITN) Response Package**

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Introduction

Purpose

Lancaster County (County) and Region V Systems (Region V) issue this Invitation to Negotiate (ITN) for the purpose of gathering cooperative and creative proposals for the transition of Lancaster County Mental Health Center (CMHC) service array to a new recovery-based service model. The County/Region V model will integrate behavioral health services and primary health care, with peer supported programming and extensive consumer involvement.

Invitation to Negotiate Process

The ITN is intended to function as an open process for groups and organizations interested in submitting responses and is less rigid than a formal Request for Proposals (RFP). It provides an opportunity for interested parties to learn about County/Region V expectations and specifications and provide written documentation in response. The ITN process will lead to further discussions with qualified parties and eventually lead to potential offers and related details.

The current array of services provided by CMHC includes a mix of crisis, outpatient, and rehabilitation services and does not include integration with primary care. It is possible the County and Region V will negotiate with more than one entity in order to develop a service system inclusive of crisis, outpatient, rehabilitation, and primary care services that best fits the needs of the community. Collaboration among providers in the design of a mix of services (crisis, outpatient, rehabilitation and primary care) is encouraged.

Groups and organizations submitting successful ITN Responses will enter into service contracts with Region V. ITN Responses will be evaluated based on responsiveness to the requirements of this document and a demonstrated ability to perform.

Background Documents

CMHC Planning Committee Report: The Lancaster County Board of Commissioners established the CMHC Planning Committee in June of 2011 for the purpose of reviewing how the County is providing behavioral health services at the CMHC; determining the best model for providing services in the future; and advising the Lancaster County Board as to the proper role of the County in funding and providing these services. The Report and Recommendations of the CMHC Planning Committee is in Attachment A.

Health Management Associates Report: Delivery and coordination of mental health services in the County was also addressed in a report prepared by the Health Management Associates (HMA) for the Community Health Endowment. The HMA report specifically addresses the CMHC and provided the County Board with a recommendation on how to provide services in the future. A copy of the HMA report can be found at:
http://www.chelincoln.org/images/pdfs/HMA_CHE_Report_1_30_2012.pdf.

The Recovery Project Report: Consumers of Lancaster County have a vested interest in the CMHC transition process and have provided input into this ITN in a set of standards and recommendations relating to recovery-based integrated services. (Attachment B) The report is based on extensive research on recovery-based models of behavioral healthcare. Vital information

regarding standards and recommendations from over 40 white papers and federal publications help to operational a recovery-based model of care. These recommendations and standards serve as an excellent reference for providers in the development of a recovery-oriented system of care.

CMHC

CMHC was established by Lancaster County in 1976 through a federal grant under the Comprehensive Community Mental Health Centers Act for the purpose of treating persons with severe and persistent mental illness in the community rather than in state institutions. Original services included inpatient care, outpatient care, medical services, consultation and evaluation, children’s services (no longer provided), and program evaluation.

The CHMC services and numbers of persons served relevant to this ITN is displayed in Table 1. Nebraska Behavioral Health Division (NBHD) and Medicaid behavioral health service definitions, which provide detailed service definitions can be found at:

http://dhhs.ne.gov/behavioral_health/Pages/beh_bhsvcdef.aspx

A summary of Nebraska behavioral health service rates is included in Attachment C.

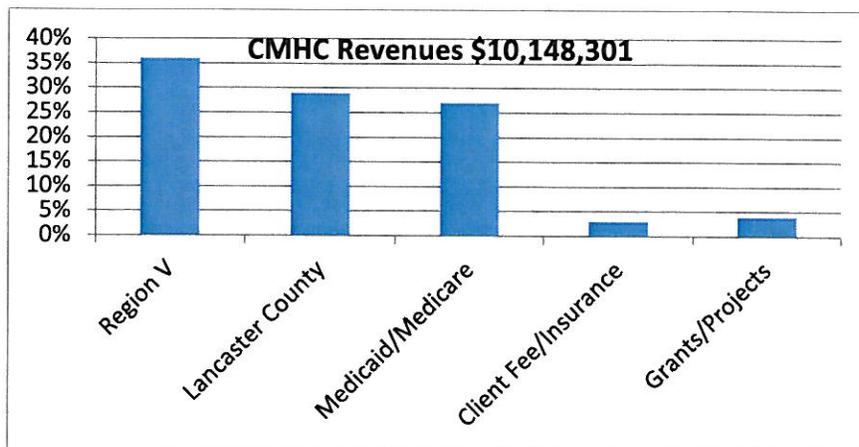
Table 1. CMHC Programs/Services and Number Served

CMHC Services	Persons Served by CMHC-20?? (Duplicates Included)
<u>Community Support Mental Health</u> : Case management and services to adults and vulnerable elderly through the Harvest Project, and residential support services at The Heather, Independent Living Project, and Transitional Living for adults with severe and persistent mental illness.	1,238
<u>Medication Management</u> : Outpatient psychiatric services including assessment, therapy, medication education and management, and inpatient psychiatric care.	1,909
<u>Inpatient Psychiatric Care</u> :	347
<u>Outpatient Psychotherapy</u> : Individual and group therapy focused on symptom alleviation, stabilization, and recovery. Community-based sex offender management. Should this be separate category?	883
<u>Day Treatment</u> : Short term, intensive treatment provided through group formats, 6.5 hours daily, Monday-Friday. May serve as an alternative to inpatient treatment or as a step down for individuals making the transition from a hospital setting to the community.	227
<u>Day Rehabilitation</u> : The Midtown Center, open Monday-Saturday, is a clinical rehabilitation program engaging consumers in life skills, recovery and vocational activities.	195
<u>Supported Employment</u> : Employment and benefits counseling, job placement, and vocational support.	44

CMHC Services	Persons Served by CMHC-20?? (Duplicates Included)
<u>Homeless/Special Needs Outreach</u> : Outreach and case management for adults who have a mental illness and are homeless, near homeless, or in contact with the criminal justice system.	253
<u>Psychiatric Residential Rehabilitation</u> : The Heather is a structured residential facility operated by CMHC and OUR Homes as a residential transition from the Lincoln Regional Center back into the community.	28
<u>Assertive Community Treatment</u> : A collaboration designed to serve individuals who have not responded well to traditional outpatient care. Services are provided to the consumer in their home and the community.	79
<u>24 Hour Crisis Line</u> : Crisis assessment, intervention, and information available 24 hours by phone.	4,897
<u>Crisis Response</u> : Mobile services available to law enforcement or agencies requesting consultation/intervention after regular business hours.	

Total Revenue for CMHC in 20?? was \$10,148,301. Revenue sources by percentage of the total revenue are displayed in Figure 1. CMHC expenditures included 74% for personnel; 6% for Region V; and 20% for operating.

Figure 1. CMHC Revenue Sources



Region V

Region V, a political subdivision of the state of Nebraska, has the statutory responsibility for organizing and supervising comprehensive mental health and substance abuse services in the Region V area, which includes 16 counties in southeast Nebraska. The provider(s) selected will contract with Region V for the delivery of services.

Region V, one of six regional behavioral health authorities in Nebraska, along with the state's three Regional Centers, make up the state's public mental health and substance abuse system, also known as the Nebraska Behavioral Health System. Region V is governed by a board of county commissioners, who are elected officials from each of the counties represented in the Regional geographic area. The Regional Governing Board (RGB) is under contract with the Nebraska Department of Health and Human Services, the designated authority for administration of mental health and substance abuse programs for the state.

Each RGB appoints a regional administrator (RA) to be the chief executive officer responsible to the RGB. The RGB also appoints an advisory committee for the purpose of advising the RGB regarding the provision of coordinated and comprehensive behavioral health services within the Region to best meet the needs of the general public. In Region V, the Behavioral Health Advisory Committee is comprised of 15-20 members including consumers, concerned citizens, and representatives from other community systems in the Region.

Region V's purpose is to provide coordination, program planning, financial and contractual management, and evaluation of all mental health and substance abuse services funded through a network of providers. Region V is responsible for the development and management of a provider network that services the behavioral health needs of southeast Nebraska. Currently, Region V has 12 providers in its network who have met the minimum standards required to be a member of the network; each provider has a contract with Region V to deliver a variety of behavioral health services. Region V, as payer of last resort, primarily serves financially eligible adults and youth with or at risk of serious mental illness, substance abuse, and/or substance dependence.

Region V's geographical area includes Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York counties in southeast Nebraska.

Eligible Respondents

Eligible respondents may be a state, county, or community-based public; private not-for-profit; private for profit; or faith-based organization. Respondents must be a legal entity already established and functioning with paid personnel and demonstrable experience in working with the target population as evidenced by the following:

- a. Region V Provider Network member or demonstrate necessary prerequisites;
- b. In operation and in good standing (based on a current independent audit) for at least 24 months;
- c. Nebraska Medicaid approved provider for behavioral health services or willingness/ability to obtain Nebraska Medicaid provider status;
- d. National accreditation in the provision of behavioral health services by a nationally recognized accreditation organization, i.e. CARF, COA, TJC, or have an accreditation development plan that outlines the agency's timeline (minimum 2 years) of applying for national accreditation;
- e. Current applicable Nebraska behavioral health licensed clinicians and physicians on staff;
- f. Current license as a Nebraska mental health center or plan to obtain such license;

- g. Ability to build the organizational capacity to serve the population within the chosen service category(s);
- h. Ability to provide services within Region V's geographic area; and,
- i. Able to initiate services effective XXX.

Geographical Area/Population

Services shall be located in Lancaster County, Nebraska but available and accessible to persons located in all 16 counties in Region V's geographical area. The general populations for which the services shall be provided include:

- Persons over 19 years of age who reside within the Region V geographic service area;
- Adults with a risk of experiencing disruption in functioning or impairments due to behavioral health issues;
- Adults who meet financial guidelines and do not have coverage for services through other payer sources or who qualify for Medicaid; and,
- The following are mental health community service priorities:
 - 1) Persons being treated in a Regional Center who are ready for discharge;
 - 2) Persons being treated in a community inpatient setting or crisis center and who are awaiting discharge;
 - 3) Persons committed to outpatient care by a Mental Health Board
 - 4) All others.

Service Delivery Requirements

Major Requirements

The goal of the County and Region V is to establish a new service model, which is highly effective and financially sustainable. Major requirements for the new service system include:

1. Integration of behavioral health and primary care services- Proposals must address how the integration of behavioral health services and primary health care will be accomplished.
2. Core Services-Proposals must identify the core behavioral health programs and services that will be offered at one central location, and which services can be effectively offered at other locations throughout the community.
3. Consumer involvement and peer supported programming-Proposals must include a plan for how consumer involvement and peer supported programming will be incorporated in all phases of design, development, implementation operation, and delivery of programming. (See The Recovery Project Attachment B)

Some suggested alternative language:

The goal of the County and Region V is to establish a new service model, which is highly effective and financially sustainable. Major requirements for the new service system include:

Integration of Behavioral/Primary Healthcare Services- Various models of integrated behavioral/primary healthcare exist and, based on the needs of the individual, different models are appropriate. A background document on integrated behavioral/primary healthcare, "Evolving Models of Behavioral Health into Primary Care," authored by the Millbank Foundation (2010), can be found at: <http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf>. It is highly recommended that all ITN Respondents review this document as they plan for integrated services.

Although, integrated behavioral/primary healthcare is an essential component of the envisioned County/Region V system, it is anticipated that some behavioral health providers may not be offering primary care as a part of their service package, and some primary care providers may not be offering a complete package of behavioral health services (crisis, outpatient, rehabilitation). However, in both scenarios, providers must address how they will ensure the behavioral and primary healthcare needs of those they serve. Partnerships between behavioral health and primary care providers are highly recommended.

Core Behavioral Health Services- As can be seen in Table 1., CMHC offers a wide variety of crisis, outpatient, and rehabilitation services. Over the past few years, the Nebraska Behavioral Health Division (NBHD) developed new service definitions designed to meet the needs of the population while promoting service delivery efficiency and effectiveness. NBHD service definitions can be found at: http://dhhs.ne.gov/behavioral_health/Pages/beh_bhsvcdef.aspx.

It is expected that the Region V/County service delivery system will take advantage of the new service options and incorporate a full range of crisis, outpatient, and rehabilitation services in a variety of settings. Utilizing a multitude of service levels is encouraged in maximizing system efficiency and effectiveness as well as meeting the varying and changing needs of the population. ITN Respondents must identify the core behavioral health services they intent to offer and planned service locations. Locations must be convenient to the population (along bus lines).

Consumer Involvement and Inclusive of Peer Supported Programming- All ITN Respondents must include a plan for how consumer involvement and peer supported programming will be incorporated in all phases of design, development, implementation operation, and delivery of programming. (See The Recovery Project Attachment B)

Relationship with Lancaster County

Although Lancaster County will no longer be a provider of community-based behavioral health services through CMHC, the County still has a direct interest in how effectively those services are delivered by the new provider(s). The new provider(s) will need to maintain an excellent working relationship with the County. Areas of mutual interest include:

- Location of CMHC facility-To help guarantee a smooth transition, the new provider(s) will be allowed to remain at the existing location of 2201 S. 17th Street for at least two (2) years.
- Midtown Center-Lancaster County owns the Midtown Center at 2966 O Street, which houses CMHC programs for psychiatric rehabilitation and other related services. The County will consider proposals for the continued use of this property for this or other behavioral health services.
- CMHC Staff-All efforts should be made to retain as many of the current CMHC employees as possible. CMHC employees are highly trained and have years of experience providing

specialized care, often to consumers with severe and persistent mental illness. Retaining existing employees will also provide a continuity of care, which is essential to consumers.

- Crisis Center-The County will continue to operate the Crisis Center. For the immediate future, the Crisis Center will remain on the 2nd floor of the CMHC building. Preliminary planning is now under way to relocate the Crisis Center to the County's old Intake and Detention building . The new provider(s) will need to demonstrate the ability to work closely with the Crisis Center.
- General Assistance- Behavioral health services are provided by CMHC to consumers receiving County General Assistance. With the integration of behavioral/primary health care, the new provider(s) will need to demonstrate how they will deliver both behavioral health and primary health care to consumers receiving General Assistance.

Use of Funds

Allocation of Funds

Fee for Service (FFS): Services are reimbursed based on a unit of service up to the designated capacity specified in the contract. The funding amounts are annualized based upon 12 months of service or upon units of service delivered during the fiscal year. The use of funds provided under Region V Network Provider Contracts are limited to the employment of personnel; technical assistance; operation of programs; leasing, renting, maintenance of facilities and minor improvements; and for the initiation and continuation of programs and services. Region V will not fund:

- Financial contributions to individuals.
- Fund-raising events.
- Lobbying.
- Abortion.
- Laboratory or clinical research.
- Projects which do not serve the Region V geographical area.
- Purchase or improvement of land, purchase or permanent improvement for any building or other facility, or purchase major medical equipment.
- Cash payments to intended recipients of health service.

Non-Transfer of Funding Award

Any contract awarded to a successful applicant may not be transferred or assigned by the applicant/contractor to any other organization or individual.

Use of Subcontractors

The chosen provider may be permitted to subcontract for the performance of certain required administrative or programmatic functions. Anticipated use of subcontractors must be clearly explained in the ITN Narrative identifying the proposed subcontractors and their proposed role. Use of treatment subcontractors and the terms and conditions of the subcontract must be approved by Region V in advance of execution of any subcontract. The successful applicant is fully responsible for all work performed by subcontractors. No subcontract into which the successful applicant enters with respect to performance under the contract will, in any way, relieve the successful applicant of any responsibility for performance of its duties.

Application Process

The County and Region V expect to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. In addition, the County and Region V reserve the right to issue a Request for Proposals if enough information is not gathered through the ITN responses received.

Activity		Date/Time
1.	Announce ITN Process and Deadlines	1/2/13
2.	Closing Date for Receipt of Proposals	
3.	Evaluate Contractor Proposals	
4.		
5.		
6.		
7.		
8.		
9.		

ITN Response General Instructions

All instructions, conditions, and requirements included in this document are considered mandatory unless otherwise stated. ITN responses that do not conform to the items provided in this document will not be considered. All applicants must adhere to the following guidelines.

1. The closing date for receipt of ITN responses is 4:00 pm Central Standard Time on **XXXXX**. Proposals must be sent or delivered in person to:

Region V Systems
1645 N St.
Lincoln, NE 68508

 - a. FAX copies will not be accepted.
 - b. Two-sided coping is allowed, but not required.
 - c. No requests for extensions of the due date will be approved.
 - d. Region V/County accepts no responsibility for mislabeled/mis-sent mail.
 - e. Proposals received late will not be accepted and will be returned to the sender unopened.
2. ITN responses must be clearly referenced as **ITN Response** on the outside of the envelope or package.
3. Respondents must submit one (1) original and ten (10) copies of the ITN Response.
4. Responses must be typed in 10-point font or larger, submitted on standard 8 ½" by 11" paper, numbered consecutively on the bottom right-hand corner of each page, starting with the Cover Page through the last document, including required attachments.
5. Staple or clip the original and each copy of the response at the upper left-hand corner. Do not use covers or add unsolicited attachments to your proposal.
6. Designated information must be provided on Region V forms provided in the attachments of this document. **Electronic versions are available on the Region V website.**

ITN Response Format

The ITN Response must include the following components submitted in the order as listed below.

I. Cover Page

Complete the entire Cover Page (Attachment D) and obtain the signature of the chief executive officer, board chairperson, or other individual with the authority to commit the applicant to a contract for the proposed program/services.

II. Executive Summary

Complete the entire Executive Summary (Attachment E). The Executive Summary must summarize the **???Is there a form for this???**

III. ITN Narrative

A. Service Development

The County and Region V are looking for innovation in how a provider(s) can deliver integrated and coordinated behavioral/primary health care to County residents who met financial eligibility requirements. Services funded will be evidence-based, trauma informed, recovery-oriented, and include the utilization of peer supported programming. Providers must be equipped to treat co-occurring disorders with either onsite or active referral capability. The inclusion of prevention and wellness components embedded within the service(s) is expected. Providers will be capable of demonstrating efficient and streamlined admission to all levels of services.

A major component of the funded service system includes integrated behavioral/primary health care. This component must be based upon a recognized behavioral health/primary health care model. SAMHSA and The Center for Medicaid Services (CMS) have developed a Guidance Document for states that provides key questions organized according to Health Home Service components. (Attachment F.) The document is intended to be useful, however not prescriptive, for providers responding to this ITN. Further information regarding health homes can be found on the SAMHSA website.

<http://www.samhsa.gov/healthreform/healthhomes/> As mentioned earlier in this document, another important resource addressing integrated behavioral/primary care is located at: <http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf>.

Partnerships and formal collaborations are highly recommended in the development and implementation of services. In addition, collaborative relationships with local organizations outside of the provider network who can enrich the lives of those served is expected.

Please describe a vision for the recovery-oriented, integrated behavioral/primary health services you hope to deliver. Include details related to evidence-based practices, use of peer supported programming, ability to treat co-occurring disorders and provide trauma-informed services, number of individuals you intent to serve, service location(s), staffing, and any other components

you feel will strengthen your opportunity to deliver the service. Please limit this section to ten (10) pages.

B. Consumer Involvement

Consumer involvement is a priority in all aspects of behavioral health service planning and delivery. The County and Region V expect organizations to employ strategies to involve consumers in the organization's policies/planning; management/governance; service delivery; and training program development activities. Organizations must assure meaningful and significant participation by consumers and advocates in the design, development and implementation of all services. As mentioned earlier, The Recovery Project document (Attachment B.) provides guidance for consumer involvement strategies.

Please describe how you will incorporate consumer involvement in the development of the services you wish to deliver. Please limit this section of your response to two (2) pages.

C. Transition/Communication Plan

The transition from the current CMHC system to a new service delivery system will be stressful for consumers receiving services from CMHC and CMHC employees. The ultimate goal is to reduce the stress of transition and retain as many consumers and staff as possible. To accomplish this goal, careful transition planning must be employed to ensure a smooth transition for both groups. In addition, a communication plan developed to assure transparency and to assist consumers, families, and employees with the transition is expected.

A complete transition/communication plan is not expected at this time. However, a thoughtful approach to the development of the plan and plan components is required. Please discuss how you will develop a transition/communication plan (stakeholders included, process, communication, etc.) and describe the components of the plan and format you feel will be most effective. Please limit this section of your response to two (2) pages.

D. Infrastructure

The County and Region V are searching for the best possible candidates, with demonstrated success in the field, to provide services to Lancaster County residents. The infrastructure of the organization is critical in the delivery of services.

Please discuss your organization's infrastructure capacity in the following areas. Please limit this section of your response to seven (7) pages.

- a. Network Experience: Experience working with a network administrator in the delivery of publicly funded behavioral health services.
- b. Administrative Structure: Current and proposed administrative structure.
- c. Health Insurance: Capacity to work effectively with Nebraska Medicaid and other health insurance companies
- d. Program Evaluation: Data collection, analysis, and reporting.

- e. Health Information Technology: Electronic medical records, health information exchange, e-prescribing, practice management, etc.
- f. Financial Management System
- g. Quality Improvement Program

IV. Supporting Documents

Please attach the following supporting document: Financial Audit Summary, Current Facility Licensure, Accreditation Certificate, Most Recent Accreditation Report, and Number of Staff by Licensure

Evaluation Criteria

Proposals will be evaluated on the following points.

1. Service Development:

- Innovation, effectiveness, and efficiency of service delivery model
- Inclusion of evidence-based, trauma informed, recovery-oriented, and peer supported program components
- Ability to deliver co-occurring services
- Inclusion of prevention and wellness components
- Integrated behavioral/primary healthcare approach
- Utilization of partnerships and local organizations

2. Consumer Involvement:

Strength of strategies to involve on-going meaningful and significant consumer involvement in agency activities including:

- Policies/Planning
- Management/Governance
- Service Delivery
- Training Program Development

3. Transition/Communication Plan

- Logical approach to the development of the Transition/Communication Plan

4. Infrastructure

- Network experience
- Strength of administrative structure
- Experience working with Medicaid and other health insurance companies
- Strength of program evaluation
- Usage of health information technology
- Sophistication of financial management system

- Evidence of an effective quality improvement program

5. Minimum Standards

- Financial Standing
- Facility Licensure
- Accreditation & Recent Report
- Depth of Current Staffing

Limits on Communications

Questions to Region V personnel regarding this ITN may be made either by fax, email, or written correspondence, using Attachment G. Request for Information. Written responses to questions will be made by Region V personnel within three business days.

Under the parameters of the ITN process, with the exception of clarifying questions, prospective respondents are prohibited from contacting Region V personnel, DHHS personnel, BHAC members, RGB members, LCMH staff, Lancaster County staff, or Lancaster County Board members regarding this ITN solicitation during the period following the release of this ITN, after the release of available funding amounts, during the proposal evaluation period, and until a determination is made and announced regarding an invitation to submit further information.

Attachments

Attachment A. Report and Recommendations: CMHC Planning Committee

Attachment B. The Recovery Project

Attachment C. Service Rates

Attachment D. Cover Page

Attachment E. Executive Summary

Attachment F. SAMHSA Health Home Guidance Document

Health Homes and Individuals with Behavioral Health Issues SAMHSA's Guidance Document Affordable Care Act Health Home Provision [Sec. 2703 & Sec. 19459(e)]

From SAMHSA's consultations regarding 2703, it is clear that States are at different stages of preparing and planning their State Plan Amendments. To that end, attached is a guidance document for States as they consider taking advantage of 2703 for people with behavioral health (i.e., mental health and substance abuse, MH/SA) disorders. The document serves as a checklist of key behavioral health questions organized according to the Health Home Service components involved in Section 2703. These components are: comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, and referral to community and social services, with health information technology used to support these services. By providing states this structured background regarding the core elements of the 2703 health home, we aim to ensure that key behavioral health topics are considered as States develop health home proposals. This document serves solely as guidance for entities thinking about health homes, and is not meant to be prescriptive or regulatory. The intended audiences for this document are those involved in developing the State Plan Amendment for 2703, although SAMHSA believes this will be useful to health home providers and others interested in health homes.

GENERAL QUESTIONS

- What is/are the target chronic condition(s) of your health home proposal?
- How will individuals be identified and referred to health homes? How will individuals not connected to either the primary care or behavioral health care system be informed and referred to your health home program?
- Describe the flow (visually or by narrative) depicting how clients will move in, through, and out of your health home program.
- What measures will be used to screen and intervene for behavioral health disorders?
 - Alcohol abuse and/or dependence
 - Drug abuse/dependence
 - Tobacco use/dependence
 - Depression and suicide risk

- Do you anticipate policy and reimbursement barriers regarding the establishment of health homes for individuals with behavioral health conditions (e.g. same day billing issues)?

SERVICE COMPONENTS (N=6)

A. Comprehensive Care Management

- How will your health home providers outreach to, plan, and communicate with other primary and specialty care providers regarding a patient's care?
- How will your health home providers develop an individualized treatment plan, informed by the patient, which integrates care across varied care systems (i.e. mental health, substance use, primary care, etc.)?
- How will your health home providers clarify and communicate the patient's preferences to all involved providers while assuring timely delivery of services?
- Composition of Your Health Home Team
 - What credentials or core competencies are recommended and/or required for health home team members serving individuals with a behavioral health condition? How are health care professionals identified as team members who can treat individuals with chronic illnesses (including MH/SA)? What are the functions of these team members?
 - What are the behavioral health workforce needs of your health home providers?
 - Will individuals in recovery from MH/SA be a part of your health home team approach?

B. Care Coordination and Health Promotion

- What are the linkages established between primary and behavioral health care providers? How will you promote care coordination among your participating health home agencies and other providers within their network (e.g., respite providers)?
- How will information be shared with other agencies patients are referred to? How will records be transferred out of the system if a patient leaves the health home?
- Will your health home providers use an agreed upon shared continuity of care record or similar vehicle? Will this be part of their medical record system?
- What specific mechanisms has your health home team established with community (e.g., YMCA) and specialty care providers? Are there formal mechanisms, such as "Memoranda of Understanding" or network alliances that link those in a specific locale?
- Do you have a shared consent form among providers? How will you manage the exchange of consent information?

- How will you educate patients on their consent options and implications of information sharing?
- How do you define health promotion in the context of your health home providers' activities?

C. Comprehensive Transitional Care (including follow-up from inpatient to other settings)

- What processes will be in place so all Medicaid provider hospitals identify and refer clients to a health home provider?
- How do you propose to ensure planning between levels of care (e.g., hospital to health home)? How will information be shared and updated between levels of care (e.g., how will discharge information be transferred from hospitals or nursing facilities to your health home providers)?
- How will you know how many individuals treated by your Health Home providers have been re-hospitalized within the last thirty days? How will you know how many have seen a primary or specialty care provider within thirty days of hospital discharge?
- Will there be mechanisms to involve health home providers with discharge planning from the hospital? Do your hospitals screen for MH/SA prior to discharge for those in or moving into health homes?
- How will your health home providers communicate and educate patients and caregivers about the transition process? What tools will health home providers use to engage patients in their care planning?

D. Patient and Family Support

- How are you defining patient and family support?
- What is the role, if any, of peers and individuals in recovery in providing patient and family support?
- How will your health home providers consider a patient-directed approach in treatment planning?

E. Referral to Community and Social Services (if relevant)

- How does the State ensure that health home providers make assessments and referral for community and recovery supports (e.g., housing, recovery support services, job training, employment placement, etc)?
- How will these referrals occur (e.g., electronically)? How will you track these referrals and the results? How will the receiving provider be notified about the referral?

Data and Health Information Technology to Link Services (as feasible and appropriate)

- What outcome data do you have/need?

- What information/data currently exist across the systems?
- What common information/data can be shared across the systems?
- What information/data would constitute evidence for a successful intervention?
- Does your EHR generate a bill and can it record a payment? If not, how do you do your billing currently? How will you bill in the health home environment?
- What medical records systems are currently in use by health home providers? How will they interoperate within the health home environment?
- Are your health home provider electronic medical records systems interoperable with other agencies?

9/27/
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Attachment G. Request for Information

ITN PROCESS

DATE	ITN PANEL	LANCASTER COUNTY	REGION 5	CONSUMERS	PROVIDERS	STAKEHOLDERS
5/25/12	ITN Panel Formed					
	↓					
8/29/12	ITN Draft Document					
	↓					
9/30/12			BHAC Review			
	ITN Document					
9/30/12		LCB Approval	RGB Approval			
				Consumer Review	Provider Review	Stakeholder Review
1/31/13	Contract Specs					
	App Process					
	Eval Process					
		LCB Approval	RGB Approval			
3/31/13	Announce Process/Deadlines				Develop and Submit Proposals	
4/30/13	Deadline to Accept Proposals					
	Evaluate Proposals					
5/31/12	Contracts Finalized					
6/30/12			RGB Approves Contracts			

EXHIBIT

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