Region 6 Behavioral Healthcare
Psychiatric Emergency Services (PES)
Request for Proposal
Guidelines
September 26, 2019

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SECTION I-INTRODUCTION

Region 6 Behavioral Healthcare

Region 6 Behavioral Healthcare (Region 6), a political subdivision of the State of Nebraska, has the statutory responsibility for organizing and supervising comprehensive mental health and substance use services in the Region 6 service area which includes Cass, Dodge, Douglas, Sarpy and Washington counties in eastern Nebraska.

Region 6, one of six mental health regions in Nebraska, along with the state's regional centers, make up the state's public mental health and substance abuse system, also known as the Nebraska Behavioral Health System (NBHS). Region 6 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 System (DHHS), the designated authority for administration of mental health and substance use 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 Board regarding the provision of coordinated and comprehensive behavioral health services within the Region to best meet the needs of the general public. In Region 6, the Behavioral Health Advisory Committee (BHAC) is comprised of 14 members including consumers, concerned citizens, and representatives from other community systems in the Region.

The purpose of Region 6 Behavioral Healthcare is to provide coordination, program planning, financial and contract management and evaluation of mental health and substance use services funded through a network of providers.

Responsibility of RGB

Each Regional Governing Board is responsible for determining which services would best meet the needs identified in the planning process. The RGB is also responsible for issuing a Request for Proposals (RFP) consistent with DHHS guidelines, state regulations and other applicable requirements.

Current Region 6 Provider Network

Region 6 is responsible for the development and management of a provider network that serves the behavioral health needs of eastern Nebraska. Currently, Region 6 has 21 providers in its network to deliver a variety of behavioral health services.

Region 6 Population Served

Region 6, as a payer of last resort, primarily serves financially eligible adults and youth with or at-risk of serious mental illness and/or substance use. Region 6's geographical area includes Cass, Dodge, Douglas, Sarpy and Washington Counties in eastern Nebraska. For the purposes of this proposal, the population served will be adults (19+) experiencing a psychiatric crisis. Chosen provider is expected to pursue all commercial and public health insurance utilizing Region 6 funding as a payer of last resort.

SECTION II-REQUEST FOR PROPOSALS

Purpose/Summary of RFP Requested

The purpose of this Request for Proposal (RFP) is to seek qualified, interested providers to engage in negotiations regarding the development and provision of Psychiatric Emergency Services (PES) in the Region 6 geographical area. The RFP process is designed to be a competitive selection process, where cost is not required to be the sole determining factor.

RFP Program/Service Categories

The service Region 6 wants to develop through this RFP process is a Psychiatric Emergency Service program using Medicaid's Treatment Crisis Intervention service definition and the DHHS-DBH's corresponding Crisis Stabilization service definition. See Attachment E. Applicant using this service definition can be licensed as a mental health center or a hospital.

Hospitals applying for the PES have the choice between using the above Treatment Crisis Intervention/Crisis Stabilization. In addition, they may select Medicaid's Observation Room service definition and DHHS-DBH's corresponding Emergency Psychiatric Observation service definition. See Attachment F. Note: If the Observation Room definition is used, it is locked into a length of stay of up to 24 hours only.

With either of the above service definitions, the necessary components listed below should be included in the proposal. Applicants should describe in detail the PES model they are proposing, and must use the service definitions identified above and include at a minimum, the components below:

1) Initial Diagnostic Interview (IDI): An IDI can be performed by a licensed practitioner who is able to diagnose and treat major mental illness within his/her scope of practice as defined by Medicaid and Division of Behavioral Health regulations. When a person comes to the PES under an involuntary status, the Interview will need to follow the requirements set out by the NE Mental Health Commitment Act (NE Statute Chapter 71-901 to 71-962). This would include Emergency Protective Custody (EPC) or Board of Mental Health (BOMH) petition and must be performed by a mental health professional as defined by the NE Mental Health Commitment Act.
2) Triage Health Assessment
3) Basic Lab Work
4) Medication Management
5) Pharmacy (Medications)
6) Substance Use Screening (as needed)
7) Staff Support
8) Peer Support (Preferably)
9) Discharge Planning/Referral/Aftercare Coordination and Communication
10) Other Indirect Activities

PES Philosophy

The experience of many PES centers across the United States suggest that acute psychiatric crises can often be resolved in an outpatient or non-inpatient setting. PES philosophy is to provide intensive treatment in a setting that is welcoming and safe, with the goal of rapid stabilization. Its philosophy is also to be accepting of all consumers no matter how frequently they present or what difficult behaviors are presented.

Mission of the PES

The mission of the Region 6 psychiatric emergency system is to provide an integrated, person-centered approach to the delivery of emergency psychiatric services by providing adult consumers (age 19 and older) the right level of care, at the right time, in the right setting. Rather than merely triaging and transferring psychiatric consumers as is standard practice at the typical hospital emergency department (ED), consumers at the PES are evaluated, receive robust treatment, and are allowed time for observation and recovery. The PES will consist of accessible, professional, specialized, cost-efficient services delivered to consumers in our five-county area experiencing a psychiatric crisis. As a result of the PES, consumers should be able to avoid long lengths of stay at community emergency departments.

Proposed Setting

The PES unit can be stand alone, be attached to a community emergency department or a psychiatric hospital (county or private). The facility will most likely need to hold either a mental health center or hospital license in compliance with state facility licensure requirements. If the setting chosen is a hospital, the PES unit will be distinctly separated from the ED. It may be adjacent. If the setting chosen is a freestanding unit, it will preferably be close to a hospital for easy access to the ED for consumers presenting at the PES who need medical attention. The optimal setting for the PES may be as a component of an existing hospital ED due to cost-sharing and staffing capabilities. In addition, a hospital setting provides easy access for consumers presenting with medical issues and safer transfer for patients who may need inpatient acute care.

PES settings vary from one location to another. Applicants may select other components of a PES. Whichever setting is selected, it must be a trauma-informed, safe, secure environment to protect the physical and emotional integrity of the consumers. It is estimated that an area of 1500 to 2000 square feet is needed to house the PES.

It is recommended that the selected applicant allow enough square footage to expand if future services might be incorporated into or near the PES.

Service Description

The PES model of interest for our community would offer three service components: Interview/ Triage phase, an Observation phase and Secure Care phase. All components are based on psychiatry's 'biopsychosocial model' of evaluation and treatment. Each of the service components are designed to stabilize or reduce the consumer's psychiatric symptoms that are causing distress. From start to finish, all operations of the PES are guided by a mandate to minimize coercion without sacrificing safety. Treatment is done in the least restrictive setting and in most PES's, the majority of the consumers will return home or to the community within 24 hours.

Length of Service of the PES

The PES should be able to provide at least initial management for all degrees of psychiatric acuity, including the most severe. In this respect, it can provide the kind of initial interview and triage that an initial admission unit in a psychiatric hospital provides. There is some overlap between a PES and a hospital. But a PES cannot do everything a full-service psychiatric hospital can do. The three phases found in the proposed PES and their approximate length of stay are:

1) Interview/Triage (Average length of stay of up to 4 hours),
2) Observation (Average length of stay of up to 23 hours), and
3) Secure Care (Average length of stay between 16-72 hours).

Interview/Triage Phase
A significant percentage of consumers using the PES will improve enough to be ready to discharge in approximately 4 hours. A PES's brief treatment track is ideally suited to people with known mental illness who are experiencing an acute flare-up that responds well to brief, intensive treatment. Ideally, this is an open and welcoming but safe and secure area where staff can gather as a team (nursing triage, psychiatry) as needed to engage the individual, rapidly assess medically and psychiatrically, and address acute psychiatric symptoms such as agitation for which non-coercive de-escalation is the goal. Immediate personal needs can also be addressed, such as inadequate clothing and impaired personal hygiene.

The main goal of Interview/Triage Phase is to assess consumers' psychiatric needs and relieve psychiatric distress as quickly as possible in a supportive, collaborative manner. Coercion is used only as a last resort to ensure physical safety. Consumers arriving at the PES will receive a timely evaluation by a licensed practitioner to determine acuity.

Depending on the severity of the condition, the IDI begins during or shortly after triage. In consultation with the individual, active treatment is initiated. All of this is expected to begin within minutes of the consumer's arrival. In the case of psychotic agitation, for example, it should begin immediately. As treatment progresses, practitioners determine the least restrictive environment for the consumer including the following:

- Consumer is stabilized and discharged from the PES to home/community services with a discharge plan/referral(s).
- Consumer is moved to one of the other phases within the PES for continued stabilization.
- Consumer is at imminent risk for harm to self or others, is expected to require a longer stay, and may go to the secure area or be transferred to a local inpatient psychiatric hospital.

Staffing will be determined by the provider.

Observation Phase – This phase is considered a brief treatment area. It will be equipped with lounge chairs that can pull out flat for sleeping. Individuals in this phase will receive robust treatment within minutes of arriving at the PES and will have discharge planning that includes a safety plan, etc. before leaving the facility. Individuals moved to this phase need more assistance and are of moderate risk for harm to self or others.

Practitioners performing assessment and treatment will refer consumers needing more time for continued treatment, rest, recovery, and discharge planning to the PES's Observation area. The Observation area will be a safe and secure environment which protects the physical and emotional integrity of the consumer. Brief Treatment staff will provide continuity of care as established during the IDI and treatment component. Communication will flow between all of the PES components for maximum treatment results.

Consumers may stay in the Brief Treatment area up to 24 hours without requiring additional authorization. Arrangements for an inpatient psychiatric bed will be made for those who do not reach a point where they feel safe to return to the community or, in the staff's judgement, the consumer is not safe to return to home or to a community placement.

Typically, psychiatric nurses, psych techs, social workers, and peers will intermingle with consumers rather than be behind a nursing station. Staff will ensure individuals leaving the PES have an aftercare plan to help maintain their gains and avoid recurrence of crisis in the future. Consumers will have access to the following during their stay in the Brief Treatment area:

- Rapport Building and Engagement in Treatment
- Medication Monitoring
- Recovery-based Services
- Crisis Prevention Planning (also known as Relapse Prevention)
- Basic Medical Care (mild-to-moderate alcohol withdrawal, asthma, diabetes management, pain, continuation of outpatient psychotropic medications, etc.)
- Lab Work
- Peer Support Services Activities (Preferred)
- Discharge Planning
- Family Meetings (if applicable)
- Phone or Email Communication

Staffing will be determined by the service provider.

Secure Care – This phase is for individuals who are seen as being of high risk to harm self or others. Individuals may be aggressive and will likely need to be transferred to an inpatient setting. Rooms will have the ability to be locked (if needed). Treatment will be started, plans will be developed, and consumer will be monitored for up to 72 hours.

The individual whose acuity exceeds the ability to be safely managed and stabilized at the PES should go on to inpatient care. In some cases, because of mental illness that is particularly severe or persistent, it may be obvious at the outset who needs inpatient treatment.

Note: There may be a certain number of individuals who need medical stabilization and would not return to the PES (i.e. cannot be medically stabilized). For those individually medically cleared and returning to the PES, once treatment has begun, they are moved to the appropriate phase for care.

Note: If the applicant selects to use the Medicaid service definition for Observation Room and the corresponding DHHS-DBH service definition of Emergency Psychiatric Observation, then the length of stay for the PES will need to be up to 24 hours. This service definition is an option for hospitals **only.**

Peer Service Activities
Although peer support services are not mandatory, they are highly encouraged. The purpose of Peer Services is to offer a unique form of assistance for individuals experiencing crisis that promotes hope, healing, recovery, and a person-first understanding of behavioral health challenges. Services are trauma informed and consumer-driven. Focus should be on the

development of mutually-beneficial relationships based on shared experience of mental health and/or substance use challenges.

Peer Services staff utilize unstructured, conversational interactions to assist consumers through crisis. This may include connecting one-on-one with individuals or engaging with impromptu groups. Peer Service interactions are neither directed by individual treatment goals nor in competition with them. Peer Services staff will spend most of their time on the floor interacting with individuals in crisis. Peer Services are 100% voluntary.

Peer Services are not to be used as a replacement or supplement for any other role in the PES including, but not limited to, techs, therapists, security, and nursing staff. Peer Services staff should never be involved in coercive activity of any kind, without exception. It is not the role of Peer Services to develop plans for treatment or relapse-prevention, nor to provide referrals to community-based services.

PES Capacity

During the six-month period from July 2019 to December 2019, the average monthly census for consumers visiting 11 local emergency departments in the Region 6 area and the Lasting Hope Assessment Center was 1,397. Based on those numbers, annually the number of visits to the PES could potentially be 16,764 consumer visits per year or the equivalent of 47.8 consumers per day. Recognizing that not all individuals will use the PES, we are estimating capacity at the PES to be approximately 35-37 consumers at any given time.

PES Admission Criteria

The typical PES should serve as a single point of entry, for voluntary and involuntary adult medically stable consumers experiencing a psychiatric crisis coming from all avenues including ambulance, law enforcement (EPC) and medically cleared individuals from community Emergency Departments (EDs). A full PES takes all individuals, who present with symptoms consistent with a psychiatric crisis and require a period of observation, assessment, and treatment. Individuals may present with a full range of acuity; some individuals may be self-referred, ambulatory level of care and can be seen briefly and discharged, while other individuals may present with higher acuity and are imminently dangerous. Overall, no one will be turned away on the basis of their presentation. Admissions will occur 24 hours a day, 7 days a week. Individuals presenting at the PES who have medical concerns will be transferred to a community medical ED for medical stabilization and/or medical clearance, then once cleared or stabilized, transferred back to the PES for evaluation and treatment. (Figure 4). Note: It is noted that a certain number of individuals who need medical clearance may need to stay in the hospital, due to medical needs, and not return to the PES.

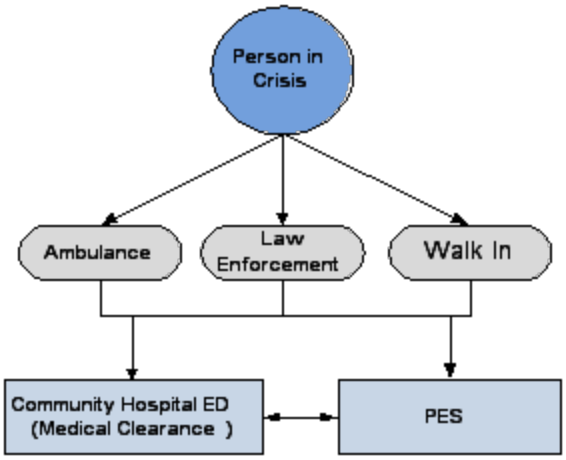
The PES will also need to adhere to the medical necessity clinical criteria as outlined in the service definition(s) as selected by the provider and consistent with regulatory standards.

The following admission guidelines are mandatory.

- Adult, age 19 or older (primary population served);
- Medically stable;
- Consumers can be voluntary or involuntary arriving via ambulance, police, self-presentation, and ED transfers;
- No exclusions for specific individuals, no “no-admit” lists; everyone processed in the same manner;

- No denying of admission based upon an individual's psychiatric acuity or behavioral presentation including aggression;
- Individuals accepted whether or not they have health insurance and no denials based on insurance carrier;
- Individuals with a primary diagnosis of dementia or severe traumatic brain injury are generally not appropriate for this setting. Individuals with a secondary diagnosis of dementia or severe TBI may be eligible on a case-by-case basis;
- Individuals with co-occurring disorders but do not require medical detoxification (e.g., requiring intravenous medications and fluids).

Figure 4. PES Access Point



Collaboration with local university/school programs to utilize psychiatric residents and other students (social work, physician's assistant, nursing, etc.) is encouraged. This is an excellent learning environment for residents and students to gain experience, do rotations, etc. It could also have a helpful impact on the program's budget.

Community Partners

Strong relationships with a variety of community partners are necessary to the success of the PES. Relationships will be established via Memorandum of Understanding (MOU), contract, or other acceptable methodology at a minimum with the following community partners.

- Hospital Emergency Departments (ED): Collegial partnerships established between the PES and Region 6 EDs for the purposes of ensuring medical and psychiatric needs of consumers served are optimally met.
- Nursing Homes and Community-based Residential Programs (Developmental Disabilities Homes, Assisted Living Settings, etc.): Boundaries established that outline the requirement that upon discharge from the PES, consumers will be accepted back to the residential setting from which they came.
- Law Enforcement: Mutual understanding of PES and law enforcement officials on programmatic and legal obligations as they relate to consumers who are placed under

Emergency Protective Custody (EPC) and transported to the PES. PES staff are encouraged to contribute to police CIT curriculum and training.

- Homeless Shelters: Mutual agreement on process for PES admissions from Homeless Shelters and referrals to Homeless Shelters from the PES.
- Inpatient Psychiatric Providers: Procedures established between the PES and inpatient psychiatric settings for the transfer of consumers from the PES to acute psychiatric services.
- Medication Management and Outpatient Therapy Providers: Establish pathways for urgent medication management and outpatient therapy service needs of consumers discharging from the PES.
- Detoxification Centers: Mutual agreement to differentiate consumers appropriate to be treated at PES and consumers who need detoxification services before treatment at the PES.
- Transportation Providers: Contractual arrangements for consumer transport to inpatient settings, EDs, etc.
- Pharmaceutical Services: Contractual arrangements for pharmaceutical services on a 24/7 basis.
- Security: Contractual arrangements for 24/7 security services.

Additional Items for Consideration

While it is not mandatory, it is recommended that consumers be involved in the development of the PES. They are able to provide insight and have a unique perspective on the needs of individuals in a psychiatric crisis.

It is also recommended that a community oversight committee be established to help monitor the outcomes, provide guidance to problems that will arise and to strengthen community buy-in and support.

SECTION III-ELIGIBILITY CRITERIA

The applicant:

- May be a state, county, or community-based not-for-profit agency.
- Must be a legal entity already established and functioning with paid personnel and demonstrable experience in working with the identified target population as evidenced by the following:
  - Must be able to agree to items in the 'Minimum Standards for Enrollment' in Region 6 Behavioral Healthcare Provider Network document;
  - Must demonstrate capacity to accept Medicare, Medicaid, and commercial insurance as payment source;
  - Must hold national accreditation in the provision of behavioral health services or in the process of applying for national accreditation. Accreditation must be with one of the following: 1) The Joint Commission, 2) the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). Any other accreditation body must go through an approval process;
  - Must have staff onboard with a professional license such as a physician; psychologist, licensed mental health practitioner, or other related professional license;

- Must possess appropriate state licensure and credentialing by appropriate State of Nebraska Departments, Divisions, or Boards, as approved by NE DHHS or have a plan in place to achieve such licensure/credentialing before the Agreement is awarded;
- Must be experienced in working collaboratively with community agencies, hospitals, other key stakeholders;
- Must demonstrate a sound financial position based on audited financial statements from the past year;
- Must be able to provide programs/services within the Region's geographical area;
- Must be willing to work in partnership with Region 6 staff to further develop the PES. This includes identifying additional funding sources and negotiating with additional funders for coverage to include all of the service components.

SECTION IV-FUNDING CRITERIA

The Regional Governing Board (RGB) will conduct a fair and comprehensive evaluation of all proposals in accordance with the criteria set forth in this document.

Applicants must comply with all instructions and conditions and meet all the requirements included in this document to be eligible for funding. Proposals that do not conform to the items provided in this document will not be considered.

SECTION V-USE OF FUNDS

Allocation of Funds
Nebraska Behavioral Health Services are reimbursed in one of two ways:

1. Non-Fee for Service (NFFS): Services are reimbursed based upon actual monthly expenditures up to the designated amount specified in the contract.

2. Fee for Service (FFS): Services are reimbursed based upon a unit of service up to the designated capacity specified in the contract.

Region 6 will not fund:

- Legal Fees
- Financial contributions to individuals
- Fund-raising events
- Lobbying
- Abortion
- Laboratory or clinical research
- Projects which do not serve the Region 6 geographical area
- Purchase or improvement of land, purchase or permanently improve any building or other facility or purchase major medical equipment
- Cash payments to intended recipients of health service
- Vehicles

Funds Available

Region 6 has $700,000 in funding to assist in start-up costs. These funds are not sustainable and their use must be pre-approved by Region 6.

It is the Region's expectation that the selected provider would bill Medicaid and DHHS-DBH for the units reimbursed under the service definition rate. Additional funding sources determined to be available include Medicaid, Medicare and commercial insurance. It is the applicant's responsibility to identify appropriate additional funding sources that can be used.

Financial coverage of the components expected, but not included in the service definition will need to be negotiated with Medicaid, Medicare and other third-party payers. The selected applicant is expected to help identify additional funding sources to help cover the service components that fall outside of the selected services definition(s). See Section II Request for Proposals – RFP Program/Service Categories.

To summarize, the expectation is that the provider will ensure that services delivered are eligible for reimbursement and subsequently billed to Medicaid and other insurance when at all possible.

Non-Transfer of Funding Award
The contract awarded to the successful applicant may not be transferred or assigned by the applicant/contractor to any other organization or individual.

SECTION VI-RFP CHANGES OR TERMINATIONS

If anticipated funds for the programs/services described in this RFP are not available or are not approved by DHHS, Region 6 Behavioral Healthcare may add to, limit, reduce, or withdraw any part(s) in this RFP.

SECTION VII-APPLICATION PROCESS

This RFP is designed to solicit proposals from qualified applicants who will be responsible for the development and provision of Psychiatric Emergency Services at competitive and reasonable cost. Region 6 is hoping for a PES start day of July 2020, however that timeframe is negotiable.

Emphasis should concentrate on conformance to the RFP instructions, responsiveness to requirements, and completeness and clarity of content. If the applicant's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that points will be lost in the evaluation process. Elaborate and lengthy proposals are neither necessary nor desired.

The RGB retains the right to seek additional proposals or not allocate funding if proposals submitted do not adequately meet the requirements set forth in this document.

Region 6 will post any additional information that we feel may be helpful on the Region 6 website: www.regionsix.com. **It will be the responsibility of the applicant to check the website to obtain additional information. Additional information may be added up to the date the RFP is due.**

Schedule of Events

Release of RPF at 10:00 a.m. (CST)	Thursday, September 26, 2019
RFP Proposals Due to Region 6 by 4:00 p.m. (CST)	Friday, October 25, 2019
RFP Review Committee Meets and Interviews Conducted (if needed)	Monday, October 28 – Tuesday, November 5, 2019
Review and Recommendations of Proposals By Behavioral Health Advisory Committee	Wednesday, November 6, 2019
Approval of Selected Proposals by Region 6 Governing Board	Wednesday, November 13, 2019
Written Allocation Announcements of Funding Disseminated by Regional Governing Board and Contract Negotiations Begin	Thursday, November 14, 2019

Limits on Communication

After the release of the RFP, no verbal statements made by individual members of the RGB, Region 6 Behavioral Healthcare personnel, or members of the Review Committee shall be binding by the RGB. Questions regarding this RFP must be presented in writing to be answered. Applicants may submit written questions to the Director of Network Services at tpetersen@regionsix.com. Responses to all written questions will be posted on the Region 6 website: www.regionsix.com.

All applicants are responsible for reviewing the questions and answers on the website. NOTE: Posts can be made to the website up to the closing date/time.

With the exception of written communication as outlined above, prospective applicants are prohibited from contacting Region 6 Behavioral Healthcare personnel, DHHS personnel, BHAC members, or RGB members regarding this RFP, during the proposal evaluation period and until a determination is made and announced regarding the selection of a contractor.

Rejection of Proposals

Prior to the evaluation of the proposals by the Review Committee, a specific review of each proposal will be completed to determine if the submission has followed the basic standards for the bid. Reasons for rejection at this stage include:

- Proposal was not received by the deadline posted or at the location specified.
- The proposal was not submitted on 8 ½" x 11" paper, was smaller than 10-point font, was not numbered consecutively, or not stapled or clipped in the upper left-hand corner.
- One original and 10 copies, in the format specified, were not received.
- The cover page was incomplete or the appropriate Region 6 form was not used.

- All sections required in the Program Narrative were not addressed.
- Program Narrative exceeded the 12-page limit.
- BH-5 form(s) was not included.
- All funds must be identified in the proposal and additional funds will not be made available after the award.
- Budget forms, BH-Summary and BH c-g were incomplete.
- Budget Justification Narratives were not included.
- A copy of the applicant's financial audit was not included. This only applies to agencies not currently in the Region 6 provider network.
- A signed copy of the 'Minimum Standards for Enrollment' in Region 6 Behavioral Healthcare Provider Network was not included. This only applies to agencies not currently in the Region 6 provider network.

The Region 6 Governing Board retains the right to reject any and all proposals. The RGB shall provide written notice to the applicant whose proposal was rejected during this stage of review at the time of notification of funding allocation.

The RGB also reserves the right to void its intent if the applicant's proposal is not approved by DHHS.

Cost Liability
Region 6 Behavioral Healthcare assumes no responsibility or liability for costs by the Bidder, or any Bidder prior to the execution of an agreement between the organization and Region 6 Behavioral Healthcare.

Disclaimer
All the information contained within this RFP and its attachments reflect the best and most accurate information available to Region 6 Behavioral Healthcare at the time of the RFP preparation. No inaccuracies in such information shall constitute a basis for legal recovery of damages, either real or punitive. If it becomes necessary to revise any part of this RFP, a supplement will be issued on the Region 6 website: www.regionsix.com.

Evaluation of Proposals
Each proposal will be independently evaluated by members of the Review Committee, established by the RGB. This committee may include, but is not limited to: consumers, representatives of the BHAC, the RGB, DHHS, consultants, Region 6 staff and other interested stakeholders. Review Committee names and any working documents, including applicant's proposal scores, will not become public information nor will be released to individual applicants. Recommendations from the Review Committee will be forwarded to the RGB for final determination.

Oral Interviews
Oral interviews may be required for this RFP. Applicants will be contacted and specific times arranged for their organization's interview if needed. Interviews may involve whomever the applicant wishes to include to represent their organization. Only representatives of the RGB, Review Committee, designated Region 6 personnel, Region 6 PES consultant(s) and the applicant and their designees, will be permitted to attend the interviews.

The intent of the interviews (if needed) is to ask any clarifying questions the review committee has, to further explore the philosophy of the applying agency, to respond to any questions the applying agency may have, etc.

Once the review is completed, the RGB reserves the right to make a final determination without any further discussion with the applicant regarding the proposal received.

Any cost incidental to the interviews shall be borne entirely by the applicant and will not be compensated by Region 6 Behavioral Healthcare or the RGB.

Announcement of Funding Allocations
Applicants will be notified by mail of the final funding decisions. All decisions regarding funding allocations will be made on November 13, 2019, by the Regional Governing Board.

Opportunities for appeal should be made after the recommendation phase at the Region 6 Behavioral Health Advisory Committee meeting by contacting Taren Petersen prior to the Regional Governing Board meeting where the award is made. Contacts to Ms. Petersen must be in writing through e-mail at tpetersen@regionsix.com. Appeals must be received no later than November 8, 2019 (4:00 p.m. CST). Region 6 will address all appeals within 2 business days from the November 8, 2019 deadline.

Withdrawal of Application
The applicant may withdraw their proposal, with written notification, at any time during the process. In such an instance, a typewritten letter of withdrawal with an original signature by an authorized officer/executive must be received by either hand delivery or by certified mail to:

Region 6 Behavioral Healthcare,
4715 S 132nd St., Omaha, NE 68137
Attention: Taren Petersen

Region 6 Behavioral Healthcare will not accept a verbal communication, e-mail or a faxed letter of withdrawal.

Indemnification
The applicant shall assume all risk of loss in the performance of the contract and shall indemnify and hold harmless Region 6 Behavioral Healthcare, its Governing Board, Advisory Committee members, consultants and employees from all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments and all expenses incident thereto, for injuries to persons and for loss of, damage to, or destruction of property caused by the negligent or intentional acts or omissions of the applicant, its officers, employees or agents; for any losses caused by failure of the applicant to comply with the terms and conditions of the contract; and for any losses caused by other parties which have entered into agreements with the applicant in connection with the performance of the contract.

SECTION VIII-GENERAL INSTRUCTIONS ON SUBMISSION OF PROPOSALS

All instructions, conditions, and requirements included in this document are considered mandatory unless otherwise stated. Proposals that do not conform to the items provided in this document will not be considered.

All applicants must adhere to the following guidelines for submission of proposals.

1. The due date for receipt of proposals is October 25, 2019. All proposals must be received in Region 6 Behavioral Healthcare's office by 4:00 p.m. (CST).

Proposals must be sent OR delivered in person to:

Region 6 Behavioral Healthcare
4715 S 132nd St
Omaha, NE 68137
Attention: Taren Petersen

- Applicants shall not be allowed to alter or amend their proposals.
- FAX or e-mailed copies will not be accepted.
- No requests for extensions of the due date will be approved.
- The RGB accepts no responsibility for mislabeled/miss sent mail.
- Proposals received late will not be accepted and will be returned to the sender unopened.

2. Applicants must submit one (1) original and ten (10) copies of each proposal.

3. Proposals 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 appendices and attachments. NOTE: Cover Page is not considered part of Program Narrative.

4. Originals and each copy must be stapled or clipped at the upper left-hand corner. Do not use covers or add unsolicited attachments to your proposal.

5. All information must be provided on the actual Region 6 Behavioral Healthcare forms (the attachments provided in this RFP). An electronic version of the forms will be available via the Region 6 website: www.regionsix.com. The forms may be retyped by the applicant; however, the form must look EXACTLY the same, including, but not limited to, headings, appendix number, required information categories, number of pages, and font size.

SECTION IX – PROPOSAL FORMAT

Proposals must be organized in the following sections in the order listed below:

1. **Cover Page** (Attachment A)

   Complete the entire "Cover Page" 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/service.

2. **Capacity Development Plan**

   A. **Program Narrative**

The Program Narrative is a written plan that describes, in detail, the PES to be funded. The narrative should include a response to the following requirements as they relate to the service definition. Using a 10-point font or larger, the Program Narrative should not exceed twelve (12) typed pages. The Program Narrative shall cover the following points in a clear and concise manner, prepared in the following order using headings as listed below:

1) **Organizational Capability:** Describe the organization's capability to provide the service, including:

    - Brief organizational history;
    - Explanation of how provider is capable of providing the PES;
    - Ability to collect demographic information;
    - Ability to collect and submit any and all program data and outcomes;
    - Cultural/gender competency;
    - Identify the specific amount of time needed to develop the service. **NOTE: The target date for PES opening is by July 2020, however, this is negotiable.**
    - Ability to meet eligibility criteria as listed in Section III of this RFP;
    - How the PES mission/philosophy is compatible with the organization's mission/philosophy;
    - Explain your willingness to work with Region 6 staff during development of the PES. Willingness to be part of the Region 6 network system, outcome monitoring, reporting etc.;
    - State willingness to work with Region 6 staff oversight of the PES within the larger psychiatric emergency system, stakeholder participation and outcome monitoring.

2) **Purpose:** Explain the purpose of the service in terms of the result expected to meet the needs of the consumers and the benefits to the system.

3) **Target Population and Geographic Area:** Describe the target population and geographic area to be served, including:

    - How applicant will market the program to the entire Region 6 area;
    - How applicant will serve the entire Region 6 geographical area;
    - Specify how service will be located in easy access for consumers (i.e. bus line).

4) **Goals:** List and explain the goals of the program/service and process and outcome indicators that are measurable.

    <u>Goals must</u>:
    - Directly relate to the PES service;
    - Deal specifically with issues related to service delivered;
    - Address expected short-term and long-term benefits, both from a system perspective as well as an individual consumer perspective.

Process indicators must:

- Measure the quality of service delivery;
- Focus on the efforts expended rather than the results achieved;
- Include measures of what service was delivered, to whom, by whom, for how long and how often;
- Ensure that the service will be implemented as intended.

Outcome indicators must:

- Measure the results achieved or the effectiveness of the service as related to the consumer and consistent with the program goals;
- Account for program effectiveness;
- Identify what consumers are expected to achieve as a result of the service provided by the PES;
- Be expressed in terms of behavior, condition, or thing that are attainable by an individual consumer who is served by the service being evaluated.

5) **General Overview:** Provide a general overview of how the PES will be organized.

- Include information about how the applicant's resources (facility space, personnel, equipment, etc.) and administrative structure are coordinated and directed to meet the needs of the consumers through the service;
- Include which state service definition(s) the agency plans to use;
- Describe how individuals presenting with substance use needs will be handled;
- Describe how individuals with medical issues will be handled;
- Describe how assessment and treatment will use trauma informed principles;
- Describe how your organization will keep the PES environment safe for both consumers and staff;
- Describe your process in obtaining additional funding information such as Medicaid, Medicare, commercial insurance and any other funding sources.

6) **Funding/Contract Securement**:

- Briefly explain your experience in negotiating/securing contracts with other payer sources;
- Briefly discuss how you think costs might increase in the future.

7) **Admission Criteria:**

- Thoroughly describe procedures for consumers to access the service;
- Describe how the PES Admission Criteria will be used in this service to determine consumer appropriateness for admission.

8) Assessment Process:

- Describe the assessment procedures that will be used in the service;
- Include an explanation of what information will be gathered for each consumer and any screening tools that might be used;
- Provide details of the medical screening to be provided and protocol for those who have medical needs beyond the scope of the PES.

9) Specific Services:

- List and include complete explanations of the specific services to be provided directly to the consumer;
- Describe how individual treatment planning will be done with the consumer and what is included in this individual plan;
- Describe what is involved in the PES services (all phases) to be provided within the program;
- Describe how the services will be coordinated with other programs including hospital emergency departments; nursing homes and community-based residential programs; law enforcement; homeless shelters; inpatient psychiatric providers; outpatient behavioral health providers; detoxification centers; transportation providers; pharmaceutical services, security services, etc.;
- Describe discharge planning procedures, criteria, and any follow-up
- Describe the projected average length of stay in the program for the consumer to successfully reach the desired results as specified in the goals;
- Describe if there will be a role for peer support within the PES and how peer support will be supported in maintaining non-clinical roles in a clinical environment.

10) Consumer Involvement: Describe the procedures for direct consumer involvement in the program/service, including:

- How consumers will participate in treatment planning (individual level);
- How potential consumers will be informed about the program and consumer rights (individual level);
- Describe how meaningful participation of consumers will be incorporated into the development, implementation, evaluation and ongoing monitoring of the program/service.

11) Capacity: Discuss the capacity anticipated for the service, including:

- Program capacity – the total number of individual consumers considered “active” in the program at any given time;
- Daily census – the number of individual consumers who can be served on a single business day;

- 12-month period – estimate the total number of consumers served during a normal 12-month period.

12) Service Staffing: Discuss program/service staffing proposed, including:

- An explanation of the qualifications and supervision of the positions which will provide any services (direct and indirect) in the program;
- Efforts to recruit, hire, and train PES staff and possible usage of telehealth;
- Describe if you see a role for peer support within the PES and how peer support will be supported in maintaining non-clinical roles in a clinical environment.

13) Quality Improvement: Describe the quality assurance plan which will be used for this service, including:

- How information and data will be gathered to evaluate the service, how it will be used, and who will be involved in making this happen;
- What quality indicators will be used, how it will be used, and who will be involved in making this happen;
- Overview of the quality improvement functions the agency plans to use in this service.

14) Facility: Explain how the applicant will develop the PES facility, including:

- Information on the intended PES facility including: facility address (if known) or projected location; facility structure-free-standing or hospital; current or intended facility licensure; distance to closest hospital; environmental safety features; security of environment; square footage; etc.;
- How will the applicant secure adequate square footage;
- Any required renovations, including how they will be paid for;
- When (date or estimated date) the applicant feels they can secure the identified space;
- Identify if additional space may be available for future expansion (if desired).

Program Development and Implementation Schedule, BH-5 (Attachment B)

Several copies of the BH-5 form may be required to identify the goals and objectives necessary to develop and implement the service capacity. Complete a separate BH-5 for each service goal. Goals should address the following:

- Development process/implementation schedule: Explain in detail a clear step-by-step plan of how the program/service will be developed over the given period of time. List reasonable and necessary goals and objectives needed to develop and implement the service capacity. Activities stated should be

comprehensive, can be accomplished, and have clearly identified time frames, staff responsibility assigned, and outcome indicators;
- How the applicant organization will complete a formal evaluation of the service, including steps in the process, and services provided;
- Applicant is asked to include in the BH-5 a projected timeline that would project how long it will take to maximize 3rd party billing.

For service start-up, capacity development goals should include, at a minimum, how the applicant will do the following:

- Develop administrative structures and personnel for service;
- Develop facility for providing service, as needed;
- Develop program plan, program operating policies and procedures, operation plan, registration/referral system for service;
- Develop reporting, financing, and quality improvement systems;
- Develop an infectious disease policy and disaster plan;
- Indicate when PES will be operational.

B. Budget and Budget Justification Narrative

1) Budget Forms -BH-20 Summary and BH c-g (Attachment C) – Use forms BH-20 Summary and BH c-g to develop the detailed budget for the service. **Two** separate budgets must be submitted as a part of the proposal. The first budget must show start-up expenses for the program. The second budget should include a full one-year contract term for FY21 (7/1/20 – 6/30/21) showing a full year's operational budget.

Note: In the first budget (start-up), the provider must identify what additional expenses may be necessary for start-up.

Revenue Summary (BH-20 Summary)
List the revenue requested from Region 6 under Section (C) STATE FUNDS, on the MH-general. List any other program/service revenue on the appropriate line. Be sure to identify expected Medicaid, Medicare and third party commercial insurance revenue.

Expense Summary (BH-20 Summary)
This form is a re-cap of detailed budget forms, BH-20 c-g. The total from each detailed budget form will transfer to the BH-20 Summary, Expense Summary, on the appropriate expense category line. List indirect administration expenses in column 1, if applicable. **Note:** No more than 15% of funds may be used for indirect expenses/costs unless applicant has a federally approved cost rate. A copy of the letter stating the federally approved cost rate must accompany the budget forms.

Detailed Budget Forms (BH-20 c-g)
In the column titled, "Total HHS/BH Funds Requested," show the funds you are requesting from Region 6 through this RFP process. In the column titled, "Total Project Funds (includes HHS and other)," show the

total cost of the line item expense which may include revenue from another source.

Note: All funds must be identified in the proposal and additional funds will not be made available after the award.

The following outlines specific items to use within each expense category:

Personnel Services (BH-20c)

- Direct personnel (includes all FTEs directly related to the provision of services, including direct supervision)
- Permanent salaries/wages
- Temporary salaries/wages
- Overtime pay
- Compensatory time paid
- Vacation leave expense
- Sick leave expense
- Holiday leave expense
- Military leave expense
- Civil leave expense
- Injury leave expense
- Administrative leave expense
- Retirement plans expense
- Social Security benefits expense
- Life/accident insurance
- Health insurance
- Unemployment compensation insurance
- Employee assistance program
- Management salaries/wages/fringe benefits
- Accounting support
- Personnel/human resources support
- Clerical Support
- Operations personnel support

Operations (BH-20d)

- Postage
- Communication (i.e., phone/voice mail)
- Data processing/computer hardware/software
- Publications/newsletters/printing
- Training booklets, pamphlets, curriculum, videos, etc.
- Copying
- Dues/subscriptions
- Conference/professional development
- Job applicant expense
- Utilities (i.e., electric/water/gas)

- Rental expenses (i.e., building/equipment/vehicle)
- Office supplies
- Office equipment
- Workshops/retreats/trainings/classes
- Program marketing advertising
- Equipment supplies
- Legal services expenses
- Educational services
- Accounting/auditing expenses
- Janitorial/security expenses
- Board meeting support
- Building/auto insurance
- Professional liability insurance
- Directors and officers insurance
- Medications
- Other operating expenses

Travel (BH-20e)
- Board and lodging
- Meals
- Personal vehicle mileage
- Miscellaneous travel expense

Capital Expense (BH-20f)
- Office equipment
- Equipment on purchase agreements
- Medical equipment
- Hardware (data processing)
- Software (data processing)
- Communications equipment
- Household/institution equipment
- Photo/media equipment
- Security system
- Other property/equipment

Other (BH-20g)
- Consultants
- Contracts for other service (i.e., accounting/auditing services)
- Indirect personnel costs – Region 6 can only approve indirect personnel costs up to 15%, unless a federally approved Indirect Cost Rate Document is included with the budget submission.
- Other

2) **Budget Justification Narrative** – A separate budget narrative is required for both budgets. These narratives will help explain the rationale behind

the budgeted items, please justify costs clearly. These narratives should explain in detail:

- Why the costs listed on the budget itemization forms are necessary;
- How those costs were calculated.

The following items should be addressed separately in the narrative:

- Specific start-up (one-time) costs;
- Ongoing staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately;
- Explanation of how ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined;
- Include a description of other sources of funding currently committed to the service and other sources being pursued and how they are to be utilized in addition to funds requested in this proposal.

3) Financial Audit

A copy of the most recent audit of its financial operation by certified public accountants, using generally accepted auditing techniques, principles, and standards. **NOTE: A copy of the applicant's most recent financial audit must be included with the proposal(s) submission. This does not apply to applicants who are already in the Region 6 Provider Network (as we already have copies of this information).**

SECTION X-MINIMUM STANDARDS FOR ENROLLMENT IN REGION 6 BEHAVIORAL HEALTHCARE PROVIDER NETWORK

Any applicant, not a current member of Region 6 Behavioral Healthcare Provider Network, shall attest that they can meet the minimum requirement for Enrollment in Region 6 Behavioral Healthcare's Provider Network by reading and signing the Minimum Standards for Enrollment Form. (Attachment D) Please include a signed copy of the form with your application packet.

SECTION XI-RFP EVALUATION

Selection Process

The RGB shall conduct a fair and comprehensive evaluation of all applications received in accordance with criteria set forth below.

All complete proposals will be scored as part of the evaluation process. Each proposal will initially be reviewed to ensure it meets the basic standards for the bid as outlined in the RFP Guidelines.

Proposals that meet all the requirements of this initial review will be forwarded to the Review Committee for evaluation.

Evaluation and Scoring

The following point values will be given to each of the three areas listed:

1. Program Narrative – a total of 100 Points available
2. Program Development and Implementation Schedule (BH-5) – a total of 50 points available
3. 2 Budgets and Budget Narratives (BH 20 Summary and c-g) – a total of 100 points available

SECTION XII – ADDITIONAL INFORMATION PER SERVICE PACKET

The current Medicaid and DBHS-DBH service definitions are included in the RFP packet. The service definitions must be used when developing the service.

The PES will need to be registered through the state's Central Data and Electronic Billing systems. The selected applicant will receive training on both systems once they are selected and Region 6 staff feel it is appropriate.

ATTACHMENTS

- Attachment A: Cover Sheet
- Attachment B: BH-5 Form
- Attachment C: Budget Forms -BH-20 Summary and BH c-g
- Attachment D: Minimum Standards for Enrollment Form
- Attachment E: NE Medicaid Service Definition for Treatment Crisis Intervention / Crisis Stabilization (hospitals and others)
- Attachment F: NE Medicaid Service Definition for Observation Room /Emergency Psychiatric Observation (only applies to hospitals)