LOCAL PLAN & NETWORK DEVELOPMENT

FY 2009-2010

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I. MISSION and VALUES

Mission…

"To ensure access to services and supports that enrich the lives of the individuals and families we serve."

Values…

- Self-determination in life's decisions.
- Access to a choice of services.
- Respect for each person served.
- Efficiency in how we do business.
- Integrity in all our relationships.
- Accountability to our communities with whom we do business.

II. AGENCY OVERVIEW

The beginning of Lakes Regional MHMR Center's creation was the 1996 TDMHMR board's directive to move the delivery of mental health and mental retardation community services to local control. This coincided with TDMHMR's determination to form State-Operated Community MHMR Services, in the place of State Facility Community Service Divisions. This reconfiguration of community services brought mental health and mental retardation services under one administrative structure and separated community services from their host state hospital or state school. As part of this process, Lakes Regional State-Operated Community MHMR Services was created. This new entity encompassed services from the following community service divisions: Terrell State Hospital and Denton State School.

Discussions continued for several months with other surrounding MHMR centers who were interested in a consolidation of services with Lakes Regional SOCS. Then, after all such discussions proved fruitless, on January 28, 1999, the nine County Judges of the counties served by Lakes Regional SOCS sent a letter to TDMHMR Commissioner Hale expressing their intent to press forward with their desire to form a new MHMR Center. On April 29, 1999, Commissioner Hale responded favorably to the County Judges of Camp, Delta, Franklin, Hopkins, Kaufman, Lamar, Morris, Rockwall and Titus Counties In the intervening months, great effort was expended by all staff and the Board of Trustees to complete the complicated preparations associated with conversion of this state operated program into a private, board governed, community nonprofit agency. Formation of Lakes Regional MHMR Center was successfully completed and the Center initiated operations on December 1, 1999.

In September of 2003, after several months of discussion with local officials at TDMHMR and within Hunt County, the MHMR Services of that County formally merged with LRMHMRC. Then Crossroads Council on Alcohol and Drug Abuse in Hunt County ceased operations early in 2004. Soon thereafter, Lakes' applied for a facility license from TCADA. We received the licensure and hired two Licensed Professional Counselors who had worked for Crossroads. A grant was written and received, in conjunction with Hunt County Community Supervision and Corrections Department (HCCSCD), to provide substance abuse treatment services to individuals from HCCSCD. This is an Intensive Intervention Diversion Program (IIDP). Those services are provided in our Greenville Center. Lakes also provides DWI Education classes, Drug Offender Education classes, and Minor in Possession classes. Lakes provides Intensive and Supportive Outpatient services to appropriate individuals through NorthSTAR in our center in Terrell.

Then in April of 2006, the MR services of Ellis and Navarro counties merged with LRMHMRC. Having successfully completed the Hunt County merger, we had experience with the tasks required. The transition went smoothly and continues to be a successful part of our programs.

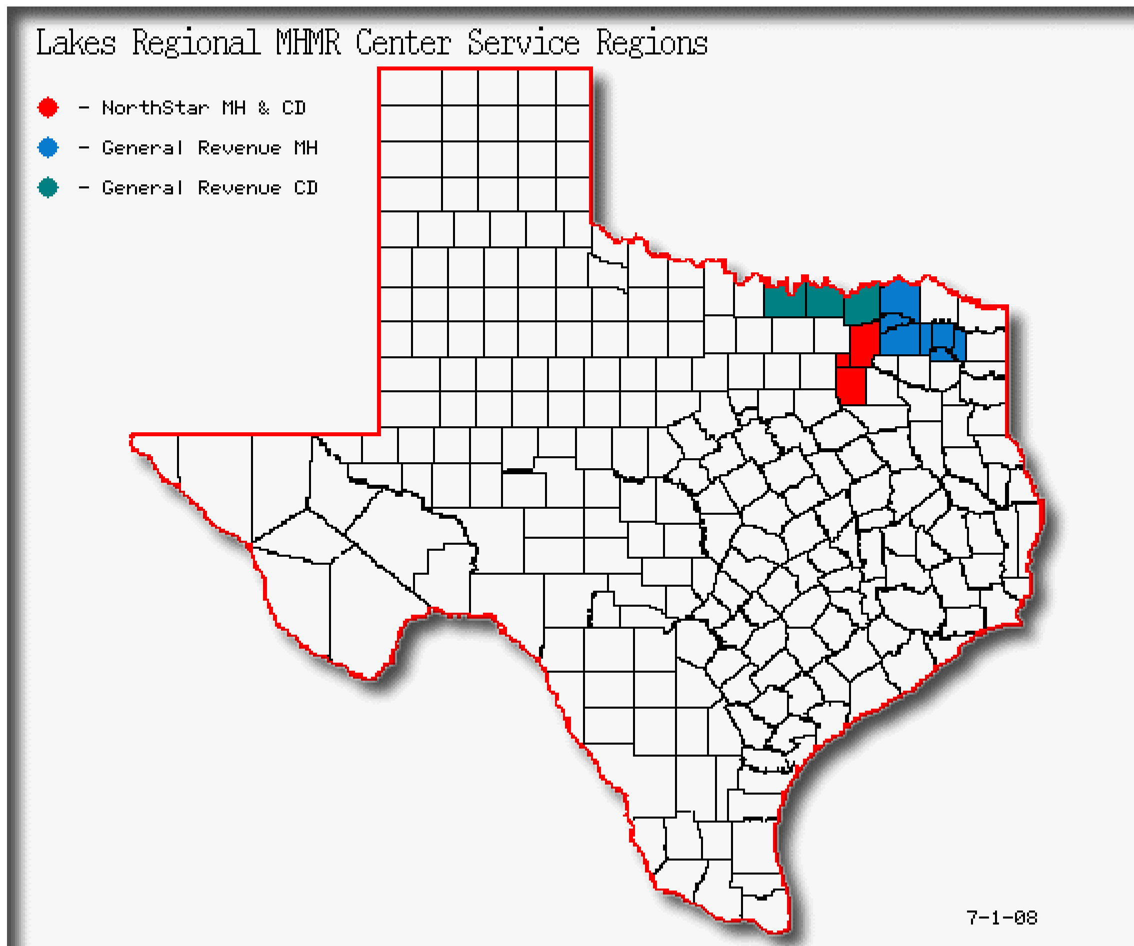
In 2006, the Northeast Texas Council on Alcohol and Drug abuse in Paris, Texas closed effective November, 2006. Lakes was asked to provide services in Fannin, Grayson and Cooke counties. Once again, Lakes stepped forward to ensure the continuity of services for consumers in need. It has been gratifying to foster growth in programs and services in all the areas we have assimilated. Lakes administration is highly skilled in managing new aspects of business and keeping our organization financially viable.

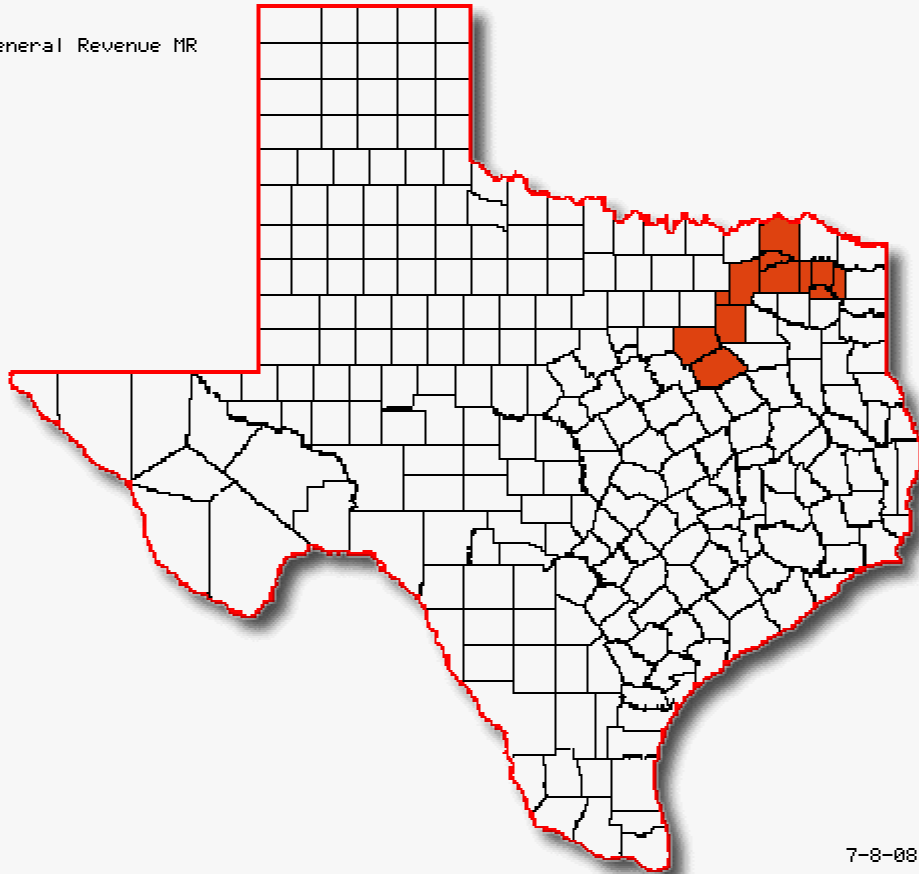
LRMHMR Center serves as the MRA for Camp, Delta, Ellis, Franklin, Hopkins, Kaufman, Lamar, Morris, Navarro, Rockwall, Hunt, and Titus Counties. It also serves as the MHA for seven of the above counties. The exceptions are Ellis, Hunt, Kaufman, Navarro, and Rockwall counties, which are in the NorthStar Medicaid project and for which LRMHMRC is not recognized as the Mental Health Authority. Chemical dependency services are provided in Kaufman, Rockwall, Hunt, Fannin, Grayson and Cooke counties. TCOOMI adult parole and MH services are provided in Delta, Hopkins and Franklin counties. TCOOMI parole continuity services are provided in Hopkins, Delta, Lamar, Titus, Franklin, Morris and Camp counties.

LRMHMR Center operates as authorized under Texas Health and Safety Code, Chapter 531, Section 531.001(h). The TDMHMR Board has designated local entities as Mental Health and Mental Retardation Authorities (MHA MRAs). The 74th Texas Legislature amended the Texas Health and Safety Code to define a local mental health or mental retardation authority as an entity to which the board delegates the authority and responsibility within a specified region for planning, policy development, coordination, resource development and allocation, and for supervising and ensuring the provision of services to persons with mental illness or mental retardation in one or more local service areas.

III. Service Area & Demographics

Lakes Regional MHMR Center includes 12 counties that cover 6,831 square miles and has a population of 601,809. Lakes provides discrete chemical dependency services to an additional three counties. The annual budget is $21,548,197 and we employ 365 FTE staff. Mental health services are provided to 3,006 consumers, Mental retardation services are provided to 1,020 consumers, Substance Abuse services are provided to 368 consumers and 375 consumers receive services through Early Childhood Intervention, Private Contracts, etc.



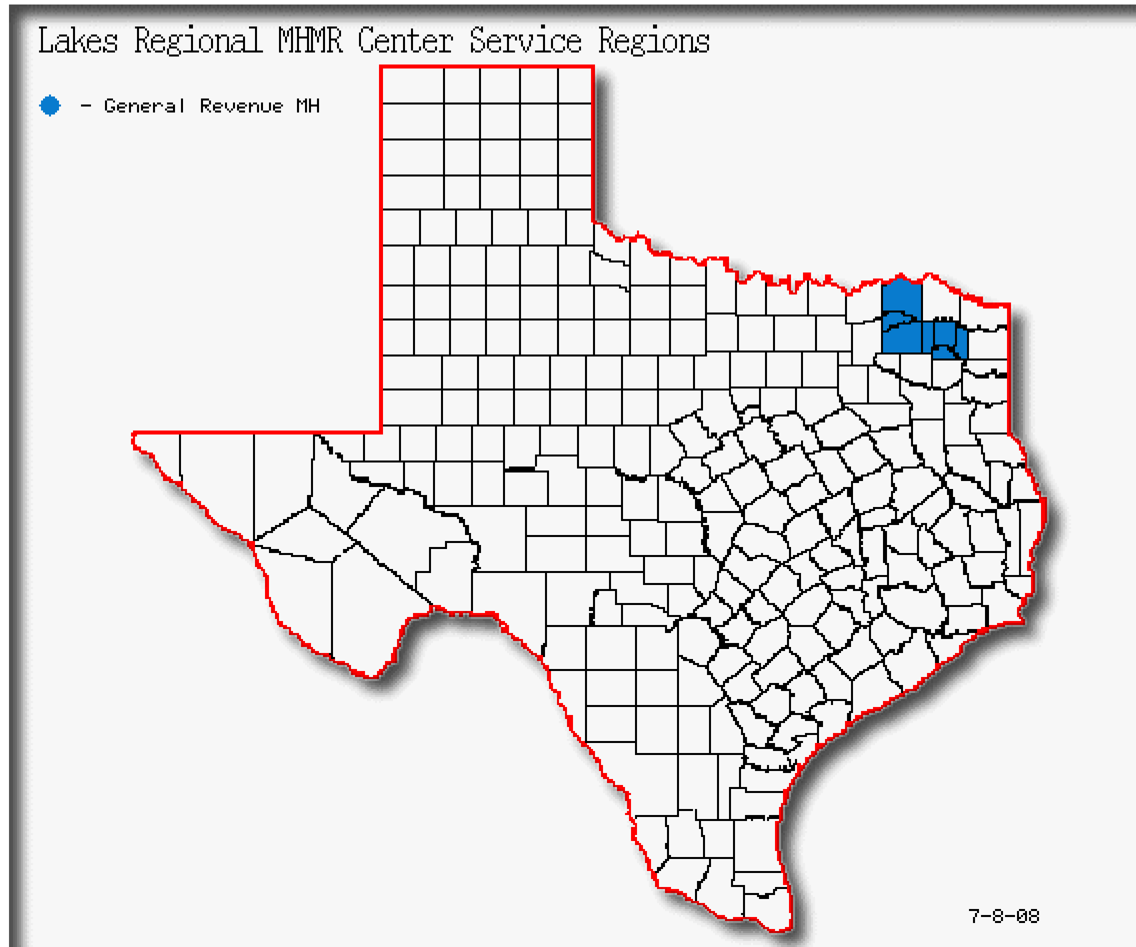

LAKES REGIONAL MHMR CENTER SERVICE REGIONS
- General Revenue MR
7-8-08

DEMOGRAPHIC INFORMATION

GENERAL REVENUE MENTAL HEALTH

	Lamar	Delta	Hopkins	Titus	Morris	Camp	Franklin	Texas Average
Population, 2006 estimate	49,863	5,561	33,496	30,306	13,002	12,410	10,367	
White persons, percent, 2006	83.6%	89.0%	90.0%	88.1%	74.0%	80.4%	92.7%	82.7%
Black persons, percent, 2006	13.2%	8.1%	7.7%	9.6%	23.7%	17.3%	5.4%	11.9%
Hispanic or Latino origin, percent, 2006 (Hispanics may be of any race so also are included in applicable race categories)	4.8%	3.8%	12.5%	**36.0%**	4.2%	19.4%	10.5%	35.7%
White persons not Hispanic, percent, 2006	79.2%	85.8%	78.0%	53.1%	70.2%	61.9%	82.6%	48.3%
Language other than English spoken at home, pct age 5+, 2000	4.7%	2.2%	9.8%	**26.9%**	3.9%	15.9%	10.1%	31.2%
Persons with a disability, age 5+, 2000	10,775	1,278	6,607	5,589	2,988	2,472	2,102	
Persons below poverty, percent, 2004	17.7%	15.9%	14.5%	16.0%	16.4%	17.1%	13.6%	16.2%

Provider of Last Resort Counties



IV. SYNOPSIS OF LOCAL PLAN & NETWORK DEVELOPMENT

Local Planning and Network Development (LPND) is the result of legislation that: "articulates a clear preference for a system of service delivery in which consumers have **choice** from among multiple service providers and in which the MHMR Center's role is to provide management and oversight."

Additionally, the law: "states that MHMR Centers have the responsibility for ensuring that mental health services are provided in their local area and, further, requires MHMR Centers to consider public input, ultimate cost-benefit, and client-care issues to ensure consumer choice and the best use of public money in assembling a network of service providers."

Surveys were conducted in May, 2008 to learn consumer thoughts on what was important to them in the way services are delivered and in what services they would like to see a choice of providers. Surveys were received from 293 consumers and 31 family members.

When asked the three most important factors in considering a provider for services, 198 people said **convenient location to home**, 138 said **transportation available** and 126 said **cost of services**.

When asked which services were most important for having a choice of providers, 145 people said **physician services** and 132 said **counseling**.

The decision was made to contract out all physician and counseling services in the seven county area of Hopkins, Delta, Lamar, Franklin, Titus, Morris, and Camp. Those contracts will also specify the need for convenient locations, transportation and reasonable cost.

Consumer input was taken very seriously. We received an excellent amount of feedback that is considered reliable. We realize we do not have the staff resources to provide the amount of counseling desired by our consumers. Nor do we have a great deal of choice of physicians. By allowing private providers the opportunity to provide services, it is our hope that our consumers will be well-served and have more options.

A. Local Planning Process

1. Understanding our Local Planning Process

The approach to planning at Lakes Regional MHMR Center is based on pragmatic realities impacting the organization and the need for rapid adjustments in operations as major external forces continue to push continuous significant changes in operations. The process also involves an analysis of socio-demographic characteristics and population estimates of our service area of, Hunt, Kaufman, Rockwall, Hopkins, Delta, Lamar Franklin, Titus, Camp, Ellis, Navarro, Morris, Fannin, Grayson, and Cooke counties. Allocation of financial resources from DADS, DSHS, TDCJ and TCOOMI for adult, children and adolescent mental health and mental retardation services is also examined. Other data reviewed in the planning process include all persons on waiting lists for mental health, mental retardation and HCS waiver services.

Monthly, the Board receives reports from senior staff on issues of concern to the Center, as well as recommendations for service improvements, investments in resources, or other program improvements. These discussions are directly related to strategic initiatives, continually forcing review of our progress toward annual planning goals. The Board also gives monthly opportunity for public input at their meetings. This has resulted in the development of additional programming.

The Planning Network Advisory Committee provides another structured mechanism for obtaining ongoing comments about Center services. The Public Information Officer reports on committee activities as part of her monthly Board report. Members are also encouraged to attend the Board meetings.

The Local Planning Process at LRMHMRC is driven by:

- Periodic Community-wide MHMR needs assessment
- Input from the Regional and Local PNAC
- Development of a Strategic SWOT analysis, and
- On-going analysis of unplanned systems demands

Needs Assessment Information

Lakes Regional MHMR Center conducts regular efforts to assess the needs of the diverse segments of the community served by the Center's multiple program sites, as well as a review of key data elements on DADS and DSHS prevalence data for adults and children and use of state facilities.

Annually, the Center organizes formal focus groups or public forums of various stakeholders to discuss concerns regarding the quality of Center services, operational issues, managerial recommendations, access issues, complaints about perceived issues and developing services for consumers. Staff and leadership evaluation surveys are also conducted periodically. Satisfaction surveys were conducted in FY 2007 as part of the Regional Planning Network Advisory Committee activities. Community input was solicited in FY

08 for the Crisis Redesign project. In addition, the Center obtains other public input through service need questionnaires sent to consumers, families, and other public and private stakeholders to determine current and future service development within LRMHMRC counties.

The Center summarizes these formal and informal assessments into annual objectives for management implementation. This occurs during annual budgetary planning, and service planning cycles that require budgetary support.

Fiscal Year 2008 Assessment Information

In the fall and spring of FY 2008 LRMHMRC updated its comprehensive MHMR needs assessment, which was collected in 2005. Staff worked closely with our community advisory committees in reviewing previous and new survey results. The results of this process validated the original conclusions obtained in the previous planning cycle. These findings, though essentially the same have been updated to include the affiliation of Hunt, Ellis and Navarro Counties into the Lakes Regional Center.

SWOT Analysis

LRMHMR Center utilizes an ongoing SWOT (**S**trengths-**W**eaknesses-**O**pportunities-**T**hreats) analysis model to identify key factors that may affect desired future outcomes of the Center. The use of periodic staff and stakeholder surveys is a step in this process. The membership of our community advisory committees, executive management staff, and Board of Trustees were enlisted to provide feedback.

Planned and Unplanned Systems Demands

During the course of this past two years our Board was required to respond to a number of planned and unplanned systems demands outside of the more systematic process of formal needs assessment and SWOT analysis. Examples have included specific MH and MR service delivery issues that are expressed in our performance contract with DADS and DSHS such as the delivery of substance abuse services in Fannin, Grayson and Cooke counties, Crisis Redesign, TCOOMI parole, Federal probation services and responses required to ensure viability of our Mental Health provider services in the NorthStar managed care pilot. We responded to Board and community demands for Day Habilitation services in an additional county in our service area. Responses to these system demands are often outside the analysis or recommendations of our advisory committees.

Recent Planning Outcomes and Projects

Over the past 12 months there have been several important outcomes and products attributable to our local planning process, including:

- Ongoing stakeholder input through the Planning Network Advisory Committee
- Best value determinations of services through analysis by the RPNAC
- Updated needs assessment, consumer surveys and public forums
- Expansion of LRMHMRC services through acquisition of chemical dependency services in Fannin, Grayson and Cooke Counties
- Creation of a Day Habilitation Program in Royse City, Texas
- Implementation of Crisis Redesign
- Participation in NorthStar planning meetings
- Participation in the Sherman Council of Governments planning meetings
- Participation in ETBHN planning initiatives

Local Plan Review

Quality Management Plan Review Process

- An essential component of any planning initiative is monitoring and evaluation. The process for review and monitoring of the LRMHMR Center's plan for FY 2008–2009 is part of our annual Quality Management Plan. The QM Plan describes the annual quality management and evaluation activities for LRMHMRC. The Quality Director and internal committees, appointed by the Executive Director, are responsible for the oversight of the center's Quality Management Plan including goals and objectives and ongoing recommendations derived from the local planning process actions and submit these to the Quality Assurance department. The Quality Assurance department will report the follow up actions taken to the Utilization Review Committee, Center's administration, Board of Trustees, and MHMR Planning Advisory Committees as necessary.

- Questions and concerns raised throughout the year will be incorporated into the MHMR Planning Advisory Committees' planning process for next Local Plan revision.

2. Participating Agencies, Organizations and Other Stakeholders

The following table represents planning efforts for both the Crisis Redesign Plan and the current Local Planning Network Development.

Description And Date or Timeframe	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
Survey March, 2007	Consumers, Stakeholders	85	24	24
Meeting 9-27-07	Regional Planning Network Advisory Committee	3	2	14
Meeting 10-18-07	Local Planning Network Advisory Committee		3	
Meeting 10-23-07	Hopkins Co. Courthouse			6
Training 4-10-08	Board Members			3
Training 5-5-08	Lakes Center Directors			3
Presentation 5-13-08	Titus County Summit			20
Training, 5-20-08	Law Enforcement			20
Survey May, 2008	Consumers, Stakeholders	293	31	79
Open Forum 6-3-08	Public	1		

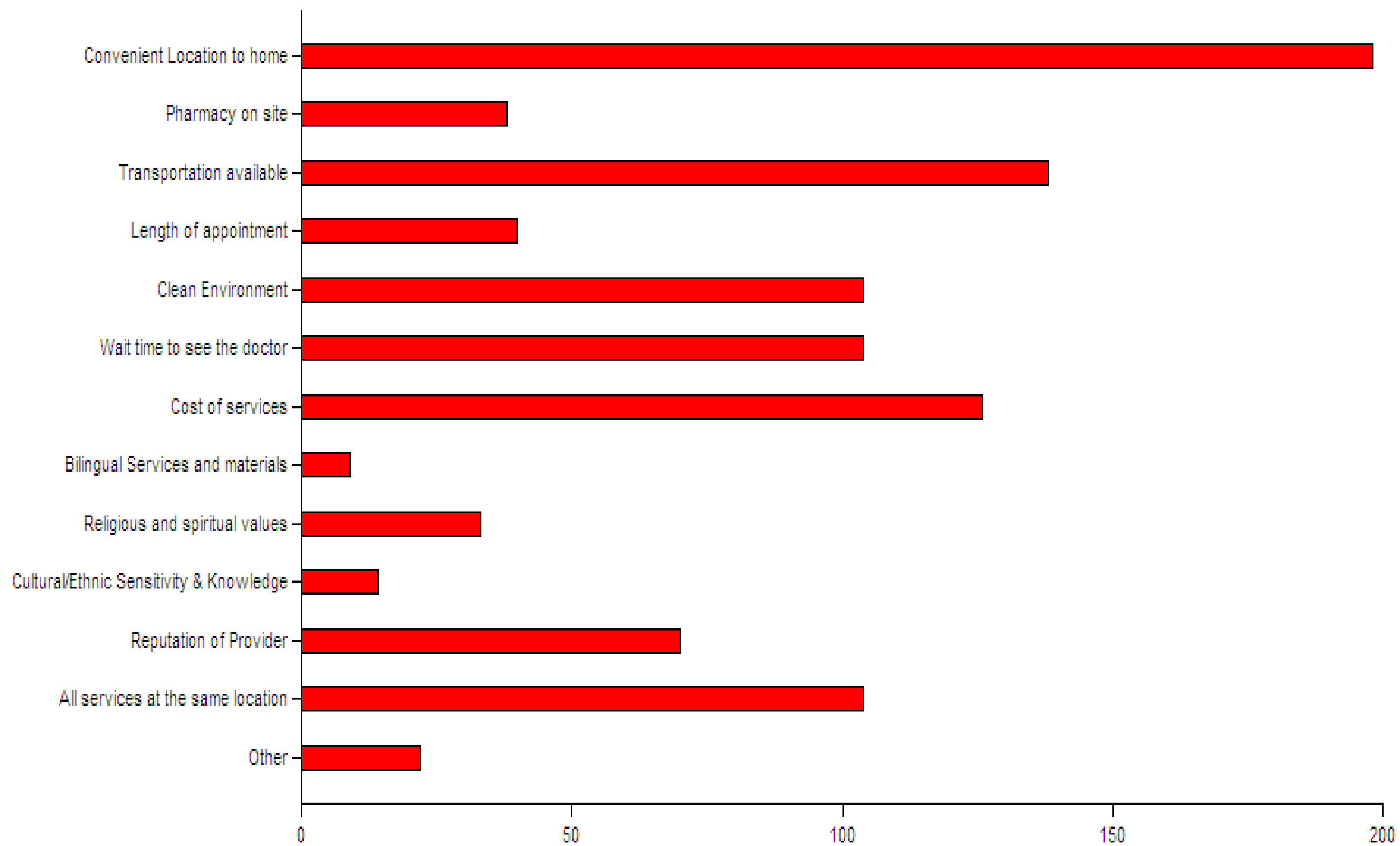
3. Summary of Discussions and Input Received

Participation in the consumer and stakeholder surveys exceeded our expectation and exceeded the numbers of participants in previous surveys. Multiple meetings were held to obtain input from our local community. At a minimum, the goal of each meeting was to obtain answers to the following questions:

1. What are the most important factors you look for in a provider of services?
2. For which services would you most like to have a choice of providers?

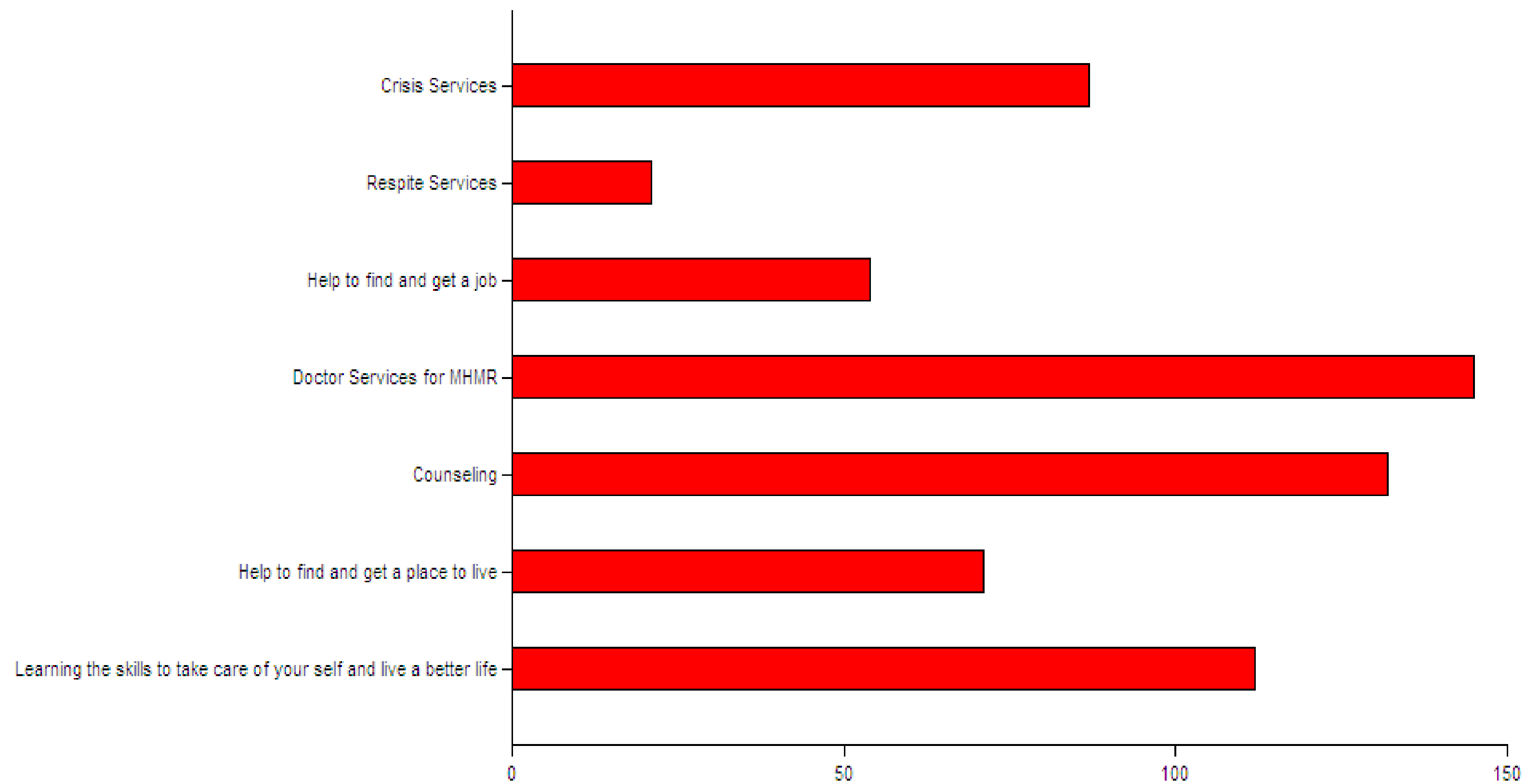
Results for consumers are on the bar graph below:

What are the most important factors you look for in a provider of services?



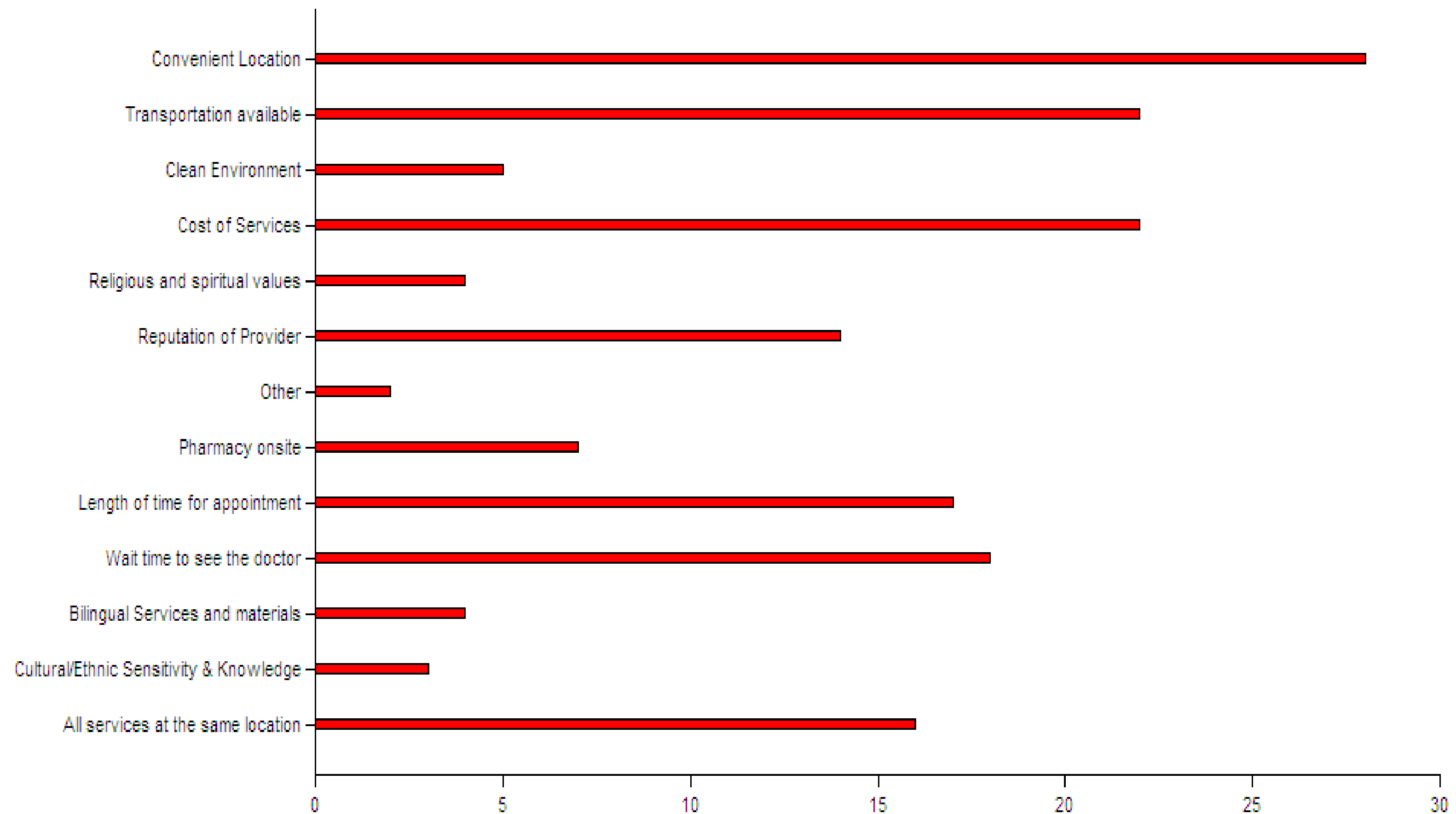
Results for consumers are on the bar graph below:

For which services would you most like to have a choice of providers?



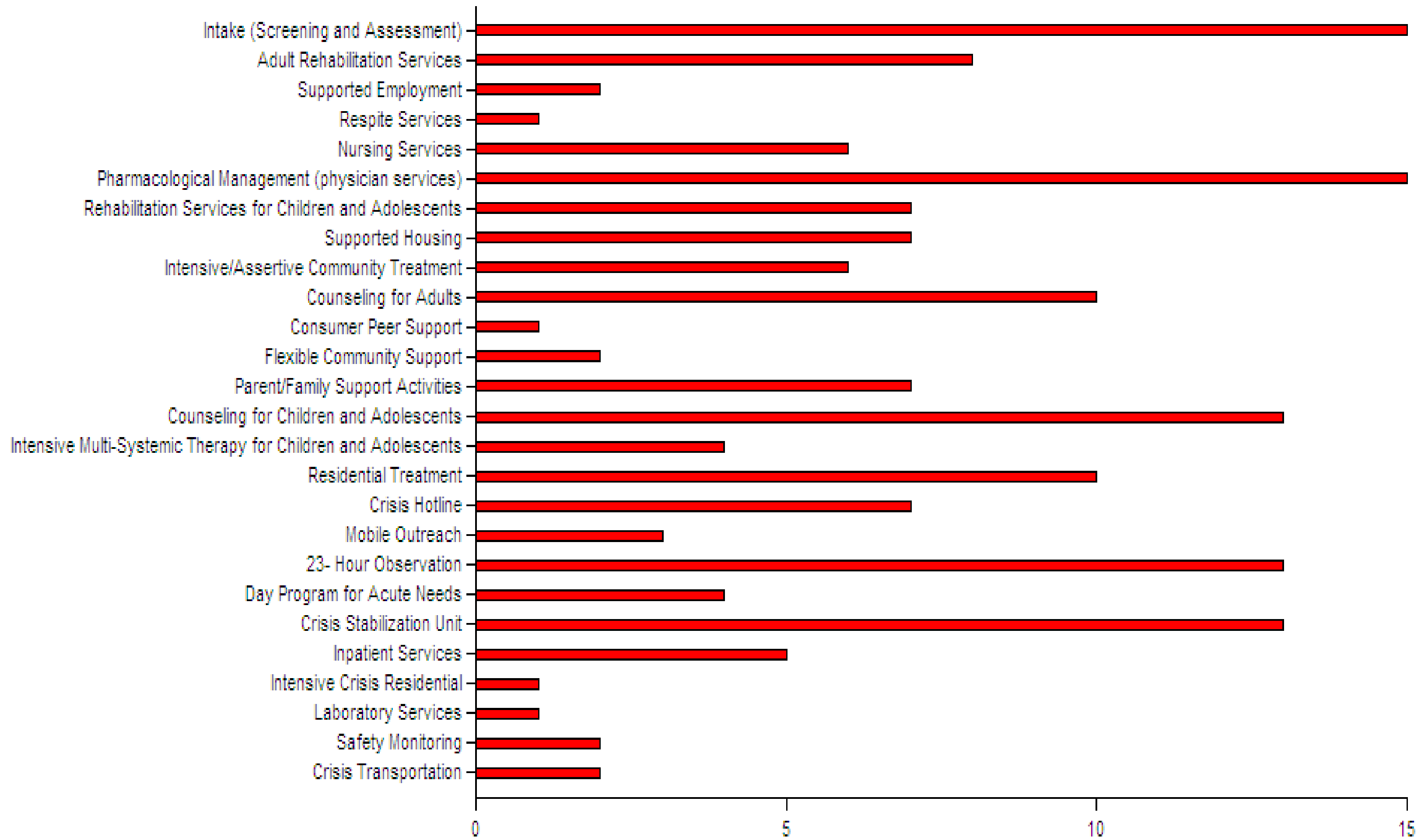
Results for stakeholders are as follows:

What are the most important factors you look for in a provider of services?



Results for stakeholders are as follows:

For which services would you most like a choice of providers?



4. Service Delivery Needs and Priorities, including gaps in service

A survey for consumers and stakeholders was developed by the Regional Planning and Network Advisory Committee (RPNAC) and conducted in March, 2007. An independent consultant summarized the responses. There were 109 surveys returned, 85 were consumers and 24 were families. A few agencies responded. Consumers conveyed a need for additional dental services, additional counseling services, more staff and more time with the caseworker and physician. The agencies responded that their priorities are primary mental health services, chemical dependency services and acute crisis/inpatient services.

The Regional Planning and Network Advisory Committee (RPNAC) identified the following strengths, weaknesses, opportunities and threats, as well as gaps in services:

Strengths:

Desire to involve families and consumers
Extensive experience in providing service
Implementing business approaches to be more competitive
Proven to be adaptable and flexible
Adapting to scarce resources
Continues to provide services with limited financial resources
Responsive to needs of the community
Strong board of trustees that advocate for centers at the state level

Weaknesses:

Under funded
Forced to implement waiting lists
Large geographical service areas
State mandates put centers at a disadvantage when competing
Population is defined for us – we cannot choose who we serve

Opportunities:

Diversify to other services to broaden base
Educate general public to needs
Develop the mail order pharmacy

Threats:

Legislation restricts what we can do
Provider of last resort
Manner in which equity is determined
Funding cuts
Staff retention
Not an equal player with private providers
Difficult to plan for the unknown
Complying with regulations
Not a popular cause with the legislature
CAM data is not consistent and not reflective of true comparisons

Gaps in Services

MH adults:
Too many in the low service packages
Resource limitations
Not able to provide needed services due to RDM
No funding for outreach, education
Jail diversion is under-funded and so not as effective
Housing options (few licensed boarding homes in the area)
Community resources, particularly psychiatrists to refer people to
Transportation
State hospital bed availability
Dual diagnosis (Chemical dependency/mental health)
Dual diagnosis (Mental retardation/mental health)
Few resources for detox
Counseling and Therapy services for GR funded consumers

MH children:

Limited availability of Child Psychiatrists
State hospital bed availability
Residential care
Transportation
Counseling services
Willing foster care providers for RDM foster care
Dual diagnosis (Chemical dependency/mental health)
Few resources for detox
Limited integration with public schools

Many of the gaps in services identified by stakeholders are due to a lack of adequate funding. We continue to work with our legislative delegation and Texas Council of Community MHMR Center to encourage greater funding for mental health and substance abuse programs.

5. Changes over the next Biennium

With the initiation of this Local Service Area Plan and the development of an external network of providers, the Center strongly considered several factors to gauge its readiness for this endeavor:

- The strength of the Center's organizational structure and technical experience and expertise including competency of staff in provider procurement, negotiation and management of contracts; utilization management and clinical authorization and claims adjudication;
- Established Best Value criteria such as local stakeholder input, data related to quality, access, consumer choice and satisfaction, availability of current or potential contracted providers, and ultimate cost benefit, including the cost of any staff training associated with managing an external network of providers
- The capability of the Center's information technology (IT) system to accept and process an external provider's clinical and fiscal information.

The Center considers itself moderately experienced in Network Development and with a deliberately graduated schedule of procurement, the center can develop a provider network for mental health services that will maintain stability and integrity of the entire local service delivery system over time. We have limited infrastructure and historical experience or expertise to utilize some of the more complex contracting methodologies during the first biennial planning period (i.e., sub-capitated contracts, under arrangement contracts). However, during the next 2 years appropriate staff shall be trained and/or thoroughly educated in this area.

With the funding of crisis redesign, the center received an annualized crisis re-design funding amount of $239,541 for nine months of FY08 and $299,541 in FY09. This funding will cover the mandatory enhancements to LRMHMR Center's Crisis Hotline and Mobil Crisis Outreach Team (MCOT). Rural Community MCOT services are required to have one team on duty during peak crisis hours with awake coverage eight (8) hours per day, seven (7) days a week. There must also be a team on-call twenty-four (24) hours per day, seven days a week.
Lakes contracted with Avail Solutions, Inc. for the crisis hotline. They are AAS accredited and man a dedicated 800 phone line. We also implemented an MCOT team to cover our three rural centers. It consists of four QMHPs and one LPHA supervisor. They all completed a one month specialized training.

B. Current Services and Providers

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***. 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, the LMHA isolated the costs associated with the services already delivered under contract by External Providers. The LMHA 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 LMHA 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 LMHA's ability, identify the costs associated with services delivered directly by the LMHA 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.

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	80,101			N/A
Routine Case Management (Adult)	X	250,910			N/A
Routine Case Management (Child/ Adolescent)	X	23,187			N/A
Respite Services					
Supplemental Nursing Services	X	432			
Pharmacological Management	X	208,252			
Provision of medication			**East Texas Behavioral Health Network** 4101 S. Medford Dr. Lufkin, TX 75901 **NEC Health Networks** 14603 Huebner Rd. Bldg 2 San Antonio, TX 78230	582,300	9-1-06/8-31-09
Psychiatric evaluation	X	41,301			
All Rehabilitation Services (Adult)	X	815,960			
All Rehabilitation Services (Child/Adolescent)	X	133,440			
Supported Employment	X	4,312			
Supportive Housing	X	16,703			
Assertive Community Treatment		-			
Inpatient services		-	**Terrell State Hospital** 400 Brin St. Terrell, TX 75160		N/A

Residential Treatment		-	**Individual Care of Texas** PO Box 1810 Quinlan, TX 75474 **Ellen Harkey** 215 Dukes Chapel Rd Pittsburg, TX 75686 **Hardy Teycer** 515 S. O'Tyson Rd Mt. Pleasant, TX 75455	45,494	9-1-07/8-31-08
Intensive Case Management (Child/Adolescent)	X	21,032			N/A
Counseling (Adult)	X	16,541			
Counseling (Child/Adolescent)	X	2,517			
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)	X	409			
Flexible Community Support (Child/Adolescent)	X	-			
Multi-Systemic Therapy (Child/Adolescent)	N/A	-			
Consumer Peer Support	X	3,826			
CRISIS & OTHER DISCRETE SERVICES					
Hotline					
Crisis Intervention Services	X	7,062			
Mobile Crisis Outreach Team	NA				
Extended Observation	NA				
Day Program for Acute Needs	N/A				
Crisis Stabilization Unit	N/A				
Respite Services	N/A				
Inpatient/Hospital Services	N/A				
Crisis Residential Treatment Services	N/A				
Safety Monitoring	NA				

Crisis Follow-Up and Relapse Prevention	N/A				
Crisis Transportation	NA				
Crisis Flexible Benefits	NA				
Laboratory Services			**DRL Labs** P. O. Box 6400 Tyler, TX 75711 **Don O'Neal, M.D.** 105 Medical Plaza Sulphur Springs, TX 75482 **Med West, Inc.** 4770 Regent, Irving, TX 75063	32,609	9-9-07/8-31-08
Totals	1,625,9 84			660,403	

*An organization that provides mental health services that is not an LMHA; or an individual who provides mental health services who is not an employee of an LMHA.

C. Provider Network Development

1. Provider Availability

In April 2004, the Center completed a Request for Information (RFI) process that 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 questions 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 areas, thus giving the respondents the opportunity to indicate the preference to serve the entire local service area or a portion thereof. Only one respondent indicated an interest in children's services, but since that time their affiliation with a children's program has ended.

The center also reviewed the DSHS website and found two providers who completed the Provider Interest Form. The center also keeps a potential contractors file, which included one currently interested party.

2. Provider Inquiries within the last 2 years

Date of Inquiry	Summary of Inquiry	LMHA Response
6-6-07	US Script for pharmacy and medication services	Keeping on file until next RFP
12-6-07	The Wood Group for residential, skills training, crisis, hotline services	Keeping on file until next RFP
March 2008	Sunwest Behavioral Health Org for RDM and all services	Keeping on file until next RFP

3. Service Capacity and Procurement

	3a	3b	3c	3d	3e	3f
Service	**Current Capacity**	**Projected Capacity**	**Availability of Current and Potential External Providers**	**Procurement Planned?**	**Capacity to be Procured**	**Method of Procurement**
ADULT SERVICES						
RDM SP 1	1007	1043	2	No		
RDM SP 2	4	42	2	Yes, for counseling & physician	100%	Open enrollment
RDM SP 3	108	108	2	No		
RDM SP 4	9	6	2	No		
RDM SP 0	46	30				
RDM SP 5						
CHILD/ADOLESCENT SERVICES						
RDM SP 1.1	50	33	2	No		

RDM SP 1.2	3	1	2	Yes for counseling & physician	100%	Open enrollment
RDM SP 2.1						
RDM SP 2.2	1		2	No		
RDM SP 2.3						
RDM SP 2.4	1		2	No		
RDM SP 4	7	11	2	No		
RDM SP 0	3	2				
RDM SP 5						
CRISIS & OTHER DISCRETE SERVICES						
Hotline			Avail Solutions, Inc.	NA		
Mobile Crisis Outreach Team				No		
Extended Observation						
Day Program for Acute Needs						
Crisis Stabilization Unit						
Respite Services						
Inpatient/Hospital Services			Terrell State Hospital	NA		
Crisis Residential Treatment Services						
Safety Monitoring						
Crisis Follow-Up and Relapse Prevention				No		
Crisis Transportation						
Crisis Flexible Benefits						
Laboratory Services			DRL Labs, Dr. O'Neal, MedWest, Inc.	NA		
Supported Housing						
Supported Employment						

4. Justification for Procurement of Discrete Services

Discrete Service to be Procured	Rationale
Counseling	Current LPHAs perform other duties, reducing their availability for counseling. Consumer comments in the surveys indicate a desire for more choice of counseling providers.
Physician services	Additional providers are needed and consumer comments in the surveys indicate a desire for more choice of physician providers.

Plan for Fidelity and Continuity of Care
Pre-service training will be required to teach the fidelity model. Lakes will have access to the electronic record to review documentation for accuracy and appropriateness. Casemanagers will monitor service provision when they meet with their consumers. Site management will be included in oversight. Provider meetings will be scheduled to provide additional oversight. The provider will also be subject to surveys, credentialing and compliance with applicable federal and state laws**.**

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.*

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	100	5	Need to maintain critical infrastructure to maintain the role of the safety net.	100	To summarize, in the first 2 years as external providers are trained to provide services in compliance with rules and standards set by the Center and DSHS Performance Contract, it is prudent that the internal network remain operational as a safety net. As has been our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reduction of the internal network. In years 3-4 service areas which have been successfully contracted and stabilized shall be considered for further network expansion. This continued graduated approach during the next planning cycle shall also incorporate new input gathered from the local community regarding additional service areas where choice is desired.

RDM SP 2	100	5	Need to maintain critical infrastructure to maintain the role of the safety net	100% except for physician & counseling services	Same as above
RDM SP 3	100	5	Need to maintain critical infrastructure to maintain the role of the safety net	100	Same as above
RDM SP 4	100	5	Need to maintain critical infrastructure to maintain the role of the safety net	100	Same as above
RDM SP 0	100	5	Need to maintain critical infrastructure to maintain the role of the safety net	100	Same as above
RDM SP 5	100	5	Need to maintain critical infrastructure to maintain the role of the safety net	100	Same as above
RDM SP 1.1	100	5	Need to maintain critical infrastructure	100	Same as above
RDM SP 1.2	100	5	Need to maintain critical infrastructure	100% except for physician & counseling services	Same as above
RDM SP 2.1	100	5	Need to maintain critical infrastructure	100	Same as above
RDM SP 2.2	100	5	Need to maintain critical infrastructure	100	Same as above plus negligible volumn
RDM SP 2.3	100	5	Need to maintain critical infrastructure	100	Same as above
RDM SP 2.4	100	5	Need to maintain critical infrastructure	100	Same as above
RDM SP 4	100	5	Need to maintain critical infrastructure	100	Same as above plus negligible volumn
RDM SP 0	100	5	Need to maintain critical infrastructure	100	Same as above
RDM SP 5	100	5	Need to maintain critical infrastructure	100	Same as above
Hotline	0		Contracted to Avail Solution, Inc.	0	Currently contracted
Mobile Crisis Outreach Team	100		Not required to be contracted out		Not required to be contracted
Extended Observation					
Day Program for Acute Needs					
Crisis Stabilization Unit					
Respite Services					

Inpatient/Hospital Services	0		Provided by Terrell State Hospital	0	
CrisisResidential Treatment Services					
Safety Monitoring					
Crisis Follow-Up and Relapse Prevention	100		Not required to be contracted out		Not required to be contracted
Crisis Transportation					
Crisis Flexible Benefits					
Laboratory Services	0		Contracted to DRL, Dr. O'Neal, MedWest, Inc.	0	Currently contracted
Counseling	0		Plan to do open enrollment	0	
Physician services	0		Plan to do open enrollment	0	
Supported Housing	100	5	Need to maintain critical infrastructure	100	Gradual roll-out is deemed best
Supported Employment	100	5	Need to maintain critical infrastructure	100	Gradual roll-out is deemed best

6. Structure of Procurements

Service or Combination of Services to be Procured	**Geographic Area(s) in Which Service(s) will be Procured**	**Rationale**
Counseling	Hopkins, Delta, Lamar, Titus, Franklin, Morris, and Camp counties	Services are needed in all these areas.
Physician services	Hopkins, Delta, Lamar, Titus, Franklin, Morris and Camp counties	Services are needed in all these areas.

7. Maximizing Consumer Choice and Access

The Center agrees that maximizing choice of those who receive services is a primary goal of this Plan. Obviously one of the strategies

will be attempting to increase the number of external providers in certain service areas to increase the choice of providers. However, there is a realistic expectation of a shortage of willing and qualified providers available for rural service delivery areas. While we may not initially be successful in developing a large external provider network during this planning cycle, we are cognizant that choice can also occur and be maximized at an organizational level. Strategies to increase choice at the organizational level include:

- Having more than one physician available at each major clinic facility. This may be accomplished through the utilization of Telemedicine/Telepsychiatry in the event finding a "physical" person to provide psychiatric services is fruitless.
- Allowing consumers to choose his/her service coordinator/case manager instead of being auto assigned to a caseload. There may still be a limitation of choice as staffs caseloads fill.
- Allowing consumers to have access to Clinic listings and choosing which facility is preferred instead of being auto-assigned to the facility assumed closest and most convenient. (example if you live in Paris, you are automatically assigned to the Paris Clinic; however in a few instances consumers preferred to receive services in Mt. Pleasant due to work location.)
- Allowing consumers to switch internal or external providers at any time by request.

Access to psychiatrists and prescribed psychiatric medications is a critical mental health treatment element. Over the past several years, the Center has taken considerable action to expand and improve greater access to psychiatrists and prescribed psychiatric medications. These include the submission of multiple additional funding requests specifically for the support of prescribed psychiatric medications; increased and enhanced direct assistance to consumers in applying for available benefits and maximized patient assistance programs. The Center participates in the East Texas Behavioral Healthcare Network ("ETBHN") pharmacy program; which provides effective and efficient pharmacy services, and assures best cost value of medications – maximizing limited resources. The Center is continuing to evaluate ways to assure immediate access to services for those adjudicated; yet maintain capacity and assure continued service. The Center has expanded staffing support to the local jails, to complement previously existing mental health support and services there.

With regards to the External Provider Network, the Center shall ensure that:

- Services hours are the same if not greater than the Centers. The Center operates Monday through Friday from 8:00 a.m. to 5 p.m. External Providers shall have the same or extended hours.
- At a minimum clinic locations shall remain in the geographic areas of Sulphur Springs, Paris, and Mt. Pleasant, Texas. There are no clinics in the most rural areas of our counties. A clinic in one of those geographic service areas would be considered when selecting a service provider.
- Procurement of services shall not cause individuals who receive services to have a decreased level of access to services.

8. Service to be Provided by a Single Provider

Service to be Provided by a Single Provider	Economic Factors Preventing Consumer Choice
Crisis services	This is an Authority function at this time.
Case Management	This is an Authority function at this time.
Rehab, Supported Housing, Supported Employment	This is necessary for maintenance of critical infrastructure. Discussions were held regarding procurement of Service Package 2 for adults and Service Packages 1.2 and 2.3 for children. Both of these packages offer counseling, SP2 adults routinely get physician services, and many of those children's packages do also. However, we are unable to contract out case management as it is an authority function, thus the two primary services of these packages can be best met by providers able to offer discrete services rather than a full service package. Procurement of other service packages in full would also require the contracting of Medicaid Rehab services. Since community centers are the only authorized entities to bill and receive payment for the Federal portion of the Medicaid Rehab rates, contracting out these services would require our Center to enter into what is called an "Under Arrangement" contract. Since our Center would be financially at risk for ensuring compliance with all Medicaid rules and regulations, we have determined that we do not have the infrastructure and expertise necessary to utilize this contract methodology.

9. Cultural and Linguistic Diversity

It is the position of Lakes Regional MHMR Center that all persons receiving services have the opportunity to communicate effectively with providers, regardless of the cultural background from which the individual comes or the language which the person may speak. We allow and encourage full participation for all consumers and their families.

The Center also strives to ensure that individuals receive effective, understandable, and respectful care from its internal staff. As with many entities, bi-lingual staff are sometimes difficult to recruit. Human Resources does have the authority to initiate a pay incentive for hiring purposes to assist in alleviating this barrier. Unfortunately the need on occasion is greater than our internal resources thus we have a contract in place for interpreter services as well as translation services when needed. The Center proactively tries to ensure that care and information is received in the individual's preferred language. Census data reflects that Titus Co. has the heaviest concentration of Hispanic population; it is also the closest to the Texas state average.

The Center gives annual refreshers on individual rights information annually. Staff also can access training modules to ensure competency in this area:
. Cultural Diversity - This course is an introduction to understanding the various components of cultural competence and how they apply to providing mental health and other human services to various groups of people and to individuals from within those groups.

10. Cost Efficiency

The Center will continue in its long-standing efforts to provide quality administrative oversight and management of Center services, both internal and external; yet continue to maximize available service delivery dollars. As the Center moves towards its implementation of its network development goals, the Center's administrative services – especially those related to Authority Services will be reviewed and adapted as needed. The Center believes that its past experience in provider network development will assist in minimizing expenses; but increased costs of administrative operations should be expected. The Center projects that at a minimum there will be an increased need for staff with contract monitoring experience; as well as an increased need for expanded data management and reporting. Coupled with the ever increasing cost of basic operational needs, the Center's concern is the availability of adequate funding to support the projected increased expenses.

To assist in minimizing overhead and administrative costs, and meet the anticipated oversight needs; the Center will continue to look to and expand on collaborative relationships and cost efficiency efforts. Examples of this collaboration with other local authorities are as follows:

Regional Planning and Advisory Committee – Each Center in ETBHN has representatives on the RPNAC, which takes the place of each Center having their own PAC and NAC. This gives a broader perspective on community impact and allows consumers and their families to learn about services of other Community Centers.

Regional Utilization Management Committee – Each Center has a representative on the ETBHN UM Committee. This replaces the need to have a Center UM Committee and allows for more comparison between Centers. Some Centers continue to have a local Committee, as well, but find the regional one to be invaluable with benchmarking.
Electricity Contracts – Currently, all Centers that are in non-regulated utility areas are utilizing one contract for Electricity provision. This results in lower pricing on competitive bidding due to the size of the contract. We are now exploring online utility auctions for this contract.

Pharmacy – The ETBHN Closed Door Pharmacy has saved Centers hundreds of thousands of dollars. We are looking to expand to other Centers and non-profits at this time.

Sharepoint – Recently, ETBHN has implemented a Sharepoint Website. This is a working Website that allows Committees and Workgroups to each have their own Site with calendars, document sharing, message boards, etc… Video Conferencing will soon be available, as well. Each ETBHN Center will be implementing their own Sharepoint Site to replace current Websites. This will all connect to the ETBHN Site for quick interfacing.
Wide Area Network – ETBHN currently has an RFP out for a Wide Area Network (WAN). This will connect all 8 of our Centers for "real time" data retrieval and Video Conferencing. This is a cornerstone for future consolidation efforts.

Service Code Matching – ETBHN is in the process of matching the service codes of all ETBHN Anasazi Centers. This is a step in the direction of standardization and will make the data comparable.

Planning and Quality – ETBHN continues to coordinate meetings and sharing of information for planning of state-wide initiatives including Local Planning Network Development, Crisis (MCOT) planning, etc… These projects being coordinated by the region allows for more standardization between the Centers and pools the knowledge base of key staff.

CFO Consolidation – ETBHN is in the planning stages of offering a regional CFO for 3 Centers on the menu option plan.

Board of Trustee Retreats – Every 6 months, ETBHN plans and sponsors a Board Retreat for all Member Centers. Any Board training that is needed is completed during this time and the Boards of each Center are kept aware and involved in all ETBHN projects.

ETBHN, also, explores opportunities for cost savings and quality improvement in all areas. All senior staff at each Center are involved in meeting and planning for their area. As an example, HR Directors recently reviewed new software for staff development and training that could possibly be regionalized. CFO staff recently met to review areas for growth and improvement, Information Technology Directors meet monthly and are working on several projects at the current time to improve efficiencies, etc…

Business Opportunities Committee – This committee is reviewing how ETBHN Centers can think outside the box and create opportunities in other non-GR related businesses. Areas such as housing, Autism services, and private clinics are just a few of the areas being explored currently.

11. Previous Efforts to Develop a Provider Network

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 questions 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 areas, thus giving the respondents the opportunity to indicate the preference to serve the entire local service area or a portion thereof. Only one respondent indicated an interest in children's mental health services, but since that time their affiliation with a children's program has ended. The majority of the responses were for mental retardation services.

12. Barriers to Attracting Providers

Barriers	Plans
The rates may not be attractive.	Request additional funding from the legislature.
Our areas are very rural.	Promote telemedicine.
There is a shortage of providers in the rural areas.	Promote telemedicine.
Transportation is not readily available.	Collaborate with the community in future planning.

13. Attraction of Providers

The Center recognizes that there are barriers and challenges to attracting external providers to this market and its service area as depicted above. However there are many positive aspects to living and working in the Hopkins, Lamar, and Titus County communities which one should consider:

- If one hates the hustle and bustle of metropolitan traffic, a smaller community may be ideal
- The Center's catchment area is close enough to Tyler that you have enhanced shopping and entertainment beyond the local community
- Real Estate is usually more economical in the suburban to rural areas of Texas
- Close enough that you could commute from Tyler
- Unique family centered fun

14. Long Term Planning

The Center is responsible for developing, updating, and maintaining a local service area plan that complies with the requirements of the DSHS Performance Contract. This plan is designed to develop a local network of mental health service providers that will at a minimum meet the local needs and priorities of consumers and stakeholders, provide consumers a choice of providers, improve access to services, make the best use of available funds, and promote partnerships among consumers, providers, and caregivers.

As the Center enters this initial phase of the development of a local network of providers, the diverse role of the Center will inevitably change over time. The Center currently acts as the Local Mental Health Authority as well as a provider of services. The ultimate goal of this process and plan is to incorporate strategies to ensure continuous consumer access to services while the Center increasingly expands its network of external providers while steadily decreasing its share of internal service provision. The desired outcome is for consumers to have choice from among multiple service providers and for the Center to provide management and oversight of the provider network.

Under the new local network planning requirements, it is important to remember that the Center will continue to be required to capture, retain, and report certain information to DSHS and to continue to manage key internal processes. These operations and internal processes are applicable to all consumers and all services, whether provided internally by the Center or externally by another provider. These key operations include providing certain services and adhering to acceptable clinical practices, generating and managing operational revenue, accommodating state reporting and fiscal requirements, and managing the general operations of standard business and clinical practices. As the local network of providers develops gradually over time, the Center must continue to maintain at least a “safety net” share of service provisions as well as manage all internal operational processes in order to continue to maintain the effectiveness and efficiency of the Center while minimizing disruptions in service delivery to consumers and meeting the mandated objectives of the local network.

While the most crucial objective of the network planning rules is the assembly and management of an external network of providers, this cannot be accomplished through the demise of the Center and the local safety net. Assembly and management of a network of providers must be well planned and sequenced with the Center’s technical expertise to do so. External providers, too, should be well versed in and prepared for any contractual arrangement undertaken.

As the Center progresses through this initial 2 year plan and its associated procurement, the Center will analyze and assess the system of providers obtained to determine the stability of the current network as well as the cost effectiveness of provider contracts in order to ensure that the proper shift of overhead and administrative costs is financially sound. The Center shall also use this time period to evaluate certain operations and functions of the Network Development Department. The importance of this evaluation is to gauge the stability and effectiveness for increasing the Network of Providers during the next planning cycle starting for FY11. The evaluation shall include but not be limited to:

- Redefining areas where technical assistance or additional training may be warranted; i.e., provider profiling, claims management, etc.
- Identifying gained experiences to better meet the goals of the plan.
- Determining whether the needed expertise was obtained to utilize one of the more complex procurement/contracting methodologies such as procuring an entire comprehensive service delivery package or sub-capitation.
- Determining if staffing is adequate to manage a larger network of providers.

• Determining if the network has remained financially viable.
• Ultimately the Center will be assessing the Network's readiness for further expansion.

The Center plans to start its second input gathering stage approximately 6 months prior to the submission of its next Network Development Plan for the 2 year cycle including FY2011 and 2012. There is an expectation that the Center will have gained some added expertise so as to procure more services during the second cycle. There is also the expectation that consumers will be more familiar with choosing a provider, thus the input gathered on where they may want more choice in the future may be more focused, direct and meaningful, thus resulting in the Center better meeting the needs and priorities of the service area.

D. Procurement and Transition Timelines

Date	Key Activities and Milestones
11/1/08-12/31/08	Develop draft procurement document – specify RFP or Open Enrollment or both
1/5-20/09	Publicize draft procurement document (Public comment period – 14 day minimum)
1/21/09-2/9/09	Timeframe for LMHA to consider all public comment and revise procurement document
2/29/09	Publication of final procurement
3/13/09	Due date for procurement responses
4/3/09	Award date

An important part of the development of an external provider network is that it expands choices available to consumers. Please identify the specific steps for consumer's selection of a provider and the time lines for transitioning consumers to new providers.
The steps listed are "model" steps. You may have additional steps in notifying consumers of external provider choice. These additional steps should be inserted at the appropriate location in the following table.

Steps	Time Frames For Completion
Develop a provider list	May 2009
Verify provider information	May 1-31, 2009
Post Provider list to website and distribute to consumer and advocacy groups	June 1, 2009
Conduct provider forums to allow providers to share information with consumers, LARs, and other stakeholders.	June 1-July 15, 2009
Develop internal procedures and forms for consumer selection of providers	June 1-July 31, 2009
Develop consumer information materials relating to selection of providers	June 1-July 31, 2009
Train internal staff on consumer selection procedures	June 15-July 15, 2009
Ensure external providers are trained on consumer selection requirements and procedures	August 1-31, 2009
Implement provider selection procedures for new intakes	Sept. 1, 2009

Implement provider selection procedures for current clients (in conjunction with treatment plan reviews)	Sept. 1, 2009
Develop and implement continuity of care plans for transitioning individual clients to new providers	Sept. 1-January 30, 2010
Consumer transition complete	Feb. 1, 2010

Service	**Time Needed to Re-establish Service Volume**
All	Lakes Regional MHMR Center has established a ninety-day period to reestablish all services. Historically when clinical staff leave, Lakes works quickly to continue services often by shifting existing staff and contracting for additional help including locum tenens doctors and contracting with recruiting firms. Such efforts create added workloads and unexpected costs. This has the added liability of potential financial penalties paid to DSHS when our MHA's collective effort fails to meet contractual minimums. Therefore until a strong base of external providers is established that can assist the MHA in covering unexpected lapses in service, this will remain a challenge and is not fully reflected in a "90 day standard to reestablish services".

E. Staff Qualifications

Notwithstanding that all providers whether internal or external must be trained and competent in the tasks to be performed; qualifications for individual practitioners must at a minimum meet the Mental Health Community Service Standards in order to provide services. All individuals providing services must also complete a criminal background check (for absolute bars to employment go to Texas Health and Safety Code, §250.006.)

Provider Qualifications for Adult Services

1. Pharmacological Management: MD, RN, PA, Pharm.D, APN, LVN
2. Psychiatric Diagnostic Interview Examination: LPHA
3. Counseling: LPHA or LPHA Intern
4.Routine Case Management: QMHP-CS, or CSSP
5. Rehabilitative Services: QMHP-CS, Licensed medical personnel, CSSP, or Peer Provider (consult Rule for specific credential requirements for sub-component services)
6. Supported Employment: QMHP-CS or CSSP or Peer Provider
7. Supported Housing: QMHP-CS or CSSP or Peer Provider

8. Crisis Intervention Services: QMHP-CS
9.Crisis Transportation: No restrictions

Provider/Qualifications for Children's Services

1. Intensive Case Management: QMHP-CS, CSSP
2. Skills Training and Development: QMHP-CS, CSSP
3. Medication Training and Support: QMHP-CS, CSSP
4. Routine Case Management: QMHP-CS, CSSP
5. Family Partner: paraprofessional
6. Parent Support Group: paraprofessional, QMHP-CS
7. Psychiatric Diagnostic Interview Examination: MD psychiatrist (preferably a child psychiatrist)
8. Pharmacological Management: MD, RN, PA, Pharm D, APN, LVN
9. Family Training: QMHP-CS, CSSP
10. Family Case Management: QMHP-CS, CSSP
11. Crisis Intervention Services: QMHP-CS
12. Safety Monitoring: QMHP-CS or trained and competent adult
13. Crisis Transportation: No restrictions
14. Crisis Respite: Trained and competent adult
15. Extended Observation: Meet staffing requirements in Performance Contract (Information Item V)
16. Children's Crisis Residential: Meet staffing requirements in Performance Contract (Information Item V)
17. Counseling: LPHA, intern
18. Group Counseling: LPHA, intern
19. Family Counseling: LPHA, intern
20. Multi-systemic Therapy (MST) team member: LPHA or QMHP-CS under supervision (as permitted by MST certification)
21. Engagement Activity: paraprofessional or QMHP-CS

F. Stakeholder Comments on Draft Plan and LMHA Response

Comment	Stakeholder Group(s)	LMHA Response and Rationale