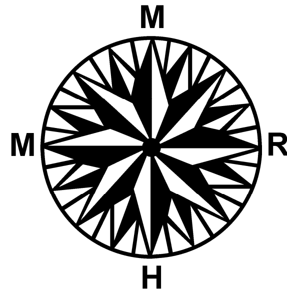
MENTAL HEALTH MENTAL RETARDATION SERVICES OF TEXOMA

SERVING COOKE, FANNIN, AND GRAYSON COUNTIES



"QUALITY SERVICES FOR QUALITY LIVES"

LOCAL PLANNING & NETWORK DEVELOPMENT
For Mental Health Services

FY 2009 – 2010

The mission of the center is to provide services that improve quality of life and support self-determination for persons with mental and developmental disorders.

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I. MISSION, VISION, & VALUES

MISSION STATEMENT

The mission is to provide services that improve quality of life and support self-determination for persons with mental and developmental disorders.

VISION STATEMENT

MHMR Services of Texoma envisions a community-based system of effectively coordinated service providers who are committed to eliminating stigma associated with mental and developmental disorders and providing cost managed services that enhance independence, dignity, and opportunities for exercising personal choice.

To achieve this vision, the center is committed to:

- engaging in individual treatment planning, service coordination, and service monitoring activities that demonstrate regard for choice while improving levels of functioning;
- promoting a network of providers that demonstrate good cost management while providing effective service outcomes;
- providing community education that focuses on eliminating stigma and promoting the capabilities of persons with mental and developmental disorders;
- promoting satisfying lifestyles for persons served;
- promoting wellness;
- promoting awareness of the disabling effects of mental and developmental disorders;
- assuring that services are delivered in environments that appreciate ethnic and personal diversity.

VALUE STATEMENTS

Individual Worth:

We affirm that the individuals we serve share with us common human needs, rights, desires, and strengths. We celebrate our cultural diversity and individual uniqueness.

Quality:

We believe in the provision of quality services.

Integrity:

We pledge our professional integrity as the basis to optimize and enhance service delivery and revenue sources.

Dedication:

We take pride in our commitment to serve the public and to advocate for the people we serve.

Innovation:

We are committed to developing staff support systems which provide an effectively trained work force and reward productivity and performance excellence.

Teamwork:

We believe that our responsibilities are best defined by partnerships with consumers, family members and service providers working together in teams.

Uniqueness:

We recognize that we are a flexible organization, not in an exclusive contract arrangement, and we will expand services to meet identified community needs.

II. AGENCY OVERVIEW

Historical Perspective: Federal and state initiatives enacted during the l960's and l970's led to a major overhaul in the treatment of individuals with mental illnesses and developmental disorders throughout the United States and to the development of a community-based service delivery system. The community movement was based on the belief that individuals with mental disorders could improve and participate in the life of their communities. Personalized and individualized services in a community setting were considered to be more humanitarian than an institutional approach, and could also result in an economic benefit to communities by assisting people to become more self-sufficient and independent of support systems.

As a result of federal initiatives that made funding available to the states, most states responded by establishing regional community mental health and mental retardation centers to provide services to individuals most in need of services. Initially, the individuals served included persons being discharged from state mental hospitals or state schools, persons at risk of hospital or state school placement, and others within the region in need of services. Treatment strategies promoted the principles of normalization, least restrictive environment, independence, individualized services, and community integration. The definitive component of these principles was the belief that individuals with mental and developmental disabilities could and should have lives as much like others in their communities as possible.

Mental Health Mental Retardation Services of Texoma (MHMRST - the Center) was established in September 1974 as a community mental health and mental retardation center through petition of the sponsoring governments of Cooke, Fannin, and Grayson Counties and the cities of Sherman, Denison, Gainesville, and Bonham. Since that time, MHMRST has been committed to providing meaningful services and supports to individuals and families with mental and developmental disabilities within the Texoma region. Approximately 15 years ago, the State narrowed the focus of individuals served to a "priority population" which includes persons who have mental retardation, schizophrenia, bipolar disorder, major depression, or who are in a mental health crisis that present an immediate risk to self or others.

Like other community centers, MHMRST has had to adapt to significant legislative, political, economic, and societal changes. In the midst of all the changes and challenges, the Center remains as committed to individuals and families today as it was in l974. The Center is responsible for developing, maintaining, and updating a Local Service Area Plan in compliance with the Department of State Health Services (DSHS) Performance Contract. The development of the general two-year Local Service Area Plan 2009 – 2010 and the specifics outlined in this Local Plan and Network Development (LPND) component are based on a continued desire to provide quality, cost-effective services that promote independence, improve the lives of individuals and families, and impact our local communities in positive ways. This required LPND Plan is designed to develop a network of providers that will meet local needs and priorities, promote consumer choice, improve access to services, make the best use of available funds, and maintain a safety net for consumers.

III. SERVICE AREA & DEMOGRAPHICS

MHMR Services of Texoma is one of 39 community mental health and mental retardation centers in Texas who contract with the State of Texas to provide services and function as a "Local Mental Health Authority" (LMHA) and a "Mental Retardation Authority" (MRA) in designated regions. Although community centers are designated as local units of government, they are not state agencies.

The Red River, together with Lake Texoma, forms the northern boundary of the Center's service area that includes a population of approximately 189,921 people within Cooke, Fannin, and Grayson Counties according to 2007 U.S. Census Bureau statistics. The following chart reflects specific demographic data for each of the counties.

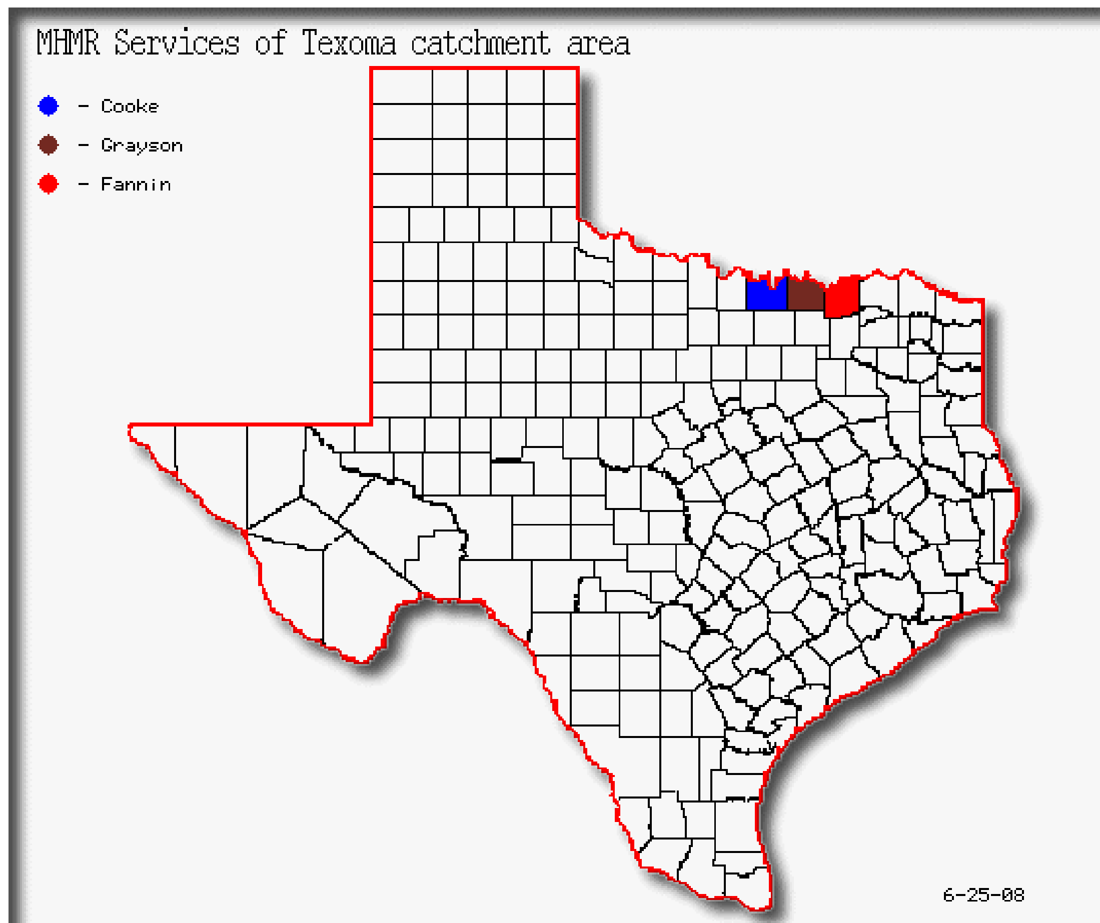
U.S. Census Information – 2007

County	Population	Racial Make-up	Household Income	Education	Disability Status/ Veteran Status
Cooke 874 square miles	38,626 increase of 6.22% since 2000 Census	88.8%--White 3.1%--African Am. 10%--Latino	Median household income is $37, 649 -- *U.S. average is $48,451* Families below poverty level—10.9% Individuals below poverty level—14.1% compared to: *U.S. average for families---9.8%* *U.S. average for individuals—13.3%*	79.2% –H.S. Graduate 15.7%- College Degree compared to: *84.1% --U.S. H.S.* *27%--U.S. College*	20.4% –Disability 13.9%—Veterans compared to: *15.1%-U.S. Disability* *10.4%-U.S. Veterans*
Fannin 891 square miles	32, 620 increase of 4.41% since 2000 Census	86.6%--White 8.0%--African Am. 5.6--Latino	Median household income is $34, 501 Families below poverty level—9.9% Individuals below poverty level—13.9%	72.5% –H.S. Graduate 12.6%—College Degree	24.4%—Disability 14.5%--Veterans
Grayson 934 square miles	118,675 increase of 4.83% since 2000 Census	88.7%--White 5.7%--African Am. 9.2%--Latino	Median household income is $43, 328 Families below poverty level—11.3% Individuals below poverty level—14.8%	81.7%—H.S. Graduate l7.9%—College Degree	15.9%—Disability 12.0%--Veterans

MHMRST acknowledges the importance of service area demographics in the development of the broad Local Service Area Plan and this Local Planning and Network Development component. Although the Latino population has increased slightly and there has been a slight increase in the general populations of all three counties since the 2000 Census, the service area remains essentially rural. Perhaps what is especially striking about the most recent demographics is that the percentage of individuals in each county who

identified themselves as having a disability is higher than the national percentages. The percentage of veterans within the populations of each county also exceeds the national average. These statistics seem to reinforce the importance of continued services that reflect local community needs. The service area must also be viewed in terms of its economic and social challenges. While the median household income for Grayson County is higher than Cooke and Fannin, data reflects that the number of individuals and families that fall below the poverty level in all three counties is higher than the national averages. Although there is no concrete data reflecting the number of homeless people in our communities, homelessness is a growing concern. As the Center progresses through the planning process to develop the LPND Plan, it understands that planning must essentially be ongoing to meet changing needs and dynamics of its communities.

This map shows where the Center is located:



IV. MENTAL HEALTH SERVICES (DSHS)

A. *Local Planning Process*

1. General Description:

The Center understands that planning is an ongoing process of identifying and evaluating local service needs, understanding changing internal and external forces, prioritizing needs and establishing strategies based on state requirements and available resources. Planning includes the allocation of resources, establishment and implementation of goals and objectives, and the development and evaluation of outcomes.

In contrast to past years when center decisions were made primarily by program managers and endorsed by the Board of Trustees, the planning process is now much more inclusive. The Center now actively solicits and incorporates opinions and information from a broad spectrum of stakeholder groups who have an interest in the welfare of individuals served. Stakeholders represent consumers, family members, advocacy groups, local government officials, law enforcement, local hospitals, other service organization representatives, interested citizens and community groups, including churches and schools. The Center's Planning and Network Advisory Committee (PNAC) is a vital link in the planning process.

2. Overview of Planning Components:

The following components are indicative of the Center's efforts to carry out its mission while ensuring that local service area planning processes produce outcomes that are cost efficient, clinically effective, represent the interests and needs of the community and individuals served, and are compliant with the Performance Contract with the Department of State Health Services.

- **Information:** The Center has an organized methodology for acquiring information related to perceived needs and interests of stakeholders. The methodology addresses the level of satisfaction with center services, local needs of the service area, legislative initiatives and State requirements. To gather information the Center utilizes the following: complex data management systems, surveys, questionnaires, community forums, designated staff teams and committees, community collaborative meetings, networking with other social service agencies, collaboration with other community mental health mental retardation (MHMR) centers and regional coalitions. To date, the acquired information has been effective and useful in collaboration with local officials, law enforcement, and hospital emergency room staff for the purpose of diverting individuals from jails and hospitals to less restrictive community supports.

- **Key Decision Makers:** Important decision-making groups of the Center include the Administrative Management Team (AMT), Leadership Team, Mental Health Action Team, the Mental Retardation Quality Improvement Team, and Board of Trustees. Although the Planning and Network Advisory Committee (PNAC) does not actually make decisions about Center policies and procedures, the committee provides input and makes recommendations that are indispensable to the planning process. All key

groups clarify the center's purpose, assist with planning activities, acquire needed information, and provide program specificity in an ongoing process.

- **Local Service Area Plan:** The Center uses a comprehensive process of reviewing information that results in a document referred to as the Local Service Area Plan (LSAP.) As the Center recruits its Board and PNAC members, emphasis is placed on recruiting participation from a broad spectrum of individuals who reflect the cultural and ethnic diversity of the service area in order that unique perspectives and needs may be recognized. As information is acquired from these and other stakeholders, a final document reflects broad planning over a two-year cycle. Sections of the LSAP include a Crisis Services Plan, Jail Diversion Plan, Quality Management Plan, and a Local Planning and Network Development Plan.

- **Local Planning and Network Development Plan (LPND):** Information contained in this document reflects the Center's efforts to develop the LPND Plan to be submitted to DSHS by August 31, 2008. The plan details the process of soliciting input from many groups of stakeholders in a variety of ways, evaluating that input, identifying service area needs and priorities, analyzing financial and cost-accounting considerations in order to determine which services to contract out through a Request for Proposal (RFP) or Open Enrollment (Request for Application) Process.

3. Process for Soliciting Stakeholder Input:

From February through August 2008, the Administrative Management Team (AMT), Mental Health Action Team, MHMRST Planning and Network Advisory Committee (PNAC) and designated staff involved in the local planning process held numerous Local Planning and Network Development (LPND) strategic meetings. The broad purpose of these meetings was to fulfill the requirement to implement Local Planning according to the Texas Administrative Code or "Rule." More specific purposes focused on developing sequential methods to: 1) increase the Center's understanding of the Rule; 2) to schedule and complete many educational activities for consumers, families, the PNAC, advocacy groups, local officials, and other stakeholder groups; 3) to develop specific survey tools and ways of soliciting stakeholder input; 4) to organize and understand collected input in order to develop a plan consistent with the Rule's requirements; 5) to obtain additional stakeholder comments and input; and 6) modify the plan as needed. The following specific areas reflect the Center's efforts to involve participants in meaningful, practical, and culturally sensitive ways at many junctures of the process.

- **Education/Training Activities:** Staff involved in the local planning process participated in the weekly conference calls available for centers. Information and resources introduced by the LPND Oversight Committee proved very helpful during the process. Center staff used and adapted the Local Planning and Network Development training modules developed by the State, including the "You Have a Voice" module for consumers. During the training and input gathering stages, the Spanish version of the module and three bilingual staff were made available as needed. Specific explanation about education/training activities is reflected below:

  - **PNAC Training and Involvement in the Process:** The PNAC, consisting of ten representatives, in addition to a non-voting Board of Trustees liaison and a non-voting staff liaison, was provided education and engaged in discussion about the process. During meetings held on February 25, March 24, and April 21, 2008, the committee reviewed additional LPND education initiatives to be presented to consumers and stakeholders. The committee chose a stakeholder survey from three options and made recommendations about letters to be sent to stakeholders and information to be posted on

the MHMRST website. PNAC members also hosted two stakeholder meetings held at Grayson County College on May 13, 2008. The committee met on May l9, 2008 to review responses obtained from surveys and from discussion surfacing during the May meetings. Finally, the PNAC made recommendations relative to the next stages of the planning process at meetings on June 16, July l4, and August 11, 2008 which included review and suggestions of the Draft LPND Plan to be posted on the website for review and additional input.

Once the plan development is complete, there is also an expectation that the PNAC will review and make suggestions on criteria to be used to evaluate Provider submissions from a published RFP or Open Enrollment, as well as evaluate submissions from potential providers and make recommendations to the Board of Trustees.

It is also noteworthy that the PNAC has been actively involved in the development and implementation of the Crisis Services Plan submitted to DSHS in October 2007. Members of the PNAC play essential roles in the ongoing jail/hospital diversion and community networking/marketing focus groups that continue to meet as part of the Center's Crisis Services initiatives for the Texoma region.

- **Staff Training:** Executive Director Tony Maddox distributed letters to MHMRST staff explaining the LPND Rule, the process for implementing the rule, and some of the implications for the Center, staff, and consumers. All mental health staff attended a training class on May 2, 2008 and were given written resources for providing consumer training and instructions for distributing LPND surveys to mental health consumers.

- **Consumer Training:** Mental health clinical staff held small group meetings with consumers in Cooke, Fannin, and Grayson Counties during the first two weeks of May to provide information about LPND and to answer questions. There was general consensus among staff and PNAC members that it was necessary to conduct these training groups prior to asking consumers to complete the surveys.

- **Training for Stakeholder Groups:** Two stakeholder meetings were held on May 13, 2008 at Grayson County College for the purpose of presenting information about the LPND rule, the Center's requirements by the state for submitting a plan for expanding the network of mental health providers, answering questions, and obtaining stakeholder input through completing the surveys. Although the turnout for these meetings was small, the emerging discussion by those who attended was helpful in the overall process.

- **National Alliance on Mental Illness - Grayson, Fannin, Cooke (NAMI-GFC):** MHMRST PNAC staff liaison attended the local NAMI meeting on April 17, 2008 to provide LPND information and distribute flyers for the May 13, 2008 Stakeholder meetings. Unfortunately, there were only nine individuals attending the meeting, but the NAMI-GFC president was given 35 additional sets of handouts to distribute.

- **MHMRST Website Postings:** Postings on the website included information adapted from the state's LPND and "You Have a Voice" training modules, surveys, announcement of stakeholder meetings, and contact sources for acquiring additional information.

- **Newspaper, Radio, Local Television:** The Center's Public Information Officer provided all media sources in the Center's service area with information and announcements about LPND and public meetings.

- **Soliciting Stakeholder Input:** The training and education activities outlined above were integral to acquiring stakeholder input. The Center and the PNAC recognized the importance of presenting information in an understandable way in order to elicit meaningful input and to clarify any concerns or questions that stakeholders might have. MHMRST wanted stakeholders to understand how important their input was in the process of developing a plan to expand consumer choice and still maintain a safety net to meet local service needs. The Center understands that the PNAC is the primary link for stakeholder input. The group has been actively involved in all of the planning stages of the LPND process, as well as the development of the Crisis Service Plan. The Center, with guidance and assistance from the PNAC, solicited stakeholder input in the following ways:

  - **Mailed Invitations:** Over 200 mailings that contained the May 13, 2008 stakeholder flyer, LPND stakeholder survey, and a one-page information sheet were sent to a variety of stakeholder groups from within the tri-county area. Stakeholder groups included local government officials, law enforcement, advocacy groups, other community human service agencies, families, consumers, churches, and private providers in the region.

  - **Posting of Flyers and Surveys:** Flyers containing LPND information and stakeholder meeting times and dates, as well as LPND stakeholder surveys were posted or distributed in each of the Center's mental health sites in Cooke, Fannin, and Grayson Counties. The PNAC staff liaison was listed as a contact person if additional information or assistance in completing the survey was needed.

  - **Website Postings:** LPND information was posted on the Center's website from April through July 2008. Information included listing of times and dates of stakeholder meetings, explanation of the LPND Rule, and a contact number to request a LPND survey. Following the stakeholder meetings, input by the PNAC for developing the LPND Plan, review by the PNAC of the proposed plan, the LPND proposed plan was posted on the website for public comment and recommendations.

  - **Newspaper, Radio, Local Television:** The MHMRST information officer has been instrumental in implementing a variety of coverage that both informs and invites community participation. Between September 2007 and August 2008, newspaper articles about Crisis Redesign, Jail Diversion, Local Planning and Network Development, and specific stakeholder meetings have been printed in local newspapers. In addition, Center staff have been guest speakers on several local talk shows. Executive Director Tony Maddox, Chief Operations Officer Jill Livingston, Mental Health Services Assistant Manager Brent Phillips have discussed jail diversion efforts, how to access mental health services, crisis services procedures, and Local Planning and Network Development.

  - **Stakeholder Meetings:** The PNAC and Center staff sponsored a stakeholder meeting in October 2007 to obtain input about crisis service needs from many stakeholder groups for the purpose of developing a Crisis Service Plan to submit to the State in October 2007. As previously cited, two LPND stakeholder meetings were held in May 2008.

- **Surveys:** Satisfaction surveys completed by consumers and family members have historically been a primary vehicle for obtaining stakeholder input. More recently, the LPND surveys were mailed to stakeholder groups or distributed face to face to consumers and distributed at stakeholder meetings.

- **Focus Groups:** As part of the ongoing implementation of the Center's Crisis Service Plan, the jail diversion focus group and the marketing/information focus group continue to meet to resolve issues, improve communication and education, and produce outcomes that are mutually beneficial to meeting mental health community needs through networking with law enforcement, advocacy groups, judicial and government sectors, and mental health professionals.

- **Small Group Interactions with Consumers:** Mental health clinical staff have engaged consumers in a variety of small group interactions for the purpose of LPND training, as previously mentioned, but also to solicit input and answer any questions consumers may have about LPND or the LPND survey.

The chart below depicts the Center's efforts to solicit stakeholder input through community stakeholder meetings, advocacy meetings, focus groups, and surveys.

Crisis Redesign and Local Planning and Network Development Activities

Description **Date or Timeframe**	**Participating Organizations**	**Number of Consumers**	**Number of Family Members**	**Number of Interested Individuals** Advocates, Community, Law Enforcement, Mental Health Professionals, Government, Judicial
October 12, 2007 Crisis Redesign Stakeholder Meeting—at Grayson County College: 10:00a.m. – 12:00 Crisis Redesign Presentation—Small group discussions to identify priorities and make recommendations followed by recap of small group discussions (53 Attendees)	▪ NAMI GFC ▪ Fannin County Sheriff's Office ▪ Texas Council on Governments (TCOG) ▪ Denison Independent School District ▪ Fannin County Adult Probation ▪ Fannin County Auditor ▪ District Attorney's Office—Grayson ▪ Parkview Church--Sherman ▪ Wilson N Jones Hospital ▪ Texoma Medical Center--ER ▪ First Baptist Church—Bonham ▪ Grayson County Health Dept. ▪ Bonham Police Dept.	5	6	42

Description Date or Timeframe	Participating Organizations	Number of Consumers	Number of Family Members	Number of Interested Individuals Advocates, Community, Law Enforcement, Mental Health Professionals, Government, Judicial
	(continued from previous page) ▪ Grayson County Courts at Law ▪ Texoma Chapter Red Cross ▪ Pottsboro Police Dept. ▪ Texoma Medical Center Behavioral Health C. ▪ Temple Church—Sherman ▪ Grayson County Adult Probation ▪ Grayson County Inmate Health ▪ Justice of the Peace—Precinct 1 ▪ Fannin County Indigent Health Care ▪ Whitesboro Police Dept. ▪ The Salvation Army ▪ Area Agency on Aging—Texoma ▪ Sherman Police Dept. ▪ Grayson County Juvenile Probation			
From January 2008 – July 08 Crisis Services—Jail and Hospital Diversion focus group meetings were held at least once a month in Fannin and Grayson Counties as part of the implementation of the MHMRST Crisis Services Plan	▪ NAMI ▪ VA Hospital—Bonham ▪ Justice of the Peace ▪ Fannin County Judge ▪ Grayson County DA Office ▪ County Clerk's Office—Bonham ▪ Texoma Medical Center ER ▪ Sheriff's Office—Fannin ▪ Sheriff-s Office—Grayson ▪ Adult Probation—Fannin & Grayson ▪ Juvenile Probation—Fannin & Grayson	0	0	30

Description Date or Timeframe	Participating Organizations	Number of Consumers	Number of Family Members	Number of Interested Individuals Advocates, Community, Law Enforcement, Mental Health Professionals, Government, Judicial
	(continued from previous page) ▪ Sherman Police Department ▪ Grayson County Jail			
April I7, 2008—Meeting with NAMI GFC— at Behavioral Health Center in Sherman: 7:00 – 8:00 pm LPND training— Presented sections of "You Have a Voice"; distributed flyers about May 13 LPND Stakeholder Meeting. (9 Attendees)	▪ MHMRST Staff ▪ NAMI members	4	2	3
May 13, 2008—LPND Stakeholder Meeting—at Grayson County College: 10:00 a.m. – 11:30 a.m. LPND Training—Surveys 26 Attendees	▪ Child and Family Guidance Center ▪ District Attorney's Office—Grayson ▪ Other interested citizens and consumers	8	2	16
May 13, 2008—LPND Stakeholder Meeting—at Grayson County College: 6:30 p.m – 8:00 p.m. LPND Training—Surveys (8 Attendees)	▪ Texoma Medical Center ER ▪ Pregnancy Shelter—Sherman ▪ TCOG-211	0	0	8
Small group meetings with consumers—LPND Training and Surveys—	MHMRST case managers met with small groups of consumers to present information, answer questions, and distribute surveys.			

Description Date or Timeframe	Participating Organizations	Number of Consumers	Number of Family Members	Number of Interested Individuals Advocates, Community, Law Enforcement, Mental Health Professionals, Government, Judicial
May 7—Fannin Mental Health Center May 14—Grayson Mental Health Center (4 different meetings)	→	14 17		

4. Summary of Discussions and Input Received:

The Crisis Redesign Stakeholder meeting in October 2007 and the many jail and hospital focus group meetings held from January 2008 through July 2008 have been invaluable in developing and implementing the MHMRST Crisis Service Plan. Networking and improved communication with law enforcement, hospital, advocate, and judicial groups has been effective in diverting individuals from jails and hospital emergency rooms to less restrictive environments. These outcomes have been a direct result of the input from the 53 stakeholders attending the initial October meeting. The multiple Local Planning and Network Development meetings during May 2008 and the 73 LPND surveys received have provided the Center an opportunity to engage individuals in discussion, as well as opportunity to understand how consumers and other stakeholders perceive the effectiveness or ineffectiveness of different kinds of services, choice, and specific mental health concerns as they apply to individual and community needs.

- **Stakeholder Input—Crisis Response System and Services:** Individuals who attended the October meeting represented law enforcement, community, advocates, other human service agencies, school, and judicial groups. The clear purpose of the meeting was to first identify priorities relating to crisis services and the implementation of the Crisis Service Plan for FY2008 and then to identify priorities for FY2009. The process consisted of a Crisis Redesign presentation focusing on core requirements of the additional crisis funding by the state to community centers, then small group discussions to identify priorities, and then the general recap of each group's ideas. There was significant emphasis on the need for increased communication about MHMRST crisis procedures throughout the community and a need for cooperation among mental health, law enforcement, hospital emergency room, jail, and judicial groups to minimize misunderstandings and promote appropriate diversion of individuals with mental illness to less restrictive environments. There was general consensus about the need for mental health deputies but also an overall understanding of budgetary constraints; however, stakeholder groups also expressed a need for more training about mental illness for officers. High on the identified needs list was the expressed desire for a "drop-off center" in order to divert individuals from emergency rooms and jails. Families and advocates also suggested a need for greater communication with families who may not understand system procedures. See chart on page 16 for additional input.

Stakeholder Input for Crisis Services 2008—Hotline and Mobile Crisis Outreach Team

- Increase funding for training law enforcement officers.
- How to access MHMRST Hotline must be clearly understood by community and stakeholder groups.
- Need improved coordination among 211, 911, and the MHMRST Crisis Line.
- Need an annual mental health conference with community stakeholders to share information.
- Need planned coordination for referral of services including substance abuse.
- Crisis Plan must include clear guidelines for hotline response.
- Need more immediate hospitalization for suicidal individuals.
- Drop-off center needs to be centrally located to accommodate all three counties.
- Would be ideal if there could be a peace officer on the MCOT.
- Need to expand “priority population.” Too many people are not served.

Stakeholder Input for Crisis Services 2009

- Need a Crisis Intervention/Drop-off Center instead of jail or hospital—incorporate into Grayson jail.
- MCOT should have law enforcement on the team.
- Comprehensive jail diversion program is needed.

- **General Stakeholder Input—Local Planning and Network Development Meetings:** The purpose of these meetings and the surveys was to obtain input regarding service needs and priorities for children, adolescents, and adults, other significant issues or concerns, and to collect information toward the development of an external provider network. Despite sending out over 200 invitations, news articles, posting on the website, and distribution of flyers and information about LPND and the May 13 stakeholder meetings, the actual attendance of l6 and 8 individuals at these meetings was disappointing. Yet, there was a positive outcome. Discussion generated at the sparsely attended meetings allowed the Center to answer general questions reinforcing to the Center how important it is for the community to have accurate information about what MHMRST can and can not do, based on Performance Contract requirements and the availability of funding sources. The chart below contains some of stakeholder questions and concerns.

Stakeholder Input: General Questions

- Are MHMR Centers the same “across the board” for example, Dallas County and Grayson County?
- What are the criteria for getting services at MHMR?
- Will MHMR be looking for contractors to provide counseling?
- How does the crisis hotline work and how can it help the ER?
- How are MHMR psychiatrists trained?
- What services are available for the homeless?
- What is available for substance abusers?
- What is the structure of MHMR and what services are provided by the center?
- How was it decided to define the priority population as it is now?
- As a person who works with the 211 network, I have received frustrated callers that can’t get their meds because they haven’t been assessed by MHMR.

- **Service Needs and Priorities for Children, Adolescents, and Adults:** When reviewing input obtained through many meetings, including the ongoing focus group meetings with hospital ER physicians, law enforcement offices, judicial and probation groups, and advocates, some recurring needs emerge. There seems to be general consensus that crisis services need to be expanded to include mental health officers and drop-off centers in order to really implement a jail diversion program. Individuals who fall outside of the priority population are in need of intake and psychiatric medication services prior to full crisis escalation, and individuals with substance abuse issues are in need of treatment or hospitalization that the Center cannot provide. Adolescents with substance abuse issues also have specific unmet needs. Many individuals need assistance with medication costs and may not qualify for Medicaid. Affordable, safe housing, or group homes for individuals with mental illness, and specific programs for people with mental illness who are homeless are also needed.

- **Stakeholder Input—Overview of Responses from Surveys:** Of the 73 surveys received, 48 were from consumers and 25 were from individuals other than consumers. Of the responding consumers, 57% receive services in Grayson County; 38% receive services in Fannin County and only 7% in Cooke County. Of the 25 other individuals, 19% were local officials; 19% were local providers; 14% were family members; 10% were interested citizens; 5% were NAMI, and 5% were mental health professionals. It is also noteworthy that 81% of these respondents were from Grayson; 14% from Fannin and 5% from Cooke. While it is disappointing that there were not more responses from Cooke County, it is not necessarily surprising as thus far it has also been more difficult to engage Cooke in some of the jail diversion initiatives. It is anticipated that the Center will have to explore additional strategies for engaging consumers and community representatives in Cooke County.

  When analyzing the collective survey input, consumer responses were tabulated separately from non-consumer responses. It was thought that an awareness of the differences and similarities of consumer and non-consumer perspectives could be quite helpful in developing the external provider network and in considering service needs and priorities.

  - **Additional Services:** When consumers responded to the survey question asking what, if any, additional services are wanted or needed, 59% said no additional services were needed, 9% said counseling was needed. 34% felt other specific things were needed, including: transportation, better food, more vehicles, ability to see case manager every day, more staff for the ACT team, hypnosis regression therapy, and budgeting for independent family structure and living.

  - **Services That Are Most Helpful and Important:** Consumer responses to this question were varied but centered around seeing the doctor and receiving medication, rehabilitation - skills training services, and group or social activities.

  - **Satisfaction with Services:** When asked to rate satisfaction of MHMRST services, 63% of consumers said they were very satisfied; 16% said they were somewhat satisfied; 12% were neutral; 5% were somewhat unsatisfied; 5% said they were very unsatisfied.

  - **Services Negatives:** When asked whether there was anything negative or anything that made it hard to get services at MHMRST, 68% said there were no negatives; 6% said transportation and gas were problems. The 28% of other responses included: staff turnover, not knowing their current case manager, excessive paper work they are required to complete, unreturned phone calls and not knowing when their next doctor appointment is.

- **Development of an External Provider Network:** One of the most interesting differences in consumer and non-consumer responses was the question asking whether the individual would like to have a choice of providers besides the Center with 55% of consumers saying no, and 63% of non-consumers saying yes.

  - **Types of Services Most Important to Have a Choice of Providers:** Consumers and non-consumers both agreed that having a choice of providers was most important first in psychiatric doctor services and then in counseling services. Third on the consumer list was skills training, and third on the non-consumer list was crisis services. See chart below:

Types of Services Most Important to Have a Choice of Providers	
Consumer Responses	**Non-Consumer Responses**
70% Psychiatric doctor services	60% Psychiatric doctor services
57% Counseling	45% Counseling
46% Skills training	40% Crisis Services
32% Crisis Services	35% Skills training
22% Help to find and get a place to live	25% Respite services
16% Intake (1st appointment)	15% Help to find and get a place to live
11% Respite services	10% Intake (1st appointment)

  - **Important Criteria for Choosing a Provider of Services:** Survey question asked respondents to choose three most important factors in choosing a provider of services from a list. Top three factors for consumers were: convenient location to home, transportation available, and the ability to pick up medications on site: Top three factors for non-consumers were: cost of services, convenient location to home, and wait time to see the doctor. See chart below:

Important Criteria for Choosing a Provider of Services	
Consumer Responses	**Non-Consumer Responses**
65.5% Convenient location to home	55.% Cost of Services
53.5% Available transportation	45% Convenient location to home
51.2% Pick up meds on site	45% Wait time to see the doctor
27.9% Wait time to see the doctor	35% Available transportation
27.9% Cost of services	20% Cultural/ethnic diversity
23.3% Clean environment	20% Pick up meds on site
23.3% Length of appointment	20% Services in English or Spanish
16.3% Religious and spiritual values	20% Other *(Local offices preferable if financially possible)*
7.0 % Other *(Case Management—Availability of other Services)*	15% Clean environment
4.7% Services in English or Spanish	10% Religious and spiritual values
2.3% Cultural/ethnic diversity	

5. Service Delivery Needs and Priorities, Including Gaps in Service:

The primary priority of MHMRST is to assure that services to individuals in the target population continue to be provided with the same or improved level of access and quality of care. Community input and both internal and external analysis through surveys and processes referenced above show the primary service gaps to be the need for a drop-off center for individuals experiencing a mental health crisis. The drop-off center would serve as a diversion from local emergency rooms and the criminal justice system wherever feasible. Another equally important recognized gap is the absence of adequate substance abuse recovery and treatment options. These gaps create both opportunities and challenges for the coming biennium.

Previous planning initiatives by the Center's PNAC, Management Team, and Board of Trustees have also identified the following strengths, weaknesses, opportunities, and threats that will affect services over the next biennium:

Strengths:

Desire to involve families and consumers
Extensive experience in providing services in the Texoma area
Track record of reducing administrative overhead to remain viable
Proven record of ability to be adaptable and flexible
Experienced in adapting to scarce resources
No waiting list for services
Significant financial improvement during FY 07 and FY 08
Strong Board of Trustees – very committed to the center and its consumers
Proven history of collaborating with local entities (Probation Department, Sheriff's Department, local schools, etc)
Committed Planning and Network Advisory Committee (PNAC)

Weaknesses:

Under-funded for mental health services
Lack of interested or willing providers
State mandates inflate cost of services when trying to compete
Population is defined for us – we cannot choose whom to serve
No weekend hours
Very limited amount of financial reserves
Limited number of administrative staff – everyone must do "double" duty

Opportunities:

Diversify to other service areas to broaden financial "base"
Continue to educate stakeholders regarding LPND process
Seek additional grant opportunities as available

Threats:

Limitations imposed by legislation
Funding cuts
Not an equal player with private providers
Difficult to plan for the unknown
Rising gas prices and economic recession – affects entire community
Difficult to compare ourselves to other centers due to regional diversity in Texas

6. Changes over the next Biennium:

The response from the local communities to the newly developed Mobile Crisis Outreach Team has been very positive. As a result of this positive response, two additional staff positions will be added to the Mobile Team in order to expand the hours of team coverage. Other desired outcomes in the biennium are the addition of Mental Health Officers, Mental Health Courts, and a drop-off center for individuals experiencing a mental health crisis.

A. *Current Services and Providers - OVERVIEW*

Following is an overview of and rationale for the methodology used to calculate the amounts listed in the columns entitled, "Dollars Spent on Direct LMHA Services" and "Dollars Spent on External Provider Services."

As recommended by DSHS, the Texas Council of Community MHMR Centers utilized members of its various consortia to develop a consistent methodology. The basis of the methodology developed is ***cost*** for units of service. Costs (as opposed to revenues) were utilized because of their direct relationship with the services delivered. The rationale to use cost is summarized as follows – the costs are the costs, regardless of the funding source.

To utilize the methodology, MHMRST isolated the costs associated with the services already delivered under contract by External Providers. The Center conducted a detailed allocation of all costs associated with the services it provided directly, including direct costs, provider-related overhead costs and the appropriate proration of general administrative costs. As instructed by DSHS, administrative expenses associated with Authority functions were not included in the calculations. The data submitted by the Center to DSHS in response to the FY07 Cost Accounting Methodology requirement was the basis for the unit costs used in the methodology.

While the methodology used does, to the best of the Center's ability, identify the costs associated with services delivered directly by the Center in FY07 and identifies the amount of DSHS-related funding spent on External Provider services in FY07, one should not consider the former as the definitive amount of DSHS-related funding available for contracting under the LPND rule. Other factors must be considered and are discussed in later sections of this plan.

Tips for understanding the table:

1. *LMHA stands for Local Mental Health Authority = MHMR Services of Texoma*
2. An *"X" in the column labeled "LMHA" means that the Center provides the service* ***directly.*** *The second column identifies the Center's direct service expenditures for the service in FY 2007.*
3. *If the service is provided (in whole or in part) through contract with an external provider, the name and address of the external provider and the Center's expenditures for the external provider contracted services in FY 2007 is noted.*
4. *If the service is not provided, N/A is noted*
5. *An "external provider" is any organization <u>other</u> than the Center or any individual who is <u>not</u> an employee of the Center.*

DSHS-Funded Services

Service Type	LMHA	Dollars Spent on Direct LMHA Services	External Provider* (Name/address)	Dollars Spent on External Provider Services	External Provider Contract Start and End Dates
ROUTINE SERVICES					
Intake (Screening, Pre-admission Assessment)	X	$115,307	Avail Solutions 4455 S.P.I.D. Suite 44B Corpus Christi, TX 78466	$26,402	09/01/2006 – 08/31/2007
Routine Case Management (Adult)	X	$180,663	N/A	N/A	N/A
Routine Case Management (Child/ Adolescent)	X	$16,953	N/A	N/A	N/A
Respite Services		Although this service is available, the costs for FY06 are reflected in "crisis respite" below			
Supplemental Nursing Services	X	$24,210			
Pharmacological Management	X	$310,821	Dr. Gleason 140 W. Lamberth, Ste. 300 Sherman, TX 75092	$7,038	09/01/2006 – 08/31/2007
Provision of medication		$213,638	US Script, Inc 5500 E Loop 820 South Fort Worth, TX 76119	$377,023	09/01/2006 – 08/31/2007

Service Type	LMHA	Dollars Spent on Direct LMHA Services	External Provider* (Name/address)	Dollars Spent on External Provider Services	External Provider Contract Start and End Dates
Psychiatric evaluation	X	$4,615			
All Rehabilitation Services (Adult)	X	$263,549			
All Rehabilitation Services (Child/Adolescent)	X	$7,072			
Supported Employment	N/A*	This service is provided as a part of rehab services and the costs are not separated out			
Supportive Housing	N/A*	This service is provided as a part of rehab services and the costs are not separated out			
Assertive Community Treatment	X	$118,162			
Residential Treatment			The Wood Group, Inc 3610 Barnett Rd. Wichita Falls, TX 76310	$63,835	1/1/2007 – 08/31/2007
Intensive Case Management (Child/Adolescent)	X	$24,292	N/A	N/A	N/A
Counseling (Adult)	X	$10,820			
Counseling (Child/Adolescent)	X	$3,020			
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)			Charles “Don” Moore 201 Knight Road Whitesboro, TX 76273 Pat Owens 202 N. Willow St. Sherman, TX 75090	$1,006 $1,323	6/11/2007 – 08/31/2007 09/01/2006 – 05/31/2007
Flexible Community Support (Child/Adolescent)	X				
Multi-Systemic Therapy (Child/Adolescent)	N/A				

Service Type	LMHA	Dollars Spent on Direct LMHA Services	External Provider* (Name/address)	Dollars Spent on External Provider Services	External Provider Contract Start and End Dates
Consumer Peer Support	N/A				
CRISIS & OTHER DISCRETE SERVICES					
Hotline			See above under “intake” – Avail Solutions		
Crisis Intervention Services	X	$45,895			
Mobile Crisis Outreach Team	X	*This service was not provided in FY06, but has been added in FY08*			
Extended Observation	N/A				
Day Program for Acute Needs	N/A				
Crisis Stabilization Unit	N/A				
Respite Services	X	*This cost is combined above with Residential Services*			
Inpatient Hospital Services			Texoma Medical Center – Behavioral Health Center 2601 Cornerstone Sherman, TX 75090 Community Specialty Hospital 1111 Gallagher Dr. Sherman, TX 75090	$140,756 $30,775	09/01/2006 – 11/30/2006 12/06/2006 – 08/31/2007
Crisis Residential Treatment Services			The Wood Group, Inc 3610 Barnett Rd. Wichita Falls, TX 76310	$77,566	1/1/2007 – 08/31/2007
Safety Monitoring	X	*This service was not provided in FY06, but has been added in FY08*			

Service Type	**LMHA**	**Dollars Spent on Direct LMHA Services**	**External Provider* (Name/address)**	**Dollars Spent on External Provider Services**	**External Provider Contract Start and End Dates**
Crisis Follow-Up and Relapse Prevention	X	*This service was not provided in FY06, but has been added in FY08*			
Crisis Transportation	X	*This service was not provided in FY06, but has been added in FY08*			
Crisis Flexible Benefits	X	*This service was not provided in FY06, but has been added in FY08*			
Laboratory Services			Clinical Pathology Lab 9200 Wall St. Austin, TX 78754 North Texas Medical Center 1900 Hospital Blvd. Gainesville, TX 76240 Red River Hospital PO Box 841308 Dallas, TX 75284	$23,120 $3,661 $8,790	09/01/2006 – 08/31/2007 09/01/2006 – 08/31/2007 09/01/2006 – 08/31/2007

C. Provider Network Development

1. Provider Availability

In order to determine the viability of expanding the Center's network of external providers, MHMR Services of Texoma completed an analysis to assess the level of provider availability. The analysis included:

1. Contacting current providers
2. Consulting business directories
3. Searching the internet (including the Department of State Health Services website for Local Planning), and
4. Reviewing the 2004 Provider of Last Resort Plan/Request for Information

In April 2004, the Center completed a Request for Information (RFI) process which was developed and initiated as a means of determining interest in a comprehensive treatment network for people with mental illness and mental retardation. Respondents were asked to provide information on various service packages and include any topics or question the respondent or any other interested parties believed important to address in any future Request for Proposal (RFP.) The RFI document included a geographic description of the local service area, thus giving the respondents the opportunity to indicate the preference to serve the entire local service area or a portion thereof. This process resulted in five respondents to the adult MH services portion of the RFI and one respondent to the child and adolescent portion of the RFI. Of the five respondents for adult mental health, the center currently contracts with two of the respondents. One of the other respondents was a local counseling organization, one respondent was located in Dallas and one respondent was located in Austin. The local counseling organization also expressed interest in providing child and adolescent mental health services.

The only other known interested parties at this time are those listed on the Department of State Health Services Local Planning website. The two providers are Sunwest Behavioral Health Organization located in El Paso, Texas and The Wood Group based in Wichita Falls, Texas. The center currently already has a contract with The Wood Group for crisis respite, crisis residential services, and a small amount of rehabilitative services under arrangement. The Center expects to continue this contractual arrangement with The Wood Group. Additional services previously procured through RFP processes that are currently being provided are: crisis hotline services with Avail Solutions, closed-door pharmaceutical services with US Scripts, Inc., and inpatient psychiatric services with Texoma Medical Center - Behavioral Healthcare Center and its associated private psychiatrists. The Center expects to continue these contractual arrangements.

2. Provider Inquiries within the last two years

Date of Inquiry	Summary of Inquiry	LMHA Response
10/18/2007	National Extended Care Networks sent an e-mail requesting to be added to an e-mail or mail-out list to be notified when an RFP becomes available.	Informed the provider that they would be notified of any future RFP opportunity.

3. Service Capacity and Procurement

Tips for understanding the table:

a) *Column 3a reflects the Center's current service capacity (for a one-year period) using data from the LPND Web page [http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/default.shtm]. If the service is not currently provided, "N/A" is noted.*
b) *Column 3b reflects the projected service capacity.*
c) *Column 3c identifies any current or potential external providers.*
d) *Column 3d reflects if the Center will attempt to procure each service package/service during FY 2009 - 2010.*
e) *If a service will be procured, column 3e reflects the capacity to be procured during FY 2009 -2010.*
f) *If a service will be procured, column 3f reflects the method of procurement, e.g. request for proposal (RFP) or open enrollment.*

Service	3a Current Capacity	3b Projected Capacity	3c Availability of Current and Potential External Providers	3d Procurement Planned?	3e Capacity to be Procured	3f Method of Procurement
ADULT SERVICES						
RDM SP 1	641	641	The Wood Group, projected capacity = 200 Sunwest Behavioral Health, projected capacity = 100	Yes	100%	RFP
RDM SP 2	16	16	The Wood Group, projected capacity = 25 Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 3	108	108	The Wood Group, projected capacity = 100 Sunwest Behavioral Health, projected capacity = 300	Yes	100%	RFP
RDM SP 4	25	25	The Wood Group,	Yes	100%	RFP

Service	3a Current Capacity	3b Projected Capacity	3c Availability of Current and Potential External Providers	3d Procurement Planned?	3e Capacity to be Procured	3f Method of Procurement
			projected capacity = 50 Sunwest Behavioral Health, projected capacity = 150			
RDM SP 0	20	20	Sunwest Behavioral Health, projected capacity = 200	No	0%	N/A
RDM SP 5	10	10	Sunwest Behavioral Health, projected capacity = 200	No	0%	N/A
CHILD/ADOLESCENT SERVICES						
RDM SP 1.1	37	37	Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 1.2	6	6	Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 2.1	N/A	N/A		Yes	100%	RFP
RDM SP 2.2	3	3	Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 2.3	3	3	Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 2.4	6	7	Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 4	21	21	Sunwest Behavioral Health, projected capacity = 50	Yes	100%	RFP
RDM SP 0	4	4	Sunwest Behavioral Health, projected capacity = 50	No	0%	N/A
RDM SP 5	0	10	Sunwest Behavioral Health, projected capacity = 100	No	0%	N/A
CRISIS SERVICES						
Crisis Hotline	63*	75				
Mobile Crisis Outreach Team	79*	100				
Extended Observation	0	0				

Service	3a Current Capacity	3b Projected Capacity	3c Availability of Current and Potential External Providers	3d Procurement Planned?	3e Capacity to be Procured	3f Method of Procurement
Day Program for Acute Needs	0	0	The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began in March 2008. The development of local crisis services occurred using the planning and procurement requirements that existed at that time. The efforts related to crisis services are not subject to the new Local Planning and Network Development rules for the FY09-FY10 biennium. The Center does intend to continue contracting with Avail Solutions for Crisis Hotline services and with The Wood Group for Crisis Respite and Crisis Residential Services. * Since these services were not provided/counted separately in FY2007, May 2008 data was used to provide an estimate.			
Crisis Stabilization Unit	0	0				
Respite	0	0				
Crisis Residential Treatment Services	10 beds/day	10 beds/day				
Safety Monitoring	5*	10				
Crisis Follow-Up and Relapse Prevention	5*	10				
Crisis Transportation	0	0				
Crisis Flexible Benefits	1*	1				
OTHER DISCRETE SERVICES						
Laboratory Services			If a provider is located for the adult or child and adolescent RDM service packages, the provider will be expected to procure a contract for laboratory services and provide these benefits as part of the service package(s)			
Pharmacy Services			If a provider is located for the adult or child and adolescent RDM service packages, the provider will be expected to procure a contract for pharmacy services and provide these benefits as part of the service package(s)			
Inpatient/Hospital Services	10 bed days/month	10 bed days/month	The Center has already issued an open enrollment for inpatient services (in Fall 2007) and currently contracts out 100% of this service. These contractual arrangements will be continued for the upcoming biennium.			

4. Justification for procurement of discrete services

Discrete Service to be Procured	Rationale
N/A	The Center does not intend to procure any discrete services at this time.

Plan for Fidelity and Continuity of Care
Fidelity to the Resiliency and Disease Management (RDM) model is accomplished over time and through training, supervision, and continuous reassessment. In order to insure that the consumers receive the necessary services within the designated service packages, providers will be required to attend specified quarterly meetings, staffing, and/or training programs. The providers will be notified by the Center of any such meeting or training program or staffing at least 15 days prior to the meeting date. In addition to the meetings and trainings, the providers shall be subject to on-site audits, desk reviews, provider assessments, surveys, profiling, and credentialing as well as compliance with all applicable federal and state laws. The frequency of these reviews will be specified in the Center's Quality Management Plan. The Center will continue to provide Routine and Intensive Case Management since centers are prohibited to contract this service in accordance with the State's Medicaid Case Management Plan. These case managers will work to insure continuity of care by monitoring services provided by external providers. They shall be responsible for insuring individuals are receiving services from within the designated service package that are appropriate to their level of need.

5. Rationale for Keeping Services

According to the Rule, the rationale for the decision to continue providing services at any level for any of the services listed above must be based on:

- A determination that the current network of external providers serves 100 percent of the service capacity and meets levels of consumer choice and access specified in 25 TAC §412.758(a)(2) and (3)
- OR one of the following conditions (Refer to the Appendix for complete language as specified in 25 TAC §412.758):
  1. *Willing and qualified providers are not available.*
  2. *The external network does not provide minimum levels of consumer choice.*
  3. *The external network does not provide equivalent access to services.*
  4. *The external network does not provide sufficient capacity.*
  5. *Critical infrastructure must be preserved.*
  6. *Existing agreements restrict procurement or existing circumstances would result in substantial revenue loss.*

The table below reflects that the Center does not plan to continue providing services at any level, except for crisis services which are not required to be contracted out during this first two year planning cycle.

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
ADULT SERVICES					
RDM SP 1	0%		The Center will continue to provide only Routine Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 2	0%		The Center will continue to provide only Routine Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 3	0%				
RDM SP 4	0%				
RDM SP 0	100%	6	Crisis services are not required to be included in this first two year planning cycle. The Center will continue to provide these services at this time.		The Center has been working diligently with elected officials and law enforcement from the three counties to develop a strong jail and ER diversion program. It would undermine this process to contract with a private provider for crisis services at this time.
RDM SP 5	100%	6	Crisis services are not required to be included in this first two year planning cycle. The Center will continue to provide these services at this time.		The Center has been working diligently with elected officials and law enforcement from the three counties to develop a strong jail and ER diversion program. It would undermine this process to contract with a private provider for crisis services at this time.

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
CHILD/ADOLESCENT SERVICES					
RDM SP 1.1	0%		The Center will continue to provide only Routine Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 1.2	0%		The Center will continue to provide only Routine Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 2.1	0%		The Center will continue to provide only Intensive Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 2.2	0%		The Center will continue to provide only Intensive Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 2.3	0%		The Center will continue to provide only Intensive Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will		

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
			coordinate and oversee the provision of the other services within the service package.		
RDM SP 2.4	0%		The Center will continue to provide only Intensive Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 4	0%		The Center will continue to provide only Routine Case Management as centers are prohibited from contracting this service due to the provisions of the State's Medicaid Case Management Plan. Case Managers will coordinate and oversee the provision of the other services within the service package.		
RDM SP 0	100%	6	Crisis services are not required to be included in this first two year planning cycle. The Center will continue to provide these services at this time.		The Center has been working diligently with elected officials and law enforcement from the three counties to develop a strong jail and ER diversion program. It would undermine this process to contract with a private provider for crisis services at this time.
RDM SP 5	100%	6	Crisis services are not required to be included in this first two year planning cycle. The Center will continue to provide these services at this time.		The Center has been working diligently with elected officials and law enforcement from the three counties to develop a strong jail and ER diversion program. It would undermine this process to contract with a private provider for crisis services at this time.
CRISIS & OTHER DISCRETE SERVICES					
Crisis Hotline	0%				
Mobile Crisis Outreach Team	100%				

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
Extended Observation	N/A	The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began in March, 2008. The development of local crisis services occurred using the planning and procurement requirements that existed at that time. The efforts related to crisis services are not subject to the new Local Planning and Network Development rules for the FY09-FY10 biennium. The Center does intend to continue contracting with Avail Solutions for Crisis Hotline services and with The Wood Group for Crisis Respite and Crisis Residential Services.			
Day Program for Acute Needs	N/A				
Crisis Stabilization Unit	N/A				
Crisis Respite Services	0%				
Crisis Residential Treatment Services	0%				
Safety Monitoring	100%				
Crisis Follow-Up and Relapse Prevention	100%				
Crisis Transportation	100%				
Crisis Flexible Benefits	100%				
Laboratory Services	0%		These services are already contracted out		
Inpatient Services	0%		These services are already contracted out		

6. Structure of Procurement(s)

The table below reflects how procurement will be structured and provides a rationale. It also identifies the geographic area to be covered by any potential external provider. At this time, it will not be permissible for an external provider to contract for services in only a portion of the service area, because this would diminish consumer choice and access.

Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
Adult SP 1-4	Cooke, Grayson and Fannin Counties – Provider will be required to serve all three counties since clients can currently receive services in each of the counties. It would reduce client choice if they had to travel to another county to receive services they can currently	MHMR Services of Texoma is a small center with a fairly small geographic area (3 counties) and a small client population. The total population served is small enough that fragmenting the service packages would not be financially viable. If the service packages were fragmented, the Center would have to essentially run dual systems. For example, the external provider would have to have a psychiatrist and the Center would have to maintain a psychiatrist to continue services for the percentage of clients that the Center would continue to serve. This

Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
	obtain in their county of residence.	would basically double the cost of this service because the psychiatrist salary would remain static while the number of clients to be served by the Center would be reduced. If the service packages were split and the Center continued to provide any percentage of the services, it would be virtually impossible to maintain viability due to the cost of running dual systems.
C&A SP 1.1 - 4	Cooke, Grayson and Fannin Counties – Provider will be required to serve all three counties since clients can currently receive services in each of the counties. It would reduce client choice if they had to travel to another county to receive services they can currently obtain in their county of residence.	The Child and Adolescent program of the Center is very small (less than 80 clients at any given time.) It would not be financially viable to split the children's service packages and maintain the internal cost as well as pay an external provider.

7. Choice and Access

The Center agrees that maximizing choice for the consumers served is the primary goal of this Plan. Therefore, the Center plans to contract with at least two private providers. Once consumers are determined to be eligible for services, they will be given information about the providers that are available to them. This information (pamphlets, brochures, etc) will be obtained from the providers at the time that the contract is established and copies of the information will be maintained by the center so it can be provided to the consumers in an unbiased manner. The Center wants to insure that consumers continue to have the same access to services that is available currently. This means that in order to be considered for a contract, the provider must adhere to the following requirements:

- Service hours must be the same if not greater than what the Center currently has. The Center is currently open from 8:00 AM to 5:00 PM, Monday through Friday.
- One clinic (a physical location) must be open during the above hours in each of the following cities: Bonham, Sherman, and Gainesville.
- A psychiatrist must be available at least one day a week in each of the three counties so the consumers do not have to travel to receive pharmacological management services.
- Medications and laboratory services must be available within each of the three counties.

8. Single Provider

The following chart depicts which services will be provided by a single provider as well as any economic factors which prevent the LMHA from offering consumers a choice.

Service to be Provided by a Single Provider	Economic Factors Preventing Consumer Choice
Routine and Intensive Case Management	Only the LMHA may provide this service, per requirements of the State's Case Management Plan.
Crisis Hotline Services	Only one provider is necessary to efficiently provide this service. The Center plans to continue its contractual arrangement with Avail Solutions for this service.
Crisis Respite and Crisis Residential Services	The Center cannot afford to contract for more than 10 crisis respite/residential beds on a daily basis. It would not be financially viable for more than one provider to provide that number of beds. It also would not be practical to offer a choice to consumers while they are in the midst of a psychiatric crisis. The Center intends to continue its' contractual arrangement with The Wood Group for these services.

9. Diversity

It is the position of the Center that all individuals receiving services have the opportunity to communicate effectively with providers, regardless of their cultural background or language spoken. The Center encourages full participation for all consumers and their families. It strives to ensure that individuals receive effective, understandable, and respectful care from its internal staff and from its contracted providers. Bilingual staff receive additional incentive pay to assist with interpretation as needed. However, it is sometimes difficult to recruit bilingual staff so the Center has a contract in place for interpreter services as needed. Overall, in developing a network of providers, the Center desires to maintain one that meets the needs of the local community, improves access to treatment by minorities, reduces disparities in treatment and improves quality of care. External providers will be required in the RFP process to specify how they plan to provide interpreter services and how they will meet the needs presented by the cultural diversity of the individuals served.

10. Cost Efficiency

During Fiscal Year 2006, the Center experienced some significant financial losses. As a result, the management team developed an extensive plan to reduce administrative overhead. Several positions were eliminated/re-structured and the overhead costs were reduced by 8.3%. This is a fairly significant reduction considering the small size of the Center. At this point, all administrative staff "wear several hats" in an effort to reduce overhead costs. For example, there is only one clerical (support) position to support the Executive Director and all other administrative staff. There is one clerk for both accounts payable and accounts receivable. The Utilization Coordinator doubles as the Medicaid Administrative Claiming coordinator and the Rights Protection Officer doubles as a Quality Management Specialist. The Staff Development Coordinator serves as the liaison to the PNAC. The Chief Financial Officer

serves as the Center's Human Resource Officer and the Chief Operations Officer oversees data management, authority functions and provider services.

The Center is also a member of the North Central Texas Coalition. The North Central Texas Coalition is a group of six centers in the northern portion of Texas. The Coalition continuously looks for purchasing and procurement opportunities. The Coalition has continuously shared information regarding systems operations in an effort to assure that each center operates as efficiently as possible through recognition and use of best practices. On many occasions, the Coalition has shared staffing resources for special projects. The group also meets regularly with representatives of the North Texas State Hospital to assure consistent communications and continuity of client services. Four of the centers (including MHMRST) share a Medical Director. This collaborative initiative has resulted in cost savings, assured consistency in medical practice across the centers, and provided exceptional oversight from a psychiatrist who stays engaged in state level activities and current on medical issues. The Coalition has also researched numerous methods of bulk purchasing and procurement opportunities. Unfortunately, these endeavors have not led to collective or individual center cost savings. The Coalition will continue to seek new opportunities for cost savings and resource sharing.

11. Previous Efforts to Develop a Provider Network

Section IV, C, 1) of this document provides specific information regarding the Center's FY 2004 state directed initiative to determine the presence of existing providers for potential contracts and expansion of its service provider base. However, the Center had established an intent and planning processes for network expansion and provider choice long before that requirement was issued. With the passage of House Bill (HB) 2377 in 1999, which provided clarity to both Mental Health and Mental Retardation Authorities for their role as agents in seeking best value in the use of public funds, the Center established its "Network Advisory Committee" and began in earnest to have it review existing services in consideration for future contracts with external providers. Following establishment of HB 2377, the Center began recognizing its responsibility for expanding the network of local providers in its local planning processes, incorporating in its vision statements forward-looking language such as, "engaging in individual treatment planning, coordination, and management of services and activities that demonstrate regard for choice while improving levels of functioning" and "promoting a network of providers that demonstrate good cost management while providing effective service outcomes."

In recognition of HB 2377, the Center began re-configuring its operations to more clearly distinguish its Authority functions and provider services. A tacit expectation imbedded in HB 2377 was that community mental health and mental retardation centers would eventually have to choose to either be an "Authority" that provided coordination and oversight for a network of providers, or be a provider among other providers. This legislation, and other legislation subsequent to it, created a lack of certainty regarding the future role of centers.

The next legislative session created a law that required a statewide committee to determine the geographic areas for a greatly reduced number of Authorities with which community centers would contract. This law created a definite expectation that centers would exclusively be providers of service, likely in competition with private providers. The Committee was unable to make the determination required by legislation, resulting in a stalemate with the only tangible outcome being a determination that centers should seek affiliation and mergers where it made sense to local constituents. The Center did not abandon its commitment, during

this period of uncertainty, to seek best value in services through contracting where possible. However, the Network Advisory Committee discontinued its intensive review of services with an expectation that it would ultimately be a publicly governed provider of services in competition with private providers.

In the 78th Legislative session, covering the fiscal years of 2003 and 2004, the Center again began to focus its attention on development of a firm Authority system as a result of passage of HB 2292. HB 2292 clearly stated that centers were to become "providers of last resort." With approval provided through the state's Performance Contracts, the Center merged its Network Advisory Committee with its co-existing citizen/advocate advisory and planning committee, forming a new one referred to as the Planning and Network Advisory Committee (PNAC). It was understood that the Committee would play a vital role in guiding the Center in developing its Authority structure and issuing contracts with service providers.

While HB 2292 directed centers to re-shape themselves to become providers of service only in the absence of other qualified providers, there continued to be uncertainty during the following two year period regarding status of centers as Authorities and/or providers. The author of HB 2292 stated that he had not meant "provider of last resort" status to be applied to mental health services. Still, the law had been written without specification of application to either mental retardation or mental health services. The next legislative session provided additional lack of certainty regarding the future status of the centers. HB 2572, which would have essentially maintained centers under their current methods of operation with a continued expectation for seeking best value and expansion of local provider choice, received almost unanimous vote of approval from the full Legislature. The bill was vetoed, and an Executive Order was issued for centers to continue to move forward with plans to become a "provider of last resort." While the Executive Order was certain in its expectation for centers, uncertainty existed in respect to applicability of the actual law to mental health services. An Attorney General's Office opinion was requested. Also during this time period, the state recognized the complexity and controversy related to converting centers to function exclusively as Authorities and appointed a committee to negotiate a rule for directing implementation of the requirement. The Attorney General's Office affirmed the relevance of the law to mental health services. However, the rule negotiating committee yielded a state supported opinion that mental retardation services would not be held to the "provider of last resort" provision if all centers limited future growth in their Medicaid waiver supported programs. At the same time, the Committee laid out the initial roadmap for implementation of the "provider of last resort" provision for mental health services.

The 80th Legislative Session passed HB 2479. This legislation supported codification of "provider of last resort," but added provisions to assure that centers remain financially solvent to perform their Authority functions, prevent contracting of services that result in diminished treatment access and quality of care, and required that each establish a plan for maintaining a "safety net" in the event external providers should fail in their delivery of services.

During the protracted period of uncertainty described above, the Center's PNAC has remained active. It has provided oversight and recommendations to the Board of Trustees for implementation of new program activities, it has extended guidance for new contracts with external providers, and continued its oversight of the Local Plan development process.

It should be recognized that the Center, with the support of its PNAC and Board of Trustees, has continued to seek best value over the years. During the past decade it has issued requests for proposals, on two occasions, for pharmaceutical services. It

periodically reviews its medication costs against those reported by other centers, and it has consistently materialized a cost that is among the lowest in the state. The Center has also researched the prospect of joining two different coalitions of centers that operate their own pharmacies, but has determined that the cost of medications would be equal to or above that which it consistently experienced. Over the past three years, the Center has negotiated contracts with different psychiatric hospitals, resulting in reduced costs for in-patient psychiatric treatment. It now offers open enrollment to any area hospital that accepts its payment rate and utilization management requirements. The Center has also historically maintained external provider contracts with psychiatrists, laboratories, and telephone crisis screening and referral services. Approximately one and one-half years ago the Center entered, through response to a Request for Proposals (RFP) it issued, a contract with a private provider to operate its crisis respite services.

As previously indicated, the Center expects to offer Requests for Proposals for 100% of its services, exclusive of Routine/Intensive Case Management and crisis services. The reasoning for this complete offer of services is that the Center is small enough that it makes little economic sense to divide its client population by service packages or between counties. In offering most of its services for contract, it will be necessary that the Center retain adequate funding to meet the HB 2479 implied requirements for strengthening its infrastructure to provide adequate Authority oversight and to meet the stated requirement for maintaining a safety net.

12. Barriers to Attracting Providers

Describe any encountered or anticipated barriers to attracting external providers and discuss specific plans to address each identified barrier.

Barriers	**Plans**
Rates not attractive to external providers	Continue to support legislation and lobbying efforts to improve funding
Providers reluctant to meet DSHS Contract Requirements	Continue to work with DSHS through the Texas Council of Community MHMR Centers to streamline regulations and simplify contract reporting requirements
Although the Center is thought to be the right size for effective and cost efficient management of services, it is possible that the client population will be too small to attract external providers.	Attempt to secure providers through procurement advertisements in the Dallas/Fort Worth Metroplex areas.
Limited number of providers. Only two are known to have an expressed interest in providing services in all areas of the state, and it is expected that at least one will have to concentrate on selected areas of the state; thus narrowing the prospect for two providers to meet the requirement for client choice.	Assure that both of the interested providers receive a Request for Proposal document without regard for a special request from them.
Only small practice external providers are present in the Center's service area. Thus, experience in the full spectrum of service delivery requirements and Resiliency and Disease Management (RDM) is extremely limited.	Attempt to secure providers through procurement advertisements in the Dallas/Fort Worth Metroplex areas. Also provide protracted training and service transfer time to small providers who lack experience but who are judged by the PNAC and Board to have the financial resources to assure solvency, ability to recruit staff with needed clinical skills, and the ability to meet technological data and billing requirements.

13. Attraction of Providers

There are several environmental conditions that may negatively affect attraction of providers to the Texoma area:

- Limited business opportunities
- Growth in recent years has been primarily “commuter” population (people who live in Texoma area, but they commute to other cities for employment
- Very limited public transportation
- Lack of diverse cultural events
- Limited recreational activities for youth and families

14. Long Term Planning

The Center, including its PNAC and Board of Trustees, is committed to continued local planning that expands the provider base under its Authority and to offering additional choice among providers for individuals served with a hoped-for increase in access to a broader array of services. The PNAC has been diligent in its pursuit of stakeholder input as it makes recommendations to the Board regarding future developments in a new environment for delivering and managing services. Through its deliberations, the PNAC has recognized a need to show regard for a delicate balance as it attempts to assure a strong Authority while expanding the provider base in the Center’s service area. Given the complexity of achieving both outcomes, the PNAC believes that it is important that the Center move forward as rapidly as possible in pursuit of providers to accomplish the ultimate intent of the LPND statute and Executive Order; that intent being the establishment of a strong Authority for oversight of most provider services currently under contract from the Department of State Health Services.

Three primary factors are influencing the Center’s decision to seek providers for 100% of its treatment service, exclusive of Routine Case Management and crisis services, in communities currently served by the Center. Those factors are:

1) The relatively small size of the client population offers limited potential when considering the distribution of finite income potential across multiple providers. Although the Resiliency and Disease Management (RDM) service packages, delivered as a whole, offer potential for adequate revenue generation to assure financial solvency for more than one service provider, contracting discrete service packages or any portion thereof, will offer limited revenue potential when split between two or more providers. With the Center’s relative small client population, movement of individuals between service packages and lack of the ability to guarantee a fixed number of service recipients, it will be difficult for providers to rely on a consistent level of income. Also, the revenue potential of each service package must be considered relative to a need for adequate funding of the Center’s infrastructure. Contracting the higher service packages would leave the Center with an inordinate cost for providing Service Package (SP)1 treatment, thus severely impairing its ability to earn revenue over expenditures. Doing so would result in a fund balance reduction which would obstruct its ability to fulfill the Executive Order and HB 2479 responsibility for assuring an infrastructure to provide Authority oversight of the network while maintaining a “safety net” for recovery of services and client continuity of care in the event a provider fails. Conversely, contracting only

SP-1 would shift a cost burden to private providers that would lessen the likelihood of their successful performance. Also, contracting only SP-1 would necessitate the movement of all psychiatric and medication clinic operations, creating substantially increased complexity and cost relative to coordinating services for individuals in other service packages.

2) To operate effectively as an Authority, the Center must be in a position to increase its fund balance. Although the Center had once enjoyed a history of financial solvency as a result of prudent business practices (often holding over 60 days of liquid capital in reserves); adjustment to RDM and one year of unanticipated and untoward events essentially depleted its reserves. The adverse circumstances affecting the Center's fund balance have been corrected and staff productivity is rapidly improving its financial disposition. The Center must continue to increase its reserve if it is to carry out the expectations of Local Planning and Network Development. Fragmenting its services packages between at least two providers would create data processing and oversight issues, resulting in additional costs and increased uncertainty that detract from an imperative to increase the Center's fund balance to assure adequate fulfillment of its Authority functions. Contracting all services will allow the Center to focus its staff resources on providing effective Authority supports and network management while retaining sufficient funding, through case rate-based contracts, to both fulfill its Authority responsibilities and build financial reserves to an acceptable level.

3) Again, considering the relative small size of the Center's client population, dividing caseloads between its three counties would create low revenue expectations for appealing to at least two providers in each county. Separating the counties, with a prospect for the Center having to continue to serve individuals in one or more, would increase the complexity and cost of treatment. Providers could gain an economy of scale by eliminating some treatment sites in the communities in which the Center currently operates clinics. Doing so would, however, run contrary to the state expectation that consumer access not be adversely affected. Eliminating points of service entry and treatment would also be met with severe political backlash.

As the PNAC guides the Center through its pursuit of contracts for an extensive array of services, it recognizes that staff will be called upon to assure that the transition of services takes place with minimal risk to continuity of service for the individuals receiving treatment, while at the same time building an Authority infrastructure that is capable of responding to potential lack of adequate provider performance and assuring that no individual is injured during a period of re-adjustment in the provision of services. Additionally, it is recognized the "up front" transition of services will require detailed attention to the transfer of client diagnostic and treatment information, expansion of quality management and standards compliance capability, integration of data and billing information systems, training of providers relative to a host of state and federal regulations, and many other responsibilities related to assuring successful provider performance.

It is expected that some potential providers may be able to fairly rapidly develop systems for meeting compliance standards and transferring clients, while others will require more time and attention. In review of responses to an RFP, the PNAC will be actively involved in determining the financial, clinical and technological capability of potential providers to perform. It will accordingly make recommendations to the Board of Trustees for offering contracts to providers. Realizing that some providers may have the potential for effectively providing services, but will require more attention in areas of training and systems development, the schedule for transfer of services will be subject to revision.

It is recognized that the Center must give a great deal of attention to strengthening its Authority infrastructure to assure adequate oversight of the network and success of its providers. This will require additional human resources and a continuing contribution to the Center's fund balance up to a fiscally sound level. As mentioned earlier in this document, the Center has managed its business affairs by streamlining its administrative services to the greatest extent thought possible. Some additional administrative support will be needed to manage the expanded set of data and billing responsibilities that will accompany contracting with multiple providers. Even more important will be a need to assure standards compliance and delivery of quality services. Additional quality management staff will be needed for this purpose. Adequate quality management staffing will be especially important during the initial phase of transition when a great deal of systems development assistance will be needed by providers. For this reason, the Center will initially retain approximately 75% of its current mental health case management staff to carry out Routine Case Management activities and provide a sufficient number of quality management specialists to assure effective delivery of services. It will be necessary that payment rates established for providers be at a level that will allow the Center to retain adequate revenue for the successful transition of services to providers, insure continuation of those services, and create an improved Authority financial reserve. It is expected that, following the successful transfer of services, the need for quality management specialists will be reduced and rates will be adjusted upward.

The Center's PNAC and Board of Trustees are genuinely committed to the intent of the compelling statutes and directives that are seeking an expanded network and increased provider choice for service recipients. They realize, however, that achieving the necessary goals of creating an improved financial disposition while expanding systems for quality control and safety net capability may require that initial payment rates be set at a level that will not be attractive to providers. In the event that the Center does not secure providers during its first round of RFP offers, it will look toward a more sound reserve in FY 2011 and FY 2012 that will allow greater risks to be taken, partial service packages or treatment activities to be offered, and higher rates to be provided.

D. Procurement and Transition Timelines

The table below reflects the timeline for potential development of a provider network.

Date	Key Activities and Milestones
03/01/08 – 08/31/08	Development of Local Planning and Network Development Template for mental health services
09/01/08 – 11/01/08	DSHS LPND Template Approval
11/01/08 – 12/31/08	Develop draft procurement document – Request for Proposal (RFP)
01/05/09 – 01/20/09	Publicize draft procurement (RFP) document (Public comment period – 14 day minimum)
01/21/09 – 02/20/09	Timeframe for LMHA to consider all public comment and revise procurement (RFP) document
02/28/09	Publication of final Request for Proposal
03/13/09	Due date for RFP responses
03/14/09 – 04/30/09	Review of responses by Planning and Network Advisory Committee
05/27/09	Review of PNAC recommendations by Board of Trustees, authorization of contracts if appropriate
06/01/09	Award date
09/01/09	Start date of services for external providers

An important part of the development of an external provider network is that it expands choices available to consumers. The following table identifies the specific steps for the selection of providers by consumers and the timelines for transitioning consumers to new providers. The steps listed are “model” steps; additional steps may be initiated after the external providers are identified.

Steps	Time Frames For Completion
Develop a provider list	06/01/09
Verify provider information	06/15/09
Post Provider list to website and distribute to consumer and advocacy groups	06/15/09
Conduct provider forums to allow providers to share information with consumers, LARs, and other stakeholders.	07/01/09
Develop internal procedures and forms for consumer selection of providers	07/31/09
Develop consumer information materials relating to selection of providers	07/31/09
Train internal staff on consumer selection procedures	07/31/09
Ensure external providers are trained on consumer selection requirements and procedures	07/31/09
Implement provider selection procedures for new intakes	08/01/09
Implement provider selection procedures for current clients (in conjunction with treatment plan reviews)	08/31/09
Develop and implement continuity of care plans for transitioning individual clients to new providers	08/31/09

Consumer transition complete	11/30/09

For each service or service package to be procured, the Center estimated the amount of time needed to re-establish the service volume lost if a contract must be terminated. (NOTE: The estimated timeframe may be used as the minimum notice to be given prior to terminating an external provider contract for non-compliance.)

Service	**Time Needed to Re-establish Service Volume**
Adult SP 1 - 4	The Center anticipates that it will take 45 days to resume service delivery if the external provider should not be able to continue for any reason. The Center plans to retain approximately 75% of its current QMHP staff to provide case management services and serve as utilization management coordinators for the external contracts. This number of retained staff may be reduced and rates changed subject to successful performance of providers. If an external provider could no longer provide the services, the retained Center staff would resume their Rehabilitative Case Manager roles and a Locum Tenens Agency would be used for psychiatrist and nursing coverage until replacement staff can be employed. The intake/triage staff would resume the counseling service for Service Package 2.
C&A SP 1.1 - 4	The Center anticipates that it will take 45 days to resume service delivery if the external provider should not be able to continue for any reason. The Center plans to retain approximately 75% of its current QMHP staff to provide case management services and serve as utilization management coordinators for the external contracts. This number of retained staff may be reduced and rates changed subject to successful performance of providers. If an external provider could no longer provide the services, the retained Center staff would resume their Rehabilitative Case Manager roles and a Locum Tenens Agency would be used for psychiatrist and nursing coverage until replacement staff can be employed.

E. Staff Qualifications

All providers, both internal and external will be expected to meet the minimum qualifications as specified in the Performance Contract by the Department of State Health Services. All providers must be trained and competent in the tasks to be performed. All individuals must also receive a criminal background check (certain offenses will result in being barred from employment by the Center or by an external provider, for a complete list go to Texas Health and Safety Code, §250.006.)

Practitioner	**Qualifications**
	No additional qualifications are required

F. Stakeholder Comments on Draft Plan and LMHA Response

The Center published its draft plan for over one month on its website (www.mhmrst.org) from 7/18/08 to 8/27/08. A notice was posted in the local newspapers directing interested individuals to the Center's website to review the plan, if desired. Copies of the plan were also distributed to the local NAMI group, the Planning Network Advisory Committee (PNAC), the Board of Trustees, local judges, law enforcement groups and all individuals who requested a copy of the plan. In addition, the Center developed a summary of the document and e-mailed the summary to 93 individuals who have been involved with the center in any capacity, such as jail diversion meetings, local stakeholder meetings, and also individuals who were identified as potentially being involved with the center, like private providers in the local area and the two providers who have expressed an interest in potentially contracting with the center through the DSHS website. The e-mail was distributed utilizing a program called "Constant Contact." The e-mail contained a direct link to the document. Constant Contact provides "tracking capability" making it possible for the Center to report that 11 of the e-mails did not go through (i.e. "bounced back"), but 47.6% of the individuals reviewed the e-mail (i.e. summary) and 30.8% of the individuals opened the full document. In spite of these efforts, the response was very limited. The responses are indicated below.

The following table summarizes the public comments received on the draft plan as well as the Center's response:

- Accepting the comment in full and making corresponding modifications to the plan;
- Accepting the comment in part and making corresponding modifications to the plan; or
- Rejecting the comment. Please explain the LMHA's rationale for rejecting the comment.

Comment	Stakeholder Group(s)	LMHA Response and Rationale
"The local Administrative staff of the Texoma Behavioral Center has reviewed the above referenced plan for the purpose of providing stakeholder input into the plan's development. We are in full support of the plan's findings, analysis, and conclusions. Thank you for the opportunity to be involved in this process."	TMC Behavioral Health Center (local provider of inpatient psychiatric mental health services)	Comment accepted in full
"I have reviewed the Plan and it would seem to me that all is in order. Thanks for all the incredible work that went into this document."	Board of Trustee member, Melanie Grammar	Comment accepted in full

Other changes to the draft document after it was initially published on 7/18/08:

Various typographical errors – One of the PNAC members identified some additional typographical errors that were corrected after the initial document was published.

Item # C.2 on page 26 (Provider Inquiries) – The item regarding previous provider inquiries had previously been marked as "none." However, a more exhaustive search of previous documents revealed that there had been one previous inquiry so the correct information was provided in this section.

Following receipt of "Additional Clarifications and Guidance" from DSHS, the items specified below were modified:

Item # C.13 on page 39 (Attraction of Providers) – This item was revised because it initially listed "positive" factors that might have been an attraction to private providers, but the guidance document specified that "negative" factors should be listed.

Item # D on page 42 (Procurement and Transition Timelines) – A start date for external providers to begin delivery of services was added.

Items # E on page 43 (Staff Qualifications) – This section initially listed all of the qualifications that internal and external providers would be expected to meet. However, these were deleted as they did not exceed the standards as specified in the DSHS Performance Contract. It was re-written to clarify that all providers would be expected to meet the minimum expectations in the Performance Contract.

COMPLETE AND SUBMIT ENTIRE PLAN TO performance.contracts@dshs.state.tx.us AS REQUIRED.

Appendix **25 TAC §412.758 LMHA Provider Status.**

1) The LMHA shall provide services only under one or more of the following conditions.

a) The LMHA determines that interested qualified providers are not available to provide services in the LMHA's service area or that no providers met procurement specifications.

b) The network of external providers does not provide the minimum level of consumer choice. A minimal level of consumer choice is present when consumers and their legally authorized representatives can choose from two or more qualified provider organizations in the LMHA's provider network for service packages and from two or more qualified individual practitioners in the LMHA's provider network for specific services within a service package.

c) The network of external providers does not provide consumers of the LMHA's service area with access to services that is equivalent to or better than the level of access as of a date to be determined by DSHS. Any LMHA relying on this condition shall submit to DSHS information necessary for DSHS to verify level of access. DSHS will use the latest healthcare access technology available to the agency to measure access.

d) The combined volume of services delivered by external providers is not sufficient to meet 100 percent of the LMHA's service capacity for each RDM service package as identified in the LMHA's local network development plan.

e) The LMHA documents that it is necessary for the LMHA to provide certain services specified by the LMHA during the two-year period covered by the LMHA's local network development plan in order to preserve critical infrastructure to ensure continuous provision of services. Under this condition, the LMHA will identify a timeframe for transitioning to an external provider network, during which the LMHA procures an increasing proportion of the service capacity of the external provider network in successive procurement cycles. The LMHA shall give up its role as a service provider at the end of the transition period when the network has multiple external providers if the LMHA determines that external providers are willing and able to provide sufficient added service volume within the timeframe specified by the LMHA in its approved local network development plan, as provided in §412.756(g)(8)(F) of this title (relating to Local Network Development Plan), to compensate for service volume lost should any one of the external provider contracts be terminated.

f) Existing agreements impose restrictions on the LMHA's ability to contract with external providers for specific services during the two-year period covered by the LMHA's local network development plan, or existing circumstances would result in the loss of a substantial source of revenue that supports service delivery during the two-year period covered by the plan. If the LMHA invokes this condition, DSHS may require the LMHA to provide DSHS with a copy of the relevant agreement(s). Examples of such agreements and circumstances include:
   (1) grants or other sources of funding that require direct service provision by the LMHA and that cannot be amended;
   (2) buildings or other physical infrastructure that are not reasonably expected to be sold, leased, or otherwise disposed of;
   (3) tax-exempt government bonds or other long-term financing that place restrictions on the LMHA's ability to meet its financial obligations, either in whole or in part; and
   (4) leases or contracts that cannot be terminated.