

# LOCAL PLANNING & NETWORK DEVELOPMENT (LPND)

Fiscal Years 2009 – 2010

# Spindletop MHMR Services

## Local Planning and Network Development (LPND)

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# Spindletop MHMR Services

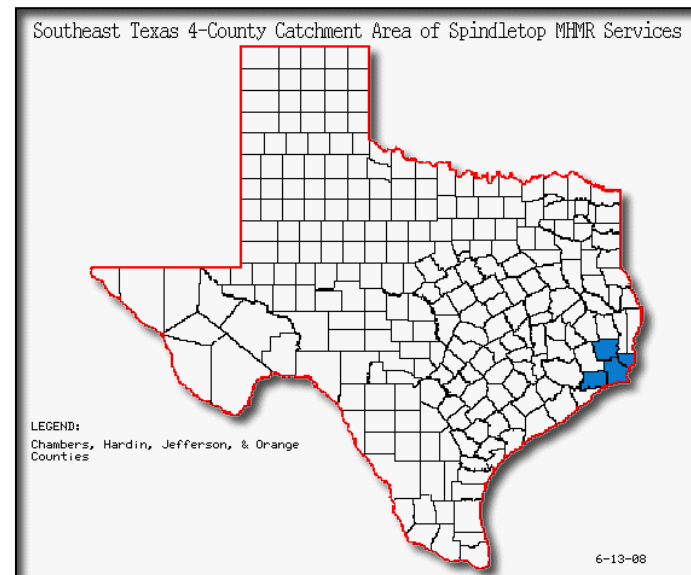
## Local Planning and Network Development (LPND) - Local Service Area Plan

### 2-Year Planning Cycle: Fiscal Years 2009 – 2010

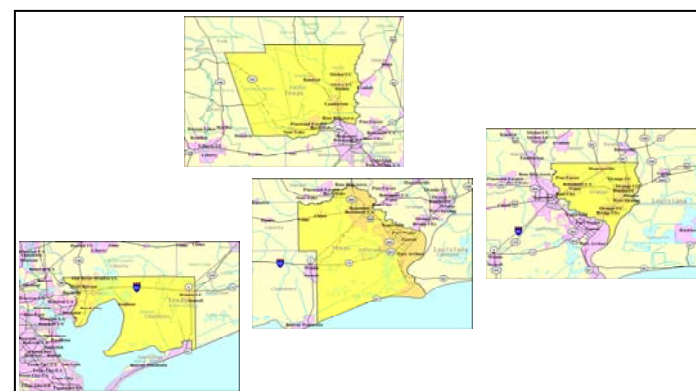


#### *I. Agency Overview*

Spindletop MHMR Services (STMHMR Services), hereinafter referred to as “the Center,” is a non-profit, tax-exempt contract agency of the state of Texas that is governed by a nine-member board of trustees appointed by the county commissioner courts of Chambers, Hardin, Jefferson, and Orange Counties. Past legislation of the state of Texas provided for the establishment and operation of community centers for mental health and mental retardation services. STMHMR Services is the local mental health authority and the mental retardation authority for Chambers, Hardin, Jefferson, and Orange Counties in Southeast Texas. This authority status was assigned to the Center by the Texas Department of Mental Health and Mental Retardation (TDMHMR), now the Texas Department of State Health Services (DSHS). Spindletop MHMR Services was created September 1, 2000, when TDMHMR ended the state agency status of the former Beaumont State Center, as it merged with the former Life Resource, a free-standing, nonprofit community center providing mental health and substance abuse services to consumers in Southeast Texas. The former Life Resource began in 1973 as the Southeast Texas Regional MHMR Center, and in 1968 the Beaumont State Center was officially opened. Staff from both agencies merged into one organization and the quality services of both organizations continue.



Community centers such as STMHMR Services were established in local communities throughout Texas to provide mental health and mental retardation services to persons with the greatest need of these services, especially individuals identified by the state contracting agency as priority population. Most of the centers also provide substance abuse treatment services. The priority population includes consumers primarily at risk of psychiatric hospitalization or state school placement, or exiting from one of these facilities. The fundamental principle that guides Center operations is that persons with mental illness and persons with developmental disabilities should be able to live, work, and play in their home community near their family and friends. The role of the community-based system of services is to support and assist these consumers in the priority population, and this principle remains the core of the Center’s mission and vision.



The mission of Spindletop MHMR Services (STMHMR Services) is to promote the independence and recovery of consumers, and to enhance quality of life by being the premier mental health and mental retardation authority in Texas. Our vision is to ensure access to high quality, professional, respectful, and cost-effective services in a supportive, consumer-centered environment, as well as to promote independence, self-advocacy, recovery, and enhanced quality of life through the development of a comprehensive network of providers.

The Center's official 4-county catchment area, assigned by the Texas Department of State Health Services (DSHS), includes 3,260 total square miles in Chambers, Hardin, Jefferson, and Orange counties of southeast Texas. The U.S. Census Bureau data for July 1, 2007 indicates the total population for this area was 405,012. U. S. Census Bureau reports also indicate that of this total population estimate, 11% of the Chambers County population, 11.2% of the Hardin County population, 20.1% of the Jefferson County population, and 13.8% of the Orange County population had incomes below the poverty level.

Spindletop MHMR Services is licensed by the Texas Department of State Health Services (DSHS), and is also accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The Center is one of only 4 community centers in Texas that are accredited by JCAHO. STMHMR Services is one of 37 community mental health and mental retardation centers in Texas, and services have been provided since 1973. In fiscal year 2007, STMHMR Services served 6,600 unduplicated consumers from Chambers, Hardin, Jefferson, and Orange counties in all Center programs, and provided emergency crisis support services to 4,300 calls for assistance through the crisis intake and assessment service. In addition, the Center served 800 unduplicated consumers in the developmental disabilities programs.

## ***II. Concerns Regarding Local Network Development***

The Center is responsible for developing, updating, and maintaining a local service area plan that complies with the requirements in the performance contract with the Texas Department of State Health Services (DSHS). The plan is designed to develop a local network of mental health service providers that will meet the local needs and priorities of consumers, 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 works to comply with legislative requirements, we must also continue to meet the needs of current consumers and their family members. For over 30 years, the Center has been the primary provider of services to consumers with mental illness who are not eligible for the limited treatment that is available through the private sector. These consumers typically also have multiple disorders, including the dual diagnoses of substance abuse disorder and mental illness, and have chronic illnesses that require long term treatment. In addition, many of these consumers are also homeless and need an array of additional support services from the Center, including employment assistance, assistance with obtaining and maintaining safe, affordable housing, assistance with obtaining food and clothing, and assistance with maintaining effective, long term medication management.

In the development of this local network plan, there are many significant operational issues related to serving this population that must be addressed. These include the process of determining the financial eligibility for Medicaid coverage of consumers who receive services from an external contractor, how the initial clinical screening will be performed, the determination of internal versus external services, how to manage any possible waiting lists for services, the continuation of services over time, ongoing clinical assessments regarding the Texas Resiliency Disease Management

(RDM) requirements, the development and monitoring of consumer treatment plans, and the process of maintaining clinical progress notes. In addition, in an operational network of providers, other issues must be addressed, including managing authorizations for services, adjudicating claims, paying external providers, utilization management, upstream billing, billing of other third-party payers, and direct consumer billing.

As the Center enters this initial phase of the development of a local network of providers, the diverse roles of the Center will inevitably change over time. Currently, the Center fulfills the two roles of the local mental health authority, as well as a provider of services. As the authority, when consumers arrive for treatment, the Center registers the consumers, determines their financial and clinical eligibility for services, and directs the consumers to a provider for treatment, either an internal or an external provider selected by the consumer. If the consumer is directed to an external provider, the authority will give the provider the authorization to permit services and the authority will subsequently pay the provider for the authorized services. On a continuing basis, the provider may request that additional services be authorized and the authority determines whether to authorize the request.

The Center must also reorganize support staff functions in the areas of provider procurement, negotiation and management of external contracts, utilization management, and clinical authorizations and claims adjudication, and the Center must have the information technology capability to accept and process external provider clinical and fiscal information. The Center's current best value operations ensure that consumers receive quality services at conveniently located facilities and can request changes in their provider. The Center also provides efficient cost-benefit results required of the Center in its role as steward of the funds received for services delivered. As the local network of providers gradually expands over time, the Center must continually maintain the most reasonable, cost-effective approach to procurement and contracting methodologies. The Center must develop a pattern of successfully implementing and managing the procurement and contracting methodologies, and must eventually develop an assessment methodology that measures the adequacy of the infrastructure of the network. These processes can take considerable time, and the period of implementation will likely require a few local planning cycles.

In the role of provider, staff employed by the Center provide services to consumers in facilities owned by the Center. The contract with the Texas Department of State Health Services (DSHS) requires the Center to provide DSHS identified services to priority populations. These are the services that the authority is responsible for providing and are the services that may potentially be directed to other external providers. Such required services include consumers with Medicaid coverage or consumers with no or low income who qualify for services funded by Texas general revenue funds.

Under the new local network plan 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 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, producing and managing operational revenue, accommodating state reporting and fiscal requirements, and managing the general operations of standard business and clinical practices. While the development of the local network naturally tends to focus on the delivery of certain identified clinical services, the Center must continue to manage the multiple responsibilities inherent in the operations of the authority role, while maintaining the high quality services that are required by DSHS. New consumers must be registered and the initial and ongoing demographic information must be maintained, while existing consumers must continue to be served. The many required financial reviews must be periodically performed, insurance coverage must be periodically determined, verified, and maintained, clinical screening of consumers must be performed to determine their initial clinical eligibility for services, initial services must be determined, clinical assignments must be made, clinical assessments must be completed and periodically updated, and treatment plans must be developed and periodically reviewed. Progress notes must be entered as

required, and third-party billing, payment, and accounts receivable management must be effectively managed. As the local network of providers develops over time, the Center must continue to maintain all required services 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.

### ***III. Mental Health Services***

#### ***A. Local Planning Process***

##### **1. Plan Objectives**

Spindletop MHMR Services (STMHMR Services), hereafter referred to as “the Center,” is the designated mental health authority for the 4-county catchment area of Chambers, Hardin, Jefferson, and Orange counties of southeast Texas. The Center is responsible for ensuring that funds received from the Texas Department of State Health Services (DSHS) and many other local, state, and federal sources are appropriately and efficiently managed, while providing quality services to consumers in the catchment area. The Center has actively pursued community involvement in its planning processes for many years. The last completed planning cycle ended August 2007, and the current cycle began September 1, 2007.

The Center facilitates a jail diversion task force comprised of representatives from southeast Texas, and also receives suggestions and recommendations from the mental health planning and advisory committee (MHPAC). These efforts ensure that the Center listens to the concerns of consumers, family members, local elected and appointed officials, and representatives of law enforcement, hospitals, and other local service agencies. The Center also actively seeks comments and suggestions from various area stakeholder groups, including the local chapter of the National Alliance for the Mentally Ill (NAMI), the Jefferson County Mental Health Association, mental health consumer groups, and the East Texas Behavioral Healthcare Network (ETBHN) regional planning and network advisory committee (RPNAC).

In 2007 the Center developed a local planning and network advisory committee (PNAC) to assist the Center with the development and implementation of a local network of mental health service providers. The PNAC has been involved in the development of this local planning and network development (LPND) local service area plan. The Center also participated in formal training on local planning and network development presented by the East Texas Behavioral Healthcare Network to the RPNAC, and received comments and suggestions from the RPNAC on the Center’s local network plan.

In addition, the Center has also presented to its governing board of trustees training on developing a local network of service providers and has involved the board in regular discussions regarding the status of the development of the plan.

The plan discusses objectives that include the development of the following:

- o A system of service delivery that is managed by the Center and that provides consumers choice from among multiple service providers;
- o A system that provides ultimate cost benefit, quality consumer care, and the best use of public money in assembling with public involvement a network of service providers;

- o A system of service delivery that meets the needs and preferences of the local community;
- o A system that demonstrates prudent stewardship of public dollars;
- o A system that has operational controls in place to provide the best possible consumer outcomes;
- o A system that protects the rights of consumers to exercise their control over and make decisions regarding their health; and
- o A system that demonstrates the greatest return on public investment in mental health services.

This plan applies to funds allocated to the Center by the Texas Department of State Health Services (DSHS) through the DSHS performance contract with the Center, as well as other funds from DSHS. These funds include federal mental health block grants and state general revenue funds.

The Center arranged special focus group meetings in Beaumont, Orange, Port Arthur, and Silsbee to involve consumers and family members in the development of the local network of service providers. These focus groups were held in these different communities in order to involve the different opinions, cultures, and ethnicities of the 4-county catchment area covered by the Center. In each focus group meeting, Center staff presented information that described the process of development of the local network and distributed surveys to participants to obtain their recommendations and suggestions regarding services the Center might consider contracting and if services might improve if provided by an outside contractor. Consumers currently receiving services and their family members were invited to attend these focus groups. In addition, the Center held a separate focus group meeting with community stakeholders involved in mental health services. Those invited to attend this stakeholder meeting included mental health service consumers and their family members, local providers of mental health services, law enforcement officers, members of mental health advocacy groups, providers of substance abuse services, staff with probation and parole departments, county judges, the local federal qualified health center, and staff from area hospitals and other medical service providers. The stakeholder meeting was arranged in order to ensure that the Center obtained the recommendations, opinions, and suggestions from the various opinions, cultures, and ethnicities that are actively involved in and concerned with mental health issues in southeast Texas.

Stakeholders, consumers, and family members were trained in the development of the local network of service providers. In addition, the Center received written comments and suggestions on survey forms from stakeholders and consumers in attendance at these meetings. The Center also received mailed surveys from stakeholders in the community who were unable to attend the stakeholder meeting.

The Center provided training for members of the local PNAC on the development of a local network of mental health service providers, and requested comments and suggestions from this committee on services the Center might consider providing through local contracts, along with services the Center should continue providing. Members of the PNAC twice received training on the development of a network of local service providers. Participants in the PNAC meetings also provided comments and suggestions on the mental health services that possibly could be provided through local contracts, and one member of the PNAC also attended the separate stakeholder meeting. In addition, a structured survey regarding the mental health service system was provided to the PNAC members. The Center also distributed to all Center staff a special memorandum from the Chief Executive Officer that explained the local network development and planning process and provided information how staff could obtain further information about this process. In addition, the Center provided at its external Web site links to further information regarding the development of this network plan and access to the survey forms used in the various forum. The final draft of the plan will be posted at the Center's public Web site and comments and suggestions on the plan will be requested when viewers access this plan at the site.

## **2. Organizations and Individuals Who Have Participated Since the Last Planning Cycle**

In fiscal year 2007, the Center participated in a regional survey of the perception of consumers and their family members about services provided by the member centers of the East Texas Behavioral Healthcare Network (ETBHN). The regional survey process resulted in 263 completed and returned surveys that asked respondents to provide their opinion about services provided by STMHMR Services and to provide comments and suggestions how the Center could improve services. The regional survey process used 2 survey instruments, including a consumer / family satisfaction survey and a separate survey directed at community stakeholders. On the consumer satisfaction instrument, STMHMR Services scored high in all domains of the instrument and consumers indicated they would like to see an increase in available counseling services. The stakeholder suggestions included increasing community education regarding Center services and requirements for admission to Center programs, increasing public forums to inform the community about the Center, using more focus groups to obtain more information from the community on how to improve services, and to continue working with local consumer advocacy groups.

Advocacy organizations that participated in this local network development planning cycle include the local chapter of the National Alliance for the Mentally Ill (NAMI) and the Jefferson County Mental Health Association. Local government entities participating included staff from the area probation and parole departments, and representatives from area county governments. Representatives from public and private stakeholder organizations included staff from area hospitals and other medical health providers, private mental health and substance abuse service providers, including The Wood Group, and other private mental health practitioners. The Center also arranged a separate meeting with the local NAMI chapter and NAMI sponsored consumer peer support groups to discuss the local network and planning process and to obtain their comments and suggestions regarding the network. This planning process involved forty consumers, ten family members, and five other interested individuals.

STMHMR Services held all PNAC meetings as open, public meetings, and meeting invitations were sent to targeted stakeholders who were asked to participate in the process. The Center also identified community mental health stakeholders who received direct invitations to the meetings, and this number has now increased to 55 persons from the approximately 40 persons on the mailing list in 2007. All interested parties were invited to committee meetings and have been kept up-to-date on the Center's local planning progress. Twenty-five percent of the invited stakeholders attended these special meetings.

The following list indicates the distribution of all participants in all the Center's consumer focus groups meetings, local PNAC and regional PNAC training sessions, stakeholder meetings, staff communication, and survey responses.

- 24% Consumers and family members
- 23% Advocacy organizations
- 21% Other stakeholders (governmental entities, law enforcement, courts, criminal justice system, medical providers, etc.)
- 15% Private providers / provider groups
- 9% Center staff
- 8% Substance abuse providers

The Center sends staff to other community meetings regarding the mental health concerns of the community, and Center staff presented in these meetings presentations on network development activities in order to ensure that there was a widespread awareness of the network development and

planning process. In addition, the Center records provider contract inquiries, and adds interested providers to the mailing list for procurement notices. Later in this 2-year planning cycle, when the Center begins to procure contracts for services, the Center will mail procurement notices to individuals and groups listed with DSHS as interested providers for the 4-county catchment area served by STMHMR Services.

The following table presents information summarizing the information gathered in the planning cycle.

<b>Description And Date or Timeframe</b>	<b>Participating Organizations (List)</b>	<b>Number of Consumers</b>	<b>Number of Family Members</b>	<b>Number of Interested Individuals</b>
Local PNAC Meeting August 2007	Jefferson County Mental Health Association Jefferson County Juvenile Probation Texas Department of Assistive and Rehabilitative Services Consumers and Family Members	1	1	4
Crisis Redesign Meeting September 2007	Memorial Hermann Baptist Hospital Orange County Sheriff's Department Jefferson County Jail Beaumont, Nederland, Port Arthur, & Port Neches Police Departments			15
2 Crisis Redesign Meetings October 2007	Community Mental Health Provider Stakeholders Law Enforcement			25
ETBHN Regional Consumer / Stakeholder Satisfaction Surveys March 2007	Consumers, Family Members, & Stakeholders	171	92	13
STMHMR Services Staff Training	STMHMR Services Staff			12
ETBHN Regional Planning & Network Advisory Committee (RPNAC) Meeting March 20, 2008	Consumers, Family Members, & Stakeholders	5	1	25
Local PNAC Meeting April 3, 2008	Jefferson County Mental Health Association Jefferson County Juvenile Probation Texas Department of Assistive and Rehabilitative Services Consumers and Family Members	1	2	3
Surveys Provided For Consumers	Consumers and Family Members	40	5	2
Surveys Provided For Stakeholders	Mental Health Service Stakeholders			15

<b>Description And Date or Timeframe</b>	<b>Participating Organizations (List)</b>	<b>Number of Consumers</b>	<b>Number of Family Members</b>	<b>Number of Interested Individuals</b>
Consumer Focus Groups April 7, 8, 10, 11, 2008	Consumers and Family Members (More consumers attended the focus groups than completed the written survey.)	63	5	2
MH Stakeholder Meeting April 22, 2008	Port Arthur Police Department The Wood Group Catholic Charities South East Texas Regional Planning Commission Texas Department of Assistive and Rehabilitative Services Hardin County Juvenile Probation Jefferson County Jail			15
NAMI Peer Support May 22, 2008	National Alliance for the Mentally Ill Peer Support Group	8		1
NAMI Board Meeting June 12, 2008	National Alliance for the Mentally Ill Board Members		5	
ETBHN Regional Planning & Network Advisory Committee (RPNAC) Meeting June 19, 2008	Consumers, Family Members, & Stakeholders	5	1	25

### **3. Input Received From Stakeholders**

In the recently completed crisis redesign planning process, The Center established an ad hoc crisis redesign planning task force to assist with the implementation of these requirements. This crisis redesign planning group included professionals from the area health network, including area hospital administrators and emergency room physicians and staff, law enforcement, judges, jails, local governments, public schools, behavioral health providers, substance abuse providers, representatives from mental health advocacy groups, and other area service agencies. The task force became the lead group in the collaborative efforts to organize and focus on resolving emergency mental health needs. The group established as a priority the need to improve the response to mental health crises experienced by individuals with urgent or emergent behavioral health problems in southeast Texas.

From the meetings with consumers and family members, the local PNAC, the regional PNAC, and mental health stakeholders, the Center received comments and suggestions regarding which services might be considered for contracting with another provider, along with other services the Center should continue providing. In addition, the Center received written comments and suggestions on survey forms provided to participants of the meetings, as well as those returned in the mail. In the Center program clinics, staff provided consumers personal, face-to-face invitations to attend the consumer focus groups in order to ensure that consumers were involved in the development of the local network.

The consumers and family members expressed concern regarding the continued availability of their current services in the current locations and were concerned about how the development of a local network of providers would directly impact their services now being provided by the Center. Consumers expressed major concern regarding the current lack of public transportation throughout the Center's 4-county catchment area, and their ability to travel to sites other than the current Center facilities in order to receive services. Consumers had no recommendations regarding any other possible provider of services. There was no statistically significant difference between the results received from participants from the different counties of southeast Texas.

The members of the local PNAC and the regional PNAC and the participants in the mental health service stakeholder group suggested the following services might be considered for contracting: rehabilitation services for adults, children, and adolescents; assertive community treatment (ACT); consumer peer support; parent and family support activities; respite services; psychiatrist visits; and counseling for adults, children, and adolescents. Of the surveys received, the services most often recommended include counseling for adults, children, and adolescents, and psychiatrist visits. Several consumers and stakeholders expressed concern regarding possible contracts with providers that might result in reducing access to services, because the locations of the providers might not be near a bus route or because consumers might have to travel to multiple locations to receive their various services. Each of the above recommendations were received by two or fewer persons.

Stakeholders expressed a preference that the Center not contract all services during the initial entry into the development of a local network, but instead slowly begin with only a select, limited number of services for a designated consumer population in a designated area. The stakeholders also expressed concern regarding the ability of any other local service provider to provide the additional, extensive array of support services the Center now provides to consumers and to adequately respond to the complex needs of consumers served by STMHMR Services. Stakeholders also expressed positive comments regarding current crisis services, while suggesting that the Center consider increasing the capacity of crisis services, indicating that many times there are not enough hospital beds for psychiatric treatment. Most of the discussion in these various group meetings focused on routine mental health services.

#### **4. Service Delivery Priorities and Gaps in Services**

The Center is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and as part of the ongoing JCAHO requirements the Center must complete an annual analysis of services and operations. In the most recent JCAHO required periodic performance review (PPR), the Center reviewed internal operations, policies, and procedures in accordance with the extensive set of JCAHO standards. The results of this review indicated minor areas for improvements in internal procedures. The next formal, on-site review of the Center by JCAHO will occur in 2009. In the 2006 local planning process, the Center received involvement from members of the local mental retardation planning and advisory committee (MRPAC), the local mental health planning and advisory committee (MHPAC), the regional public network advisory committee (RPNAC) of the East Texas Behavioral Network (ETBHN), mental health and mental retardation stakeholders, consumers and family members, and Center staff. In addition, the Center reviewed the governing board strategic initiatives, and analyzed trends identified in internal and external data and DSHS performance contract requirements.

The results of this local process guided the development of Center goals and objectives for fiscal year 2006, which are summarized here.

### Strengths

- The Center is proven to be adaptable and flexible.
- The Center has experienced staff with a low turnover rate.
- Center staff desire to involve families and consumers in decision making.
- Management has implemented competitive business approaches to operations.
- The Center provides a full array of services with limited financial resources.

### Weaknesses

- The Center remains under-funded.
- The service population is defined by external funding entities.
- Consumers voice frustration with the new outpatient appointment scheduling process.
- Texas resiliency and disease management (RDM) philosophy limits case management to certain populations.

### Opportunities

- The Center effectively uses the regional ETBHN pharmacy.
- Increased staff training is planned to increase effective interactions with stakeholders.
- The Center broadens its base to serve non-priority population through grant-writing.

### Threats

- Legislation often restricts what the Center can do and may force the Center to eliminate its authority functions.
- The provider of last resort issue may dismantle services.
- The manner of creating equity among Centers appears to be unfair and unworkable.
- Continued funding cuts jeopardize services.
- Difficult for management to plan for the unknown.
- Staff time to assure compliance with increasing regulations is growing.
- CAM data do not reflect true comparisons among Centers.
- The Center has decreased access to state hospital beds for consumers in crisis.

Challenges faced by the Center include the increase in the population expected over the next biennium, and an anticipated increase in problems finding housing for the low income population, especially homeless consumers with a mental illness. According to the South East Texas Regional Planning Commission's 2007 survey, there were approximately 700 homeless persons in Southeast Texas. Of this population, 110 were living in emergency shelters, and the remainder were unsheltered. Also, 120 homeless persons were chronically homeless, 170 were severely mentally ill, 240 had chronic substance abuse problems, 60 were military veterans, 60 were victims of domestic violence, and 30 were unaccompanied youth under the age of 18. Eighty-five percent of the homeless lived in Jefferson County, 10% lived in Hardin County, and 5% lived in Orange County. Ninety percent (90%) of the homeless population were aged 18 to 40, with 56% male and 44% female. The ethnicity of the homeless population included 58% African-American, 40% Caucasian, 1% Asian, and 1% Hispanic.

Coordinating providers of services for individuals with a co-occurring mental illness and substance abuse disorder will continue to be a recognized gap in services, as will the continued lack of enough hospital treatment beds for consumers experiencing a mental health crisis. Stakeholders focused on the continued lack of adequate public transportation for consumers, especially those living outside the Beaumont area, as well as not enough licensed and affordable housing facilities for consumers.

Another critical gap in services is the lack of available, affordable physical health treatment for consumers with a mental illness. These consumers often cannot receive physical health treatment, because of their lack of income and health insurance coverage. For consumers who do have health insurance, their physical health treatment frequently compromises their co-occurring mental health disorders, because of the polypharmacological interaction of their mental health medications with their physical health medications. In southeast Texas, indigent health consumers must travel outside the Center's 4-county catchment area in order to receive treatment at the University of Texas Medical Branch (UTMB) at Galveston.

As a result of these efforts to obtain comments, suggestions, and recommendations from consumers, family members, mental health service providers, civic and government leaders, and stakeholders in the mental health system, the following major concerns continue to challenge the Center, as well as all Texas community mental health and mental retardation centers.

- Uncertainty of the future role of local authorities
- Uncertainty of the new service delivery system
- Medicaid regulations, including applicability of rehabilitation requirements, administrative claiming, and service coordination / case management mandates
- Unstable and uncertain funding, including consideration that rates of service have not been adequately determined for all services
- Degree of control by the local authority over potential contract providers
- Inconsistency in present and future statutory, regulatory, and contractual requirements in Texas Health and Safety Code, chapters 533 and 534, 25 TAC, chapter 412, subchapter B, Medicaid rules, and performance contract requirements
- Funding guidelines for un-bundled services which may be contracted out in pieces
- Uncertainty of the impact of the loss of the local authority's role as the local "safety net"
- Confusion for providers and consumers, as well as increased administrative costs for providers when multiple locations and multiple providers attempt to provide services to consumers covered by the Texas Resiliency and Disease Management (RDM) model

## **5. Changes to Service Delivery System in the Next Biennium**

With the initiation of the crisis redesign in fiscal year 2008, the Center established the Mobile Crisis Outreach Team (MCOT). This special team of professionals improves the responsiveness and the level of care that is available to the community. The team provides dedicated, full-time employees who provide crisis response services in a less restrictive environment. This new service has reduced the need for law enforcement involvement in mental health crisis situations. In the future as additional funding becomes available, mobile crisis staff will be increased in order to further reduce the time required to respond to mental health crises in the Center's catchment area. STMHMR Services also plans to increase the stipends and training in order to expand the number of on-call staff in the mobile crisis response services. The number of providers participating in this mobile crisis response service is expected to expand as additional funds are made available. The Center plans to increase the number of mobile crisis teams in order to further reduce response times in the more rural areas of the community. The Center will continue to implement the crisis redesign plan

which became active March 1, 2008. Beginning June 1, 2008, the Center began a new contract with the Baptist Behavioral Health hospital in Beaumont to provide 48-hour extended observation services for consumers experiencing a mental health crisis. This service is funded by the DSHS crisis redesign funds and the service will extend through fiscal year 2009. The Center also received a grant from the Texas Council on Offenders with Multiple Impairments (TCOOMI) to develop telemedicine services in local jails, and is also currently in contract negotiations with JHS Associates to provide pharmacological services by physicians using telemedicine technology. The long range plan is to use telemedicine technology to improve access to services to consumers throughout the 4-county catchment area of the Center.

## ***B. Current Services and Providers***

### **1. Overview and Rationale for Methodology**

The following discussion provides an overview of and rationale for the methodology used to calculate the dollar amounts listed in the below columns entitled “Dollars Spent on Direct LMHA Services” and “Dollars Spent on External Provider Services.”

As recommended by the Texas Department of State Health Services (DSHS), the Texas Council of Community MHMR Centers used members of its various consortia to develop a methodology that would be consistent throughout the Texas community centers to determine the dollars spent on services. The basis of the developed methodology is the cost of services, and costs were used because of the direct relationship between the costs of the services and the delivery of the services. The rationale to use costs is summarized as follows. The costs represent the actual costs to deliver the services, regardless of the funding source.

To use the methodology, the Center isolated the costs associated with the services already delivered by external providers under contract with the Center. The Center performed a detailed allocation of all costs associated with the services it provided directly, including direct costs, provider-related overhead costs, and the appropriate pro-ratio of general administrative costs. As instructed by DSHS, administrative expenses associated with the Center’s authority functions were not included in the calculations. The data submitted by the Center to DSHS in response to the fiscal year 2007 Cost Accounting Methodology (CAM) requirement was the basis for the unit costs used in the methodology.

While the methodology does, to the best of the Center’s ability, identify the costs associated with services delivered by the Center in fiscal year 2007 and identifies the amount of DSHS-related funding spent on external provider services in fiscal year 2007, the former should not be considered the definitive amount of DSHS-related funding available for contracting under the LPND rule.

The chart below provides an overview of the service delivery system in fiscal year 2007 and provides a snapshot picture of the Center’s existing network. A review of this chart provides the foundation for the following sections of the plan on service capacity and procurement, and provides the Center and stakeholders a baseline for considering progress made towards the network development goals.

### 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
<b>ROUTINE SERVICES</b>					
Intake (Screening, Pre-admission Assessment)	X	\$261,532	Fannin Behavioral Health Center of Memorial Hermann Baptist Beaumont Hospital 3250 Fannin Street Beaumont, Texas 77701 The Wood Group 2750 South 8 <sup>th</sup> Street Beaumont, Texas 77701	\$1,082,382 (Total for both contracts)	3-1-07 - 2-28-09  5-1-07 – 8-31-08
Routine Case Management (Adult)	X	\$281,386			
Routine Case Management (Child/ Adolescent)	X	\$20,102			
Respite Services					
Supplemental Nursing Services	X	\$57,937			
Pharmacological Management	X	\$184,831	Dr. Charles Adkins Dr. Victor Cardenas Dr. Victor Fermo Dr. Sudheer Kaza Dr. Doina Vacalie Dr. Byron Wilkenfeld Spindletop MHMR Services 2750 South 8 <sup>th</sup> Street Beaumont, Texas	\$453,386 (Total for all physicians)	9-8-05 – 9-8-08 1-1-07 – 2-29-07 9-1-06 – 8-31-07 9-1-06 - 8-31-07 11-1-06 – 12-31-06 11-1-06 – 11-30-06
Provision of medication			Community Pharmacy 365 Forsythe Beaumont, Texas 77701 East Texas Behavioral Healthcare Network 4101 South Medford Drive Lufkin, Texas 75901	\$1,480,410 (Total for both contracts)	8-1-06 - 8-31-07  9-1-07 – 8-31-08

### 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
Psychiatric evaluation	X	\$109,811	Dr. Charles Adkins Dr. Victor Cardenas Dr. Victor Fermo Dr. Sudheer Kaza Dr. Doina Vacalie Dr. Byron Wilkenfeld Spindletop MHMR Services 2750 South 8 <sup>th</sup> Street Beaumont, Texas	\$207,388 (Total for all physicians)	9-8-05 – 9-8-08 1-1-07 – 2-29-07 9-1-06 – 8-31-07 9-1-06 - 8-31-07 11-1-06 – 12-31-06 11-1-06 – 11-30-06
All Rehabilitation Services (Adult)	X	\$2,511,432			
All Rehabilitation Services (C/A)	X	\$356,400			
Supported Employment	X	\$9,820			
Supported Housing	X	\$1,724			
Assertive Community Treatment (ACT)	X	\$186,715	Dr. Charles Adkins Spindletop MHMR Services 2750 South 8 <sup>th</sup> Street Beaumont, Texas	\$24,530	9-8-05 – 9-8-08
Residential Treatment					
Intensive Case Management (Child/Adolescent)	X	\$311,015			
Counseling (Adult)			Joanne Roper, LPC (FY '07) Spindletop MHMR Services 2750 South 8 <sup>th</sup> Street Beaumont, Texas 77701  Dorothy H. Henges. LPC #5 Dowlen Place Beaumont, Texas 77706	\$44,683  No funds expended in FY 2007.	9-1-06 – 8-31-07  This contract provider began services in FY 2008.
Counseling (Child/Adolescent)	X	\$932	No Provider in FY 2007  Dorothy H. Henges, LPC #5 Dowlen Place Beaumont, Texas 77706	No funds expended in FY 2007.	This contract provider began services in FY 2008.

### 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
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)	X	\$23,311			
Flexible Community Support (Child/Adolescent)					
Multi-Systemic Therapy (Child/Adolescent)					
Consumer Peer Support	X	\$85,231			
<b>CRISIS &amp; OTHER DISCRETE SERVICES</b>					
Mobile Crisis Outreach Team			<p>The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008. The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.</p> <p>Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.</p>		
Crisis Transportation					
Crisis Flexible Benefits					
Day Program for Acute Needs					
Crisis Follow-Up and Relapse Prevention					
Safety Monitoring					
Extended Observation					
Hotline			MHMRA of Harris County 7001 Southwest Freeway Houston, Texas 77074	\$12,645	3-1-07 – 2-28-08 3-1-09 – 8-31-09
Crisis Intervention Services	X	\$53,110	Fannin Behavioral Health Center of Memorial Hermann Baptist Beaumont Hospital 3250 Fannin Street Beaumont, Texas 77701 The Wood Group 2750 South 8 <sup>th</sup> Street Beaumont, Texas 77701	\$31,017 (Total for both contracts)	3-1-07 - 2-28-09  5-1-07 – 8-31-08
Crisis Stabilization Unit	X	\$230,478	This represents the costs to run the Center's CSU unit in fiscal year 2007. The unit was closed March 1, 2007		

### 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
Extended Observation Unit			No Provider in FY 07 Fannin Behavioral Health Center of Memorial Hermann Baptist Beaumont Hospital 3250 Fannin Street Beaumont, Texas 777701	No funds expended in FY 2007.	This contract provider began services in FY 2008.
Crisis Residential Treatment Services			The Wood Group 2750 South 8 <sup>th</sup> Street Beaumont, Texas 77701	\$ 230,582	5-1-07 – 8-31-08
Respite Services			The Wood Group 2750 South 8 <sup>th</sup> Street Beaumont, Texas 77701	\$4,000	5-1-07 – 8-31-08
Inpatient / Hospital Services* *The amount expended on inpatient services occurred after fiscal year 2007.			Fannin Behavioral Health Center of Memorial Hermann Baptist Beaumont Hospital 3250 Fannin Street Beaumont, Texas 777701	\$708,180	3-1-07 - 2-28-09
Laboratory Services			Accutox Laboratory 145 N 13th Street Beaumont, Texas 77702-2127	\$27,833	9-1-06 - 8-31-07 9-1-07 – 8-31-08
Utilization Management (UM)			East Texas Behavioral Healthcare Network 4101 South Medford Drive Lufkin, Texas 75901	This contract began in fiscal year 2008.	9-1-07 – 8-31-08

## ***C. Provider Network Development***

### **1. Provider Availability**

In order to determine the viability of expanding our network of external providers, STMHMR Services completed an analysis to assess the level of provider availability. The analysis included: (1), contacting current and former providers; (2), calling providers who may have in the past expressed interest in working with the Center; (3), reviewing business directories; (4), searching the internet; and (5), reviewing the results of the request for information in the 2004 provider of last resort process.

In April 2004, the Center developed and implemented an official Request for Information (RFI) process as a means of determining interest in a comprehensive local treatment network for people with mental illness and mental retardation. The RFI asked respondents to provide information on various service packages and to include any topics or questions the respondent or any other interested parties believed should be included in any possible future Request for Proposal (RFP). The RFI document included a geographic description of the local service area and provided respondents an opportunity to indicate a preference to serve the entire local service area or just a portion. The RFI document also included the verbatim service descriptions in the Center’s performance contract. The RFI also provided respondents an opportunity to express interest in providing all services in an entire service package, or individual services within the package.

The Center received only two responses that indicated a capacity to provide limited services in a limited geographical section of the 4-county catchment area covered by the Center. Each response also presented a severely limited capacity for service. Other respondents indicated interest in providing services in areas outside the Center’s 4-county catchment area, or did not indicate interest in any particular level of care. The Center also received a verbal request from Family Services Counseling Center of Beaumont, a local United Way funded counseling agency, for more information regarding becoming a possible provider, and Center staff provided this external provider with information in the Center’s Potential Provider packet of material.

The Center has thus far received no formal requests or letters from any service provider indicating interest in being considered for any possible request for proposal for the contracting of services. The Center also obtained information from the Web site of the Texas Department of State Health Services (DSHS) indicating interest by two private mental health providers in possibly contracting with the Center to provide services. These two providers indicated interest in providing all Center services, as well as all services for all the community mental health and mental retardation services in all of Texas. The Center will release an official request for application to area providers to solicit interest in the services considered for contracting. The Center’s current private providers have all expressed no interest in terminating their contractual relationship with the Center, as well as their preference to continue their contractual relationship when the time comes for contract renewal discussion. Therefore, any possible expansion of a local network with additional external providers in this area will be a challenge.

**2. Provider Inquiries Within the Last 2 Years**

The following table summarizes written inquiries received from providers interested in offering services received over the previous two years by the Center. Note: The information on Web site postings is effective as of August 4, 2008.

Date of Inquiry	Summary of Inquiry	LMHA Response
DSHS Web Site Posting	The Wood Group (TWG Investments LTD) – All Services – All Centers in Texas	None at the time – No response to invitation to participate this planning cycle
July 30, August 1, 2008	Telephone Contact – Followed up with E-Mail – The Wood Group (TWG Investments LTD)	The Center requested further clarification from this provider regarding which services the provider might wish to provide. The provider reiterated their interest in providing the same services they indicated in their earlier Web site posting.

DSHS Web Site Posting	Sunwest Behavioral Health Organization, LLC – All Services – All Centers in Texas	None at the time – No response to invitation to participate this planning cycle
August 8, 2008	Telephone Contact – Davin Magno, Sunwest Behavioral Health Organization, LLC	The provider indicated that while their organization currently does not have the infrastructure necessary to provide all the services indicated in their provider interest list, they intend to review any RFP package issued by all Texas LMHAs and determine, based on rates, whether to respond to the RFP. The provider also indicated that they might be interested in responding to both discrete services requests, as well as whole service packages, and will have a preference for centers that request rehabilitation services. The organization also indicated their understanding of the need for LMHAs to proceed slowly in this process and a willingness to be a partner with the LMHA to ensure the success of the authority.
Verbal Contact and Request – May 15, 2008	Family Services Counseling Center of Beaumont Counseling – Adults, Children & Adolescents – Beaumont, Texas	The Center provided the agency with the Center’s Potential Provider packet of material.

### **3. Service Capacity and Procurement**

The following data on current capacity (column 3a) by Resiliency Disease Management (RDM) service package represents 6 quarters of data. This includes 4 quarters of fiscal year 2007 and quarters 1 (Sept., Oct., Nov.) and 2 (Dec., Jan., Feb.) of fiscal year 2008.

The challenge for Spindletop MHMR Services is to successfully involve the community in planning, developing, and managing the performance of a network of local service providers that will provide the greatest value in services for consumers while maintaining integrity and stewardship over public resources. The Center must analyze its provider network to ensure that it has the capacity to provide consumers with the same access to the full range of services currently provided by the Center. This capacity is best understood by using network development analysis tools to examine the strengths and needs of the current provider system, identify gaps in services, and solicit input from consumers, family members, and other stakeholders. Accurate analysis of the findings from these tools identifies gaps in services and helps in soliciting input, both of which are necessary for planning, assembling, and managing a provider network which reflects the integrity and stewardship of public resources.

	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
<b>ADULT SERVICES</b>						
RDM SP 1	1,853	3,170	The Center has achieved very limited success in procuring contracts with physicians for this service package. The Center has contracts with some physicians and <i>locum tenens</i> to provide some of the services in SP 1. The Wood Group (TWG Investments, LTD) expressed interest in serving 200 consumers in this SP. Sunwest Behavioral Health Organization, LLC expressed interest in serving 100 consumers in this SP.	Yes, except for add-on services	10%	Request For Application (RFA)
RDM SP 2	16	45	The Center has contracts with some cognitive behavioral therapists, physicians, and <i>locum tenens</i> to provide some of the services in SP 2. The Wood Group (TWG Investments, LTD) expressed interest in serving 25 consumers in this SP. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	Yes, except for add-on services	100%	Request For Application (RFA)
RDM SP 3	269	506	The Center has experienced difficulty hiring Qualified Mental Health Providers (QMHP) to provide these services. The Wood Group (TWG Investments, LTD) expressed interest in serving 100 consumers in this SP. Sunwest Behavioral Health Organization, LLC expressed interest in serving 300 consumers in this SP.	No	N/A	N/A
RDM SP 4	71	130	The Center has experienced difficulty hiring Qualified Mental Health Providers (QMHP) to provide these services. The Wood Group (TWG Investments, LTD) expressed interest in serving 100 consumers in this SP. Sunwest Behavioral Health Organization, LLC expressed interest in serving 150 consumers in this SP.	No	N/A	N/A
RDM SP 0	24	347	The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008. The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.  Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.			
RDM SP 5	0	4				

	<b>3a</b>	<b>3b</b>	<b>3c</b>	<b>3d</b>	<b>3e</b>	<b>3f</b>
<b>Service</b>	<b>Current Capacity</b>	<b>Projected Capacity</b>	<b>Availability of Current and Potential External Providers</b>	<b>Procurement Planned?</b>	<b>Capacity to be Procured</b>	<b>Method of Procurement</b>
<b>CHILD/ADOLESCENT SERVICES</b>						
RDM SP 1.1	127	217	The Center has experienced difficulty hiring Qualified Mental Health Providers (QMHP) to provide these services, and difficulty finding child psychiatrists. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	No	N/A	N/A
RDM SP 1.2	2	3	Limited availability. While there are some Licensed Professional Counselors (LPC) in the area, none have expressed interest in contracting with the Center. The Center has a contract with a cognitive behavioral therapist to provide some of the services in SP 1.2. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	No, except for cognitive behavioral therapy	0%	Request For Application (RFA)
RDM SP 2.1	1	0	Not Applicable	No	N/A	N/A
RDM SP 2.2	129	223	The Center has experienced difficulty hiring Qualified Mental Health Providers (QMHP) to provide these services, and difficulty finding child psychiatrists. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	No	N/A	N/A
RDM SP 2.3	0	0	Limited availability. While there are some Licensed Professional Counselors (LPC) in the area, none have expressed interest in contracting with the Center. The Center has a contract with a cognitive behavioral therapist to provide some of the services in SP 2.3. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	No, except for cognitive behavioral therapy	0%	Request For Application (RFA)
RDM SP 2.4	1	0	The Center has achieved very limited success in procuring contracts with child psychiatrists for this service package. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	No	N/A	N/A
RDM SP 4	145	263	The Center has achieved very limited success in procuring contracts with child psychiatrists for this service package. Sunwest Behavioral Health Organization, LLC expressed interest in serving 50 consumers in this SP.	No	N/A	N/A

	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
RDM SP 0	5	65	The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008. The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.  Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.			
RDM SP 5	0	0				
<b>DISCRETE SERVICES TO BE PROCURED</b>						
RDM SP 1.2	2	3	Counseling – Child / Adolescents	Yes	100%	Request for Application (RFA)
RDM SP 2.3	0	0	Counseling – Child / Adolescents	Yes	100%	Request for Application (RFA)
<b>CRISIS &amp; OTHER DISCRETE SERVICES NOT APPLICABLE FOR THIS PLAN - CRISIS SERVICES HAVE ALREADY BEEN RE-DESIGNED</b>						
<i>Hotline</i>						
<i>Mobile Crisis Outreach Team</i>						
<i>Extended Observation</i>						
<i>Day Program for Acute Needs</i>						
<i>Crisis Stabilization Unit</i>						
<i>Respite Services</i>						
<i>Inpatient / Hospital Services</i>						
<i>Crisis Residential Treatment Services</i>						
<i>Safety Monitoring</i>						
<i>Crisis Follow-Up and Relapse</i>						

	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
<i>Prevention</i>						
<i>Crisis Transportation</i>						
<i>Crisis Flexible Benefits</i>						
<i>Laboratory Services</i>						

#### **4. Justification for Procurement of Discrete Services**

The Center already contracts out at least 25% of the Texas general revenue funds. The Center has chosen to cautiously limit procurement of services during this first 2-year planning cycle. As external providers are trained to provide these services, it is important that the Center maintain the operations of the internal network as a safety net for consumers. Center experience has revealed that training, quality monitoring, and fiscal stability need to be assessed over a 1-2 year time span prior to any further reduction of the internal network. In the third and fourth years of this planning process, services that have been successfully and firmly contracted can then be considered for further network expansion. This graduated approach during the next 2-year planning cycle shall also incorporate new information gathered from the local community regarding additional service areas where choice is desired. The following table presents the rationale for separately procuring services.

Discrete Service to be Procured	Rationale
Counseling – Children & Adolescents (SP 1.2, SP 2.3)	Consumers and family members expressed preference that these services be considered for possible contract. Separately procuring cognitive behavioral therapy will provide consumers with greater choice and improved access to these services. In the 4 county catchment area of the Center, the Center already contracts with the only child/adolescent psychiatrist in the area, and there is a statewide shortage of board certified child/adolescent psychiatrists.
<b>Services Already Contracted Out</b>	
Crisis Hotline	The Center already contracts out this service and plans to continue this in the next fiscal year.
Psychiatric Inpatient	The Center already contracts out this service and plans to continue this in the next fiscal year.
Laboratory Services	The Center already contracts out this service and plans to continue this in the next fiscal year.
Pharmacy Services for General Revenue (GR) Consumers	The Center already contracts out this service and plans to continue this in the next fiscal year.
Crisis Residential Services	The Center already contracts out this service and plans to continue this in the next fiscal year.

Psychiatric Extended Observation Services	In the last quarter of fiscal year 2008 the Center began a contract for psychiatric extended observation services and plans to continue this contract in fiscal year 2009.
Crisis Respite Services	The Center already contracts out this service and plans to continue this in the next fiscal year.

**a. Plan for Fidelity and Continuity of Care**

The Center is required to provide case management in order to support continuity of care. Continuity of care of consumers will be monitored by the Center’s case manager staff who will be assigned to the consumers who receive services from a contract provider. Special emphasis will be placed on providing individual case management services to ensure that consumers who are linked to external providers receive the support they need throughout the length of their treatment and the transition to a network of external providers. Additionally, the role of these case managers will be to ensure that there is ongoing communication with and coordination of services provided by both internal and external providers. Case managers will be responsible for ensuring that the consumer receives the necessary services from within the designated service package that are appropriate to their level of need. The Center’s existing quality management function will be responsible for managing the fidelity of the service provided by a contractor. This monitoring process will include on-site audits of the contractor’s performance, desk reviews of required contractor reports, and regular review of the provider’s operations as required in the provider’s contract with the Center. The Center’s utilization management function will be responsible for ensuring that the initial, refresher, and incident-specific training required of the contractor regarding contract fidelity requirements has been completed. The Center’s accounts receivable staff will be responsible for adjudicating billing claims received from contract providers, and will ensure that the claims meet all state and federal contract fiscal requirements. The Center’s human resources and network services departments will interview, assess, and verify the credentials of all providers that apply for contracts. Center quality management staff will be responsible for disseminating to contractors all requirements of state agencies. The Center will allow external contract providers to use existing Center facilities to provide services in order to ensure continuity of care and that services are provided for consumers in 1 location. In addition, the Center will require monthly meetings of external contract providers to review contract operations, fidelity of care issues, and quality management issues, and may also provide required training for potential contractors.

**5. Rationale for Keeping Services**

The following table presents the rationale to continue providing 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 the following 2 factors.

- 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 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
<b>ADULT SERVICES</b>					
RDM SP 1	90%	4	Currently, based on contacts with providers on the provider interest list, neither organization indicated that they have the capacity, staff, or the infrastructure in the LMHA's catchment area to provide these SP 1 services, although both indicated interest in meeting the capacity over time, depending on the actual rate of reimbursement.	50%	Consumers and family members expressed concern regarding the possible change in the current delivery of these services. Therefore, the Center will gradually expand the availability of external providers in order to ensure that consumers are provided a choice of providers and that the continuity of care for consumers is maintained. The Center will continue to find additional external providers during each future planning cycle.
RDM SP 2	0%	N/A		0%	
RDM SP 3	100%	5	The LMHA must continue this service in order to maintain the critical infrastructure of the organization.	75%	The Center must continue to provide current volume capacity in order to continue to meet consumer needs. The current revenue generated by this service is needed to maintain safety net services and the critical infrastructure of the Center. Therefore, the Center will gradually expand the availability of external providers in order to ensure that consumers are provided a choice of providers and that the continuity of care for consumers is maintained. Because of the complexity of contracting this SP, procurement of this SP will be considered within the next five planning cycles. This is dependent on the success of the current planning cycle and receipt of further clarification from DSHS regarding procedures for contracting psychosocial rehabilitation services. See the long range planning section for more information.
RDM SP 4	100%	5	The LMHA must continue this service in order to maintain the critical infrastructure of the organization. The Center's current contract volume and geographical area will not support the development of an additional ACT team.	100%	The Center must continue to provide current volume capacity in order to continue to meet consumer needs. The current revenue generated by this service is needed to maintain safety net services and the critical infrastructure of the Center. The Center does not anticipate increasing the number of ACT teams in this area, so this service will not be considered for external procurement.
RDM SP 0	100%	N/A	The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008.		

Service	Percent Capacity provided by the LMHA	Condition 1-6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
RDM SP 5	100%	N/A	The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.  Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.		
<b>CHILD/ADOLESCENT SERVICES</b>					
RDM SP 1.1	100%	2	The LMHA must continue this service in order to maintain the critical infrastructure of the organization. In the 4 county catchment area of the Center, the Center already contracts with the only child/adolescent psychiatrist in the area, and there is a statewide shortage of board certified child/adolescent psychiatrists. In addition, further contact with interested providers indicated that only one provider had the desire to provide child / adolescent services.	75%	The Center must continue to provide current volume capacity in order to continue to meet consumer needs. The current revenue generated by this service is needed to maintain safety net services and the critical infrastructure of the Center. Therefore, the Center will gradually expand the availability of external providers in order to ensure that consumers are provided a choice of providers and that the continuity of care for consumers is maintained.
RDM SP 1.2	100%	N/A	Discrete service (Counseling – Children & Adolescents) to be contracted out	0%	See below rationale for discrete services to be contracted.
RDM SP 2.1	N/A	N/A	The Center is not responsible for providing this service.	N/A	There is negative volume in this service package. The current capacity is zero.
RDM SP 2.2	100%	2	The LMHA must continue this service in order to maintain the critical infrastructure of the organization. In the 4 county catchment area of the Center, the Center already contracts with the only child/adolescent psychiatrist in the area, and there is a statewide shortage of board certified child/adolescent psychiatrists. In addition, further contact with interested providers indicated that only one had the desire to provide child / adolescent services.	75%	The Center must continue to provide current volume capacity in order to continue to meet consumer needs. The current revenue generated by this service is needed to maintain safety net services and the critical infrastructure of the Center.
RDM SP 2.3	100%	N/A	Discrete service (Counseling – Children & Adolescents) to be contracted out	0%	See below rationale for discrete services to be contracted.

Service	Percent Capacity provided by the LMHA	Condition 1-6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
RDM SP 2.4	100%	2	There are no service providers in the area that can provide these services, and the Center anticipates no additional interest in requests for proposals. In addition, further contact with interested providers indicated that only one had the desire to provide child / adolescent services.	0%	In the 4 county catchment area of the Center, the Center already contracts with the only child/adolescent psychiatrist in the area, and there is a statewide shortage of board certified child/adolescent psychiatrists.
RDM SP 4	100%	2	There are no service providers in the area that can provide these services, and the Center anticipates no additional interest in requests for proposals. In addition, further contact with interested providers indicated that only one had the desire to provide child / adolescent services.	75%	The Center must continue to provide current volume capacity in order to continue to meet consumer needs. The current revenue generated by this service is needed to maintain safety net services and the critical infrastructure of the Center.
RDM SP 0	100%	N/A	<p>The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008. The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.</p> <p>Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.</p>		
RDM SP 5	100%	N/A			
<b>CRISIS &amp; OTHER DISCRETE SERVICES</b>					
<i>Hotline</i>	<p>The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008. The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.</p> <p>Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.</p> <p>The crisis services redesign initiative was completed just prior to this local planning initiative that began March 1, 2008. The development of local crisis services plans occurred using existing planning and procurement requirements. The efforts related to crisis services are not at this time covered in the new local network planning and development (LPND) rules for fiscal year 2008. Current crisis service planning efforts are summarized within this plan.</p>				
<i>Mobile Crisis Outreach Team</i>					
<i>Extended Observation</i>					
<i>Day Program for Acute Needs</i>					
<i>Crisis Stabilization Unit</i>					
<i>Respite Services</i>					
<i>Inpatient / Hospital Services</i>					
<i>Crisis Residential Treatment Services</i>					
<i>Safety Monitoring</i>					
<i>Crisis Follow-Up and Relapse Prevention</i>					

Service	Percent Capacity provided by the LMHA	Condition 1-6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
<i>Crisis Transportation</i>	Note: Community centers are not required to repeat the process of local planning for crisis services when considering this network development plan, and crisis services are not subject to further procurement at this time.				
<i>Crisis Flexible Benefits</i>					
<i>Laboratory Services</i>			The LMHA already contracts out this service.		
<b>DISCRETE SERVICES TO BE CONTRACTED</b>					
<i>Discrete Service – Counseling (Cognitive Behavioral Therapy) – Children &amp; Adolescents</i>	100%	N/A	Discrete service Counseling (Cognitive Behavioral Therapy) – Children & Adolescents To Be Contracted	0%	N/A

## **6. Structure of Procurement**

The following table describes how procurement will be structured and the rationale for the procurement.

Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
SP 1	Chambers, Hardin, Jefferson, Orange Counties	Request for Application (RFA) The Center plans to contract for 10% of this service in all 4 counties of the Center’s catchment area.
SP 2	Chambers, Hardin, Jefferson, Orange Counties	Request for Application (RFA) The Center plans to contract for 100% of this service in all 4 counties of the Center’s catchment area.
Counseling (Cognitive Behavioral Therapy) – Children / Adolescents	Chambers, Hardin, Jefferson, Orange Counties	Request for Application (RFA) The Center plans to contract for 100% of this service in all 4 counties of the Center’s catchment area.

## **7. Maximizing Consumer Choice and Access**

Spindletop MHMR Services remains the only accessible and financially viable provider of psychiatric care for most consumers in southeast Texas. The Center focuses on serving consumers in crisis or those with the most severe mental illness. In addition, the Center has outpatient clinics located throughout the region, with the goal of having a facility within 30 miles of consumers. In addition, many additional support services are provided within the community and frequently to consumers in their own homes. Outpatient clinic choice currently includes providing assistance to consumers at the nearest clinic, or minimal travel to another clinic facility site. As the Center begins to develop a network of external providers, the expectation

is that access to quality care must be as good as, or better than what currently exists within Center operations. The Center will ensure that the current access to existing Center facility locations and hours of operation will be at least comparable when services are provided by an external contractor.

When the Center arranges contracts for mental health services, the list of available providers will be prepared and given to all consumers. This information will be provided during the consumer’s initial intake and assessment, when the consumer’s treatment plan is updated, and at any time a consumer requests this information. Access to services will be maximized by ensuring that providers of a service have physical locations in locations where services are currently offered to consumers. While the Center plans to contract 10% of SP 1, the Center will implement organizational level of choice procedures to ensure that consumers in adult service packages, excluding service package 4, and all children’s service packages have a choice of providers. The Center will provide consumers a list of all providers and their location when a consumer contacts the Center for services and is assigned to a provider. Consumers will be allowed to choose from among the providers on the list. Consumers are presently served by Center providers who are located nearest the consumer, and consumers who are assigned a case manager are provided a list of case managers who have available capacity in their case load from which to select to be their provider. In addition, at any time during treatment, consumers will be able to request for a change in their provider.

**8. Services to be Provided by a Single Provider**

Will any services be provided by only one provider (internal or external) because it would not be financially viable to fund two or more providers?

Yes  No

The following table specifies which services will be provided by a single provider and identifies the economic factors which prevent the Center from offering choice for the services.

Service to be Provided by a Single Provider	Economic Factors Preventing Consumer Choice
Routine and Intensive Case Management	Only the local mental health authority can provide these services.
Inpatient Services	The Fannin Behavioral Health Center of Memorial Herman Hospital is the only inpatient psychiatric hospital in the Center’s 4-county catchment area.
Assertive Community Treatment (ACT)	ACT services are essential, intensive services provided by a team of professionals who work together to meet the needs of consumers with complex problems and to keep these consumers engaged in treatment. The Center’s ACT team presently serves 75 consumers who are located in the 4 county area, and contracting this service is not financially viable for any single provider team. The ACT services model requirements for specified licensed professionals, a required staff to consumer ratio, and a required on-call staff criteria create a resource intensive service that results in an average cost per consumer per year of \$6,021. The high cost of this service and the limited resources available to the Center to support the program means that the Center cannot support two different ACT teams.

Crisis Services	The Center does not anticipate having more than one provider under contract for specific crisis services because of numerous issues of impracticality. Furthermore, the Center considers crisis services to be a primary mental health authority service that should remain the responsibility of the Center.
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**9. Cultural and Linguistic Diversity**

In order to better understand the cultural diversity of the Center’s local community, the following information was obtained from the US Census Bureau’s 2006 American Community Survey. Chambers County and Hardin County were not included in the 2006 survey, but data was available for these two counties for 2000, and some of the data elements were not available for Orange County.

According to the Census Bureau’s survey, 9.2% of the people living in Jefferson County and 1.5% of the people living in Orange County in 2006 were foreign born. In Jefferson County 91% of the population was native, including 71% who were born in Texas, while in Orange County 98% of the population was native with 72% being born in Texas. Among people at least five years old living in Jefferson County in 2006, 14.7% spoke at home a language other than English. Of those speaking a language other than English, 74% spoke Spanish and 26% spoke some other language. Fifty-three percent of the respondents who spoke a language other than English reported that they did not speak English “very well.”

From the Census Bureau, of the total population estimate for Chambers County, 81.9% were White, 9.8% were African-American, and 8.3% were Other races. For Hardin County, 90.9% were White, 6.9% were African-American, and 2.2% were Other races. For Jefferson County, 57.2% were White, 33.7% were African-American, 2.9% were Asian, and 6.2% were Other races. For Orange County, 88% were White, 8.4% were African-American, and 3.6% were Other races. For Chambers County (2000 data), 8.3% of families and 11% of individuals had incomes below the poverty level. For Hardin County (2000 data), 8.8% of families and 11.2% of individuals had incomes below the poverty level. For Jefferson County (2006 data), 15.7% of families, and 20.1% of individuals had incomes below the poverty level, and for Orange County (2006), 12.1% of families and 15.6% of individuals had incomes below the poverty level.

The policy of STMHMR Services is that all consumers will have the opportunity to effectively communicate with providers, regardless of the cultural background or the preferred language of the consumer. The Center encourages the full participation of consumers and their families in their services. STMHMR Services demonstrates cultural competence in the service delivery system when diverse cultural issues are acknowledged and addressed in all levels of an organization, including service delivery, clinical practice, and the administration of the Center. The primary mechanism used to determine the level of competency of external providers in the area of cultural competence is the Cultural and Linguistic Competency Assessment tool. This assessment instrument is required in the provider’s contract with the Center and covers the provider’s written policies, staffing patterns, use of interpreters and written translation materials, and their grievance procedures. The assessment tool ensures that external providers are respectful of cultural differences and have the resources and the flexibility within the service models to meet the needs of a culturally diverse population. The assessment is annually reviewed during each contract renewal, and recommendations are made to the board of trustees when necessary.

The Center also ensures that consumers receive effective, understandable, and respectful care from internal provider staff. When necessary, bilingual staff are requested to assist consumers in other service areas and the Center also has contracts with local interpreters who assist with languages other than English, as well as licensed sign language interpreters. The Center also has internal staff with this sign language license. The Center also ensures that information for consumers is provided in their preferred language.

The Center also requires newly hired staff to complete an initial orientation training that includes information on cultural diversity, general clinical cultural issues in treatment, and consumer rights. All staff also complete annual refresher training in these areas. The cultural diversity training includes an introduction to understanding the various components of cultural competence and how these elements apply to providing mental health and other human services to various groups of people and to individuals from within those groups. The general clinical cultural issues in treatment includes discussion about the convergence of the possible clinical, social, cultural, organizational, and financial reasons why various minority groups may be underserved by human service delivery systems. In addition, staff are trained on the effects of prejudice and stereotyping and they receive an overview of the role of the professional in responding to cultural diversity in clients and co-workers. In the development of a network of external providers, the Center desires to maintain a network which meets the needs of the local community, improves access to treatment by minorities, reduces disparities in treatment, and improves quality of care.

All new providers will engage in cultural diversity training prior to providing services and will receive this training at least annually. In addition to this training, Center staff will be trained, when assisting a consumer to choose a provider, to be mindful of these needs. All providers will be listed with any cultural / linguistic specializations in order to easily match a consumer requesting such preferences with appropriate providers. Translation services will be made available at both the Center's offices, as well as at external provider locations. Any contract provider will be required to provide similar assistance. The Center will attempt to place consumers with providers that speak the consumer's preferred language. However, when this is not feasible, translation services will be coordinated.

## **10. Administrative Cost Efficiency**

Spindletop MHMR Services has begun to explore the possible implementation of a 4-county system of telemedicine that would enable licensed professionals in one Center facility to serve consumers in the Center's outlying clinics. The use of telemedicine might also enable the Center to advance this technology into broader applications throughout the Center's operations and into multiple locations within the Center's 4-county catchment area. For many years, the Center has maintained aggressive control of administrative overhead costs when staff resign by assigning additional duties to other staff in order to prevent filling unnecessary positions. Also, the Center has now implemented automated administrative functions, including payroll and benefits management and insurance and billing functions, and the Center has developed electronic document storage and retrieval in order to reduce the cost of paper distribution to staff of key internal information. In addition, the Center is implementing a computer supported file management and retrieval system that will enable staff to more efficiently access and process key Center documents, and the Center has established electronic communications systems that enable staff to more effectively communicate while on the Center property, as well as from outside the Center facilities.

The Center is a member of the regional East Texas Behavioral Healthcare Network (ETBHN) that has assisted member centers with regional approaches to cost efficiencies in center operations. The network has organized a regional utilization review function that controls the authorization for uniform assessments for consumers admitted for services. In addition, the network is planning to address the possible regionalization of center

vehicle fleet procurement and maintenance, a possible consolidation of the functions of a chief financial officer, and the development of a regional wide area network (WAN) that will connect the communications and data management functions of the centers.

The Center strives to maximize service dollars and reduce overhead costs through its continued sponsorship with the East Texas Behavioral Healthcare Network (ETBHN). The ETBHN is a governmental cooperative of sponsoring community MHMR centers established under provisions of the Interlocal Cooperation Act to provide a means for the sponsoring entities to act jointly and be mutually accountable for the functions that can be performed with more economy, effectiveness, and objectivity at the regional level. STMHMR Services is one of eight members of this network. The mission of ETBHN is to improve the quality of service, enhance the operating efficiency, and expand the capacity of behavioral health in the communities of east Texas through greater integration of center clinical and administrative activities, while also pursuing additional revenue resources.

All ETBHN projects and programs are introduced and implemented on the “menu plan.” The “menu plan” is a way that projects and programs can be implemented if two or more Centers are interested in the project. This increases the chances of full implementation and reduces the obstacles of implementing with full participation. This also provides an opportunity for programs to run as examples. Other Centers can join in the process, if interested, at any time after implementation.

The following is a summary of cost-savings and efficiency projects coordinated by the ETBHN:

- Regional pharmacy – The ETBHN pharmacy is located in Lufkin, Texas and began operations in February 2004. Establishment of this pharmacy allows member centers to purchase psychotropic medication slightly above cost. In addition, the pharmacy provides a full array of clinical enhancement services that include retrospective utilization review, physician education, on-site visits, drug information counseling and literature, and patient assistance program activities.
- Regionalization of Authorization Process - ETBHN now completes authorization of services of 7 of the 8 Centers that comprise ETBHN, and has reduced 7 region-wide full time equivalent positions to 3. Authorization staff are located at various locations around the region and these staff log into each Center’s system and provide same day authorizations.
- Regionalization of Medical Director – Currently, 3 centers in ETBHN have chosen to use the medical director menu item, and more centers are expected to join in this effort in the future.
- Regional Planning and Advisory Committee (RPNAC) – Each ETBHN member center has representatives on the RPNAC. The RPNAC provides a broad perspective on community impact and allows consumers and their families to learn more about services of other community centers.
- Regional Utilization Management (UM) Committee – Each ETBHN member center has a representative on the ETBHN UM committee. This regional UM function provides for more comparison between Centers. While some member centers continue to support a local UM team, the regional UM team provides centers with valuable comparative benchmarking data.

- Indigent and Sample Medications Best Practices - ETBHN has identified and promulgated best practices among member centers through distribution of model policies, procedures, and forms and through staff training.
- Pharmacy Benefit Management - ETBHN acts as a liaison between member centers and Express Scripts Inc. for the expedient purchase of medications.
- Electricity Contracts – Currently, all ETBHN member centers that are in non-regulated utility areas are using 1 contract for electricity provision. This results in lower pricing on competitive bidding, due to the size of the contract, and the ETBMH is exploring online utility auctions for this contract.
- Grants / Opportunities - ETBHN researches grant opportunities and ensure that member centers are aware of them.
- SharePoint – Recently, ETBHN implemented a SharePoint Web site. This is a working Web site that allows committees and workgroups to each have their own site with calendars, document sharing, message boards, and other technology functions. Video conferencing will soon be available, and each ETBHN member center will implement their own SharePoint site to replace their current Web site. This will enable all ETBHN member centers to connect to the ETBHN Web site for quick interfacing.
- Collective Purchasing - ETBHN has implemented a plan to operate a joint purchasing cooperative that receives bulk prices for certain items, thereby reducing per-unit cost and generating savings for the member centers.
- Legal Consultation and Training - ETBHN provides legal consultation and training when a need is identified or as requested by a member center.
- Mail Order Pharmacy - ETBHN has established a class A, closed door, mail-order pharmacy for its member centers.
- Wide Area Network (WAN) – ETBHN currently has released a request for proposal for the development of a Wide Area Network (WAN). The WAN will connect all 8 of the member centers for real-time data retrieval and video conferencing. The WAN is a cornerstone for future consolidation efforts.
- Service Code Matching – ETBHN is in the process of matching the service codes of all ETBHN member centers that use the Anasazi consumer database. This is a step in the direction of standardization and will make the center data comparable.
- Planning and Quality – ETBHN continues to coordinate meetings and share information for planning of state-wide initiatives, including local planning and network development (LPND), crisis planning, and other state agency required projects. These regional projects allow for more standardization between the centers and pools the knowledge base of key Center staff.
- Chief Financial Officer (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 retreat for board members of all ETBHN member centers. Any required board training is completed during these retreats, and the governing boards of each center are updated on all ETBHN projects.
- Regulatory Requirements / Performance Contract - ETBHN establishes committees utilizing center staff across the board as way to enable each individual Center to reduce staff workloads to allow for better efficiency in staff utilization. These committees incorporate objective indicators to demonstrate best value in assembling and maintaining centers’ provider networks and to ensure compliance with all regulatory requirements including performance contracts.
- Business Opportunities Committee – This ETBHN committee is reviewing how member centers can create opportunities in businesses not funded by Texas general revenue funds. Areas of possible programs include housing, autism services, and private clinics. ETBHN also explores opportunities for cost savings and quality improvement in other areas. The senior management teams at each center are involved in meeting and planning new programs within their functional area. The human resource directors recently reviewed new software for staff development and training that could possibly be regionalized, and the financial staff recently reviewed areas for growth and improvement. The information technology directors meet monthly and are working on several projects at the current time to improve operational efficiency.

In the first 2-year local network planning process, the Center expects the LPND process to create few financial efficiencies. Until the majority of services are delivered by external providers, the Center will likely not realize efficiencies and cost-savings that may be possible from a network. When the network management costs become real, the Center will have to provide additional training for providers who are relatively new at providing services under contract, and this will result in additional start-up costs as the providers slowly become accustomed to operating within the extensive requirements of a contract. Also, the Center will likely experience additional costs for the quality management function in order to monitor and manage the provider contracts, and the information systems and billing and claims adjudication infrastructure will likely have to be modified in order to accommodate the increased upstream billing created by external providers.

**11. Previous Efforts to Develop a Provider Network**

In fiscal year 2004, the Texas Department of State Health Services (DSHS) required the Center to complete an official request for information (RFI) process for all mental health and mental retardation services. The Center developed and released the RFI to the general public and to healthcare providers in the 4-county catchment area covered by the Center. The Center received only two responses that indicated a limited capacity to provide limited services in a limited geographical section of the 4-county catchment area covered by the Center. The agencies declined to become a provider, and since the RFI did not include rates of reimbursement, required training, or any other contract terms of the requirements of DSHS, the RFI proved to be of little value in the information obtained.

**12. Barriers to Attracting Providers**

<b>Barriers</b>	<b>Plans</b>
Relatively Small Community	Continue to market the Center to the community

Close to Harris County	Enhance the general awareness of the community's attractions
Shortage of Licensed Providers	Improve relationship with area university to produce more licensed professionals, and continue to work with nearby medical school to attract more clinical residents to the area
Providers Reluctant To Meet DSHS Contract Requirements	Work with DSHS and private providers to streamline regulations and contract requirements
Shortage of Reasonably Priced Office Space	Work with local chambers of commerce to obtain reasonably priced office space and consider the option of sharing existing Center office space with external providers.
Lack of Public Transportation	Work with area transportation providers to expand public transportation.
Anticipated Growth in Population of Over 20,000 by 2009	Work with contract providers to address population increase during contract negotiations.
Center Catchment Area is in a Hurricane Area of Texas	Assist providers with storm preparation and evacuation planning
3,260 Total Square Miles in the 4-County Catchment Area	Possibly expand telemedicine services to alleviate MD travel expense
Rising Cost of Gasoline Makes Traveling to the Different Areas of the 4-County Catchment Area Difficult, if not Cost-Prohibitive	Work with providers to ensure service locations are near bus routes when possible
Relatively High Rate of Uninsured in Southeast Texas	Work with elected officials to make it easier for small businesses to obtain more affordable insurance by enforcing current law that allows small businesses to form cooperatives to purchase health insurance
Typical Service Reimbursement Rate of Payment not Attractive to Providers	Work with state and federal agencies to increase the reimbursement rate for services

### **13. Attraction of Providers**

In Southeast Texas, the rates of reimbursement must provide a significant margin of profit, or private providers will not be interested in contracting to provide mental health services. Providers are also interested in good housing and good school districts in the area, and the community economy must continue to diversify and strengthen to attract providers. Area entertainment activities must also continue to grow. Various major industries in the area have announced plans to expand their operational production capacity, and this is expected to stimulate growth in employment, especially temporary construction work. Area community business leaders expect the area population to grow by over 20,000 by 2009 as a result of this industrial expansion, with approximately 25% of the newly arriving workers expected to remain in the area after these expansion projects have been completed. Southeast Texas also has a relatively high rate of uninsured population, with 25% of the population in the Beaumont-Port Arthur

metropolitan statistical area being uninsured. With the proximity of the area to the Houston metropolitan area, this could represent an attraction to some providers, and the area is also near the beach, as well as the East Texas lakes area and the Big Thicket National Wildlife Preserve.

#### **14. Long Term Planning**

This local network plan is developed for the first 2-year planning cycle of September 2008 through August 2010 (fiscal years 2009 and 2010). However, the Center plans to begin procuring providers of services during the second year of this first cycle. Initial contracts with providers will be for a 1-year period, until the planning cycle repeats in 2011 through 2012. Over time, the Center anticipates becoming more proficient in procuring providers which will increase the number of providers. In addition, the Center also anticipates being able to procure some of the more complex services in future planning cycles. The Center plans to repeat the procurement cycle as detailed in this first 2-year cycle, and to reassess the system of providers based on the progress of network development in the first cycle. In addition, the Center will continue to analyze the cost effectiveness of provider contracts in order to ensure that the proper shift of overhead and administrative costs has occurred. The Center will also continue to arrange regular meetings of the local PNAC and the regional PNAC to continue to review the progress achieved toward development of the local network.

In the first 2 years of this network planning process, as external providers are trained to provide services in compliance with rules and standards set by the Center and required in the Texas Department of State Health Services (DSHS) performance contract, it will be vital that the Center maintain the operations of the internal network as a safety net for consumers. Center experience has revealed that training, quality monitoring, and fiscal stability need to be assessed over a 1-2 year time span prior to any further reduction of the internal network. In the third and fourth years of this planning process, services that have been successfully and firmly contracted can then be considered for further network expansion. This graduated approach during the next 2-year planning cycle shall also incorporate new information gathered from the local community regarding additional service areas where choice is desired.

As the Center progresses through this initial 2-year planning cycle, the Center will analyze and assess the system of providers 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 internal network development staff function. The importance of this evaluation is to measure the stability and effectiveness for increasing the network of providers during the next planning cycle.

The evaluation will include, but not be limited to:

- Redefining areas where technical assistance or additional training may be warranted
- Identifying gained experiences to better meet the goals of the plan
- Determining whether the needed expertise was obtained to use one of the more complex procurement / contracting methodologies
- Determining if staffing is adequate to manage a larger network of providers
- Determining if the network has remained financially viable

Ultimately, in this long term network development planning, the Center will be assessing the readiness of the network of providers for possible further expansion. In the next planning cycle (2011, 2012), the Center anticipates that additional external providers of services may become available

for consideration. Because of the limited resources to support SP 4, the Center does not anticipate being able to support an additional ACT team. In the next 5 planning cycles, the Center anticipates being able to contract out in each cycle an additional 10% of services in SP 1, 5% of services in SP 3, 5% of services in SP 1.1, 2.2, and 4, and 100% of services in SP 2.4. The Center will continue to seek out external providers to provide the entire package of services in SP 1.2 and 2.3, instead of discrete services from among these packages. For SP 0 and 5, the Center plans to continue to explore the possibility of finding external providers in accordance with the Center’s current Crisis Services Plan. In the succeeding planning cycles, the Center will work to continue contracting out the additional services in accordance with this long range plan.

#### ***D. Procurement and Transition Timelines***

The following table presents the Center’s procurement timeline.

<b>Date</b>	<b>Key Activities and Milestones</b>
March 1, 2008 – August 31, 2008	Develop local network plan and submit for approval to DSHS
September 1 – 30, 2008	Make revisions to plan as required by DSHS
October 1 - 31, 2008	Develop draft contract procurement document – Request For Application (RFA)
December 1, 2008 – January 15, 2009	Publicize draft contract procurement document Public comment period – 14 day minimum
January 15, 2009 – February 15, 2009	Timeframe for LMHA to consider all public comments and revise contractor procurement document
March 1, 2009	Publication of final contract procurement document
March 1, 2009 – April 30, 2009	Procurement response period
June 1, 2009	Contract award notification date – June 1, 2009

An important part of the development of an external provider network is that it expands choices available to consumers. The following table identifies specific steps for the consumer selection of a provider and the timeline for transitioning consumers to new providers.

<b>Steps</b>	<b>Time Frames For Completion</b>
Develop a provider list	June 1 – June 30, 2009
Verify provider information	June 1 – June 30, 2009
Post Provider list to website and distribute to consumer and advocacy groups	June 1 – July 31, 2009
Conduct forums to allow providers to share information with consumers, LARs, and other stakeholders.	July 1 – July 31, 2009
Develop internal procedures and forms for consumer selection of providers	July 1 – July 31, 2009
Develop consumer information materials relating to selection of providers	July 1 – July 31, 2009
Train internal staff on consumer selection procedures	July 1 – July 31, 2009

Develop external contract provider manual	September 1, 2008 – July 1, 2009
Ensure external providers are trained on consumer selection requirements and procedures	July 1 – July 31, 2009
Implement provider selection procedures for new intakes	July 1 – August 31, 2009
Implement provider selection procedures for current clients (in conjunction with treatment plan reviews)	July 1 – August 31, 2009
Develop and implement continuity of care plans for transitioning individual clients to new providers	July 1 – August 31, 2009
Develop information technology data integration procedures	September 1, 2008 – September 30, 2009
Develop external contract provider claims adjudication procedures	September 1, 2008 – September 30, 2009
Consumer transition complete	September 30, 2009

The following table presents an estimate of the amount of time needed to re-establish the service volume lost if a contract must be terminated.

<b>Service</b>	<b>Time Needed to Re-establish Service Volume</b>
Adults – SP 1	90 Days – This may actually take 6 - 18 months to re-establish the prior volume of service.
Adults – SP 2	90 Days – This may actually take 6 - 18 months to re-establish the prior volume of service.
Children / Adolescents – Counseling - SP 1.2	90 Days - This may actually take 6 - 18 months to re-establish the prior volume of service.
Children / Adolescents – Counseling - SP 2.3	90 Days - This may actually take 6 - 18 months to re-establish the prior volume of service.

Spindletop MHMR Services has established a 90-day period to reestablish services after contracts with external providers have been terminated. Historically when clinical staff leave, the Center has been able to quickly resume services by changing assignments for existing staff and by contracting for additional physicians with *locum tenens* businesses. However, these efforts create additional workloads and added, unexpected costs. Among the many challenges to contracting for services in southeast Texas is the ability to reestablish services. Until a strong, viable base of external providers is established that can assist the Center in covering unexpected lapses in service, this will remain a challenge that is not fully reflected in a 90-day time period to reestablish services.

### ***E. Staff Qualifications***

All providers, either internal or external, must be trained in and competent to perform the assigned tasks. The qualifications for individual practitioners must, at a minimum, meet the Texas Department of State Health Services (DSHS) mental health community service standards in order to provide services. In addition, practitioners must also meet the requirements of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). All individuals providing services must also complete a criminal background check. The absolute bars to employment are provided in the 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
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***

On Tuesday, July 15, 2008, a preliminary draft version of the Spindletop MHMR Services Local Planning & Network Development (LPND) document was posted for public comment on the STMHMR Services extranet ( [www.stmhmr.org](http://www.stmhmr.org) ). The document was pulled from the extranet on Thursday, August 7, 2008. The following table presents the comments on the plan that were received by the Center.

<b>Comment</b>	<b>Stakeholder Group (s)</b>	<b>LMHA Response and Rationale</b>
<p>“I am pleased to see the continued excellent work by Spindletop MHMR. While the state of Texas has placed many restrictions on the ability of LMHA’s to serve persons with mental health issues, Spindletop has continued to be creative, proactive, and accountable to the people of Southeast Texas. The implementation of the mobile crisis unit has already proved to be an invaluable asset to the community. Collaborative efforts on Spindletop’s part with community organizations, businesses, local and county governments, judicial involvement, and law enforcement have shown great care and concern for the well-being of every person living in the authority’s area. The proactive partnerships with private mental health providers have proven to not only be extremely helpful in crisis and post crisis care - it has proven to be fiscally responsible to the state of Texas. The forward thinking of Spindletop MHMR regarding services is commendable. Spindletop MHMR Services staff and administrators are sincere and dedicated to the health of our community.”</p>	<p>Jayne Bordelon, Executive Director Jefferson County Mental Health Association</p>	<p>STMHMR Services accepted in full this comment that did not require any modifications to the plan.</p>

## ***G. Modifications Made to Plan After Comnet Discussions with DSHS Staff***

After the plan had been posted on the Center's public extranet for public comment for the required time frame and then pulled from the extranet, Center staff participated with other community centers and staff of the Texas Department of State Health Services (DSHS) in statewide Comnet discussions about the plan. The Center also received recommendations for changes to the plan from DSHS staff in an additional telephone consultation. The DSHS staff provided additional guidance and clarification regarding the plan, and the following modifications to the Center's plan were made to ensure that the plan is understandable, reflects the Center's intent, and complies with the official requirements.

Section II, C, 2 - Provider Inquiries Within the Last 2 Years Table – The table was modified to include the results of Center staff telephone and e-mail contacts with providers who indicated on the DSHS website interest in providing services under this plan.

Section II, C, 3 – Service Capacity and Procurement Table – The table was modified to indicate the plan to procure all services in SP 1 and SP 2, except for add-on services, and to procure discrete cognitive behavioral therapy service in SP 1.2 and 2.3.

Section II, C, 4 - Justification for Procurement of Discrete Services Table – The table was modified to include the rationale to procure discrete cognitive behavioral therapy service in SP 1.2 and SP 2.3.

Section II, C, 4a – Plan for Fidelity and Continuity of Care – Additional information on case management procedures was added.

Section II, C, 5 - Rationale for Keeping Services Table – The table was modified to include an enhanced explanation of the conditions for maintaining services

Section II, C, 6 – Structure of Procurement Table – The table was modified to reflect the plan to procure services in SP 1 and SP 2 and discrete cognitive behavioral therapy service for children and adolescents in SP 1.2 and SP 2.3.

Section II, C, 8 – Services to be Provided by a Single Provider Table – The table was modified to include cost data on the ACT service.

Section II, C, 14 – Long Term Planning- Additional information on the long term strategy to increase external providers was added.