



**MEETING NOTICE**  
**INVITATION TO NEGOTIATE COMMITTEE**  
**WEDNESDAY, DECEMBER 19, 2012**  
**7:30 - 8:30 a.m.**  
**COUNTY – CITY BUILDING – 555 S 10<sup>TH</sup> ST**  
**ROOM 113**

**AGENDA**

1. Approval of Minutes - September 26, 2012
2. Input Received at Consumer, Provider and Employee Meetings from Region V
3. Discussion Regarding Meetings and Other Input Received
4. Process Recommendations from Committee

**MINUTES  
COMMUNITY MENTAL HEALTH CENTER (CMHC)  
INVITATION TO NEGOTIATE (ITN) COMMITTEE  
WEDNESDAY, DECEMBER 19, 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); Jane Raybould, County Commissioner; Gary Lorenzen, Mental Health Foundation; Gail Anderson, CMHC Advisory Committee; J Rock Johnson, consumer advocate; Kerry Eagan, County Chief Administrative Officer (Ex-Officio); Scott Etherton, CMHC (Ex-Officio); and Wendy Andorf, CMHC (Ex-Officio)

**Committee Members Absent:** Brent Smoyer, County Commissioner

**Others Present:** Linda Wittmuss, Associate Regional Administrator, Region V Systems; Amanda Tyerman-Harper, Region V Systems; Melissa Koch and Jamie Monfelt, OMNI Behavioral Health; Mary Sullivan, Consultant to CMHC; and Ann Taylor, County Clerk's Office

Sorensen called the meeting to order at 7:32 a.m.

Introductions were made.

Seibel arrived at the meeting at 7:34 a.m.

**1 APPROVAL OF THE SEPTEMBER 26, 2012 MINUTES**

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

**2 INPUT RECEIVED AT CONSUMER, PROVIDER AND EMPLOYEE MEETINGS - C.J. Johnson, Region V Systems Administrator**

C.J. Johnson, Region V Systems Administrator, presented input from the focus groups (potential providers and other stakeholders, Community Mental Health Center (CMHC) staff, and consumers) (Exhibit A). He said questions from the potential providers/stakeholder group included how to properly identify the consumers, finances,

and should certain services, such as the Assertive Community Treatment (ACT) Team or psychiatric residential rehabilitation program, be split off. C.J. Johnson said there was general consensus that a single entity should provide a core set of services. Adjunct services could be provided by other agencies.

Raybould arrived at the meeting at 7:38 a.m.

C.J. Johnson said CMHC staff responded to a list of questions (Exhibit B). He said they expressed concerns regarding their relationships with consumers and what entities might take over services. Staff identified medical services, community support, outpatient and partial care as the core services. Another message that came from staff was the need to recognize that many of the individuals who are currently receiving services have reached the highest quality of life level they are likely to achieve and need abilitative services to keep them at that level.

C.J. Johnson said the third set of focus groups involved current and former consumers and a group of consumers who have never received services at CMHC but wanted to express concerns. Parents of individuals who are receiving services at CMHC were also in attendance. He said there were concerns that core services may be fractioned and it would be difficult for them to receive support. Transportation and having services in close proximity to other services, such as a pharmacy and grocery store, were among the issues cited.

Seibel asked C.J. Johnson whether input from the focus groups changed the way he sees the process. C.J. Johnson said yes, he now believes an additional step should be added to the process, i.e., to put out a Request for Qualifications (RFQ). He said entities who are deemed qualified could then participate in a series of meetings to go through the sub-components of transitioning CMHC's services. They will then bring some of the subcontractors, such as O.U.R. Homes, which provides residential and adult day services, to help develop the final proposal. If there is competition "at the table", they will move to a Request for Proposal (RFP) process.

In response to questions from Seibel and Raybould, C.J. Johnson said he believes the core set of services needs to be under a single entity.

Halstead asked whether two entities would be precluded from applying together in the RFQ process. C.J. Johnson said no, adding there could also be collaboration after the RFQ process. He noted there is also the ability to limit the number of entities that are allowed to "come to the table."

### **3 DISCUSSION REGARDING MEETINGS AND OTHER INPUT RECEIVED**

C.J. Johnson suggested the ITN Committee assist with scoring the final proposals and make subsequent recommendations to the County Board and Region V Governing Board, unless there is a conflict of interest.

Halstead asked whether CMHC plans to apply. Sorensen said it has been discussed but there are a number of barriers.

### **4 PROCESS RECOMMENDATIONS FROM COMMITTEE**

C.J. Johnson discussed the draft timeline (Exhibit C), noting the intent is to release the RFQ by the end of January, 2013.

There was consensus to meet on January 9<sup>th</sup> and 16<sup>th</sup> to review the draft RFQ and discuss the process.

J Rock Johnson said she believes there should be more consumer involvement and felt consumer involvement, person centered, recovery-based and peers should be included in the list of ITN parameters in Item 9 (see Exhibit C). She said there may be other items that should be included and said she will forward her suggestions to C.J. Johnson.

**MOTION:** J Rock Johnson moved to have a subcommittee of consumers participate in a process that is parallel and integrated to this process.

The motion died for the lack of a second.

C.J. Johnson noted the document and process will be discussed in public meetings. J Rock Johnson said meeting times and transportation issues may prevent consumers from attending. Raybould suggested the ITN Committee hold one of its meetings at CMHC to be more accessible to consumers.

Lorenzen suggested more sharing of information with consumers on where we are in the process. J Rock Johnson said that was built into the original work plan and said she does not believe there has been any activity since May. Lorenzen and Raybould noted information has been shared through the CMHC Advisory Committee and the focus groups.

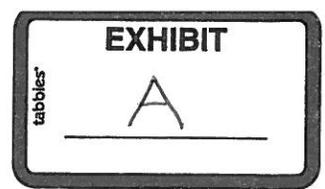
J Rock Johnson asked whether the ITN document has been modified. C.J. Johnson said it will be revised, based on input from the focus groups, and will be brought back to the Committee.

**5 ADJOURNMENT**

**MOTION:** Seibel moved and Anderson seconded to adjourn the meeting at 8:35 a.m. Sorensen, C.J. Johnson, Halstead, Seibel, Wright, Raybould, Lorenzen, Anderson and J Rock Johnson voted aye. Smoyer was absent from voting. Motion carried 9-0.

Submitted by Ann Taylor, County Clerk's Office.

**ITN Provider Focus Group  
Lancaster County Extension Office  
October 31, 2012**



*Attended by 45 individuals*

**SECTION 1: INTRODUCTION AND PURPOSE**

1.4 Target Population

- Revisit target population and funding source(s)
- Describe payor sources
- Define SPMI and SMI
- Define who is currently served at CMHC
- Define populations in terms of funding priorities and service types serving them
- Clarify that population to be served is the current population being served by CMHC (are being served or have been served)
- Who does this eliminate from service?
- Include co-occurring population as target population / recognize and address substance abuse issues
- What is stated is what Region V Systems has the authority to let bid for. However, bidders must be prepared to serve Medicaid, Medicare, other TPL
- Lancaster County target should align with Region V target population
- Where does the General Assistance population fall?
- What is Lancaster County's continued commitment?
- Could add cluster based planning breakout

1.5 Scope of Service

- Second line doesn't make sense; need to clarify
- Clarify that the count of persons served is "duplicated"
- Alternative services may be less expensive (Review of Attachment A)
- Providers may apply for one or all services, but challenges are inherent in separating some services as they are inter-related, i.e. day treatment separated from ER system—day treatment supports the Crisis Center?
- 3000+ clients served at CMHC – what are their needs?
- Community Support—possible alternative service? Will continue to allocate some dollars for community support capacity;
- Foundational / core services will be maintained
- How will alternative or new services be paid for?
- Does the Region get Medicaid match back to assist in new services?
- Define base funding
- Set aside funding for alternative recommended services, look at different approaches, pilot project; maybe use post-commitment funds? Look at the crisis center budget;
- Need to ensure accountability, best practice, evidence-based practice, data / outcomes
- ITN process—want to get a sense of who is qualified to do these services, then bring those agencies to the table
- Ensure National Quality Measures are used in the evaluation process
- Services need to be integrated; one provider—not piecemeal; consumers use a number of services; lends to efficiency of service delivery and business practices
- ITN (Negotiate); need to keep in mind the people served;
- Not have competitive proposals come in first? Collaborate / seek agreement first? Do we want to take this step?
- Start with a Letter of Interest? / less formal process, concept paper
- Break down the funding categories to remove ambiguity – specific core required services and non-required / alternative services

- Clarify which service definitions we're operating under
- Administrative accountability is different than service types. Who is accountable? What is the response if outcomes don't occur? Speak more to accountability.
- Criteria: Do the services speak to best practice standards and use of evidenced base practices and how they are measured?
- Conflict in document is strict RFP language vs ITN language – hard to live in both worlds

### 1.7 Minimum Standards of Eligibility for Respondents

- 1.7 A.6: MH License required; not required for OP, etc.—clarify licensure issues
- 1.7 B. Minimum Programmatic Requirements: 3 key elements defined
- Relationship with Lancaster County: funding will come through the Region / provider(s) must be able to maintain a relationship with Lancaster County
- General Assistance: does this imply that services have to be provided free to these individuals who are eligible for GA? Not the intent of the statement; “eligible” would be better choice of words
- Are there funding streams contemplated for integrating primary care?

### **SECTION 2: INVITATION TO NEGOTIATE PROCESS**

- Is there a plan for how collaboration among providers will happen? Seeking input on how this could happen
- Have to use a competitive process / wanted to avoid lengthy process / would like to have agencies discuss how best to move forward.
- Clarify what recovery support programs would be considered / define concept
- Limiting communication to ensure the integrity of the process
- Timeline reviewed; per the timeline contracts would be issued by July 1; proposal(s) will include a transition process; will contract for that transition process the proposal has suggested; provider will identify transition process timeline
- Will there be funding for the transition process? Can we utilize administrative funding for CMHC as their costs decrease?
- Define Recovery Support as it applies to the ITN

### **SECTION 3: FINANCIAL SPECIFICATIONS**

- 3.2 Total funding is Region V minus Crisis Center
- Reimbursement methods may be changed to support transition process

### **SECTION 4: GENERAL INSTRUCTIONS ON SUBMISSION OF PROPOSALS TO THE ITN**

- 4.2 – do we really need 50 hard copies / can we use electronic copies to some extent

### **GENERAL DISCUSSION:**

- ITN process is much less formal than the way the process is outlined currently
- Should an RFQ process be incorporated—ITN committee will revisit this; this would formalize the process a little more;
- Where would that fit in the timeline? If we do an RFQ it could fit in before the Notice of Intent (#2) of the timeline
- Priority should be about defining the target populations and their needs
- Challenges – alternative ways of doing business, peer, recovery, etc., seen as an opportunity to develop alternative services;
- 4.3.II 1) Clarify language re the Development / Implementation Plan Page 18, last sentence: The Program Development phase: once things are in place and the development part is finished and acceptable to the State, the development phase of the project is finished.
- At a minimum provider has to be able to demonstrate that they have the capability / capacity to serve the population and provide data as required by the State

### **SECTION 6: ITN EVALUATION METHODOLOGY**

- The vendor's (change word “vendor” to proposal or applicant) in last sentence in paragraph 2

- Evaluators should have expertise in areas of proposals scored / accountability
- If we add RFQ – challenge: may be entities who would want to subcontract for a component of a service; RFQ may have to allow persons who are only interested in a small piece to be at the table;
- Region V may suggest which agencies can be subcontracted with?
- Preferences of County and Region should be identified
- Submit proposals for core services separately?
- Consumer involvement in evaluation process—make a priority

### **SECTION 7: RIGHTS AND RESPONSIBILITIES**

- 7.1 is that fair? “any and all” / clarify where that line would be
- 7.3 use “multiple” instead of up to three; will rework this section
- How do we weight the various sections--Will get a variety of input from the upcoming focus groups
- Are HMA references included? Need to look at evaluation components of that
- Consumer involvement must be weighted heavily as it is core to recovery based services

### **ITN COMMITTEE QUESTIONS / COMMENTS??**

- Ensure people currently being served don't get lost / fall between the cracks / adds weight to the transition plan and / or services proposed
- When would the services be re-evaluated? (at least yearly)
- Flexible funding / pilot programs will be evaluated more frequently
- 7.3 speaks to keeping traditional services during the transition process / can it keep things stable?
- 7.1 and 7.2 looks at more development / change in the future
- Use a staged approach . . .
- First agencies should demonstrate that they could continue to run the organization
- Then tell us how you plan to promote additional elements of service development / has to show some potential to provide innovative services as a second stage
- Critical to maintain core services as one / they are inter-related (consumers support this)
- Substance abuse not addressed concurrently
- Integration with primary care will be a requirement within 5 years; will need to be incorporated; how do you offer it / how do you pay for it?
- Input from previous focus groups identified that many consumers do have a medical home
- Talking about those consumers who do not have access to primary care / use ER, etc. Those are the individuals we are interested in serving through integration
- Community Health Endowment will have some funding available to support integration—one of their identified priorities:
- Recovery-based is a core theme—questions about implementation or measurement
- Many places that consumer involvement can take place; requires some education and opportunity;
- Clarify what the focus should be as far as what we want to see initially moving forward;

Send any further comments / questions to Amanda Tyerman-Harper

November 6, 2012

Focus Groups

CMHC Staff

At the beginning of each focus group Johnson or Wittmuss provided some history about the transition process commenting that Health Management Associates (HMA) had suggested that the Invitation to Negotiate (ITN) process be used. This process allows the committee to seek entities who are qualified / have the capacity and ability to run an organization like CMHC and bring them to the table in a collaborative way. A committee was formed which included persons from a variety of arenas tasked with the development of the ITN document / process. The draft document in its current form was approved by the County Commissioners and the Regional Governing Board; focus groups were prescribed, and input recommendations gathered through that process will be incorporated into the final document / process.

Johnson also commented on aspects of the timeline. It is anticipated that document / process will be finalized by the end of January with contracts being in place by July 1; John emphasized that there will be a timeline for a transition process to take place over a number of months following the July 1 implementation.

Attendees at each session were invited to introduce themselves and explain what role they play at CMHC.

Additional comments and questions can be directed to Amanda Tyerman-Harper; contact information is on the website

**9:00 a.m. – 10:30 a.m. (5 attendees)**

Consensus from previous focus groups is that core services should be identified and remain together under one entity. Johnson posited that PIER / ACT team and the Harvest Project might be pulled out for a separate ITN process with the remaining partners taking over those services completely.

**What are Core Services (identified by this group)?**

- Medication Management
- Community Support / Case Management
- Outpatient
- Partial Care/Day Treatment (concerns were expressed about financial stability following implementation of the \$2 co-pay.)

**Other Comments / Discussion**

- These services are well integrated and allow programs to work together; the results of case management are readily apparent
- Low turnover of staff has been an asset to consumers providing continuity of care
- Consumers feel this is a safe place and some consumers come here routinely to “hang out” and socialize.
- Many staff members have been at CMHC for extended periods and expressed concerns about less pay, inferior benefits, and more staff turnover which affects the quality of care.
- **Partial care was discussed further; in general staff members in attendance felt that partial provides a step down from hospitalization** by providing groups to meet individual needs, providing CBT, allowing consumers a place to be around people who understand them. **Partial also fills a gap for persons on the wait list for OP services;** for these reasons partial care is considered a core service by many staff members.
- There was discussion about reimbursement for group therapy and the authorization process for consumers using partial care groups.
- The majority of users of day treatment utilize the full day partial spectrum rather than an occasional group.

- There was discussion regarding whether or not the Heather and Midtown were vital elements of the above identified core services. It was noted that the Heather serves relatively few individuals. As Midtown has become more rehab oriented a number of consumers no longer use the service. Difficulties in getting authorizations for Midtown were noted. Difference of active rehabilitation needs versus case management needs.
- Johnson commented that the Crisis Center will stay with the County; because the Crisis Center utilizes partial care the transition process will need to ensure that access to partial care is available, either in-house or by providing transportation. Concerns with **transportation of individuals who were EPC'd** noted.
- Johnson inquired whether or not there are individuals who utilize only med services at CMHC; would it be detrimental to provide a different access point for those persons? Staff comment indicated that separating clients in this manner may be stigmatizing, and consumers who are only accessing med services may, at some point, need more support, and would then be required to change their access point. Concerns were noted regarding the insufficient number of psychiatrists and APRNs. It was also noted that consumers who have used up insurance benefits or have been refused services by other doctors in the community rely on CMHC to provide a **safety net for med needs**. Johnson inquired whether it would be possible to determine how many clients started out as med management only, and then required more services at a later time.
- There was discussion regarding whether or not the Crisis Line was a critical function of the identified core services. Staff comments included: it provides good communication—we know if one of our clients has called the crisis line; there are no HIPAA concerns when discussing these calls, and it was noted that individuals become clients after calling the crisis line.
- There are less than 30 case managers currently. There was discussion regarding how caseloads for case management are selected. Case managers do not necessarily specialize in the types of consumers they serve, but are given an opportunity to assume clients that they feel they could work well with. Thus each case manager may have a client population with somewhat similar needs.
- Johnson inquired what **other service types / gaps** might be essential to ensure that individuals on community support would be able to continue toward recovery. Some challenges have been noted with peer support. **Transportation** was deemed as a critical element. **Housing** needs are often referred to the Rental Assistance Program at Region V. **Employment** support is available through the AWARE program though there is a wait list for that program.
- Staff expressed concerns regarding the future and whether they would continue to be employed after the transition. Johnson explained that while the ITN process can ask that agencies interview everyone, it will not be possible to negotiate that. Johnson did note that the Region has had experience with transitioning families and staff, and worked hard to make sure they had employment. There will be no guarantee regarding salary and benefits.
- Johnson closed by stating that the ITN committee is attempting to move through this process in a thoughtful way and intends to remain transparent. Johnson thanked staff members for their input and stated that the comments affirm messages that were received at the provider forum. The fact that CMHC is a familiar location is a consideration; Sorensen also commented that the severity of the symptoms of the persons served at CMHC must be conveyed moving forward.

#### 10:45 a.m.—12:15 p.m. (7 attendees)

This session was facilitated by Linda Wittmuss. Wittmuss briefly discussed the ITN document. Attendees commented that:

- the fiscal information regarding GA is missing;
- there is a lack of clarity regarding the ultimate wishes of the County; and
- evaluation criteria requires clarification. One clear message is that the Crisis Center will remain with the County.

#### Core Services Discussion (identified by this group)

- Partial care and the Crisis Center work well together with partial care facilitates discharge from the Crisis Center; partial care is also utilized by other existing services

- Medication Management: it was noted that there are individuals who only utilize med services at this time, but these individuals have access to all services.
- Lack of access to psych services in the community was noted; a number of consumers end up in MM at CMHC due to lack of funds
- A complimentary relationship exists between med services, community support, and outpatient; consumers are able to get services quickly if necessary.
- Psych res rehab and day rehab intersect with community support.
- The Crisis Line tends to be used by people seeking services ; there was discussion regarding a separate warm line perhaps using peers as Keya House does. Community Support service definition requires 24/7 access—the Crisis Line is used for that.
- Continuity of care across services—key point

### **Other Comments / Discussion**

- It may be expedient to excise the ACT team and the Harvest Project (Emergency Community Support) from the remaining core services and the remaining providers in those contracts may be asked to assume the contract. For case managers whose clients intersect these services there may be some fiscal challenges and paper work challenges as it may be necessary to keep the services separate.
- Concerns regarding salary were noted. Should CMHC staff be hired in the transition process, the salary schedule of the hiring agency would be used.
- “Level 2” services for community support are not reimbursable; does this represent a gap in services? Would recovery support fill this gap? It was noted that consumers are reluctant to transition to recovery support. Challenges with the peer specialist position(s) were noted.
- “Wishes” included more staff and more psychiatric access, a voluntary level of care that is a step down from the Crisis Center; **funding for voluntary admission to the hospital.**
- Suggested measures to demonstrate commitment to the recovery philosophy included: infusion of peer services in all areas; quality, experience, knowledge, and training for staff; strength-based approaches; inclusion of consumer input; individualized goals and treatment plans; facility is a safe and comfortable place; buy-in to recovery principles.
- Emphasis on MH, SA, & physical health integration will be a requirement of the ITN. Most clients at CMHC do have a medical home due to the fact that they are Medicaid eligible. People’s Health Center has struggled to implement the behavioral health piece for CMHC. For some clients involvement by a case manager feels invasive.
- Timeline: following revisions / clarification from input from the focus groups, the ITN document will be revised; the document will go back to the ITN committee for review and final approval by the Regional Governing Board and Lancaster County, hopefully by the end of January. The goal to have some kind of contractor(s) by the beginning of the next fiscal year; the transition planning and process may take 6-8 months or longer; initially a seamless transition, incorporation of existing staff, Division approval must take place, followed by a well-thought-out transition process.
- Other transition discussion: would **client charts** go with client to ensure that client history does not get lost in the transition; would client’s need to approve release of their charts, what happens to all the old charts? **Collaboration:** staff would like to see cooperation / collaboration between old and new staff to help in the transition process. **Location:** staff would like to see services remain in the current building as clients are comfortable here; Lancaster County has made retention of the building an option.
- Staff asked for clarity as core services are identified.
- Funding sources that are inter-mingled will need to be identified such as funding for sex offenders and transportation, etc. Other nuances that have been incorporated in service delivery must be identified, including access to homeless services through PATH grant funding (the homeless boys).
- Concerns remain with ACCESS Nebraska. Services are delayed, clients skip appointments, it is difficult to get a waiver for transportation, phone calls often result in long waits on hold; a majority of clients aren’t able to deal with ACCESS on their own.
- Crisis planning, WRAP plans, wellness planning should be incorporated in all services.

### **1:00 p.m. – 2:30 p.m. (12 attendees)**

Johnson provided additional history regarding Health Management Associates who recommended the ITN process which allows stakeholders to be invited to the table in a less formal process than an RFP. Johnson commented that the focus will not be on getting potential agencies to provide program plans, etc; rather we will be seeking input on how they are going to transition the various services and programs over time. Ability to do a transition process which is as thoughtful as possible to current employees, will be assessed. Region V is committed to doing everything we can to ensure that employees move along with programs or end up becoming employed.

The timeline was reiterated; Johnson noted that major changes will not happen on July 1; the process could take 3-12 months or longer.

When asked what agencies have expressed interest, Johnson stated that he has been contacted by a number of non-profits in the area as well as a couple non-profits. Johnson has avoided direct discussions regarding this process so as to avoid contaminating the process in any way. CMHC staff inquired about the possibility of forming their own non-profit. In addition to funding issues, Johnson stated that the Region is required by statute to use some type of competitive bidding process.

Additional concerns / questions included: what happens to all the “stuff” that the county owns such as vehicles? What about individuals who are MHB commitments who are committed to this agency? Johnson suggested that negotiations will include equipment and other tangible items; regarding the MHB commitments those situation may have to be re-negotiated through their attorney and the courts.

### **Core Services Discussion (identified by this group)**

- Last week consensus was that this location houses core services that should remain together as a package; these care service should be under a single entity. Concerns were expressed that services will not be comprehensive if services are unbundled.
- **Core services were defined as:** community support, medication management, outpatient, and partial.

### **Other Comments / Discussion**

- The current 3-way contract for ACT services was discussed and questions regarding whether it would be detrimental to core services to allow CenterPointe and Lutheran Family Services assume the full contract were noted.
- Concerns regarding moving consumers who only use medication management were noted. Staff members state that these consumers are often on General Assistance, and emergency community support is an element of that. These clients are served without compensation as are level two clients who return periodically for additional services. There has been an uptick in consumers seeking additional help since the ACCESS process came into play. The current process provides seamless assistance through informal assistance.
- Concerns with “unhooking Psych. Residential Rehabilitation (Heather) and Day Rehabilitation (Midtown) were similar in nature. Clients who use these programs often utilize other services, and the current level of communication could be missing. HIPAA concerns would also come into play. Midtown is one of the main providers of time for required time volunteering / programming for housing program.
- Crisis line: comments and concerns included: it is critical and keeps people out of the hospital; funding changed in March and evening / weekend staff took over and take calls from home—demographics for these calls are entered into the system, but call content is not. Having the Crisis line integrated with core services removes barriers around confidentiality. Clients and families depend on the crisis line as a way to communicate 24/7 with CMHC. **The Crisis Line is not just used for emergencies but is used for requests for information, requesting services, and initial screenings for persons seeking an appointment.**
- Currently do not take walk-in appointments: therapists used to keep slots open for walk in traffic, but that is no longer the case.
- Johnson commented that at the State and Federal level there are a number of initiatives (integration of behavioral health and primary care, at-risk managed care, development of a safety net for vulnerable populations, extent of Medicaid coverage, etc.) that would be driving system change regardless of the

current situation with Lancaster County. Funding will remain unchanged for the next two years; the behavioral health system and the Regions will all undergo significant change within the next two years.

- Applicants will be screened to ensure they have the qualifications and capacity to handle this transition, an interest in utilizing the expertise of current staff, awareness of the population served, and a transition plan that is respectful of the history and integrity of current programs. Concern was also expressed that applicants are able to work with clients who have mental retardation but do not fit DD categories.
- Moving forward clarification will be required regarding nuances and inter-connectedness of current services, i.e. transportation, persons on GA, persons with co-pay issues, level two clients, etc. Current culture and practices will need to be identified.

### **2:45 p.m. – 4:15 p.m. (11 attendees)**

Johnson reiterated the purpose of the focus groups which was to get input so they can return to the ITN committee and make recommendations on how the document can be changed or altered to clarify elements of the transition process. After the final focus groups are held, recommendations will be made to clarify the ITN process. Interested agencies will have to show that they have the qualifications and capability to provide the required services; through an RFQ process those qualified agencies will be invited to the table.

Johnson noted that the message he has received “loud and clear” is that a single entity should oversee core services. Johnson also reiterated elements of the timeline and noted that though contracts will begin July 1 the goal is for a smooth transition of current services and a well-thought-out plan for transition. Current staff members will remain employees of the county throughout the transition process. Lancaster County had originally committed to two years for continued funding / support.

Fears that the transition would follow the disastrous path of attempts to reform children’s services were noted. Privatization in that case resulted in loss of services and elevated costs. Johnson reminded attendees that the adult behavioral health system is capitated and a number of adjustments have been made over time when faced with cuts.

### **Core Services Discussion (identified by this group)**

- CS / OP / MM / **partial care** (lots of nuances within those services)
- CLS (Community Living Skills), the Heather, and Midtown provide related vital services to individuals with SPMI

### **Other Comments / Discussion**

- PIER / the ACT team: As program is at capacity and there are concerns of access to ACT services. General query as to current hospitalization rate for recipients of ACT services.
- The emergency system is considered a priority; services are in place to ensure that individual’s needs are met if they come into the system, and also supports are in place so they don’t re-enter the system.
- Staff expressed concerns that services would be “chopped up.” Johnson noted that input continues to be collected, but it is one option that one entity would assume all the services as a package. Recommendations regarding which services will or will not be kept together will be determined by December.
- Observation that many clients come to CMHC for MM who don’t fit the service definition, i.e. they do not meet diagnostic criteria.
- CMHC currently serves over approximately 3,000 clients. Johnson expressed that it will be critical for CMHC to determine exactly how many are served and in which services.
- Johnson commented that the proposed RFQ process will be much simpler than the ITN document indicates. Fiscal audits will be reviewed, history / number of human resources managed, ability to meet minimum standards will be reviewed. Those entities which meet the initial criteria will be invited to the table as next steps and expectations are discussed.
- Leggiadro stated that applicant entities should be required to display the ability to integrate services.

- The suggestion was made that calling an agency and trying to get services is a good indicator of how well an agency communicates on all levels. Gathering input from other agencies about the applicant agency would be another way to learn how an agency is regarded by others. Isolated phone calls and a walk through would be good practice to learn more about an agency.
- Concerns were expressed regarding some potential applicants as staff assert they serve a very different type of clientele that others are not equipped to serve.
- Concerns were expressed that the good relationship that CMHC has with law enforcement and the supports provided may not, but must be replicated by another provider.
- Other concerns:
  - The homeless population has been increasing
  - The public safety net is growing and revenue sources to support it are not growing
  - Liability issues: Lancaster County has 32 attorneys who have been able to provide advice and legal assistance
  - The **NRRI population needs to be part of the ITN** and that liability must be assumed
  - Motivation for application must be thoroughly reviewed and understood to ensure it is not research driven.

Johnson closed by saying “I can’t tell you what it will look like in a year, but we’re focused on ensuring that people have their needs met and keeping them out of the ER. We believe that you need these community services.”

## Consumer Focus Groups

November 13, 2012

### General Comments (compiled from all three groups)

- At each session the facilitator provided a brief overview of why we are making these changes, driven by desires expressed by Lancaster County to get out of the “behavioral health business.”
- The function, origin and membership of the ITN committee were explained.
- The Health Management Associates (HMA) report was referenced, and the recommendation that an ITN process be used was mentioned. An ITN process is designed to invite potential applicants to the table to discuss what the system should look like; lets applicants demonstrate ability to do the work needed.
- Input has been sought through a number of forums including these focus groups for consumers.
- The timeline was referenced; i.e. expectation that the ITN document will be finalized by the end of January; potential applicants who have shown they are able to meet qualifications will be invited to the negotiations; goal is to have a new contractor in place by July 1 **at which time the transition process will begin to take place over time.**
- **The County has committed funding at the current level for two more years, the current building will remain available for two more years;** and the goal is for the transition process to be seamless so customers of CMHC can continue to receive the service they need. The County has not identified a dollar amount that will continue. The Region currently contributes about a third of the funding received by CMHC.
- In addition to the County’s wanting to make changes, there are other developments which will necessitate change. These include the cost of health care services, the Affordable Care Act, impact of possible Legislation, changes to Medicaid eligibility, movement toward integration of primary medical care and behavioral health,
- **Core services were most commonly defined as: case management (community support), medication management, outpatient, service coordination, and some elements of partial care.**
- Potential applicants will be asked to provide a transition plan in their application; the ITN document is intentionally left vague about what that should look like to allow for innovative approaches; the document did not wish to be prescriptive in that area.

### Community Mental Health Center

9:00 a.m. to 12:00 p.m. (24 attendees)

- Wittmuss facilitated this group and began by asking that everyone introduce themselves. Some attendees identified as family members.
- Another area of change identified by this group was the movement toward **recovery based services and shared decision making.**
- A participant voiced concerns about drastic changes and felt she would be unable to function without CMHC; all services work well together. To put consumer fears to rest it was suggested that therapists and case managers assure clients that the location will not change for now.
- Wittmuss commented that Region V/ITN is cognizant of the concerns that consumers have voiced, recognizing that change is frightening. July 1 does not mean that everything is new; a central component for an applicant is an application which has a transition plan that will take place over time.
- Wittmuss discussed the Affordable Care Act and commented that it is likely that behavioral health services will be covered under traditional insurance plans and that more people will be covered by Medicaid. NBHS funding currently provides services for persons in services that are not funded by Medicaid; as Medicaid covers more of the core services it may become possible to implement more new and innovative services such as supported employment, supported housing, transportation, and peer-run, recovery based programs.
- Low staff turnover was identified as a plus for customers of CMHC; one individual commented that she had experienced significant turnover while working with another service provider. **Other comments / concerns about services: lack of continuity / availability of services needed; don’t**

**have family support or classes, difficult to get a hold of them, difficult to get answers as a family member.**

- Question: are potential contractors for-profit? Out of state? Answer: nothing has been ruled out. Various entities were in attendance at the potential provider forum.
- **Immediate access to services was an important component of services at CMHC.**
- Question: will potential providers negotiate for all services or will the services be “chopped up.” Answer: the intent is that core services will remain under one provider.
- Concerns were voiced that law enforcement does not understand persons with mental illness; “if this place closes, there will be more people in jail or at Cornhusker Place.” Wittmuss commented that the Region has done a considerable amount of training with law enforcement regarding persons with mental illness, and also the importance of not re-traumatizing a client.
- **A participant commented that the paperwork you have to fill out is daunting; he would like to see a volunteer program, possibly peer-run, which would assist consumers in filling out applications for services and navigating the system in general.**
- CTP at the Heather, for persons discharging from LRC, was considered a core service by some as it helps individuals reorient to the community; “works well because personnel has been there for many years and have a great deal of experience; personnel is what makes it work; fear we lose good people in the transition”
- Day Rehab (at Midtown) was considered a core service by some; others felt that it could be managed by a separate entity.
- Consumer voice: “they need to be part of the core; need CTP and other programs to keep people in a lower level of care.”
- Recovery was discussed: recovery is a process, but to one individual it meant “get out of bed every day, shower, be around people, don’t want to sleep all the time, symptoms are manageable.” Other components mentioned: not being hospitalized and / or making and keeping appointments, managing their home, ADLs, etc. Outcome measures for recovery based principles will be individualized. One individual felt the word “manage” was a better term than recovery. One consumer didn’t believe recovery was possible . . .
- The importance of being able to come back to CMHC for **alumni group, family support group, and / or to attend various groups in partial care on an intermittent basis, as needed was named as a strength.**
- **One consumer defined case management as having someone take you grocery shopping, to other appointments, guide you through the ACCESS process, advocate for you, be available to talk to, etc. – more case management/service coordination than need for active rehabilitation services.** One consumer voiced fears that a peer would not be able to manage to support him as well as his case manager does.
- **The possibility of having two levels of assistance, peer and community support,** was discussed. The peer support would be able to help with such things as social activities and transportation, and work with some of the non rehab elements of case management.
- **What else would help? Liaison between physical and mental health;** a doctor who specializes in the interaction of the two disciplines. Medications prescribed for primary care and mental health can exacerbate symptoms in one arena or the other.
- **Crisis Line:** it is used in times of crisis, when someone needs to talk to someone and can’t get a hold of a therapist after hours, etc; the line is also used to schedule appointments and apply for services. The question was asked whether this might be an opportunity for peer to peer services for some of these calls.
- **Weekend and evening services—**need more; people are isolated, they have too much free time and need more structure.
- Employment was a barrier to accessing services during regular work hours.
- Other strengths identified: CMHC provides support and connection, a safe place, no fear they will be discharged because “they are too much trouble,” helps keep people out of the hospital, being able to talk to a familiar person so you don’t have to repeat your “story,” continuity of care,
- Substance abuse as an attempt to self-medicate was discussed. **The importance of integrating MH and SA services was emphasized by several.**

- The importance of taking personal responsibility was noted both regarding physical health and mental health.
- Evaluation criteria for potential applicants: If they were in the room, what would you ask them?: Availability, Staffing, Programming, what they say actually comes true, staff longevity, what has worked in the past / right now, measure their capacity to do this work, continuity—a comprehensive transition plan, cost to consumer, keep everything under one roof, should be knowledgeable about medications and side effects.
- Concerns with ACCESS Nebraska and lack of responsiveness was voice several times. Ability to navigate would be impossible without case management.
- Question: Why can't Region V take it over? Answer: It's not legal: Region V can do interim services, the Region is responsible for developing an array of services; would require statutory change; current system provides checks and balances
- J.Rock Johnson provided information about recovery noting that recovery involves having a voice, being educated and involved in your treatment; doesn't mean you are cured, it means you are better than you were. J.Rock's contact information: 402-474-0202
- **Wish list item: Recovery / Wellness Center**
- Wittmuss thanked attendees for their comments, noted that the ITN documents are posted on the web site, and Tyerman-Harper's contact information is on the web site if someone wishes to provide further comment.

**1:00 p.m. (30 attendees)**

**Midtown Center**

**(For the next two forums, information captured are main ideas not previously stated in other consumer focus groups)**

- Question: will Region V be selective in who is allowed to come to the table? Answer: Region V has the responsibility to ensure that individuals get the services they need; the same eligibility and approval processes will be in place. Region V will need to ensure that the new provider has the capacity to manage an entity as large as CMHC.
- There was emphasis on **retaining core services by also providing flexibility to develop new services** such as peer support programs and services based on recovery focused support and activities.
- The Crisis Center will remain with the County and will remain at the current location for at least two more years.
- Question: Are for-profits interested in CMHC? The concern was that a for-profit agency would pare those programs that were not financially successful. Answer: all contacts to date have been from non-profits. Johnson explained that the greater capacity you have the more you can spread your fixed costs across the agency; that is how non-profits benefit.
- Question: Will my services cost me more? Answer: Consumers should not have to pay more for services.
- Question: Will I be able to keep my case worker? Answer: We hope so; we will require that the new provider interview current staff, but will not be able to mandate that current staff be retained.
- Peers may be able to provide some services for some clients who do not need such high levels of care. One consumer voiced the opinion that peer services / recovery model services "would have made a huge difference years ago; I would have been more proactive in my recovery."
- There was concern about **continued access to medications** through the med management.
- **Location was discussed**; the County is committed to making the current building available for two years, and possibly longer. There was a great deal of input **regarding the importance of the current location** as far as being close to the hospital, grocery store, pharmacy, coffee house, bus route, etc.
- The concept of a limited liability corporation (LLC) was explained; it is possible that multiple entities could form a LLC to engage in the ITN process.
- Question: Will **substance abuse be more a part of this process**? Answer: We hope there is more attention paid to substance abuse issues; about 50 percent of persons who get EPC'd have SA issues.
- Funding cuts have caused the elimination of some weekend and other activities. This group had a number of comments about how persons with mental illness can be isolated and need these types of structured activities. **Community integration was important to this group.**

- **What alternative programs might you like to see? More recovery oriented services, strength-based, support “that would help people take charge of where they are headed.” Focus on person centered, shared decision making; education on how to talk to your doctor (such as Common Ground); supported education, a recovery / wellness center; a recovery plan that is more than words, programs that empower consumers, independent living program; showing them how to do something rather than doing it for them,**
- Consumers expressed concerns that **dropping to a lower level of peer support would make case management unavailable** the consumer began to decompensate. Johnson agreed that the system would have to be flexible enough to ensure a safety net was in place.
- **Some criteria for evaluation: language providers use, culture they display (suggested a walk through), staff competencies, hiring practices, training, policies,**

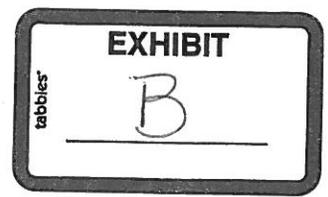
#### 6:30 PM – 9:00 PM (21 attendees)

- Deb Schorr, Lancaster County Commissioner, attended this forum and added some additional reasons why the County was interested in making this change at this time: about budget, wait list, integration, Settle retired from CMHC, looking at the building; healthcare reform and how that will impact services; Schorr noted that these concerns were discussed over months and the decision to move ahead was not made lightly.
- The definition of recovery was discussed; it was noted that for most people that term refers to recovery from substance abuse.
- Concerns regarding **peer support workers who don’t have appropriate skills and training** were stated. One of the participants commented that there is a curriculum and a certificate for completing Intentional Peer Support training.
- Is there some way the agency can be **affiliated with something like PHC** and receive additional funding from Medicaid. Also want **on site the ability for somebody to see a primary care doctor.**
- **There are a lot of intersecting supports that a private entity might not be able to provide, legal advice for example.**
- Family members: as transition goes through, don’t forget the **family support group.**
- Require **support for people who do have co-occurring issues;** try to bring in supports for those types of persons.
- How to build in some type of **support groups for people transitioning out to the community**
- Most people with MI need support because they are isolated; don’t have family support, no money, don’t work; their self worth is down; need something for when you leave the building; you can call the crisis line, people need more support, forget to take their meds, don’t have structure in their lives; nothing to make them feel good about themselves; focus on **community integration.**
- **On children’s and / or adults side there is not a centralized place to get resources / find answers, need to be easier to navigate the system.**
- **Support groups for families;** Wednesday night group interferes with church night; wish there were more nights that it was offered; should be offered at different times and different days;
- ACCESS Nebraska has created a lot of problems for people; loss of cab vouchers, chore provision, poorly coordinated transportation services, long wait to get someone on line who can help,
- One gentleman spoke of grievances with his treatment, etc., and was invited to file a grievance with the Region.
- Staff turnover / burnout was discussed in this group. We need to provide adequate training so they are not overwhelmed; how do we promote people with lived experiences; natural burnout; need to be more conscientious about that. Consumers need consistency; turnover is costly to an agency;

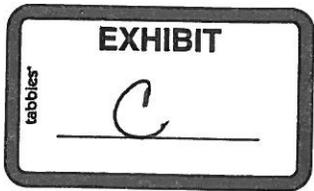
CMHC STAFF FOCUS GROUP

November 6, 2012

QUESTIONS TO CONSIDER



1. Are there any questions as to the timeline?
2. Does the document adequately speak to transition?
3. Any major concerns/issues with the document?
4. What would you see/identify as core services?
5. Do you think core services need to stay “under one roof”?
6. Could consumers/how might consumers in support services, i.e. CS, receive medication services elsewhere?
7. What would be the pros and cons of bidding out PRR (Heather) and DR (Midtown) from other services?
8. Are there any reasons that ACT (Pier) couldn’t continued to be contracted through the other 2 agencies that are currently a part of that collaboration?
9. Are there any reasons that CS-MH at OUR Homes and Area Agency on Aging couldn’t continue to be contracted through the other agencies that are currently a part of those collaborations? (CenterPointe, Area Agency on Aging)
10. What are the pros and cons of leaving Day Treatment under the Crisis Center during an interim period?
11. Where is the best location for the Crisis Line and why?
  - *Data need: are calls primarily from current CMHC consumers or external?*
12. What would be some alternatives or innovations to the service array, the delivery system, who providers services, standards, etc. if you could do some new things?
13. How would potential applicants best demonstrate the capacity to serve this population?
14. How would potential applicants best demonstrate an understanding of, commitment to & implementation of the principles of recovery?
15. How would potential applicants best demonstrate an understanding of, commitment to & implementation of integrated MH & SA (co-occurring) services?



**DRAFT Timeline  
CMHC Transition  
2012-2013**

Presented to Lancaster County Staff Meeting October 4, 2012  
Revised 12-17-12

Step	Framework	Blueprint	Timeline	Who takes the Lead
1.	Approve Timeline	<ul style="list-style-type: none"> <li>a. Meet with Lancaster County</li> <li>b. Present to ITN Steering Committee</li> </ul>	October 4, 2012	C. J. Johnson
2.	Hold Focus Groups to seek input on ITN document and process	<ul style="list-style-type: none"> <li>a. Develop key questions</li> <li>b. Schedule Focus Group Sessions               <ul style="list-style-type: none"> <li>- Providers/Stakeholders</li> <li>- CMHC Staff</li> <li>- Consumers/Family Members</li> </ul> </li> <li>c. Post ITN Document to website</li> <li>d. Send invitation, create flyers, post to websites for:               <ul style="list-style-type: none"> <li>- Providers/Stakeholders</li> <li>- CMHC Staff</li> <li>- Consumers/Family Members</li> </ul> </li> </ul>	<p>October/November 2012</p> <p>October 31 9:00 a.m. - 12:00 noon @Co. Ext. Office</p> <p>November 6 9:00 a.m. - 12:00 noon 1:00 p.m. - 4:00 p.m. @CMHC</p> <p>November 13 9:00 a.m. - 12: noon CMHC 1:00 p.m. - 4:00 p.m. MidTown 6:30 p.m. - 9:30 p.m. CMHC</p>	<p><b>Region V Team:</b> C. J. Johnson Linda Wittmuss Amanda Tyerman-Harper Ardi Korver</p> <p><b>CMHC:</b> Ron Sorensen</p>
3.	Cost Analysis/ Determine Budget	<ul style="list-style-type: none"> <li>a. Hold Budget meeting</li> <li>b. As of 12/3/12 still need final figures for consumer numbers, equipment, revenue &amp; expenditures by cost center (Medicaid, TPL, County, Region V, other) for inclusion in documents</li> </ul>	November 29, 2012	Ron Sorensen RVS Team LCB Members
4.	Present and Analyze Budget/Data, Make Recommendations, and seek approval to continue the process	<ul style="list-style-type: none"> <li>a. Summary of Focus groups &amp; recommendations</li> <li>b. Agreement on next steps in process, i.e. RFI/RFQ/RFP, concept paper</li> </ul>	December 19, 2012	RVS Team
5.	Revise ITN Document (s)	<ul style="list-style-type: none"> <li>a. Incorporate changes to the ITN document. Present DRAFT to include:               <ol style="list-style-type: none"> <li>1. Purpose/Overview</li> <li>2. Identify Requirements, including service models, integration, recovery, etc.</li> <li>3. Services to include:                   <ul style="list-style-type: none"> <li>a. Target population</li> <li>b. Base services &amp; funds</li> <li>c. Adjunct services</li> <li>d. Collaborative partners</li> </ul> </li> <li>4. Potential Concept Paper requirement</li> <li>5. Budget package</li> <li>6. Capacity package</li> <li>7. Capacity Development Plan</li> <li>8. Negotiations</li> <li>9. Scoring Procedures / Selection Criteria</li> <li>10. Timeline</li> </ol> </li> </ul>	December 2012 – January 2013	RVS Team Ron Sorensen

6.	Continue Communication  Determine Selection Committee Members	a. Meet with ITN Steering Committee bi-weekly 1. Present continual revisions to ITN document 2. Seek approval for revised document(s) 3. Select evaluation/selection committee 4. Communicate updates to the public	Hold ITN Meetings on: December 19, 2012 January 2, 2013 <sup>9th</sup> January 16, 2013 <del>January 30, 2013</del> February 13 February 27 March 13, 2013	RVS Team ITN Steering Committee
7.	Seek Qualified Applicants Purpose: to articulate, in writing, "they possess the necessary skills"	a. RVS Team releases preliminary ITN document, including: 1. Purpose/Overview 2. Request for Qualification (RFQ) Requirements 3. Request for Qualifications (RFQ) Guidelines 4. Summary of future processes a. Concept Paper (model, integration (primary care, MH/SA, transition) b. Service packages c. Capacity to innovate & move to recovery d. Ability to work with Medicaid e. Negotiations f. Scoring procedures g. Request for Capacity Development Plan h. Selection criteria i. Timeline	January 30, 2013	ITN Steering Committee RVS Team
8.	Select Qualified Applicants	a. Evaluation Committee determines qualified applicants	February 2013	Selection Committee
9.	Meet with Qualified Applicants Purpose: to demonstrate to ITN "they possess the necessary skills" – explore transition feasibility	a. Qualified bidders meet with ITN b. ITN parameters including 1. Review/require joint applications 2. Finalize co-location issues related to primary care (health homes) 3. Demonstration of co-occurring, recovery, trauma informed 4. Transition plan 5. Communication plan 6. Coordination of services in the network 7. Full budget with FTEs needed / service 8. Etc.	February 2013	RVS Team Ron Sorensen ITN/LCB Members
10.	Draft and Receive Approval for Submission of proposals/concept paper, etc.	a. Draft Guidelines for Request for Proposals/Plans/Concept Paper/Capacity Development – next submission b. Draft criteria for review of proposals c. Seek approval from ITN Committee d. Seek approval from LCB e. Seek approval from RGB	February 2013 February __ 2013 February __ 2013 February __ 2013	RVS Team Ron Sorensen ITN
11.	Qualified Applicants submit responses	a. Release Request for Proposals/Plans/Concept Paper to qualified bidders for service packages to include: 1. Guidelines 2. Negotiation Process 3. Scoring/Evaluation Process 4. Reference to future Capacity Development Plan	February 2013	RVS Team Ron Sorensen ITN
12.	Evaluation / Selection of Concept Paper proposals	a. Review Concept Papers b. Select top provider candidates c. Recommend provider(s) to submit Capacity Development Plan(s)	March 2013	Selection Committee
13.	Select Applicants to submit Capacity Development Plan	a. Seek approval for provider candidates from: 1. ITN Committee 2. LCB 3. RGB	March __ 2013 March __ 2013 March __ 2013	

14.	Release Capacity Development Plan	a. Release Request for Capacity Development Plan to selected providers to include: 1. Service delivery model 2. Goals 3. Objectives 4. Outcomes 5. Budget 6. BH-5	April 2013	RVS Team
16.	Select Providers	a. Review/select top Capacity Development Plan b. Negotiate any changes / contract	May 2013	Selection Committee RVS Committee
17.	Transition Service Packages	a. Contract(s) finalized b. DBH approval as needed c. Selected provider(s) begin to transition services	June - July 2013	RVS Team Provider(s)

DRAFT