LOCAL NETWORK DEVELOPMENT PLAN

FY 2009 – 2010

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Overview of Bluebonnet Trails Community MHMR Center Services

1. Mission

The Mission of Bluebonnet Trails Community MHMR Center is to ensure the provision of accessible, efficient and effective services that support the dignity and independence of those we serve.

2. Agency Overview

Bluebonnet Trails Community Mental Health Mental Retardation Center (the Center) was formed in 1996 through an interlocal governmental agreement among the six counties of Bastrop, Burnet, Caldwell, Fayette, Lee and Williamson. After well-attended public hearings, and at the request of these counties, the Center was legally established as a community mental health mental retardation center in 1997 by the Texas Department of Mental Health and Mental Retardation. During September 2000, Gonzales and Guadalupe Counties joined the Center establishing the current eight-county service area in which the Center is designated by the State of Texas as the local mental health and mental retardation authority.

The Center is governed by a Board of Trustees appointed by the County Judges and Commissioners' Courts from each of the eight counties. The Trustees work in responsible and accountable cooperation with local and state government and citizens of their counties to ensure the needs of the communities are heard and

considered in the strategic planning and development for the Center. The members of the Board of Trustees volunteer their time, experience and talents during regular monthly meetings as well as during Center events and discussions with our community leaders.

Today, the Center serves as the local mental health and mental retardation authority in eight counties with a population density of over 672,000 persons and a land mass of approximately 6,910 square miles.

County	Estimated Census: Year 2006	Square Mileage: Year 2000	Population Change: Years 2000 to 2006
Bastrop County	71,684	888.35	12.70%
Burnet County	42,896	996.04	25.70%
Caldwell County	36,720	545.73	14.10%
Fayette County	22,521	950.03	3.30%
Gonzales County	19,566	1,067.75	5.00%
Guadalupe County	108,410	711.14	21.80%
Lee County	16,573	628.50	5.90%
Williamson County	353,830	1,122.77	41.50%
Totals (Statistics of the US Census Bureau)	672,200	6,910.31	Average Growth Rate: 16.25%

Center services are provided to adults with serious mental illness and chemical dependency; to children and adolescents with serious mental illness or emotional disorders, chemical dependency, autism or pervasive developmental disorders; to persons with mental retardation; and to infants and toddlers with developmental delays.

The Department of State Health Services and the Department of Aging and Disability Services annually contract with the Center to function as the mental health and mental retardation authority for the counties of Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee and Williamson. The authority role holds the Center accountable for ensuring access to needed services for persons meeting the eligibility criteria established by the state. Along with defining the eligibility criteria of the persons authorized to receive services, the Departments define, through their contracts with the Center, the services that may be provided.

In addition to providing mental health and mental retardation services, the Center focuses on ensuring access to substance abuse services. The Center operates as the Outreach, Screening, Assessment and Referral (OSAR) entity in the Texas Health and Human Services Commission Region 7. As the OSAR, the Center serves twenty-four counties in Central Texas, including six of the eight counties in which the Center provides mental health and mental retardation services. The Department of State Health Services oversees the OSAR program. The goal of the OSAR program is to support prevention services and provide access to effective treatment for persons with chemical dependency.

The Center also contracts with the Department of Assistive and Rehabilitative Services to provide early childhood intervention services (ECI) to children and the families of those children, ages 0 – 3 years, who have developmental problems. ECI services are provided in Bastrop, Burnet, Caldwell, Fayette, Lee and Williamson Counties.

Local Planning Process

1. **Understanding our Planning Process**

Bluebonnet Trails CMHMR Center (BTCMHMRC) is responsible for developing, updating and maintaining a Local Service Area Plan in compliance with the Department of State Health Services (DSHS) Performance Contract. The Plan is designed to develop a Network of Providers that will meet the local needs and priorities, allow for more consumer choice, improve access to services, make best use of available funds and promote consumer, provider, and caregiver partnerships.

The Local Plan serves to address the Center's political, clinical, and financial status in an integrated fashion through the utilization of information and data. Information is assimilated from community leaders, advocates, family members, clients, and staff. This is used to identify perceived, potential, and/or actual strengths and weaknesses of, opportunities for, and threats to the organization and the Mission of the Center. Available resources and the most appropriate allocation or deployment of those resources is considered in order to meet anticipated challenges and work towards desired outcomes. Finally, outcomes and progress toward goals are monitored in order that the plan may be adjusted in an ongoing, dynamic process.

Satisfaction Surveys. Meeting the needs of the clients is increasingly challenging in an environment of dwindling resources and increased administrative demands. The Center strives to provide the most effective and efficient services possible without sacrificing quality. During this planning process the Center ensured that the community as well as the clients/families receiving services through our system of care was well represented. In past survey's we have found that individuals admitted into services were typically satisfied with their care, although those still waiting to be admitted or not eligible for services were not very happy with the current system of care. In this planning process the Center undertook this initiative with the understanding that we would attempt to gather "all the MH needs" of the community and define our role in a much broader sense to help meet those needs. The LPND process will not only shape how MH services are administered in our service areas but will place the Center in a role to help resolve and prioritize the needs of the communities we serve.

Fiscal Plan. Having a fiscal plan is essential to maintaining a financially healthy organization with long-term potential. Each goal of the Local Plan has a budget implication that must be considered. The proposed expenditure and revenue estimates comprising the Center budget are submitted to the Center Board of Trustees for consideration and approval. The approved financial goals are then added to the service goals established by the service units. A budget is developed with each service unit. Each service unit is required to monitor revenues and expenditures and adjust accordingly. On a monthly basis, the service units review the budget to ensure programmatic goals will be achieved within fiscal limitations. On a quarterly basis, the Board of Trustees reviews the Center budget versus actual expenditures to assist them in actively governing the Center. When the budget requires revision to accurately reflect the business of the Center, an amendment is reviewed for approval by the Board of Trustees.

Senior Management Team. The Senior Management Team prepares a proposed budget for the fiscal year including the costs to address our strategic goals for the next fiscal year. The Senior Executive Management Team consists of the Chief Executive Officer, Chief Administrative Officer, Chief Operating Officer, Director of Crisis Services, Director of Mental Health Services, Director of Authority Mental Retardation Services, Director of Provider Mental Retardation Services, Director of Quality Management and Director of Information Services. With Board approval, this group of senior management staff determines the operating policies, procedures, staffing, and service planning from which the budget is derived.

2. **Stakeholder Participation**

Planning and Network Advisory Committee (PNAC). BTCMHMRC has actively pursued community involvement in its planning processes for many years through a number of strategies. One of which includes stakeholders comprised of both consumers, family and interested citizens who serve as members of the

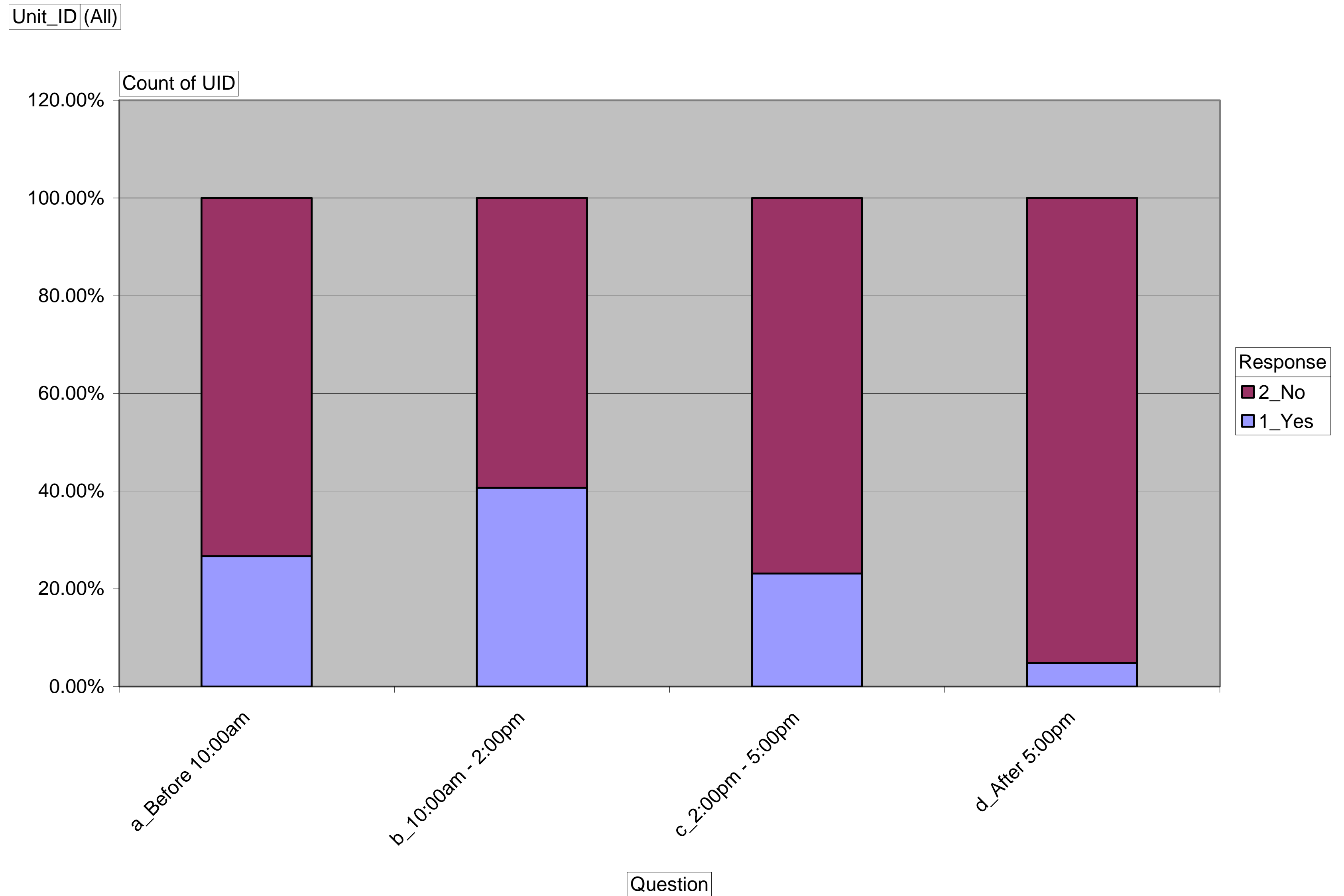
Planning and Network Advisory Committee (PNAC). During this planning cycle, the PNAC played a vital role in guiding center staff in the review process used to obtain stakeholder input from the local community. Once the plan development is complete, the PNAC will approve the final planning document and help identify and evaluate external providers. They will then make recommendations to the Board of Trustees.

The Center has a combined Mental Health and Mental Retardation Planning and Network Advisory Committee. The primary purpose of the PNAC is to ensure that local stakeholders have direct input and involvement in assessing and determining the mental health and mental retardation service needs of each county in the Center's service area. The PNAC is comprised of between five and nine members representative of people with mental illness and mental retardation, local practitioners, and other interested members of our community. Meetings are held quarterly. In January 2006 for example, the PNAC decided to survey agencies and organizations in their communities, including other advisory boards, local law enforcement, local government, and faith-based alliances, to determine the impact that the Center is having and to learn more about the Mental Health and Mental Retardation needs of the communities. Based on the findings of the survey, recommendations were made to the Board of Trustees regarding community education needs. At this planning cycle our process will follow this same general principle, although the community forum process provided a better understanding of the needs in our communities than in previous attempts to gather this data. The committee will advise the Board of Trustees on planning, contract issues, needs and priorities for the service area and for the community MHMR Center.

In the past participation in the local plan has focused on input from client and families, as well as seeking information from local advisory members and the Board of Trustees, and the emphasis was weighted toward the satisfaction of our customers and not as much on community needs. During this planning cycle we have provided a more comprehensive and inclusive assessment of our MH Service priorities within the communities we serve, developing more of a community-focus as a result. None the less we have collected excellent data

from our clientele either directly through the community forum platform or by data collected from two separate survey instruments. We provided opportunities through community forums and meetings with stakeholders in our countywide service areas to receive input regarding the Center's strengths, weaknesses, barriers and gaps in services. It provided the Center the opportunity to educate the community on the issues confronting our service delivery system and the opportunity to expand our provider network.

Surveys. Stakeholder surveys were made available to the public via our survey link https://www.surveymonkey.com/s.aspx?sm=OElNOK3NhWb6bHirmuUDRg_3d_3d, as well as a comprehensive mail out, handouts and face to face interviews at the clinic and consumer homes. We mailed out surveys to 7,000 consumers who had received services in a 12 month period with a return rate of 14%. We provided surveys in our clinic waiting areas and distributed them during the community forums provided in all our service areas. The survey allowed for written feedback as well as direct questions regarding service priorities and areas where greater access was thought to be needed. We designed two separate surveys which provided information on service priorities / gaps as well as answered preference questions related to provider choice, service location, transportation, and best time for the provision of services. The following charts represent information from our survey summaries. Service location in one area and clinic hours of operation are significant variables to consider in recruitment of external providers.


Unit_ID (All)
Count of UID
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100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Response
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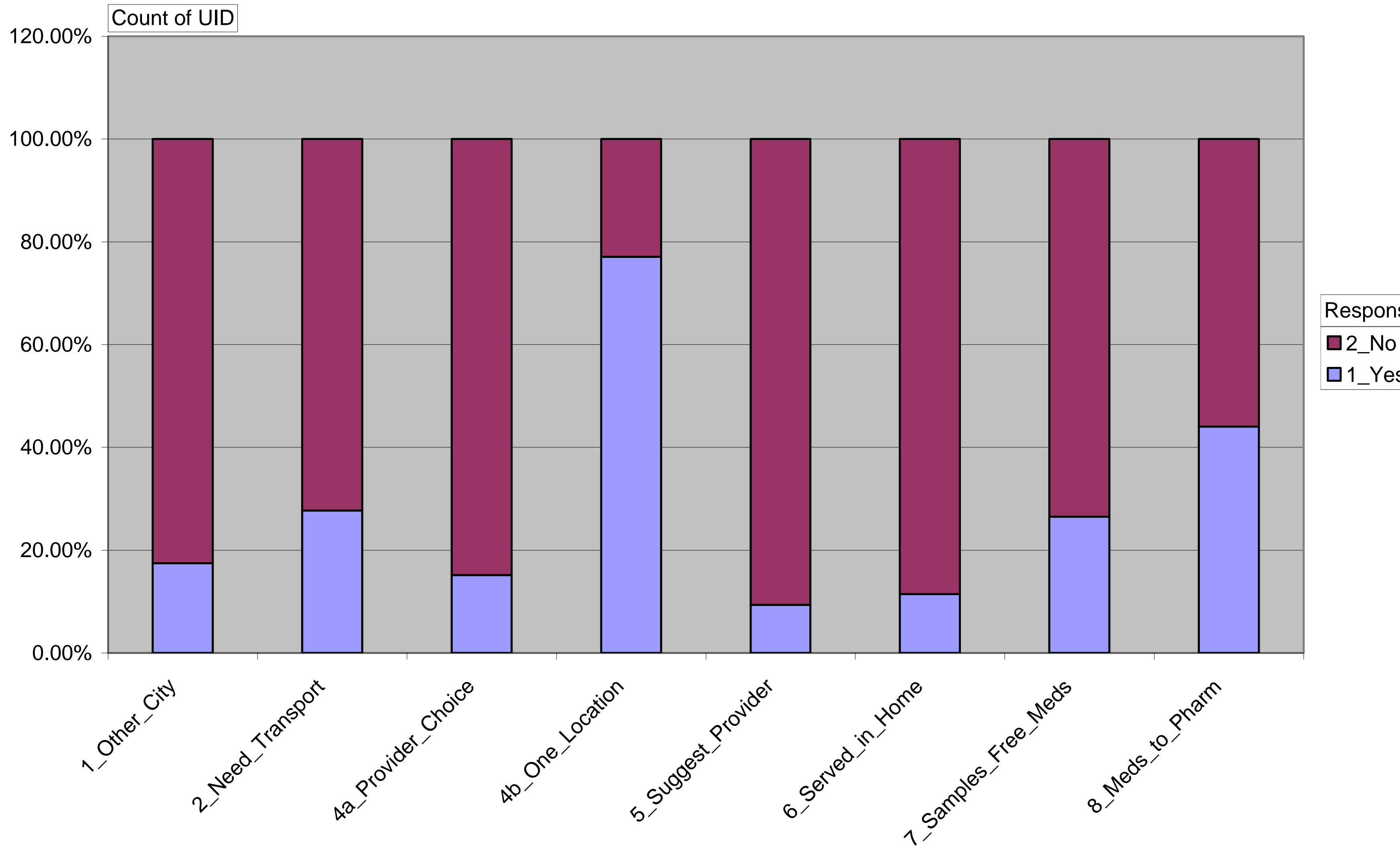
1_Yes
a_Before 10:00am
b_10:00am - 2:00pm
c_2:00pm - 5:00pm
d_After 5:00pm
Question


Unit_ID (All)
Count of UID
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
1_Other_City
2_Need_Transport
4a_Provider_Choice
4b_One_Location
5_Suggest_Provider
6_Served_in_Home
7_Samples_Free_Meds
8_Meds_to_Pharm
Question
2_No
1_Yes

Public Forums and Meetings. The Center provided public / community forums in most of our county service areas. The Center provided forums for both County officials / community agencies that have interest in mental health issues, but in addition conducted separate forums for the clients / families receiving services through the Center. Public notice of the events was provided by email, mental health mailing list, handouts/flyers and local media. Meetings to discuss and get feedback were also held with local MH advisory boards, MH Task Force (Williamson County), Safe School Healthy School Advisory Committee (Williamson County), Bluebonnet Trails Staff and the Children's Support Coalition.

3. Participating Agencies, Organizations, and Other Stakeholders

Description and Date and Timeline	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
WM County Mental Health Task Force Committee Meeting April 24, 2008 @ WM County Children Advocacy Center	Local Hospitals, FQHC (Lone Star Circle of Care), Commissioners, District Attorney, County Attorney, JP, ISD representative, CIT, MOT, Wm County Health District, Sheriffs office, Bluebonnet Trails Staff	0	0	28
WM County June 17, 2008 Forum – Williamson County Commissioners Court	County Judge, Commissioners, County Attorney, St. David's Hospital, CIT, MOT, BT Staff,	0	0	19
Williamson County July 8, 2008 Client and Family Forum @ BT Conf. Rm	Bluebonnet Trails Consumer and Family members	1	7	11
Gonzales County Advisory Board Meeting July 10, 2008	Local Advisory Board Members	0	0	15

@ BT Conf. Rm				
Bastrop County July 15, 2008 Agency Forum 3 pm and Client / Family Forum 6 pm @ BT Conf. Rm	Family Crisis Center, District Attorney's Office, Bastrop Adult Probation + Family members and Bluebonnet Trails Staff	0	6	6
WM County July 17, 2008 Local Agency Forum @ BT Conf. Rm	Agency Forum with State Hospital, ISD, Legislative Aide, Round Rock PD, CIT, Williamson County Health District	1	2	16
Guadalupe County July 21, 2008 Agency Forum 3 pm and Client / Family Forum 6 pm – Silver Center in Seguin Texas	Adult Probation Officers, District Attorney's Office, Advisory Board Member, Counseling Center, And Family / Consumers	13	6	6
Burnet County July 24, 2008 Agency Forum 3 pm and Client / Family Forum 6 pm @ BT Conf. Rm	BT Board Member, BT Staff, and Local Advisory Board Member	0	0	5
Fayette County July 29, 2008 Agency Forum 3 pm and Client / Family Forum 6 pm @ BT Conf. Rm	BT Board Member, BT Staff, Adult Probation Officers, District Attorney's Office, local Police Officers, County Judge, and EMS Director	0	0	9
Gonzales County July 31, 2008 Agency Forum 1 pm and Client / Family Forum 3 pm @ Episcopal Church in Gonzales, TX	FQHC, Adult Probation Officer, BT Board Member, BT Staff, and Consumers / Family Members	10	2	9
Caldwell County August 1, 2008 Agency Forum 1 pm @ BT Conf. Rm in Lockhart, TX	FQHC, County Jail Staff, County Judge, BT Board Member, and BT Staff	0	0	7

4. Stakeholder Input: Community Needs/Forum Feedback/Gaps/Priorities

The forum format proved to be valuable in our efforts to collect and address concerns within our eight county areas. All forums were attended by key members of the Executive/Senior Management Team and the Board of

Trustees. It provided an opportunity for both the Board of Trustees and Management Team members to listen and understand the needs of their local communities. The following statements address each areas common and unique concern. It also addresses the service gaps and needs of our communities.

Identification of County Mental Health Needs

June 17, 2008

Williamson County Courthouse
701 Main Street
Commissioners Courtroom – Second Floor
Georgetown, Texas

	Community Need
1	Services for Active Military on Leave and Returning Veterans/Outreach to Families
2	Services for Persons in Need Outside of Priority Population/Access to Services
3	Educating Key Stakeholders and Legislators Regarding Needs
4	Identifying Key Measures (Data/Stats) that Will Inform the System of Care
5	Focus on Prevention/Education Services for Clients and Families, Defraying Cost of More Intensive Services/Partner with Community Providers/Seek Education to Make Informed Decisions
6	Collaboration on Message to Congress/Legislature
7	Meeting/Planning for the Community's Future Needs for Crisis Services
8	Access to Benefits to Cover Services
9	Transition Programs to Address Needs As Persons Move Through Levels of Services/Continuity of Care/Community Network of Providers
10	Engagement of Persons Needing Services

11	**Informing Healthcare Partners of Admission Criteria/Eligibility Criteria/Expected Outcomes/Intake Process**
12	**Timely Access to Physician and Medication Services**
13	**Developing Partnerships to Share Key Resources (Physicians, Child Psychiatrists, Nurses, etc.)**
14	**Availability of Referral Sources to Promote Community Living/Consider Engagement (Attachment) with Providers/Provide Continuity of Care to Ease Transition/Consider Effects of Switching Providers**
15	**Expansion of Provider Network**
16	**Identify Key Partners/Identify Key Issues of Concern to Best Support with Funding/Consider Cost Savings Opportunities Between Partners/Consider How Best to Engage Client's Family Doctor in Ongoing Care/Establish Communication between Physicians/Partner with FQHC (Lone Star Circle of Care)/Coordination of Goals in the Development of Processes**
17	**Ensure Ease of Access to Staff/Address Phone System/Ensure User Friendliness**
18	**Transportation (East Williamson County)/Consider Best Value of Taxi Service and Other Options/Opportunity to Partner to Create Options/CARTS/Consider Mutually Beneficial Arrangements**

Identification of County Mental Health Needs

July 8, 2008

Williamson County Family Meeting
1009 N. Georgetown Street
Round Rock, Texas

	Community Need
1	**Access to programs: autism, psychiatric services, medications—persons with multiple needs.**
2	**Better coordination between MH and MR services (and other programs). Improve communication. Overlapping issues to be addressed (persons with multiple needs).**

3	**Exploring options to address the limits: services and financial capacity (Medicaid, insurance).**
4	**Autism services: services for adults. Transition period.**
5	**Need for providers of services accepting Medicaid: physicians, medications, autism, nurse services. (Difficulty going through the process to be able to bill Medicaid.)**
6	**Children transitioning to adulthood: need for smooth transition of services (skills training for adolescents, skills building for families/parents, fostering self-sufficiency for the adolescent).**
7	**Need for case managers to provide skills training (now, specific to service package).**
8	**Skills training for parents (i.e., training for parents with adolescents moving into adulthood)**
9	**Turnover of staff: concern about consistency of treatment and stability of relationship between family and provider.**
10	**Availability of after hours physician services: timely access to needed service.**
11	**Partnerships/relationships with emergency service providers (law enforcement, ERs) to benefit the families needing services (from multiple providers).**
12	**Cross training/education (including sensitivity training and general awareness) for providers to offer ease of collaborative services benefiting the families**
13	**Self-reliance: peer support network (transportation, education).**
14	**Client education regarding medications—more time with provider to discuss medications. Self-advocacy by client.**
15	**Transportation to services for consistency in participation.**
16	**Transportation for children to services when parents are unable to transport (work, lack of vehicle).**
17	**More accessible transportation than currently offered by CARTS (must currently schedule well in advance for transport).**
18	**Consider vans operated by MHMR--costs to be partially covered by riders based on ability to pay.**
19	**Need for more room for psychosocial services: consider redistributing space in building in Round Rock.**

20	**Labeled by diagnosis—be aware of impact on client (sensitivity). Education of community/providers: Stigma.**
21	**Getting businesses involved sponsoring activities valued by the clients.**
22	**Crisis respite services.**
23	**Supported employment.**

Identification of County Mental Health Needs

July 15, 2008

Bastrop County Family Meeting
275 Jackson Street
Bastrop, Texas

	Community Need
1	**Family Partner services to other packages beyond SP2._ Packages. Increased availability of family partner services.**
2	**Medication Education: Lowering service packages while increasing medication dosage.**
3	**Respite services for families. Partnership family respite, weekends; a few hours.**
4	**Access to physician services: timely services/available when needed, increased physician service time at Center**
5	**Parent assistance to deal with family issues/parent training: evaluations, medication education, medication services, parenting skills, coping skills**
6	**Additional supports for Service Package 1 (Adult Services).**
7	**Summer programs for children; transportation from the family home to the services.**

8	**Provision of services at the school; provide education to schools/teachers regarding signs, symptoms and effects. (Smithville) Work with schools regarding scheduling of services and meetings convenient for the families.**
9	**Transportation: doctor's appointments during workday, flexibility with appointments; rescheduling appointments results in long delays; pick up children from schools for appointments; inflexible scheduling for CARTS; flexible appointments afterhours for working parents (after 5:00 and weekends)**
10	**Life skills training (age-appropriate) for children—balancing checkbook, scheduling activities, completing homework, preparing lunch, sexuality, establishing relationships, navigate through/connect with the school system, establishing scholastic goals, obtaining (specialized) tutoring services, interpersonal communication relationships/socialization**
11	**MHMR to work on partnership with Smithville schools to discuss options for children receiving services**

Identification of County Mental Health Needs

July 15, 2008

Bastrop County Agency Meeting
275 Jackson Street
Bastrop, Texas

	Community Need
1	**Specialized caseload for offenders with mental illness: consider need, training, TCOOMMI**
2	**Coordination of client information: release of information and sharing of key information to best serve the client with dual system needs (probation, MHMR), identification of diagnosis/mental health issues; bridge gaps in communication between agencies**
3	**Coordination of system information: determination of eligibility for services; education concerning crisis services and access to/qualifications for ongoing care**

4	Ease process to obtain services through multiple service providers (MH, OSAR, TCOOMMI); reduce obstacles for timely care
5	Need for more timely services (currently, two-week wait for licensed staff; six-week wait for MD for medications); reduce waiting time
6	Psychiatric Services: medication education; group education/training services for clients to educate clients regarding their illness; access to interagency staff members to staff cases to best achieve common goals established with the client; building supports for SP1 clients (who are not eligible for group skills training services)
7	Pull together an interagency discussion group to best pool together talents, skills, availability of services, funding and other resources to meet the needs of those persons shared between agencies. Use this group to continue education of available services and needs for additional services. Include law enforcement, service agencies, hospitals, healthcare providers, probation, schools.
8	Adult probation requests additional mental health training.
9	Training (sensitivity training) for sheriff's department staff to ensure best care of persons calling through the Crisis Hotline for mental health services/assessment; need for ongoing training; consider development of mental health deputy program.
10	Better identification of persons with mental illness to ensure appropriate services may be provided at an appropriate time. [Example: Persons moving through criminal justice system and mental health systems that may be identified as a user of services—intended to best serve clients we have in common—"tagging".]
11	Substance Abuse (OSAR): Evaluation prior to sentencing? Need timely access to OSAR to get persons into services.
12	Affordable Housing: Ongoing need for supported housing, funding sources to support the ongoing needs
13	Transportation needs inside and outside county. Current resource: CARTS—requires advance appointments.

Identification of County Mental Health Needs

July 17, 2008

Williamson County Agency Meeting
1009 N. Georgetown Street
Round Rock, Texas

	Community Need
1	Psychiatric Services: Difficult to find a psychiatrist for Medicaid funded persons, dually diagnosed (MHMR, Autism, substance abuse), medication services, ongoing services beyond crisis services.
2	Need for additional providers of psychiatric services (medication, counseling) for Medicaid/Medicare funded persons—for effective referrals from community partners (agencies, schools). Issue: Lack of payer (insurance).
3	Focus on child & adolescent needs: psychiatric services, therapies.
4	Lack of Spanish-speaking providers: recruitment.
5	Availability of medication services—access to providers for medications in crisis situations. Medication samples to alleviate need for immediate medications. Alternative options for medications (cost-prohibitive to clients).
6	Providers of diverse ethnicities other than Anglo—to best serve the community.
7	Coordination between medical partners to collaborate on care and "honor the scripts".
8	Finding quality providers: psychiatrists. (High priority)
9	Transportation for persons to services: limited resources are available, affects ability to attend appointments. Flexibility to better schedule and meet the needs of the client.

10	**Referral resources to better manage the "back door" and reduce the numbers of persons "recycling" into programs.**
11	**Crisis inpatient services: availability of beds (increase capacity for children and adults meeting the growth of the community) and emergency treatment; public/private options to meet the needs of persons needing this intensive level of care; local options (for involuntary as well as voluntary); collaboration with local ERs; address "revolving door" of persons needing crisis services.**
12	**Growth has exceeded the current infrastructure and requires additional funding to meet the needs of the community. Need for partnerships has increased due to this growth and funding shortage.**
13	**Jail diversion: Need for detox/substance abuse services.**

Identification of County Mental Health Needs

July 21, 2008

Guadalupe County Agency Meeting
Silver Center
Seguin, Texas

Community Need	
1	**Increase client involvement in mental health system when being served by multiple agencies (i.e., probation): collaboration of community resources (psychiatrist, nurse) to ensure continuity of care, diversion from jail/incarceration, appropriate level of service placement. Address roadblocks presented by system. Ability to have timely responses to immediate needs.**
2	**Improve/increase/education about access to services through MHMR Center.**
3	**Increased need for coordinated services for offenders with mental illness—apparent gaps in services provided to offenders. Provide increased education; consider available funding (TCOOMMI). Need for**

	collaboration in gathering data and stats to support additional funding to address gaps in services for needs. Compare data to identify persons served by multiple agencies.
4	**Conduct coordination meetings with law enforcement, probation and other agencies providing interventions for offenders with mental illness. Goal: Catch and communicate issues identified for the offender before moving through systems.**
5	**Limited resources: medication services (have some ability to work with primary care physicians); cost of meds present difficult decision/choices for client (to pay for medications or pay for food, etc.).**
6	**Gap for psychiatric services for clients under 65 years of age.**
7	**Continuity or access to services—3 to 4 months waiting for services or continuity of services through psychiatrist; expansion of service coordination to better be able to coordinate care and share information between multiple agencies; reduce duplication of services; reduce cost of services; improve care for client.**
8	**Involvement in multi-agency association to identify common issues and possible coordination of services; shared funding/grant opportunities; shared referral sources/resources. [Currently meets monthly, every 3rd Thursday] Offers opportunity for case review to consider and review outstanding issues. Keeping track of the data will inform the system and provide leverage for awareness and action to alleviate the needs. Evaluate differences between the adult and juvenile services needs (probation, schools)—currently, more emphasis has been placed on children's services. Identify persons active in services across agencies, within the parameters of collaborative healthcare (HIPAA) and a MOU between agencies. Benefit: Agency staff familiar enough with each agency to know the referral sources ("knowing a name")—leads to better coordination for the client. Possible participation needed for future services for county: VA services (for returning veterans).**
9	**Transportation: no longer have the community bus system; CARTS requires advance notice of approximately 24 hours; need for access to transportation to get to appointments.**
10	**Collaboration between law enforcement, ER staff and crisis staff to best be able to address the immediately identified needs of the client in crisis (MCOT). Issue: Crisis staff are not seeing the issues prompting the need for medication in the ER—crisis staff are not seeing the behaviors prompting the crisis. Collateral**

	information is key in the assessment of the client when the medications cease to be effective—and the behaviors resume.
11	**Five ISDs with 27 schools, 4 private schools in Guadalupe County: Currently, needing to coordinate with probation to ensure the children receive services.**
12	**Employment Services: availability of opportunities when developing working relationships between agencies. (Moving services in association with senior living apartments across the street from the MHMR Center.)**
13	**Informing the public: Multi-agency approach to public communication of services and issues. Informing schools, parents, community providers. PSAs to promote services (i.e., radio spots to announce events, services)—ensure public knows where to go for services—and what services are available. Education and recognition of symptoms (depression, substance abuse, etc.) and outcomes (jail, suicide, overdose, etc.)—tap into multiple resources for campaign. Consider available and effective resources (how/who best to communicate the information)—radio station, DARE officer, school counselors, teens/persons having experienced a need for services, information packets.**
14	**Shared resources to fund testing (i.e., probation's testing for substance use through hair).**

Identification of County Mental Health Needs

July 21, 2008

Guadalupe County Family Meeting
Silver Center
Seguin, Texas

	Community Need
1	Support groups: peer support (offering education, encouragement, opportunities for interaction; collaboration with providers). Connect with NAMI (National Alliance for Mentally Ill—support group for families and consumers of mental health services); consider development of a local chapter.
2	Supported employment: Opportunities for employment in the community, ability for persons to "have their own lives". Additional assistance (job coaching) to find jobs in the community for clients seeking employment. Coordination with resources (Goodwill, local employers) for the benefit of the clients.
3	Family support (adults and children): Education regarding services and Medicaid supports.
4	Better coordination between personal medical physician (primary care doctor) and the psychiatrist at the Center.
5	Transportation: New vehicles for transporting clients. Need for transportation services to the Center—increase availability of service. CARTS—Medicaid clients access CARTS for free—cost for clients receiving Medicare benefits. Center no longer has van driver/van to transport clients to and from Center—this was a beneficial service. Consider planning for a transportation program tied to service appointment schedule.
6	Clubhouse for clients for socialization, classes, education, activities: Needing funds to support the therapeutic activities supported by the Clubhouse. (Alleviates anxiety, increases socialization.) Needing larger space—consider better use of current space. Need increased frequency for services through Clubhouse.
7	Children's Services: Need for family support to deal with the stress of the mental health of the child/children; support/education for families to be able to meet together—Family Partner/Family Support Services.

	Assistance for families seeking services in the community.
8	**Counseling services for children—to build skills (anger management) prior to teen years. Services (skills training) for families to understand and build the skills to work with the child. Groups for single parent households. Parenting skills training for family members.**
9	**Respite services for families. Flexible funds to support payment for respite services for parents to use (payment for selected friends to provide respite, community members). Consideration of the additional time the parents spend with schools and personal physicians to manage the healthcare for their child—respite. Need for available resources to reduce the stress on family members as well as the person receiving services.**
10	**Expand facility to better support group and peer support activities. Increase funding for the psychosocial program to allow for peer support and advance vocational training. Look at options (Example: Sunrise Villa) to quickly remedy need for growth—and a long term plan to expand. Psychosocial skills have alleviated problems noted by parents—reducing stress on the family.**
11	**Additional counseling services needed for persons who are not eligible for brief CBT (Cognitive Behavioral Therapy) services. Need for specialized group counseling based on age, diagnosis/symptoms, functioning levels.**
12	**Education of the community and family members regarding mental illness—community awareness. Stigma regarding mental illness results in difficulty in obtaining employment, being a part of the community. Consider annual event to get attention and educate the public. Need for a campaign—newspaper articles, volunteers to support events. NAMI (National Alliance for Mental Illness)—consider a local chapter to promote awareness of the needs for persons and families experiencing mental illness—provides education regarding illness, symptoms, diagnoses. Bring events occurring in other areas (marches, other events) to Guadalupe County. Consider peer support (from NAMI in San Antonio) in starting a local chapter in Guadalupe County.**
13	**Education regarding services MHMR Center provides: Provide better information describing services to family members seeking services.**
14	**Address the Waiting List for Services. Need for referral resources in the community to better move persons**

	from MHMR services to community services—allowing other persons in the community to receive services through the MHMR Center. No other psychiatrist able to serve persons (under 65 years of age) when discharged from the Center. Funding is needed to support the additional need for staff to address the persons seeking services. Consider grant funding opportunities, foundations, private donations, client fees for services (co-pays), fund raising events supporting the Center.
15	**Better coordination with other providers to ensure clients are best served by all providers. (Review with Rosa: Client choice between providers.)**
16	**Workshop that was available through Camino Real—clients were able to earn money while providing a service for TIBH.**
17	**Medication services: Education regarding prescription programs such as Patient Assistance Programs (PAP) offering medications at little or no cost for clients.**
18	**Crisis Services: After leaving ER, experienced little or no continued contact or care for the individual needing crisis services. [Mobile Crisis Outreach Team (MCOT) has now been established in Guadalupe County.] Education to contact 800-841-1255, toll free hotline to access crisis services.**
19	**Access to refreshment machine in the lobby.**

Identification of County Mental Health Needs
July 23, 2008

Burnet County Family & Agency Meeting
McLean-Reioux Building
Marble Falls, Texas

	Community Need
1	Local psychiatrist needed for continuity of care—need to accept Medicaid.
2	Waiting list: 5 clients. Persons with low needs, without Medicaid. Revisit capacity limitations.
3	Medication costs: fewer drug samples, more stringent patient assistance programs (pharmaceuticals) resulting in denied applications. Finding costs for generic medications are similar to name brand.
4	Transportation: financial assistance to purchase transportation, availability of transportation [CARTS, medical transport (MTB)], current routes are not convenient for clients and client appointments. Explore opportunities for shared transportations services (MHMR, churches, CAPMetro)—work with Burnet County Transportation Committee [meeting once per month: Commissioners, councilmen, mayor, TxDOT].
5	County Interagency meeting: second Tuesday of each month, rotating locations. [Consider bringing transportation issue to agenda.]
6	Grant applications: Helping Center, Seriff legacy foundation (end of August).
7	Education of families/caregivers regarding the need for independence of the consumer. (Associated with a minimum fee for transportation.)

8	**Public education of service Boards and general public regarding needs of the client—PSAs, newspapers, editorials, agenda for interagency council, County Commissioners, County Judge, City Manager—continuous education to bring issues to light—stay plugged in. Positive reports of successes for mental health to reduce stigma of mental illness.**
9	**Supported employment opportunities—for MH population: (1) stigma pre-empts ability to remain employed (job coaching results in the employee identified as a mental health client); (2) need successful job matching focusing on productivity of the employment and reduction of stress, leading to success of client. [Note: RDM has given supported employment a back seat by not including in service packages. Consider other program designs, within reasonable funding parameters, allowing for flexibility of service provision.] Must know business market in local community to know if supported employment opportunities exist. Must have expertise in supported employment services. Consider opportunities to address needs to local groups who may have skills and connections to support the clients.**
10	**Getting psychiatric appointments for persons in crisis (Burnet County has a psychiatrist 3 days/week). Need flexibility for schedule (two days without psychiatrist and after hours). Using residents.**
11	**Diversion from jail: increasingly seeing clients in jail due to lack of beds in state hospitals. Consider supports needed for new county jail. Consider availability of Center psychiatrist providing services at the jail.**
12	**New Scott & White Hospital, Llano: Consider if partnership for psychiatric services exists.**
13	**MH Deputy Program: Educate officers—consider cost and need for education of budget/decision makers regarding the need for educated officers. Address security and transportation issues.**

Identification of County Mental Health Needs

July 29, 2008

Fayette County Agency Meeting
MHMR Center Building
La Grange, Texas

	Community Need
1	**Ongoing communication with agencies responsible for healthcare and county needs.**
2	**Standardized system for intake and eligibility into healthcare system. (FQHC)**
3	**Collaboration with law enforcement for access/assessment services. Screenings need to be face-to-face by MH professional. Develop an assessment system that will include all participants considering functions/responsibilities of each participant (law enforcement, MH professional, social workers, JP, primary physicians). If evaluation/assessment paperwork is completed by MH professional, the length of time of the process is reduced, benefitting the client and county/city law enforcement staff.**
4	**Transportation for clients assessed to need intensive levels of care (crisis respite, state hospital). Clients are transported by law enforcement: poses problems for the client as the client is experiencing a mental health issue not presenting for a criminal offense.**
5	**Consider if, afterhours, law enforcement may use a peace officers' warrant (POEC). Consider addressing this afterhours option with the Chiefs. If option is favorable, consider training for new staff.**
6	**Conduct ongoing planning meetings (approximately every two months), giving at least 3 weeks notice, holding the meetings in the morning.**
7	**Juvenile Services: Need for psychiatric services for children/adolescents. LPHA service availability for**

	non-crisis situations. (Reduce waiting time of approximately 5 weeks.) Child psychiatrist, medication services, counseling.
8	**Consider TCOOMMI services for Fayette County.**
9	**Open capacity: Ensure ongoing treatment is available addressing the needs in the evaluations.**
10	**Telepsychiatry: Accessibility to services. Consideration of partnership with police stations/jails for assessments.**
11	**Transportation: CARTS, taxi services are available. Access to transportation to appointments is not flexible.**
12	**Transferring elderly patients to more appropriate community services. Ability to have assessments provided prior to transfer to state hospital (or less appropriate level of care). Consider options for psychiatric services for elderly patients in nursing facilities.**
13	**Referral resources: 5 primary care physicians in La Grange. Consider options for referral sources for persons needing less intensive levels of care (medication services, only).**
14	**Reduce the waiting list for MH services.**
15	**Increased inpatient services.**
16	**Interagency Meeting: MHMR to notify participants of meeting date and time. (If none scheduled, will hold meeting at MHMR to consider the identified priority issue: child psychiatrist.) Consider development of interagency resource manual available to participants.**
17	**Access to placements (residential/respite services) for children in the criminal justice system—children require services. Invite Whispering Hills to Interagency Meeting and Pam Harbers (LGISD).**
18	**Substance Abuse Services: Inform Adult Probation of access to OSAR.**

Identification of County Mental Health Needs

July 31, 2008

Gonzales/Caldwell County Family Meeting
Gonzales, Texas

	Community Need
1	Decrease the wait time to be able to see a physician in a timely manner for first time consumers
2	More options for assistance in payment of utilities
3	Offer options to increase peer socialization
4	Transportation needs to assist with socialization activities
5	Group activities to assist with socialization i.e. bowling, movies, games
6	Housing options that allow availability of pets
7	Explore volunteer opportunities within the community
8	Having more public housing options in Caldwell County

Identification of County Mental Health Needs
July 31, 2008

Gonzales County Community Meeting
Gonzales, Texas

	Community Need
1	Better communication between the primary health care provider such as the FQHC and Bluebonnet Trails; having access to medication history for prescribing. Preventing duplication of previous medications that were not effective or to prevent "doctor shopping".
2	Having access to the physicians at the Community Health Clinic to discuss treatment options.
3	Establish memorandum of understanding between the community health clinic and community agencies (i.e.; adult probation) to assist with on going communication and progress of patients/consumers.
4	Lack of treatment options for the non-priority population established by DSHS.
5	Improved access to obtaining medications in the community for the non-priority population.
6	Explore opportunities for Bluebonnet Trails to collaborate with the Community Health Clinic in Gonzales County.
7	Identification of transportation resources
8	Collaborate with the courts regarding sentencing recommendations so that the individual is not having to decide between paying court costs and their medications. How to identify the cases that need the collaboration of legal and mental health treatment. There is not an identified MH court.
9	Need to establish an inter agency meeting for discussion of on going community needs.

10	**Need to reach out to the area churches to educate and tap into the resources that might be available to the community. Suggest having someone from the ministerial alliance to attend the inter agency meeting.**
11	**Need to identify local counseling resources**
12	**Need to involve and educate law enforcement regarding mental health awareness.**
13	**Coordination of a mental health officer training offering TECLOSE credits.**

Identification of County Mental Health Needs

August 1, 2008

Caldwell County Community Meeting

Lockhart, Texas

	Community Need
1	**Better communication of 800-Crisis Number for integrated activation of crisis services. (Public service announcements, educations for community, local officials and staff.) *Conduct meetings* with JPs, law enforcement (sheriff, deputies, police, Constable), MCOT, MHMR staff, and county officials to *establish protocol* and *coordinate efforts* for apprehension and assistance from MHMR Center. (Examples: Adult family member making application. Mental health evaluations at jail. Consideration of cases.) [Priority]**
2	**Partner with FQHC to provide psychiatric services in Caldwell County. (1) Access to "patient navigator" system for persons seeking healthcare services (information system providing beneficial healthcare details to user: education, local services, etc.). (2) Improved collaboration between physical and psychiatric care. Reducing duplication of services. Reducing costs of services to patients as well as to the providers (340B Medications, shared staff resources including psychiatrist, etc.). FQHC has an in-house pharmacy with pharmacist in attendance weekly—FQHC is considering other pharmaceutical partnerships. (3) Coordination of services through Medical Directors offering collaboration of shared services as well as options for referral**

	services when patient is discharged from Bluebonnet. (4) Consideration of grant opportunities supporting key partnerships. (5) Consideration of options for co-location of FQHC and MHMR. (6) Consideration of a MOU to assess common patients/clients/consumers for planning.
3	**Coordination of providers to support the jail system and persons in jail as well as persons discharged from the jail with MH and physical health needs.** *Note:* **Jail will soon be expanding by 100 beds.**
4	**Interagency discussions benefitting coordination of care in the county. Caldwell County Rural Health is the interagency coalition—looking at: (1) integration of care; (2) providing assistance to persons to better navigate through healthcare systems; (3) development of referral system.**
5	**Increased access to LPHA by the jail—look at setting up physician-to-physician contacts.**
6	**Transportation for clients to get to appointments. CARTS offers some relief, but schedule is not flexible meeting the needs of the client. Client must find a ride to the city in order to catch the CARTS bus. Consider partnership with CARTS to extend routes and increase number of vans available. (See Rick Elizondo, Gulf Coast Center—the MHMR just established a partnership in Galveston and Brazoria Counties for transportation.)**
7	**Seton provides PAP program for physical healthcare patients. Consider accessing program (offered by the National Association of Counties) providing cards for consumers allowing 20% discount for medications.**
8	**Recruitment of medical professionals (FQHC): Texas Association of Health Centers and National Association of Health Centers. (May be coordinated through FQHC.)**
9	**Medication costs incurred by MHMR physician (Dr. Price) for jail: Jail to provide doctor (who is currently using our formulary) with the jail formulary to ensure the costs of medications are maintained. Center to look at formulary for Dr. Price. [Priority for Jail]**

LPND Summary of Forum Priorities

1. Lack of transportation for health care appointments was expressed at most of our forums. Lack of public transportation and/or inflexible scheduling for CARTS services.
2. Lack of community psychiatrists that will take Medicaid or Health Insurance and decreasing the wait time for first time consumers to see an MHMR psychiatrist.
3. Increase MH Community Awareness or Education, as well as increase awareness of MHMR local services. Participate and re-establish the Interagency Meetings to improve awareness and partnership opportunities.
4. Identify and partner with key community agencies. Establish, as an example, local partnerships between MHMR and the Federally Qualified Health Clinics (FQHC).
5. Eliminate or decrease the MH wait list.

5. Crisis Response System and Services

Stakeholders reported the following items as comprising the most significant needs and priorities for the Crisis Response System & Services in the local community:

Expand State Hospital Beds
Stakeholders want to expand the statewide availability of inpatient beds in Texas. On many occasions recently we have had no beds in the State Hospital System and no place to supervise individuals who present with risk of harm to self and others.
Medical Clearance Protocols
Not all persons who are hospitalized (private and state hospital issue) need medical clearance, although we are being asked to provide this at a cost to the county. Can admission protocols be developed to prioritize those clients at most risk for medical complications?
Increased Collaboration with Local Jails
Improve service delivery to inmates who present with a diagnosis of mental illness. Establish partnerships locally to ensure inmates with mental health needs are being prioritized and treated.
Increased Funding & Staffing
Stakeholders want the provision of true "24/7" crisis services, adequately funded for full staffing after hours and on weekends. Full crisis services would also include onsite medical clearance to avoid the need for tandem emergency room utilization.

6. Development of an External Provider Network

Stakeholders reported the following items as comprising the most significant opportunities and concerns regarding the development of the Center's External Provider Network:

Opportunities:

Increased Choice: There are many worthwhile agencies and providers, especially non-profits, who could add quality and choice to the external network.
Integrated Health Care: Expansion of the network should work toward the goals of increasing integrated health care and providing total health care service to consumers in one location.
Increased Collaboration: Mental health services and programs are very isolated. There is not enough true collaboration between agencies; often joint venturing is simply making referrals. Increase collaboration between agencies and services, traditionally siloed, by partnering with providers who truly have a support network of care already in place. That kind of community participation goes directly to "best value."
Grow Existing Relationships: The opportunity to grow existing community collaborations by combining services with other local entities such, as the Federal Qualified Health Clinics.

Concerns:

Does Not Address Insufficient Funding: While increased consumer choice is a positive outcome and better in concept than the current structure, if the basic community service model does not change, more providers will not equal better care. Without additional program funding, the current faults in the service delivery system will persist.
Cherry Picking by For-Profit Providers: Many stakeholders were skeptical of large, for-profit providers, whose profit margins might discourage adequate care for higher need/higher cost consumers. In such a "bottom-line" scenario, contracted providers might seek to "cherry pick" the more cost efficient

consumers, leaving the Center with money-losing programs and high-cost consumers it will no longer be funded to adequately treat.

Alienation of Consumers: Many stakeholders also felt it is dangerous to force consumers who are comfortable with Center services, and who prefer Center services, to transition to new providers, for fear of them dropping out of the system completely, to possibly disastrous results. These stakeholders prefer a system in which the Center continues to be an equal provider in the network of provider care.

Decreased Community Involvement: The current Center administration has been instrumental in bringing the current mentality of community collaboration and education regarding mental illness to the forefront of the issues. Dealing with private providers might diminish the consistency and service quality as well as weaken the currently established community relationships. Stakeholders expressed concern that if the Center ceases service provision, there is a great chance that the current gaps in service in the community will increase.

7. Changes to the Service Delivery System in the Next Biennium

In the initiation of this Local Planning Network Development Plan and in the continued efforts to develop and enhance its existing external provider network, the Center must consider the many factors directly influencing its ability to implement regulated changes in the next biennium. Centers have a difficult challenge ahead and must prepare for the development of the provider network that will increase access to services and provide true choice of providers. Centers must partner with external organizations to develop protocols and design how this new system of care will transition from MHMR providers to external providers as seamless as possible. In addition the Center is asked to ensure "safety net" protocols to handle any service issues that may develop in this new system of care. As a result Centers must approach these new responsibilities with caution and mindful planning. Centers must develop contract monitoring

protocols that will ensure quality services, successful billings, provider training, credentialing requirements, PNAC development, consumer satisfaction, etc. Chief among these factors are:

- The strength of the Center's organizational and technical structure;
- Staff competency in the areas of procurement, contract negotiation and management, utilization management and clinical authorization, and claims adjudication;
- Determining Best Value criteria, including local stakeholder input, availability of current or potential contracted providers, and ultimate cost benefit, including the cost of any staff training associated with managing an external network of providers;
- The capability of the Center's information technology system to process an external provider's clinical and fiscal information.

Center infrastructure must support these initiatives in order to promote a healthy and productive relationship with our external partners. Community involvement is critical in making these changes in the coming years. The Center is committed to this initiative and will continue its efforts to support and plan for the inclusion of a provider network to best serve our eight (8) county service area. In addressing changes the Center will make in the next biennium, it must be noted that many of the service gaps identified by community stakeholders are directly related to a lack of adequate funding for programs and services. The Center will continue to work with its legislative delegation and the Texas Council of Community MHMR Centers to encourage greater funding for mental health and substance abuse programs for Community Centers.

Current Services and Providers

The following is an overview of and rationale for the methodology used to calculate the amounts listed in the columns entitled, "Dollars Spent on Direct LMHA Services" and Dollars Spent on External Provider Services." As recommended by DSHS, the Texas Council of Community MHMR Centers utilized members of its various consortia to develop a consistent methodology. The basis of the methodology developed is *cost*. Cost, as opposed to revenues, was utilized because of their direct relationship with the services delivered.

To utilize the methodology, the Center isolated the costs associated with the services delivered under contract by External Providers during FY 2007. The Center conducted a detailed allocation of all costs associated with the services it provided directly, including direct costs, provider-related overhead costs and the appropriate proration of general administrative costs. As instructed by DSHS, administrative expenses associated with Authority functions were not included in the calculations. The data submitted by the Center to DSHS in response to the FY07 Cost Accounting Methodology requirement was the basis for the unit costs used in the methodology. While the methodology used does, to the best of the Center's ability, identify the costs associated with services delivered directly by the Center in FY07 and identifies the amount of DSHS-related funding spent on External Provider services in FY07, one should not consider the former as the definitive amount of DSHS-related funding available for contracting under the LPND rule. Other factors must be considered and are discussed in later sections of this plan.

To reiterate, the chart below is an overview of the service delivery system for the Fiscal Year 2007 operating period; and provides a snapshot of the Center's service delivery network for the period of time. As the Center moves forward in its Network Development goals, and the service delivery system changes due to legislative requirements, funding, community needs, and other Factors; the available funding will also change accordingly. Review of this chart and the information contained will provide the initial foundation for the

upcoming sections on service capacity and procurement; as well as give the Center and its stakeholders a starting baseline for considering progress 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**
ROUTINE SERVICES					
Intake (Screening, Pre-admission Assessment)	X	$ 500,515	Alaverez, Maria Antonia P.O. Box 5011 Georgetown, TX 78627	$ 168,576	
			Avail Solutions, Inc. P.O. Box 60811 Corpus Christi, TX 78466		
			Blanke, Bernie P.O. Box 5011 Georgetown, TX 78627		
			Good, Donald 787 E. Hemstead Giddings, TX 78942		
			Jackson-Moore, Cecilia 2185 Jakes Colony Rd. Seguin, TX 78155		

			Richter, Kimberly 612 St. Andrew Gonzales, TX 78629		
			Webb, Barbara 155 Colene St. Giddings, TX 78942		
Routine Case Management (Adult)	X	$ 619,047	N/A	N/A	N/A
Routine Case Management (Child/ Adolescent)	X N/A	$ 543,445	N/A	N/A	N/A
Respite Services	N/A	$ -		$ -	
Supplemental Nursing Services	X	$ 15,054	Burns, Pamela 1004 PRD 1417 Giddings, TX 78942	$ 5,698	
			Davis, Thelma P.O. Box 614 Giddings, TX 78942		
Pharmacological Management	X	$ 546,739	Burns, Pamela 1004 PRD 1417 Giddings, TX 78942	$ 227,291	
			Davis, Thelma P.O. Box 614 Giddings, TX 78942		

			Herndon, Paul 301 Whitetail Cove Manchaca, TX 78652		
			Howe, Don 25 Ryans Point Dr. San Antonio, TX 78248		
Provision of medication	N/A			$1,841,446	
Psychiatric evaluation	X	$ 140,040	Herndon, Paul 301 Whitetail Cove Mancahca, TX 78652	$ 67,732	
			Howe, Don 25 Ryans Point Dr. San Antonio, TX 78248		
			Gregory, Paul 9100 Lantana Way Austin, TX 78749		
All Rehabilitation Services (Adult)	X	$ 3,036,362	Webb, Barbara 155 Colene St. Giddings, TX 78942	$ 811	
All Rehabilitation Services (Child/Adolescent)	X	$ 370,681		$ -	
Supported Employment	N/A	$ -		$ -	
Supportive Housing	N/A	$ -		$ -	

Assertive Community Treatment	N/A	$ -		$ -	
Inpatient services	N/A	$ -		$ -	
Residential Treatment	N/A	$ -		$ -	
Intensive Case Management (Child/Adolescent)	X	$ 119,290	N/A	N/A	N/A
Counseling (Adult)	X	$ 6,304	Cabrera, Henry 15711 Heimer Rd. San Antonio, TX 78232	$ 3,211	
			Gould, Christina P.O. Box 1729 Bastrop, TX 78602		
			Lawson, Debra 1930 Rawhide Dr, STE 402 Round Rock, TX 78681		
			Thueson, Roganne 1706 Ibis Court Bryan, TX 77807		
Counseling (Child/Adolescent)	X	$ 63,335	Briery, Johnathan P.O. Box 2174 Georgetown, TX 78624	$ 4,229	

			Lawson, Debra 1930 Rawhide Dr, STE 402 Round Rock, TX 78681		
			Thueson, Roganne 1706 Ibis Court Bryan, TX 77807		
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)	X	$ 1,692	Jackson, Angela 1201 Ridgemont Street Round Rock, TX 78664	$ 45,271	
Flexible Community Support (Child/Adolescent)	N/A	$ -		$ -	
Multi-Systemic Therapy (Child/Adolescent)	N/A	$ -		$ -	
Consumer Peer Support	N/A	$ -		$ -	
CRISIS & OTHER DISCRETE SERVICES	N/A				
Crisis Hotline	N/A	$ -		$ -	
Crisis Intervention Services	X	$ 231,701	Absher, Darla 116 Valley Run Trail Elgin, TX 78621	$ 467,219	

			Alvarez, Maria Antonia P.O. Box 5011 Georgetown, TX 78627		
			Blanke, Bernie P.O. Box 5011 Georgetown, TX 78627		
			Cunningham, Sara 1006 E. Bluebonnet San Marcos, TX 78666		
			Good, Donald 787 Hempstead Giddings, TX 78942		
			Jackson-Moore, Cecilia 2185 Jakes Colony Rd. Seguin, TX 78155		
			Richter, Kimberly 612 St. Andrew Gonzales, TX 78629		
			Unger, Casey 908 Navidad Bryan, TX 77801		
			Webb, Barbara 155 Colene St. Giddings, TX 78942		
Mobile Outreach	N/A	$ -		$ -	
23 Hour Observation	N/A	$ -		$ -	

Extended Observation Unit	N/A	$ -		$ -	
Crisis Residential Services	N/A	$ -		$ -	
Crisis Respite Services	N/A	$ -		$ -	
Crisis Stabilization Unit	N/A	$ -		$ -	
Crisis Follow-Up and Relapse Prevention	N/A	$ -		$ -	
Crisis Transportation	N/A	$ -		$ -	
Crisis Flexible Benefits	N/A	$ -		$ -	
Laboratory Services	N/A		Central Texas Paramedical 1212 Chisolm Trail Round Rock, TX 78681	$ 37,798	
			CPL 9200 Wall Street Austin, TX 78754		
			Guadalupe Region Med Ctr 1215 Court Street Seguin, TX 78155		
			Johns Community Hospital 3118 N. Main St., Ste 105 Taylor, TX 76574		
***An organization that provides mental health services that is not an LMHA; or an individual who provides mental health services who is not an employee of an LMHA.**					
***Submitted template would include rounding amounts to nearest $1,000**					
Linked to FY07 Funding for Reconciliation		**$ 6,194,206**		**$ 2,869,281**	**$ 9,063,487**

Provider Network Development

1. Provider Availability

In determining the potential of increasing external providers of mental health services in our area, Bluebonnet Trails reviewed the 2004 Provider of Last Resort Plan/Request for Information, the list of providers expressing an interest in working with Bluebonnet Trails consumers in the past, the list of current providers contracting to provide services, as well as the list of providers who completed the Provider Interest Inquiry Form on the DSHS website. In April 2008, the Center released a "Request for Information" (RFI) in an effort to ascertain interest from mental health providers in providing publicly funded mental health services to adults and children diagnosed with serious mental illness, including schizophrenia, bipolar disorder, and manor depressive disorders.

This process although valuable in understanding the interest and availability of external providers, it does not tell us if and when external providers are ready to take on provider functions. Therefore, the Center plans to have a Provider Conference in FY 09 to invite interested providers and help define the circumstances in which external providers are available and willing to be included in the Center's External Provider Network. The Center is interested in providing "Choice of Providers" to enrolled individuals, and would be interested in contractors who are available to provide the fully array of services available in each service package., including psychiatric evaluations and reviews.

2. Provider Inquiries (within the last two years)

Date of Inquiry	Summary of Inquiry	LMHA Response
Feb. 6, 2007	US Script	Informed that we were not doing RFP this year
June 6, 2007	" "	Informed that we were not doing RFP this year
January 2008	" "	Informed that we were not doing RFP this year
June 24, 2008	" "	Informed that we were not doing RFP this year
February 7, 2007	Corphealth	Informed that we were not doing RFP this year
January 14, 2008	"	Informed that we were not doing RFP this year
April 4, 2008	JSA Health LLC – Tele-Psychiatry	We are considering a contract for crisis Tele-psychiatry – we reviewing the contract specifics at present
June 10, 2008	The Wood Group – Crisis Respite Proposal	Proposal accepted
June 10, 2008	Sunwest Behavioral Health Organization LLC – Crisis Respite Proposal	Proposal rejected
2008	Telecare Mental Health Services of Texas, Inc. completed Provider Interest Inquiry Form	Telephone conversation with David Pan. Will be invited to the Provider Conference in FY 09
2008	Excel …Rise Above the Rest, completed Provider Interest Inquiry Form	To be Determined in FY 09. Will be invited to the Provider Conference in FY 09
2008	The Wood Group, completed Provider Interest Inquiry Form	Telephone conversation with Jerry Parker. Will be invited to the Provider Conference in FY 09
2008	Sunwest Behavioral Health Organization LLC, completed Provider Interest Inquiry Form	Left a message on voice mail. Will be invited to the Provider Conference in FY 09

2008	Monty & Muniz Rehabilitation , completed Provider Interest Inquiry Form	To be Determined in FY 09. Will be invited to the Provider Conference in FY 09
2008	Providence Services of Texas, completed Provider Interest Inquiry Form	Telephone conversation with Richard Wallace. Will be invited to the Provider Conference in FY 09

3. Service Capacity and Procurement

	3a	3b	3c	3d	3e	3f
Service	**Current Capacity**	**Projected Capacity**	**Availability of Current and Potential External Providers**	**Procurement Planned?**	**Capacity to be Procured**	**Method of Procurement**
ADULT SERVICES						
RDM SP 1	2,131	2,131	(No Current Providers, other than discreet services) 4 – Provider Interest Inquiry Forms Completed	YES	450	RFP

RDM SP 2	44	50	(No Current Providers, other than discreet services) 4 – Provider Interest Inquiry Forms Completed	YES	50	RFP
RDM SP 3	403	403	(No Current Providers, other than discreet services) 4- Provider Interest Inquiry Form Completed	NO	NONE	n/a
RDM SP 4	43	43	(No Current Providers, other than discreet services) 4 – Provider Interest Inquiry Forms Completed	NO	NONE	N/A
RDM SP 0	80	80	N/A	NO	NONE	N/A
RDM SP 5	2	2	N/A	NO	NONE	N/A
CHILD/ADOLESCENT SERVICES						
RDM SP 1.1	216	216	(No Current Providers, other than for discreet services) 4 – Provider Interest Inquiry Form Completed	NO	NONE	N/A
RDM SP 1.2	109	109	(No Current Providers, other than for discreet services) 4 – Provider Interest Inquiry Form Completed	NO	NONE	N/A

RDM SP 2.1	0	0	(No Current Providers) 3 – Provider Interest Inquiry Form Completed	NO	NONE	N/A
RDM SP 2.2	27	27	(No Current Provider, other than for discreet services) 3 – Provider Interest Inquiry Form Completed	NO	NONE	N/A
RDM SP 2.3	6	6	(No Current Provider, other than for discreet services) 3 – Provider Interest Inquiry Form Completed	NO	NONE	N/A
RDM SP 2.4	6	6	(No Current Provider, other than for discreet services) 2- Provider Interest Inquiry Forms Completed	NO	NONE	N/A
RDM SP 4	221	221	(No Current Provider, other than for discreet services) 3 – Provider Interest Inquiry Form Completed	NO	NONE	N/A
RDM SP 0	17	17	N/A	NO	NONE	N/A
RDM SP 5	2	2	N/A	NO	NONE	N/A

CRISIS & OTHER DISCRETE SERVICES			**Per the Oct 31, 2007 memo from Rod Swan DSHS Unit Manager of MH Contract.** The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began April 1, 2008. The development of local crisis service plans occurred using the prior existing requirements. The efforts related to crisis services are not subject (at this time) to the new Local Network Planning and Development rules for FY08. Current crisis service planning efforts are summarized within this plan. **Important to note**: Centers are not required to repeat the process of local planning for crisis services when considering this Network Development Plan, thus crisis services are not subject to further procurement at this time.
Hotline			
Mobile Crisis Outreach Team			
Extended Observation			
Day Program for Acute Needs			
Crisis Stabilization Unit			
Respite Services			
Inpatient/Hospital Services			
Crisis Residential Treatment Services			
Safety Monitoring			
Crisis Follow-Up and Relapse Prevention			
Crisis Transportation			
Crisis Flexible Benefits			
Laboratory Services			

4. Justification for Procurement of Discrete Services

Although presently we have external contractors providing discrete services such as psychiatric evaluations and reviews, CBT counseling, crisis intervention, and pharmacy services, for the purpose of the LPND Plan the Center's intention is not to seek discrete service providers. The procurement process will seek instead to review contractors who are willing to provide the full array of services available in each of the service packages, including psychiatric evaluations and reviews. If this process results in limitations to the external provider network, we will consider an RFP for discrete services within each of the packages available for mental health services.

5. Plan for Fidelity and Continuity of Care

Fidelity with be maintained as a result of the Center's careful review of its current processes through the UM/QM Management Protocols. Utilization review is an analysis of the patterns of service usage to evaluate the appropriateness and efficiency of services. A variety of data and reports give us the tools to determine how to structure our organization to provide best value to our consumers: the right service, to the right person, at the right time, in the most cost – effective manner. This data has been used to guide us in decision-making regarding staffing, organization and cost effectiveness. The UM/QM Unit ensures provider performance through consumer service authorization, on-site audits, desk reviews, documentation, billing, credentialing, and compliance with applicable federal and state laws. Over the next two years we will be evaluating the functions of this department to ensure we are able to maintain and implement a provider network system.

Case Management will work to ensure continuity of care by monitoring services provided by contracted providers. They will maintain the responsibility for ensuring that individuals receive services from within the designated service package that is appropriate for their level of need. The Center recognizes the importance of continuity and has 1- FTE at the local State Hospital to ensure transition from an inpatient setting to outpatient care is smooth and client specific. This philosophy will be continued as the Center proceeds with the implementation of the LPND Plan.

6. Rationale for Keeping Services

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

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

For each service in the table below, describe the rationale for a decision to continue providing service at any level. For each service the LMHA will be providing, state the percent capacity to be provided by the LMHA, identify the condition from 25 TAC §412.758(a) that

applies if the LMHA will continue to provide services at any level, and provide an explanation of why the condition from 25 TAC §412.758(a) is applicable. In addition, state the percent capacity of service necessary to make service provision by the LMHA financially viable and the rationale for arriving at this volume.

If discrete services are being procured separately from one or more service packages, enter them in the blank rows at the end of the table (enter additional rows as needed) and follow the instructions above.

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
ADULT SERVICES					
RDM SP 1	75%	4	**Interested providers have not expressed sufficient capacity to serve the present SP-1 consumers. <u>See Provider Interest Inquiry Forms on DSHS Website.</u>**	0	Interested providers have indicated they would be able to serve 720 clients under SP-1 Services or **34% of our capacity of 2,131**. Therefore we do not have sufficient capacity from external providers to relegate total responsibility for this package at this time. We will set up a provider conference (FY09) to review specifics for an RFP and to encourage more participation from external providers. We are hopeful that in the future more interested providers will step up to consider services for this level of care.
RDM SP 2	20%	5	Maintain role as a safety net, thus we must preserve some critical infrastructure	20%	Maintain role as a safety net, thus we must preserve some critical infrastructure. We anticipate updating this percentage and increasing choice in the 2010 planning cycle.

<table>
<tr><td>RDM SP 3</td><td>100%</td><td>5, 6</td><td>This level of care has more client care demands than SP -1 and 2, and therefore until the infrastructure and safety net is completely outlined and secured, we will wait to consider this package at a future date. Currently the TAC Case Management Rule has blended all monitoring activities into Pyschosocial Rehabilitative Services, provided by the provider only. <u>Issue</u>: Monitoring activities by the Authority are not funded at present.</td><td>100%</td><td>Critical infrastructure, including information technology's ability to accept and process an external provider's clinical and fiscal information, and technical experience/expertise in managing a network must be prioritized before assuring access and choice in this service package.</td></tr>
<tr><td>RDM SP 4</td><td>100%</td><td>5, 6</td><td>This level of care has more client care demands than SP -1 and 2, and therefore until the infrastructure and safety net is completely outlined and secured, we will wait to consider this package at a future date. Currently the TAC Case Management Rule has blended all monitoring activities into Pyschosocial Rehabilitative Services, provided by the provider only. <u>Issue</u>: Monitoring activities by the Authority are not funded at present.</td><td>100%</td><td>Critical infrastructure, including information technology's ability to accept and process an external provider's clinical and fiscal information, and technical experience/expertise in managing a network must be prioritized before assuring access and choice in this service package.</td></tr>
<tr><td>RDM SP 0</td><td></td><td></td><td colspan="3" rowspan="2"><u>Per the Oct 31, 2007 memo from Rod Swan DSHS Unit Manager of MH Contract.</u>
The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began April 1, 2008. The development of local crisis service plans occurred using the prior existing requirements. The efforts related to crisis services are not subject (at this time) to the new Local Network Planning and Development rules for FY08. Current crisis service planning efforts are summarized within this plan.

<u>Important to note</u>: Centers are not required to repeat the process of local planning</td></tr>
<tr><td>RDM SP 5</td><td></td><td></td></tr>
</table>

			for crisis services when considering this Network Development Plan, thus crisis services are not subject to further procurement at this time.		
CHILD/ADOLESCENT SERVICES					
RDM SP 1.1	100%	5	We must maintain the infrastructure and safety net for the C/Y Service Packages. Children and Adolescent Service Packages will be considered in FY 2010 and FY 2011 planning cycle.	100%	Critical infrastructure, including information technology's ability to accept and process an external provider's clinical and fiscal information, and technical experience/expertise in managing a network must be prioritized before assuring access and choice in this service package.
RDM SP 1.2	100%	5		100%	
RDM SP 2.1	N/A	5		100%	
RDM SP 2.2	100%	5		100%	

RDM SP 2.3	100%	5	We must maintain the infrastructure and safety net for the C/Y Service Packages. Children and Adolescent Service Packages will be considered in FY 2010 and FY 2011 planning cycle.	100%	Critical infrastructure, including information technology's ability to accept and process an external provider's clinical and fiscal information, and technical experience/expertise in managing a network must be prioritized before assuring access and choice in this service package. SP-4 services will be strongly considered for procurement after the Provider Conference in FY 09
RDM SP 2.4	100%	5		100%	
RDM SP 4	0%	5		0%	
RDM SP 0	100%	N/A	**Per the Oct 31, 2007 memo from Rod Swan DSHS Unit Manager of MH Contract.** The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began April 1, 2008. The development of local crisis service plans occurred using the prior existing requirements. The efforts related to crisis services are not subject (at this time) to the new Local Network Planning and Development rules for FY08. Current crisis service planning efforts are summarized within this plan. **Important to note**: Centers are not required to repeat the process of local planning for crisis services when considering this Network Development Plan, thus crisis services are not subject to further procurement at this time.		
RDM SP 5	100%	N/A			
CRISIS & OTHER DISCRETE SERVICES					
Hotline					
Mobile Crisis Outreach Team					
Extended Observation					
Day Program for Acute Needs					
Crisis Stabilization Unit					
Respite Services					
Inpatient/Hospital Services					

Crisis Residential Treatment Services			Discrete Services will not be considered under the LPND Plan, the Center will focus on contractors who are able to provide the entire array of services available in each Service Package (including doctor services).
Safety Monitoring			
Crisis Follow-Up and Relapse Prevention			
Crisis Transportation			
Crisis Flexible Benefits			
Laboratory Services			
Supported Housing	100%	1	No interested providers noted on DSHS website. MHA will continue to provide 100% of these services at this time and will update plan during the planning cycle in 2010.
Supported Employment	100%	1	

7. **Structure of Procurement**

In the table below, describe how procurement will be structured and provide a rationale. Make a separate entry for each service or combination of services that will be procured as a separate contracting unit. Identify the geographic area(s) in which the service will be procured, and whether an external provider will be required to cover the entire area. If an external provider will be permitted to contract for services in only a portion of the service area, describe how the area may be partitioned.

Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
Service Package 1 (adults)	Williamson County	**Note: Providers, who have expressed interest in SP-1, are not willing to take 100% of this package. See Provider Interest Inquiry Forms on DSHS Website** **RFP** – The Center will consider interested providers who are willing to contract with the Center for SP-1 (full package) services. Goal is to provide increased choice and access. The Center will concentrate its efforts in Williamson County since 50% of it service capacity is located in this area and since all the interested providers would like to consider this area. Our UM/QM Unit is headquartered in Williamson County and will be able to assess the departmental impact of expanding our provider network if we concentrate our efforts in this location.
Service Package 2 (adults)	Williamson County	Same as above.

8. Choice and Access

Consumer access and choice are critical aspects of expanding the provider network. Consumers expressed their desire for improvements in terms of relationship, access and service quality. Minimally, it is expected that individuals who receive services can expect high quality of services and improved access. Through the survey process, public input, meetings, and other opportunities to gather consumer concerns, individuals have expressed a desire to have services closer to home or able to access transportation services (Carts). Consumers desire pleasant wait areas with timely appointments and shorter wait for services. If appointments are cancelled for any variety of reasons, consumers want to be assured that they will be rescheduled promptly. They would welcome ease of access to providers in person and by telephone. They would appreciate timely

return of telephone calls and assistance in negotiating conflicts with providers and an opportunity to choose a provider, particularly doctors and counselors. Consumers expressed the desire to be engaged with providers who are professional, friendly, sensitive and who clearly communicate expectations of care. Consumers want someone who believes in their recovery. This feedback will be used to improve internal services and will be incorporated into the Request for Proposal process.

9. **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 __x__ No______

If yes, specify which services will be provided by a single provider and identify the economic factors which prevent the LMHA from offering consumers a choice.

Service to be Provided by a Single Provider	Economic Factors Preventing Consumer Choice
Intake (Screening, Pre-admission Assessment)	The Center believes that this is an essential LMHA role to retain these services in order to establish eligibility for services. The Center is also responsible for ensuring that authorized services do not exceed dollars allocated
Case Management Services	CM services will continue to be an essential role for the LMHA to assess the right level of service and monitor recovery of the person receiving services.

10. Diversity

How will issues of cultural and linguistic diversity in the local community be addressed by the LMHA? Include any contract issues regarding use of external providers and how a plan to ensure that cultural and linguistic diversity will be addressed by external providers contracting with the LMHA.

The Center is committed to ensuring that all individuals who receive services have the opportunity to effectively communicate with their service providers. It encourages and works to facilitate the involvement of families and consumers regardless of the language which the consumers speak or their cultural background. The Center recognizes that culture impacts how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and utilize and respond t mental health treatment. While there is an ongoing goal of bringing quality services to consumers and to continuously improving those services through the use treatment approaches such as evidence-based practices, it is recognized that cultural adaptation must also be utilized to keep the services consistent with the consumer's culture.

The Center will maintain its position that cultural competency takes place in the mental health service delivery system when cultural issues are acknowledged and addressed at all organizational levels (administration, service delivery and clinician). Requirements that all individuals receiving services will have the opportunity to effectively communicate with their service providers will be included in provider contacts. Bi-lingual staff are recruited and hired for those positions needing that skill whenever possible.

11. Cost Efficiency

How will the maximum possible service dollars be preserved while maintaining required authority functions? The response must include a discussion of:

- Administrative costs and services directly related to those authority functions, and
- LMHA's strategies for maximizing dollars available to provide direct client services, including:
  - Efforts to minimize overhead and administrative costs and achieve purchasing efficiencies and
  - Efforts to work jointly with other local authorities on planning, administration, purchasing and procurement or other authority functions; or on service delivery

The Center will continue to direct maximum resources to direct care services and strive to restrict growth of administrative costs. The Center's Board of Trustees each year develops guidance principles for staff to prepare the annual budget. The Board emphasizes direct care services and the Center will ensure the following protocols:

1. Ensure stakeholder participation (consumers, families, employees, Advisory Committees, and local collateral agencies).
2. Budget for consumer-driven services reflecting quality, access, best practices, and best value (including family, significant others, and trained volunteers in treatment of consumers).
3. Provide compensation for all employees consistent with Board direction.
4. Provide for only mission essential improvements.
5. Budget will focus on the strategic plan.
6. Commitment to continuation of current direct services unless review of options allows no better choice than the reduction of services.

7. Maximize Federal Funding, Center participation in Managed Care Contracts from State Agencies, and all other resources.
8. Maximize consistency of qualified providers over time.
9. Fund Balance expenditures will follow Board directed parameters.

Note: *All of the above principles shall be observant of developments regarding the implementation of HHSC's Network Development Rule and resultant budgetary impact.*

Previous Efforts. (Previous efforts to develop an external provider network and the results of these efforts.)

In 2004, the Center developed an RFI process and initiated as a means of determining interest in a comprehensive treatment network for people with mental illness and mental retardation. Respondents were asked to provide information on various service packages and include any topic or question the respondent, or any other interested parties believed important to address in any future RFP. The Center received information from contract providers who were already in the provider network and three other responses for pharmacy services, substance abuse services, and counseling for children. The results were no new contracts for MH services during this period of time.

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

Barriers	Plans
Shortage of external providers willing to provide the full array of services.	Maximize the efficiency of the external network by focusing on procuring providers willing to provide the full array of mental health-related services

Rates not attractive to external providers	Continue supporting legislation and lobbying efforts to improve funding
Transportation restrictions, including increased gas prices and limited public transportation options	Work with public transportation in the community and possibly implement telemedicine services were feasible to reduce provider travel expense
Providers reluctant to meet DSHS contract requirements	Continue to work with DSHS regarding contract requirements and potential to streamline regulations

12. Attraction of Providers. (Explain what conditions must be present in order to attract external providers to your local service area)

Increased funding for mental health services by the state is the surest means for attracting both internal and external qualified providers to our service areas. Until there is greater service funding yielding higher rates of reimbursement, the vast majority of private behavioral health providers – both individuals and organizations – will remain reluctant to participate in a public health care (Medicaid & GR-oriented) system overloaded with high cost/high utilizing consumers. Local Mental Health Authorities across Texas are inadequately funded to serve their communities' needs; the LPND process will certainly recruit service providers to our areas but until the system as a whole is better funded, meeting the service needs of its ever increasing population of mental health, mental retardation, and substance abuse consumers will be difficult.

The Center will coordinate a Provider Conference on April 1, 2009 to enable external providers to review protocols and discuss package of services available to this network. Bluebonnet Trails will review and set expectations together to enable participation and involvement in our provider network. Bluebonnet Trails considers the LPND process an opportunity to expand and develop more access into services and better

provider choices in our network. We look forward to a dialogue with external providers who are currently providing MH services with other MH Authorities around the State.

13. Long Term Planning. (Discuss plans, including time frames, for at least two years beyond the period covered by this plan, for development or continued development of an external provider network)

We believe that the primary focus of behavioral health care planning and organization should lie in the community. The staff of the Center working with the stakeholders, advisory committee members, consumers and families and its board of trustees, has established business practices based on the planning considerations we have identified to prepare for this service model shift. This has allowed the Center to be able to prepare the community, consumers and their families as well as Center staff to the realities of this new environment. The Center must continue to refine our service delivery outcomes and prepare standard measures for service delivery that are consistent, timely and provide quality outcomes for people that meet our community's expectations so that this Center can position itself as having a network of Behavioral Health Care Providers that enhances services and quality of life for consumers within our service areas. Long term strategic planning has historically proven to be of value to this Center. Some of the principles we are keeping in the forefront of our future planning include:

- Consumers and families are best at determining "what's working." Using consumer input and listening to and taking direction from consumers to determine the measure of our success is part of the foundation of the quality schema.
- Viewing the wellness of the whole person and connecting physical and behavioral health will contribute to determining the appropriate course of services for individuals in treatment.
- Viewing the whole person and his or her connection to family and community will build alliances to sustain individuals in treatment and services. When providers are aware of a consumer's housing, employment, social connections, spirituality and educational desires and work in partnership with

consumers, providers and the authority, to fulfill those desires, consumers and their families can be better positioned to becoming self sufficient and live productive lives.

- Center infrastructure (Information technology, UM/QM, Case Management, and Contracts, will be developed during the first phase of the LPND process but will continue to be emphasized as we move closer to a comprehensive external provider network that will ensure quality services to the local MH service system. The financial implication to this Center will be better defined during this next phase of development.

Additionally, the Center will continue to work on access to services and public education of mental health services. We are all aware that stigma plays a large role in preventing individuals from seeking the treatment they need. Stigma is pervasive and, as mentioned in the report of the President's New Freedom Commission, must be eliminated. The President's New Freedom Commission on Mental Health sets as Goal 1: "Americans Understand that Mental Health is essential to Overall Health." In the description that follows this goal, it is stated that, "Improving service for individuals with mental illness will require paying close attention to how mental health care and general medicine care systems work together. While mental health and physical health are clearly connected, the transformed system will provide collaborative care to bridge the gap that now exists." Our communities must understand that mental health is essential to overall health. To address stigma, we need to carry out a community-based message that is tailored to match cultural, ethnic, gender, age, linguistic, and spiritual practices. These efforts require continually developing partnerships at the community level that will reach sustainability over time. We, as a unified community, want to make recovery a possibility for everyone in need of care.

14. **Procurement and Transition Timelines.** Provide your procurement timelines in the following table. Allow at least 14 days for public comment to the draft procurement instrument. If more than one procurement is planned, provide a separate timeline for each (copy and paste additional rows to the

table). The activities and milestones listed are "model" activities and milestones. You may have additional activities. These additional activities and milestones should be inserted at the appropriate location in the following table.

Date	Key Activities and Milestones
November 1, 2008 – November 30, 2008	Develop and approve BT Provider Manual
December 1, 2008 – January 31, 2009	Develop draft procurement document – specify RFP. PNAC Review and Approval.
February 2 – 16, 2008	Publicize draft procurement document (Public comment period – 14 days minimum)
February 17, 2009 – March 13, 2009	Timeframe for LMHA to consider all public comment and revise procurement document
March 20, 2009	Publication of final procurement
April 1, 2009	Provider Conference with all Interested Providers – BT MHMR Conference RM in Round Rock, Texas
May 1, 2009	Due date for procurement responses
June 09, 2009	PNAC Review
June 10, 2009 – July 10, 2009	Contract Development and Negotiation Phase
July 27, 2009	Presentation by PNAC Chair or Designee to Board of Trustees. Board approval and decision on Contract with External Providers

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

Service	Time Needed to Re-establish Service Volume
SP-1	90 days
SP-2	90 days

Staff Qualifications

Identify the specific qualifications individual practitioners must meet (only if the LMHA currently exceeds the standards set forth in the DSHS performance contract). These qualifications will serve as minimum standards to be met by the LMHA as well as the external provider.

1. Minimum requirements for all services being sought:
    - Age of staff must be over 18, has a high school diploma or a General Education Development (GED) credential or has documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
        - Written competency-based assessment of the ability to document service delivery and observations of the individuals to be served; and
        - At least three personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.
        - Current drivers license for each person that will potentially provide transportation to Local Authority consumers.
    - Current Insurance Verification including:
        - Professional and general liability

  - Vehicle (if transporting consumers is likely)
  - Workers Compensation
- Non-traditional provider shall meet state minimum training requirements as determined by the Local Authority and any additional training requirements will be determined by individual(s) served.
- Verification of criminal history checks for all staff potentially working with Local Authority consumers.
- Life Safety code review for site assessment if not certified by a state agency.
- If applicable, documentation from certifying agency:
  - Texas Department of State Health Services
  - Texas Department of Assistive and Rehabilitative Services (DARS)
- Notwithstanding that all providers whether internal or external must be trained and competent in the tasks to be performed; qualifications for individual practitioners must at a minimum meet the Mental Health Community Service Standards in order to provide services. All individuals providing services must also complete a criminal background check (for employment regulations refer to Texas Health and Safety Code, §250.006.)

Service Package 1	Qualifications of Providers
Pharmacological Management Services	MD (psychiatrist), RN, PA, Pharm.D., APN
Routine Case Management	QMHP
Rehabilitative Services	QMHP, Licensed medical personnel,
Supported Employment	QMHP
Crisis Intervention Services	QMHP-CS
Service Package 2	**Qualifications of Providers**
Pharmacological Management Services	MD (psychiatrist), RN, PA, Pharm.D., APN
Routine Case Management	QMHP
Psychotherapy- CBT	LPC, LCSW, LMFT, Licensed Psychologist, or someone working on the corresponding licensure under the supervision of a licensed person.
Rehabilitative Services	QMHP, Licensed medical personnel,
Supported Employment	QMHP
Supported Housing	QMHP
Crisis Intervention Services	QMHP

Stakeholder Comments on Draft Plan and LMHA Response

This Plan was reviewed by the PNAC committee on September 9, 2008 and approved the priorities outlined on Page 36. Involvement by PNAC members will continue during the coming months to better define "Best Value" and help develop a scoring tool to select qualified contractors into the provider network.

The Plan was reviewed by the Bluebonnet Trails Board of Trustees on September 22, 2008 and approved of the priorities outlined on Page 36. The Board is fully committed to implementing this plan and increasing consumer choice within our network. They will continue to review progress on the Plan and receive PNAC minutes and recommendations during the coming months in FY 09.

The Plan was posted on our Website during the month of September as required by DSHS.