

Mental Health Mental Retardation Authority

of

Brazos Valley



Local Network Development Plan
FY 2009~2010

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I.

MHMR AUTHORITY OF BRAZOS VALLEY OVERVIEW

VISION, MISSION, & VALUES

The Mental Health Mental Retardation Authority of Brazos Valley's (MHMRABV) Board of Trustees, Executive Management, and staff approach all planning with the agency's vision, mission statement, and values as a centerpiece. Decisions to implement change are first and foremost evaluated in terms of their relationship to our vision, mission, and values. Thus, to understand our planning process, one must first understand our guiding tools.

Vision...

As the local community mental health and mental retardation center in the Brazos Valley, we envision this community to be a place where full participation and inclusion of each individual is achieved through the provision of an array of individualized community-based services. Our vision is actualized as we:

- Promote a proactive recovery model based on quality treatment and habilitation services to foster growth, success, and full integration into one's community
- Promote a safe environment for consumers and staff
- Ensure persons seeking and receiving services are educated on all options and choices of services, and that they have access to services in the least restrictive environment appropriate to the person's care
- Offer opportunities for community-based alternatives to institutional care, including the criminal justice system
- Foster positive experiences and opportunities for consumers, staff, Board, and the community and highlight mutual dignity, respect, and cooperation in our relationships
- Educate consumers, families, and the community at large

Mission...

MHMRABV is committed to: *“Provide the highest quality of services to the customer through available resources.”*

Values...

- We value the individuality, dignity, respect, and cultural diversity of those we serve
- We value the importance of teaching and promoting independence, learning and self-esteem skills
- We value the importance of fostering natural family relationships for children and adolescents who are receiving services

- We value the role of the community in the lives of our consumers and support their efforts to achieve maximum independence in their home community
- We value consumer choice of services, and access to those chosen services for our defined Priority Populations
- We value a safe, secure and supportive work environment for our well-trained, diverse workforce
- We value the strength and therapeutic value of the treatment team approach
- We value our responsibilities as stewards of public monies in the efficient provision of our services, including seeking innovative approaches to maximize our resources
- We value successful demonstration of positive impacts and outcomes for consumers.

AGENCY HISTORY & OVERVIEW

The Mental Health Mental Retardation Authority of Brazos Valley (MHMRABV) which began March 1, 1974 grew out of the volunteer and professional efforts of local advocacy groups as well as community mental health and mental retardation professionals and has the distinction of having the first ICF-MR facility in Texas for adult men with mental retardation. In 1974, it was incorporated as a 501 (c) (3) non-profit organization and was designated a Governmental Entity by the County Commissioners of the Brazos Valley’s seven counties which includes: Brazos, Grimes, Madison, Washington, Burleson, Leon and Robertson. Early Childhood Intervention services have been expanded to also include Walker and northern Montgomery counties. Its original name, the Brazos Valley Mental Health Mental Retardation Center, was changed to its current name in 1982. MHMRABV is governed by a nine-member Board of Trustees who are appointed by the Commissioners Court of the county each represents.

Community centers such as MHMRABV, were established in local communities throughout Texas to provide community-based crisis and ongoing mental health and mental retardation services to persons most in need of those services – especially those individuals identified as priority population (i.e. primarily at risk of hospitalization or State school placement; or exiting from one of these facilities). MHMRABV is supported by funds from the Department of State Health Services; Department of Aging and Disability Services; Department of Assistive and Rehabilitative Services; as well as grants, city, county, and other local funds. As a recognized and reputable access point and service provider, funding is used to provide a cadre of services and supports that promote recovery, self-sufficiency, utilization of natural supports, and community inclusion that results in a quality of life that is acceptable to the individual. Over the years, MHMRABV has expanded its primary services to include co-occurring psychiatric and substance abuse treatment, jail diversion, and enhanced crisis services. These enhanced crisis services include a mobile crisis outreach team that provides services in conjunction with a crisis intervention team of trained mental health deputies who are employed by the Brazos County Sheriff’s Office. This collaboration is an example of many working partnerships with other service agencies and implementation strategies that have occurred over the past three decades to respond to service gaps, stakeholder priorities, and consumer/community needs.

Providing community-based services supports the philosophy that persons with mental illness, mental retardation, and developmental delays should live, work, play and be educated in the same setting as all Texans – in their community near family and friends. Those principles remain at the core of MHMRABV’s mission and visions today. During the development of this 2009-2010 Local Plan, the Center will continue to build on its history and experiences and strive to assure quality services, public understanding of the Center and its services, and effective leadership and management at all levels.

SERVICE AREA & DEMOGRAPHICS

MHMRABV covers 5,109 square miles along the Brazos River in Central Texas. Although the Brazos River lies at the center of the region, not all areas of the region are a part of the Brazos watershed. In 2006, the U.S. Census Bureau estimated the total population for the Brazos Valley area was 279,464 individuals. The Brazos Valley is home to Texas A&M University and Blinn Jr. College and residents recognize education as an important factor. High school graduation rates average 73%, as compared to the 75% statewide average and 72% of Brazos Valley residents participated in some degree of higher education. According to the U. S. Census Bureau reports, the reported median household income for 2006 (although slightly higher in Brazos county) fell below the statewide average, as was the homeownership rate and the per capita money income. Unfortunately though, the number of persons living in poverty in the Brazos Valley continues to increase. Twelve percent (12%) of the area’s population is reportedly uninsured; there is an increasing number of individuals who are homeless or literally homeless; and during the last ten months over nine percent (9%) of individuals booked into area county jails have a current diagnosis of a major mental illness. In developing this Plan, the Center will celebrate our communities’ diversity, acknowledge both the strengths and the limitations presented, but create opportunities to discuss and work to address those limitations and challenges.

Estimated Total Population of Brazos Valley service area:
279,464 (Census 2006 Data)

Estimated Total Number of Clients Served for FY 2007

Mental Health (includes Crisis)	4,508
Mental Retardation	532
Early Childhood Intervention	1,218

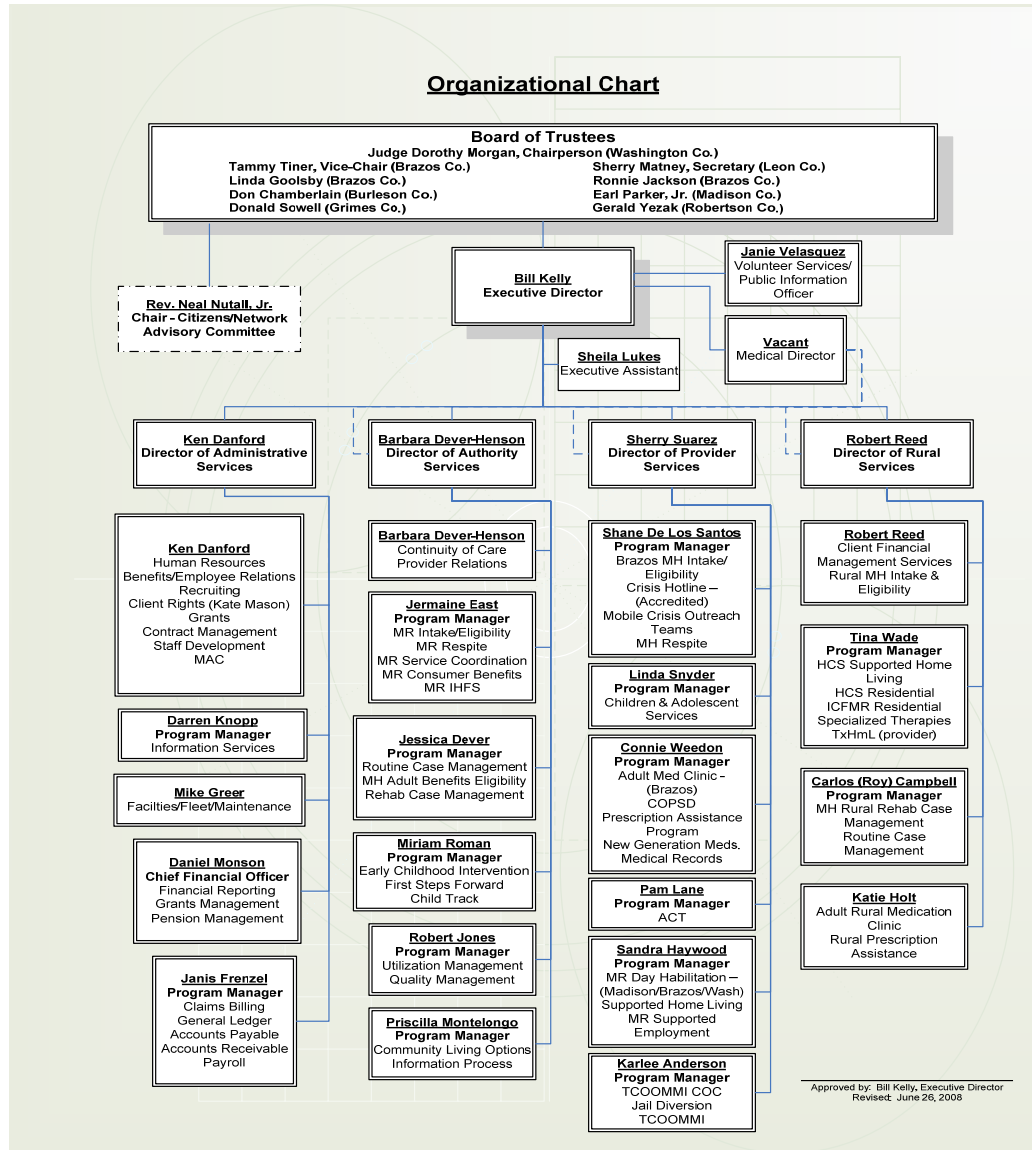
Population by Race: (based on the most recent census data)

<u>County</u>	<u>African American</u>	<u>Asian/ Pacific Islander</u>	<u>Hispanic</u>	<u>Native American</u>	<u>White</u>	<u>Unknown</u>
<u>Brazos</u>	16,970	7,789	33,199	355	115,555	18,337
<u>Burleson</u>	2,481	32	2,411	83	12,199	1,675
<u>Grimes</u>	4,700	82	3,787	76	16,909	1,785
<u>Leon</u>	1,593	28	1,213	52	12,809	853
<u>Madison</u>	2,959	54	2,042	41	8,642	1,244
<u>Robertson</u>	3,871	34	2,359	68	10,592	1,435
<u>Washington</u>	5,669	368	2,647	81	22,682	1,573

County Population Growth:

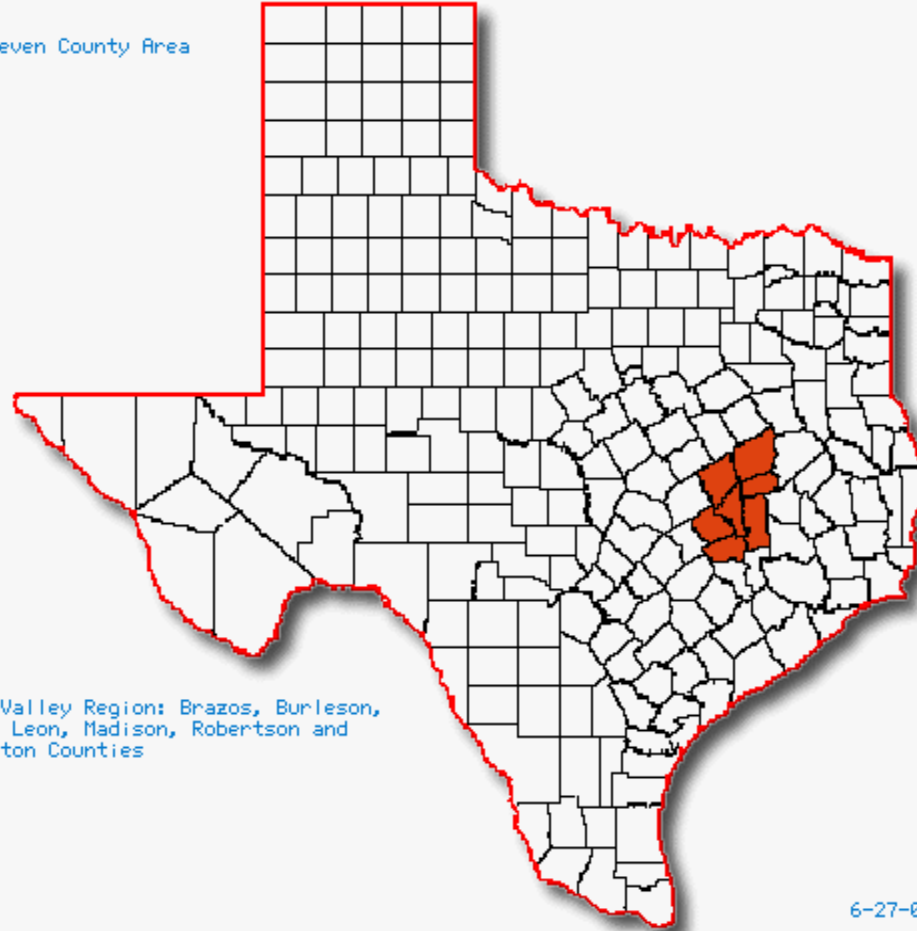
<u>County</u>	<u>2006</u>	<u>2005</u>	<u>2000</u>	<u>% of change from 2000</u>
<u>Brazos</u>	159,006	156,640	152,415	0.95%
<u>Burleson</u>	16,932	17,165	16,470	0.97%
<u>Grimes</u>	25,552	25,256	23,552	0.92%
<u>Leon</u>	16,538	16,306	15,335	0.92%
<u>Madison</u>	13,310	13,158	12,940	0.97%
<u>Robertson</u>	16,214	16,155	16,000	0.98%
<u>Washington</u>	31,912	31,486	30,373	0.95%
<u>Total of counties</u>	279,464	276,168	267,085	0.95%

Organizational Chart



MHMR Authority of Brazos Valley

● - Seven County Area



II. Local Planning Process

1. *Understanding our Planning Process*

MHMRABV 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 Center has an established tradition of successful planning to provide the Center, its Board of Trustees, and staff direction and focus. This planning process incorporates the community, service agencies, local leaders, staff, but most importantly those served and their families. Through the development of these plans MHMRABV's visions, mission, and values were developed, all of which remain the heart of the operations today. These plans and their goals and objectives were developed with the primary purpose of achieving MHMRABV's stated mission of providing the highest quality of services to the customer through available resources. Furthermore, MHMRABV's planning has also provided the basis for annual budgeting, assisting in the preparation and submission for additional funding sources, and provided a means to evaluate programs and the overall center operations.

MHMRABV has actively pursued community involvement in its planning processes for many years through a number of methodologies. One of which includes stakeholders comprised of both consumers, family and interested citizens who serve as members of the MHMRABV Citizens Network Advisory Committee (CNAC). During this planning cycle, the CNAC played a vital role in guiding center staff in the data collection and review process used to obtain stakeholder input from the local community. Once the plan development is complete, the CNAC will review and make suggestions on tools to be used to evaluate Provider submissions from a published RFP or Open Enrollment and evaluate submissions from potential providers and make recommendations to the Center's Board.

During this planning process another review of this committee to community stakeholders was conducted to identify and include any new stakeholders. Since there had been a recent comprehensive community health needs assessment in the Brazos Valley completed by the Texas A&M School of Rural Public Health, in March 2007 staff began by meeting with each Commissioners' Courts appointed Human Resource Commission in the Brazos Valley to gather community input in deciding where to focus and prioritize efforts to improve services for mental health consumers and family members. Following each presentation the stakeholders input was gathered via completion of a survey instrument that primarily focused on behavioral health needs.

During this same period, planning staff attended mental health clinic appointments in each county to gather input from consumers and family. Staff also gathered input from attendees of the Mental Health and Mental Retardation day programs, advocacy organizations, MHMRABV staff, collateral agencies, local governance, and other State agency employees via either email, mass mail out, employee payroll, and face to face interviews. A total of 687 surveys were distributed with 288 (42%) returned. Based on the tabulated survey responses, the identified additional or enhanced service needs were:

- Transportation
- Medication Clinic Services
- Counseling
- Assistance with medication purchase
- Management of Symptoms
- Crisis Hotline services

In August of 2007, a second mass mail out was sent to gather stakeholder input for the enhancement of crisis services. Considerable efforts were made to ensure that the voices of our local elected and appointed officials, law enforcement agencies, health care providers, other local agencies were heard. MHMRABV also actively solicited input from various other stakeholder groups such as the NAMI, mental health consumer groups, The Arc, and Citizen's Network Advisory Committee. Additionally for this FY09-10 Local Plan, MHMRABV hosted various stakeholder meetings in a number of locations throughout the seven-county region as detailed in table 2.1 below.

This planning cycle was slightly different than its predecessors in that the Center was required to educate and train staff, consumers, family members, government officials and other interested individuals on the new process of "Local Planning and Network Development" which proved to be extremely beneficial to the process and those we serve. Efforts made regarding consumer and stakeholder education included:

MHMRABV.com Website

- Summary of the LPND
- "You Have A Voice" brochure with notification of upcoming meetings
- Consumer, Family, and Stakeholders Survey
- Email address for stakeholder input during comment period
- Link for Local Plan during the comment period

CNAC Committee Meetings

- Comprehensive CNAC Committee Training on LPND and Monthly Updates

Consumer/Family Survey

- Coversheet with MHMRABV surveys, giving brief explanation of the LPND process
- Distribution
 - Month of April through the 15th of May attended each MH Clinic in all seven counties
 - April 16, 2008 – Mailed surveys and brochures to collateral agencies
 - April 16, 2008 – Surveys and brochures placed at MHMRABV service sites and web-site
 - Stakeholder Meetings – in all seven counties (med-clinics and Drop In Center)

2. Participating Agencies, Organizations and Other Stakeholders

The Center’s last planning cycle ended July 2007. Since that time, MHMRABV has continued its efforts to ensure that the needs and priorities of its local community were being addressed as indicated in its plan as well as addressing new initiatives. One of which was the new Crisis Redesign Plan. Center staff actively sought information for that plan from consumers, family members, local officials, local agencies and others. The stakeholders and organizations targeted to participate in various planning efforts in the crisis service redesign plan included:

Table 2.1

Independent School Districts (17)	Neuropsychiatric Clinic
Emergency Health Care Providers (6)	Cadwalder Behavioral Health
Mental Health Providers (16)	Grimes St. Joseph Behavioral Health
TAMU Psychology Clinic	Deer Oaks Mental Health Associates
The Counseling Center	Adult Probation (7)
Local Public Healthcare Providers (6)	Juvenile Probation (7)
Judicial Representatives (7)	Tx. Dept of Criminal Justice Parole Division
County Health Resource Commissions (7)	Police and Sheriff Departments (17)
County / District Attorneys (10)	Scotty’s House
Tx. Dept. of Family and Protective Services	Teen Help Foundation
Michael S. Wyatt Foundation	Adult / Children CRCG
Brazos Valley Community Action Agency	Brazos Valley Council on Alcohol and Substance Abuse
Brazos Valley Council of Governments	Alcoholics Anonymous
Barbara Bush Parent Center	Big Brothers Big Sisters
Homeless Shelters (3)	NAMI Brazos Valley
ARC	Community Partnership Board
Save Our Streets Ministries	Everyday Life, Inc.
City of Bryan Community Development	Freedom Hill
Clients and Family Members	OSAR

On March 1, 2008, the Center continued in its community planning efforts by initiating the Local Planning and Network Development process with the intent of encouraging even more community involvement as a means of truly meeting the needs and priorities of the Brazos Valley. The stakeholders and organizations targeted to participate in this planning effort are the same as detailed in table 2.1 above.

The table below depicts the scheduled information gathering meetings for this planning cycle as well as those who actively participated in each of the meetings.

Table 2.2

Description And Date or Timeframe	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
April 16, 2008 Meeting + Surveys	MHMRABV Brazos County Staff	0	0	40
April 18, 2008 Meeting + Surveys	MHMRABV Rural County Staff	0	0	9
April 22, 2008 Meeting + Surveys	Brazos County Stakeholders 430p- 600p	1	3	15
April 23, 2008 Meeting + Surveys	Madison County Medication Clinic 9a-4p	18	0	0
April 23, 2008 Meeting + Surveys	Madison/Leon County Stakeholders Meeting 430p-600p	0	0	5
April 24, 2008 Meeting + Surveys	MHMR Board of Trustees and Staff Training	0	0	18
April 25, 2008 Meeting + Surveys	Robertson Medication Clinic 10a – 3p	8	1	3
April 28, 2008 Meeting +Surveys	Mary Lake Drop In Center 1030a – 1200p	8	0	0
April 28, 2008 Meeting + Survey	Robertson County Stakeholders 430p –600p	0	0	0
April 29, 2008 Meeting + Surveys	Brazos County Medication Clinic 9a – 1p	39	8	1

April 30, 2008 Meeting + Surveys	Leon County Medication Clinic 930am – 3pm	14	2	3
May 1, 2008 Meeting + Surveys	Burleson County Medication Clinic 9a – 4p	15	1	0
May 1, 2008 Meeting + Surveys	Burleson County Stakeholders Meeting 430p – 600p	0	0	5
May 6, 2008 Meeting + Surveys	Washington County Medication Clinic 9a – 4p	6	1	0
May 6, 2008 Meeting + Surveys	Washington County Stakeholders Meeting 430p – 600p	0	0	7
May 6, 2008 Meeting + Surveys	Brazos Valley NAMI 7p-8p	0	6	0
May 9, 2008 Meeting + Surveys	CNAC	3	1	4
May 13, 2008 Meeting + Surveys	ARC of Brazos Valley	0	0	8
May 13, 2008 Meeting + Surveys	Community Partnership Board	0	0	15
May 14, 2008 Meeting + Surveys	Grimes County Medication Clinic 930a – 4pm	10	2	0
May 14, 2008 Meeting + Surveys	Grimes County Stakeholders Meeting 430p-600p	0	0	3
Crisis Redesign Meetings (ONLY)	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
March & April, 2007 Meeting + Surveys	Health Resource Commissions	0	0	42
April 2, 2007 Meetings + Surveys	Madison Medication Clinic	9	1	0
April 3, 2007 Meeting + Surveys	Washington Medication Clinic	27	5	5
April 4, 2007 Meeting + Surveys	Grimes Medication Clinic	9	4	5

April 5, 2007 Meeting + Surveys	Burleson Medication Clinic	9	0	0
April 9, 2007 Meeting + Surveys	Leon Medication Clinic	7	2	0
April 24, 2007 Meeting + Surveys	Robertson Medication Clinic	12	1	0
April 4, 2007 Meeting + Surveys	Brazos Medication Clinic	55	9	59
April 2007 Meeting + Surveys	NAMI	0	7	0
March 2007 Meeting + Surveys	CNAC	1	3	7
March 2007 Surveys	Staff and Board Members	0	0	56
April 16, 2007 Surveys	CRCG	0	0	10
March 26, 2007 Surveys	Community Partnership Board	0	0	14
March 2007 Surveys	Collateral Agency Stakeholders	0	0	18
March 2007 Meeting + Surveys	Mary Lake Drop In Center	11	0	0

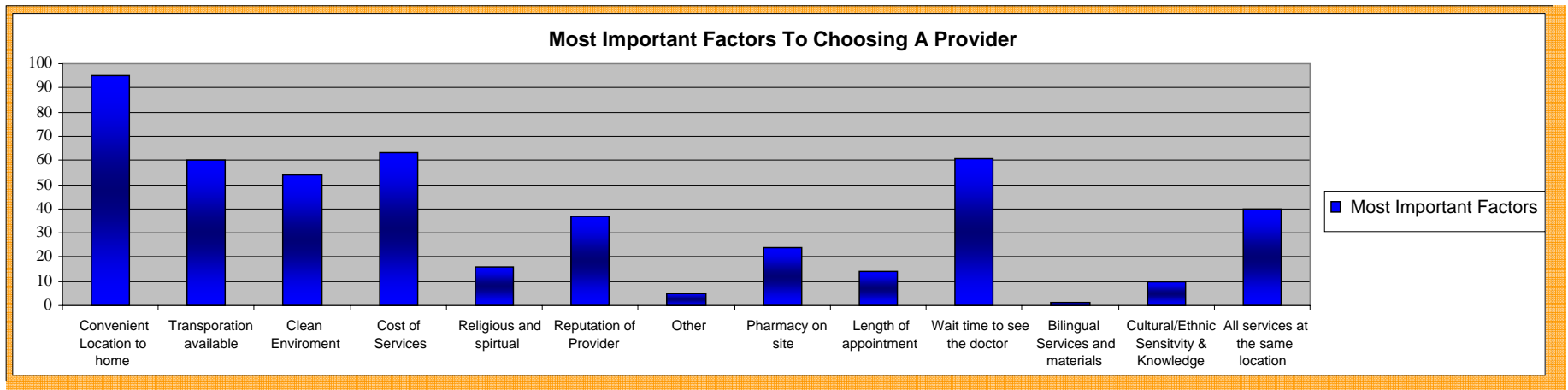
3. Summary of Discussions and Input Received

As noted above, multiple meetings were held throughout the Brazos Valley to obtain input from our local community. At a minimum, the goal of each meeting was to obtain answers to the following questions:

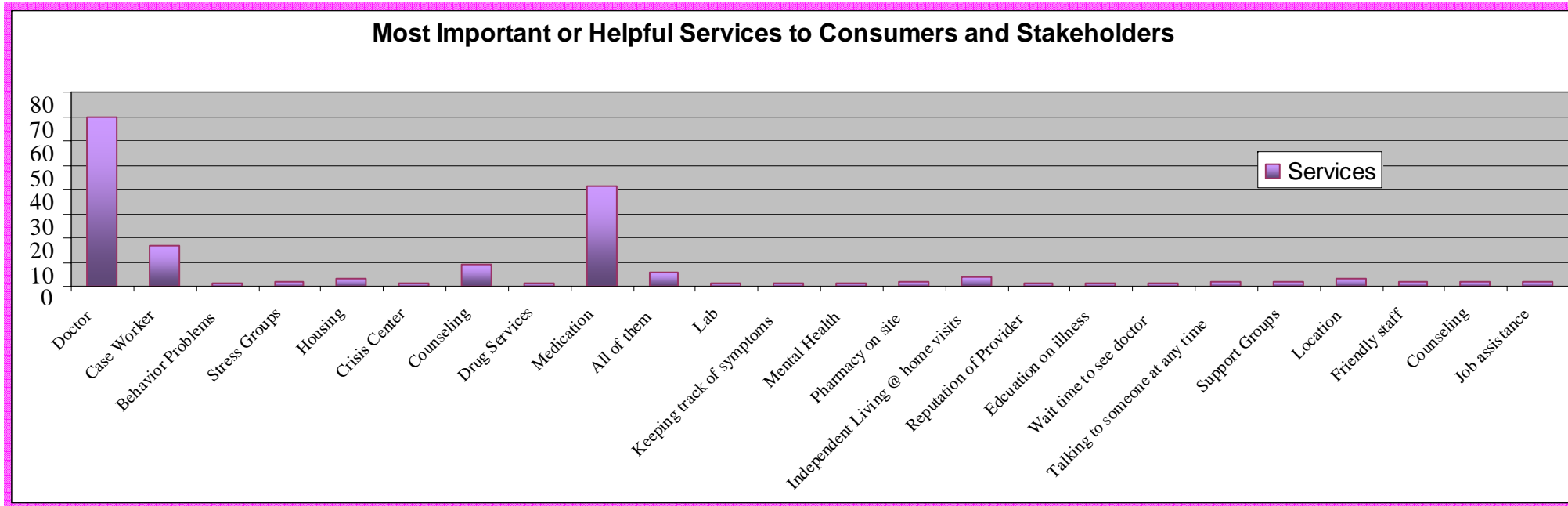
1. What are the most important factors you look for in a provider of services?
2. What service do you receive that is the most helpful to you?
3. What service would you most like to have a choice of providers for?
4. From your experience with the Center, what/where are the gaps in services?
5. Do you have other thoughts that you would like to share related to this process or your services?

MHMRABV held 20 meetings throughout its service area which resulted in input from 216 individuals which was utilized to identify service gaps in our local community. Center staff met with clients and family members during medication clinic appointments in the seven-county Brazos Valley region. Consumers and family members provided the following input regarding local planning and network development as it relates to the needs and priorities of our local community.

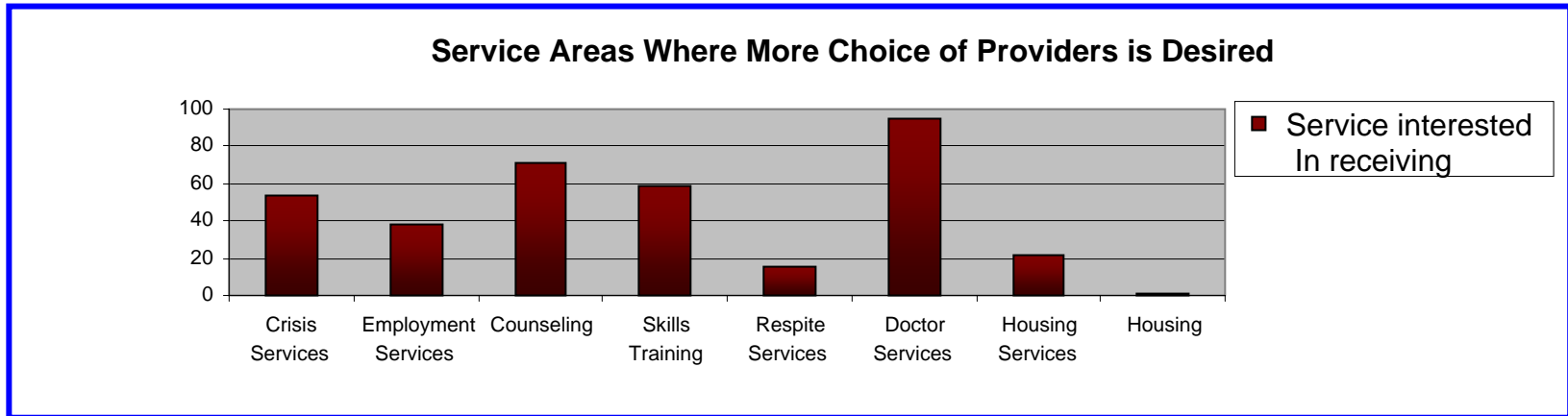
The three (3) most important factors when considering choosing a provider were: convenient location to home was the most important; followed by cost of services and wait time to see the doctor.



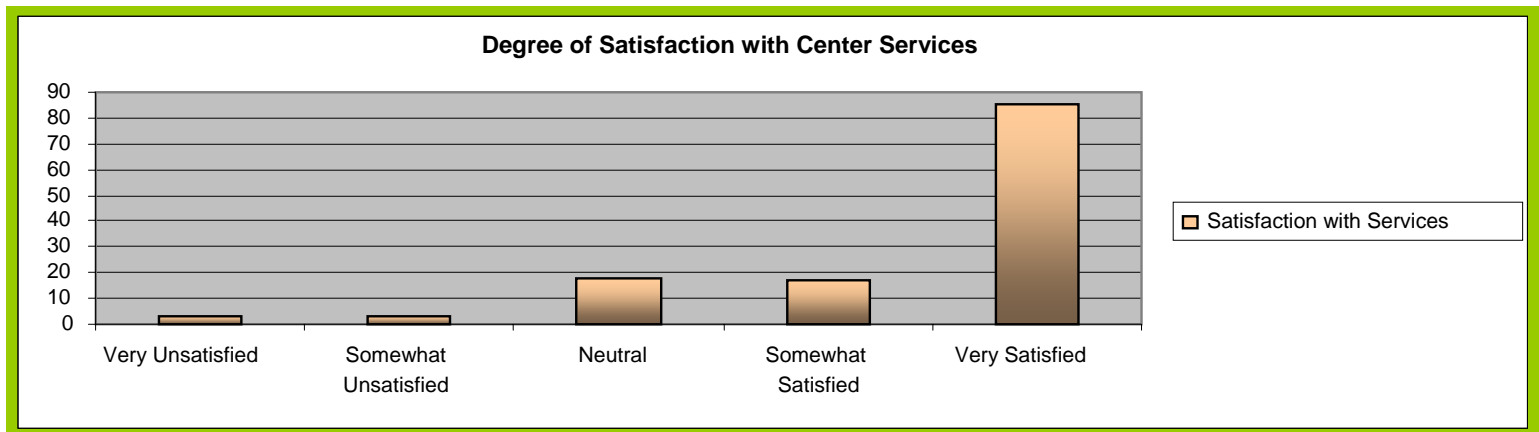
Physician Services and Medications continue to be the most important and helpful services to those we serve.



While there was a significant consumer and community voice indicating that they did not wish the Center to contract or procure any services, Physician Services, Counseling and Skills Training were the top three services.



When evaluating the consumer and community satisfaction with the Center and the services provided, overall stakeholders reported that they are very satisfied with the services.



4. LMHA's Priorities and Gaps in Services

In 2006 the Brazos Valley Health Partnership conducted the Brazos Valley Health Status Assessment, and the results of this assessment determined the following:

- access to specialty care continues to be a persistent issue for rural residents, particularly the uninsured and underinsured;
- every county of the seven-county Brazos Valley area is designated by the federal Health Resources and Services Administration (HRSA) as a mental health professional shortage area;
- Two percent (2%) of the 2582 respondents identified the emergency room as their “medical home”;
- Fifty-seven percent (57%) of respondents identified the need for some type of substance abuse treatment; and,
- Over half of the respondents reported having some personal mental health concern, even if they had never been diagnosed with a mental health problem by a health care provider. (data from Brazos Valley Health Status Assessment – 2006 prepared by The Center for Community Health Development School of Rural Public Health, Texas A&M Health Science Center)

The need for improved local psychiatric crisis services options in the Brazos Valley was further demonstrated following an analysis of state hospital bed-day utilization for fiscal years 2006 and 2007. In FY06 there were 357 admissions to the state hospital from the Brazos Valley local service area; in FY07 there were 425 admissions, representing a 16% increase.

Relapse prevention is an important component of the psychiatric crisis services delivery system. Of the 332 persons discharged from the state hospitals in FY06, 93 (28%) did not engage in aftercare services following discharge, and 103 of 358 (29%) failed to follow-through with outpatient services in FY07. Additionally, 60 of 364 persons (16.5%) were readmitted within 90 days in FY06, and 55 of 420 (13.1%) in FY07.

A “point in time” analysis of client diagnostics showed that of 1095 persons served on July 20, 2007 with a target population diagnosis, 226 (20.6%) self-reported use of alcohol and/or drugs. In that this data is based on self-report and national statistics are much higher, there is reason to believe that this number is much higher for our consumers.

The Brazos Valley Health Status Assessment coincides with service gaps and community needs identified during the initial Crisis Redesign community stakeholders meeting held in September 2007. The following service gaps and community needs were identified:

- Emergent, Urgent and Follow Up care for children and adolescents

- Crisis Stabilization Unit

- Mobile Outreach Team with immediate access to doctor
- Education and coordination and ongoing follow-up treatment with entire family system
- Consumer advanced directives to assist with decision making to minimize relapse
- Crisis Walk-In Services
- More Expedient access/response for diagnostic assessment
- Transition aftercare services following crisis
- Expansion of Crisis Intervention Team services in all counties
- Increased capacity for children/adolescents services including offenders
- Keep competent staff
- Substance Abuse Services
- Decreased wait time for Law Enforcement and CPS at emergency rooms for evaluations and medical clearance
- Enhanced aftercare follow-up for individuals discharged from psychiatric hospitals to ensure engagement
- Diversion of juveniles from detention centers prior to detention services
- Crisis prevention education both before and after crises for schools at all levels

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

Strengths:

*Partnership with local Sheriff's Departments, Police Departments, Juvenile and Adult Probation, local schools, County Health Resource Commissions, and other community resource programs
Jail Diversion Program*

*Attentive, gracious and hospitable staff
Services are vital to the community*

*Implementing business approaches to be more competitive
Proven to be adaptable and flexible
Adapting to scarce resources
Continues to provide services with limited financial resources
Responsive to needs of the community
Experience with a MR Services Open Enrollment Provider Network*

Weaknesses:

*Limited funding
Lack of providers and community resources in the rural areas (Burlison, Grimes, Leon, Madison, Robertson and Washington)
Wait lists
Large geographical service areas
State mandates put centers at a disadvantage when competing*

Opportunities:

*Continued partnerships with other community resources (rural county law enforcement)
Continued stakeholder and general public educational LPND changes
Continue to explore additional grant funding opportunities
Enhance community awareness in all counties
Expand Telemedicine Services to meet Psychiatric Service need*

Threats:

*Economic Concerns
Staff retention
Funding cuts
Legislation restrictions*

5. *Changes to Service Delivery System*

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

- Enhancement of the Mobile Crisis Outreach Team partnership with law enforcement in rural counties
- Enhancement of the Center's information technology (IT) system to accept and process clinical and fiscal information from external providers
- Addition of staff to manage oversight of external contracts, quality assurance, clinical authorization and claims adjudication
- Expansion of the Supported Employment program by adding an additional Peer Provider
- Expansion of telemedicine to rural counties
- Enhancement of Crisis Hotline Services to meet American Association of Suicidology accreditation requirement

MHMRABV has moderate experience in Network Development. In 2002, the Mental Retardation Services Provider Network was developed via open enrollment and now manages a small network of local service providers. With the anticipation of increased procurement opportunities, the center can develop a provider network for mental health services and continue to maintain stability and integrity of the entire local service delivery system over time. While we do not have the infrastructure or historical experience or expertise to utilize some of the more complex contracting methodologies during the first biennial planning period, During the next 2 years appropriate staff shall be trained and/or thoroughly educated in this area.

With the initiation of the Crisis Redesign in FY08 MHMRABV was awarded funding for FY08 and FY09 which was used to establish a Mobile Crisis Outreach Team (MCOT) which improves the responsiveness and the level of care that is available to members of the community. With dedicated full time employees partnering with local law enforcement officers (Crisis Intervention Team) to provide crisis response services, there is greater probability for providing face to face assessments and intervention services in the least restrictive environment. As additional funding becomes available staffing will be increased in order to further reduce the response time throughout the rural Brazos Valley region.

It is the intention of MHMRABV to enhance crisis hotline services via contracting with an American Association of Suicidology provider which will ensure crisis callers receive immediate access and assessment from a qualified mental health professional. MHMRABV will also research interested providers to provide face to face after-hours crisis screening assessments. There is an expected reduction in the need for hospitalizations through the use of a trained team concept.

Additional input from stakeholders included significant verbal and written consumer and community responses indicating that they did not wish MHMRABV to contract or procure any services. MHMRABV staff reiterated the goal of LPND by highlighting the option of increased choice for those we service. This clarification did assist in redirecting some individuals minimally. Other significant comments or concerns include:

- Length of time it takes to obtain an appointment for services
- Not enough inpatient beds
- Patients have to wait too long for counseling and even longer for psychiatrist.
- Need more bilingual staff
- Supported Employment is weak
- Staff Turnover
- Waitlists
- Lack of funding
- Lack of respite beds-Brazos County needs additional funding for this. The use of current funding will negatively impact the current crisis program that is proving to be a great success
- Would like to see an increase in MHMR Crisis Specialist, currently there are too few to handle the case load
- Increase availability of after hours screening specialist
- Consistency and stability with screening specialist, a private contract company that changes employees on a routine basis creates confusion due to the lack of understanding of local programs & practices
- Need more training to understand BVMHMR's current CIT officers in the collaborative. This would allow for continuing education in the mental health field as well as maintain a good working relationship between all participating officers
- Washington county needs additional case workers
- Keep up the great work
- Turn over of staff - Having a new worker every 2 months
- You folks do incredible work with the few resources you have
- Need more services for adolescents and drug abuse issues as it relates to mental illness
- Need more homeless housing and counseling

- Need salaries competitive with industry which will attract qualified people

- Did the legislature take into consideration the difficulty of recruiting psychiatrists to locate in the rural areas?
- Concerns expressed about retaining the infrastructure for safety net
- Why can't the MHMR Center be one of the choices if there are more than two qualified providers?
- Why can't the focus be on enhancing existing services rather than getting more providers?

Crisis Redesign Input Summary

The multi-agency Crisis Redesign Work Group initiated discussion on the Crisis Service Plan during meetings held on November 28, 2007 and February 22, 2008. Although all member agencies were invited by email and/or telephone, not all entities attended. Representative agencies included: Juvenile Probation, Twin City Mission, Brazos County Sheriff's Office, College Station Police Department, College Station Independent School District, OSAR, St. Joseph's Behavioral Health, Blinn College, River Bend Recovery, City of Bryan, Brazos Valley Council on Alcohol and Substance Abuse, Cadwalder Behavioral Clinics, Brazos County Community Supervision, Bryan Independent School District MHMRABV mental health services. Based on the results from the September meeting, an increase need for crisis respite beds was identified however during the work group meeting in February, a concern was raised regarding the increase of community beds and the financial impact of increased cost and uncertainty of funding cuts for the next fiscal year. It was identified that dollars could be better used to enhance the Mobile Crisis Outreach Team and Flexible Community Supports resulting in one additional staff being added to the Mobile Crisis Outreach Team to enhance service in the rural counties.

6. *Current Services and Providers Overview*

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) were utilized because of their direct relationship with the services delivered. The rationale to use cost is summarized as follows-the costs are the costs, regardless of the funding source.

To utilize the methodology, MHMRABV isolated the costs associated with the services delivered under contract by External Providers during FY 2007. MHMRABV 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 MHMRABV 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 MHMRABV’s ability, identify the costs associated with services delivered directly 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 picture of MHMRABV’s service delivery network for the period of time. As MHMRABV 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 MHMRABV 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	\$407,761			FY 2008
Routine Case Management (Adult)	X	\$473,791			
Routine Case Management (Child/Adolescent)	X	\$81,509			
Respite Services	X	\$0			
Supplemental Nursing Services	X	\$4,670			
Pharmacological Management	X	\$365,974	<u>Contract Psychiatrists</u> <u>UTMB of Galveston</u> 301 University Galveston, Texas 77555 <u>Jackson & Coker Locum Tenens</u> 3000 Old Alabama Rd. Suite 119-608 Alpharetta, GA 30022 <u>JSA Health</u> 410 Pierce Street Suite 233 Houston, Texas 77002	\$291,260	Ongoing FY 2008 Sept. 2006 – Aug. 2007 FY 2008
Provision of medication	X		<u>US Script</u> 5500 East Loop 820 South #207 Ft. Worth, Texas 76119	\$504,471	Ongoing

Psychiatric evaluation	X	\$39,094	<u>Contract Psychiatrist</u> <u>UTMB of Galveston</u> 301 University Galveston, Texas 77555 <u>Jackson & Coker Locum Tenens</u> 3000 Old Alabama Rd. Suite 119-608 Alpharetta, GA 30022 <u>JSA Health</u> 410 Pierce Street Suite 233 Houston, Texas 77002	\$59,127	Ongoing FY 2008 Sept. 2006 – Aug. 2007 FY 2008
All Rehabilitation Services (Adult)	X	\$1,194,606			
All Rehabilitation Services (Child/Adolescent)	X	\$181,001			
Supported Employment	X	\$5,082			
Supported Housing	X	Captured as part of Adult Rehabilitation Services			
Assertive Community Treatment	X	Captured as part of Pharm. Mgmt and Adult Rehabilitation Services			
Inpatient services		\$0	<u>St. Joseph Behavioral Health Unit</u> 210 South Judson Navasota, Texas 77868		Ongoing
Residential Treatment		\$0	<u>Heritage Residential</u> 307 Briscoe Devine, Texas 78016		Ongoing
Intensive Case Management	X	\$39,414			

(Child/Adolescent)					
Counseling (Adult)	X	\$0			
Counseling (Child/Adolescent)	X	\$29,888			
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)	X	\$26,026			
Flexible Community Support (Child/Adolescent)	N/A				
Multi-Systemic Therapy (Child/Adolescent)	N/A				
Consumer Peer Support	N/A				
CRISIS & OTHER DISCRETE SERVICES					
<i>Hotline</i>	X	Captured as part of Intake Services in FY 2007	<u>Cadwalder Behavioral Clinic</u> 30903 Quinn Road Tomball, Texas 77375		FY 2008
<i>Mobile Crisis Outreach Team</i>	<p>Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts:</p> <p>The Crisis Services Redesign initiative completed just prior to this local planning initiative which began March 1, 2008. The development of local crisis services plans occurred using then existing planning and procurement 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.</p> <p>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.</p>				
<i>Extended Observation</i>					
<i>Day Program for Acute Needs</i>					
<i>Crisis Stabilization Unit</i>					
<i>Respite Services</i>					
<i>Inpatient/Hospital Services</i>					
<i>Crisis Residential Treatment Services</i>					
<i>Safety Monitoring</i>					
<i>Crisis Follow-Up and Relapse Prevention</i>					
<i>Crisis Transportation</i>					
<i>Crisis Flexible Benefits</i>					
<i>Laboratory Services</i>			<u>Clinical Pathology Laboratories</u> 2010 East Villa Maria Bryan, Texas 77802	\$15,533	Ongoing

****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.***

7. Provider Network Development

1. Provider Availability

In order to determine the viability of expanding our network of external providers, MHMRABV completed an analysis to assess the level of provider availability. The analysis included:

1. Contacting current and former providers,
2. Calling providers who may have expressed an interest in working with the Center in the past,
3. Consulting business directories,
4. Searching the internet, and
5. Reviewing the 2004 Provider of Last Resort Plan/Request for Information.

In March 2004, MHMRABV completed a Request for Information (RFI) process which was developed and initiated as a means of determining interest in a comprehensive treatment network for people with mental illness and mental retardation. Respondents were asked to provide information on various Service Packages, and include any topics or questions the respondent or any other interested parties believed important to address in any future Request for Proposal (RFP). The RFI document included a geographic description of the local service areas, thus giving the respondents the opportunity to indicate the preference to serve the entire local service area or a portion thereof. This process resulted in 6 respondents to the MH services portion of the RFI, 1 responded to providing the entire service package. Since 2004, only one additional Provider has expressed interest in providing the entire service package according to the DSHS website.

When reviewing the results in relations to Provider availability and the limited network of Providers, MHMRABV is the primary provider of mental health services within the Brazos Valley region. MHMRABV's current providers collectively have expressed no interest in terminating his/her contractual relationship and desire to continue his/her contractual relationship when the time for renewal arises. As noted, expansion of the network with additional external providers will be a slight challenge; however there appears to be some potential to expand choice in the network if provider interest continues.

2. Provider Inquiries within the last 2 years

Date of Inquiry	Summary of Inquiry	LMHA Response
May 12, 2008	Sunwest Behavioral Health Organization completed the Provider Interest Form on DSHS website	Contact info noted for mailing list of potential providers for RFP/RFA. Emailed letter to confirm Provider interest and service capacity allotment. Response received requesting notification of all RFA/RFP for services identified on the Provider Inquiry Form.
May 12, 2008 January 8, 2008 July 10, 2007 December 6, 2007	The Wood Group inquired regarding providing Crisis Residential and Treatment services, Hotline, Screening and Assessment and consulting services for individuals in crisis. Also completed the Provider Interest Form on DSHS website.	Mailed: After- Hours Crisis Hotline Screenings and Assessments RFP application in June 2007 and 24 Hours Crisis Hotline RFP January 2008. Information will be maintained on mailing list of potential providers for RFA/RFP. Emailed letter to confirm Provider interest and service capacity allotment. Response received requesting notification of all RFA/RFP for services identified on the Provider Inquiry Form.
January 8, 2008	Harris County MHMRA expressed interest in providing 24 hour crisis hotline services	Mailed: 24 Hours Crisis Hotline RFP Application January 2008. Information will be maintained on mailing list of potential providers for RFA/RFP. Network Provider as of May 2008.
January 8, 2008	Tarrant County MHMRA expressed interest in providing 24 hour crisis hotline services	Mailed: 24 Hours Crisis Hotline RFP Application January 2008. Information will be maintained on mailing list of potential providers for RFA/RFP
January 8, 2008 July 9, 2007	Avail Solutions expressed interest in providing 24 hour crisis hotline services	Mailed: After- Hours Crisis Hotline Screenings and Assessments RFP application in June 2007 and 24 Hours Crisis Hotline RFP January 2008. Information will be maintained on mailing list of potential providers for RFA/RFP
June 21, 2007	Cadwalder Behavioral Clinics, Inc expressed interest in providing after-hours crisis screenings and assessments and 24 hour crisis hotline services	Mailed: After- Hours Crisis Screenings and Assessments RFP application in June 2007 and 24 Hours Crisis Hotline RFP January 2008. Information will be maintained on mailing list of potential providers for RFA/RFP. Network

		Provider since October 2007 to provide crisis screenings and assessments
June 21, 2007	Behavioral Health Response expressed interest in providing after-hours crisis screenings and assessments	Mailed: After- Hours Crisis Screenings and Assessments RFP application in June 2007. Information will be maintained on mailing list of potential providers for RFA/RFP
June 22, 2007	Philip J. Haas III expressed interest in providing after-hours crisis screenings and assessments	Mailed: After- Hours Crisis Screenings and Assessments RFP application in June 2007. Information will be maintained on mailing list of potential providers for RFA/RFP

3. Service Capacity and Procurement

	3a	3b	3c	3d	3e	3f
Service	Current Capacity	Projected Capacity	Availability of Current and Potential External Providers	Procurement Planned?	Capacity to be Procured	Method of Procurement
ADULT SERVICES						
RDM SP 1	1056	1056	Wood Group - 200 / Sunwest - 100	Yes	182	RFA
RDM SP 2	6	6	Wood Group – 10 / Sunwest - 50	Yes	2	RFA
RDM SP 3	186	186	Wood Group -100 / Sunwest - 300	Yes	41	RFA
RDM SP 4	34	34	Wood Group – 50 / Sunwest - 150	Yes	1	RFA
RDM SP 0	6	6	Sunwest - 200	No		
RDM SP 5	5	5	Sunwest - 200	No		
CHILD/ADOLESCENT SERVICES						
RDM SP 1.1	61	61	Sunwest - 50	No		
RDM SP 1.2	10	10	Sunwest - 50	No		
RDM SP 2.1	0	0	Sunwest - 50	No		
RDM SP 2.2	6	6	Sunwest - 50	No		
RDM SP 2.3	1	1	Sunwest - 50	No		
RDM SP 2.4	1	1	Sunwest - 50	No		
RDM SP 4	37	37	Sunwest - 50	No		
RDM SP 0	1	1	Sunwest - 50	No		
RDM SP 5	0	0	Sunwest - 100	No		

CRISIS & OTHER DISCRETE SERVICES						
<i>Hotline</i>	300	300	Harris Co., Tarrant Co., Avail, Cadwalder,	Yes	100%	RFP
<i>Mobile Crisis Outreach Team</i>	<p>Per the October 21, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts:</p> <p>The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began March 1, 2008. The development of local crisis service plans occurred using then existing planning and procurement 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.</p> <p>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.</p>					
<i>Extended Observation</i>						
<i>Day Program for Acute Needs</i>						
<i>Crisis Stabilization Unit</i>						
<i>Respite Services</i>						
<i>Inpatient/Hospital Services</i>						
<i>Crisis Residential Treatment Services</i>						
<i>Safety Monitoring</i>						
<i>Crisis Follow-Up and Relapse Prevention</i>						
<i>Crisis Transportation</i>						
<i>Crisis Flexible Benefits</i>						
<i>Laboratory Services</i>			Current Provider (CPL) provides 100% of service capacity	No		
<i>Supported Housing**</i>	42	50	None	No	N/A	N/A
<i>Supported Employment</i>	23	30	None	No	N/A	N/A

** Note: In FY 2007, Supported Housing Services were recorded via the 152/153 Grid Codes (Rehabilitation). Numbers used are based on CARE assignments.

4. Justification for Procurement of Discrete Services

At this time MHMRABV has no plans to procure discrete services.

Plan for Fidelity and Continuity of Care for the service package(s): N/A

5. Rationale for Keeping Services

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

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

For each service in the table below, the Center indicated 1) the percentage of services it plans to provide, 2) the “condition” which justifies the Center providing the service, 3) an explanation for why the Center continues to provide the service, 4) the percent of capacity necessary for the Center to remain financially viable, and 5) the rationale for arriving at this volume.

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	83%	5	Two (2) providers are willing to provide this service, however a phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure, and technical experience and expertise in managing a network, and assuring access and choice are relevant to the decision for procurement.	75%	As a means of determining the reliability and capability of Providers who are new to this rural geographical service area, the Center will gradually increase choice as a means to not fracture and fragment the established local service delivery system.
RDM SP 2	67%	5	Two (2) providers are willing to provide this service, however a phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure, and technical experience and expertise in managing a network, and assuring access and choice are relevant to the decision for procurement.	50%	As a means of determining the reliability and capability of Providers who are new to this rural geographical service area, the Center will gradually increase choice as a means to not fracture and fragment the established local service delivery system.
RDM SP 3	78%	5	Two (2) providers are willing to provide this service, however a phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure, and technical experience and expertise in managing a network, and assuring access and choice are relevant to the decision for procurement.	75%	As a means of determining the reliability and capability of Providers who are new to this rural geographical service area, the Center will gradually increase choice as a means to not fracture and fragment the established local service delivery system.
RDM SP 4	97%	5	Two (2) providers are willing to provide this service, however a phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure, and technical experience and expertise in managing a network, and assuring access and choice are relevant to the	90%	As a means of determining the reliability and capability of Providers who are new to this rural geographical service area, the Center will gradually increase choice as a means to not fracture and fragment the established local service delivery system.

			decision for procurement.		
CHILD/ ADOLESCENT SERVICES					
RDM SP 1.1	100%	5	A phased transition is planned to assure adequate safety net. Critical infrastructure, , the organizational structure and technical experience and expertise in managing a network, and assuring access and choice are relevant to the procurement process.	90%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice
RDM SP 1.2	100%	5	A phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure and technical experience and expertise in managing a network, and assuring access and choice are relevant to the procurement process.	90%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice
RDM SP 2.1	100%	5	Not enough consumer volume (0) to consider procurement. Provision will be maintained as “safety net”	90%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice
RDM SP 2.2	100%	5	A phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure and technical experience and expertise in managing a network, and assuring access and choice are relevant to the procurement process.	90%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice

RDM SP 2.3	100%	5	A phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure and technical experience and expertise in managing a network, and assuring access and choice are relevant to the procurement process.	90%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice
RDM SP 2.4	100%	5	A phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure and technical experience and expertise in managing a network, and assuring access and choice are relevant to the procurement process.	90%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice
RDM SP 4	100%	5	A phased transition is planned to assure adequate safety net. Critical infrastructure, the organizational structure and technical experience and expertise in managing a network, and assuring access and choice are relevant to the procurement process.	75%	Due to the Center having only one interested Provider, and as a means not to fracture and fragment the established local service delivery system and to maintain critical infrastructure, the Center shall gradually increase choice

Crisis & Other Discrete Services

<i>Hotline</i>	0%	N/A	Will remain contracted at 100%		
<i>Mobile Crisis Outreach Team</i>	<p>Per the October 21, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts:</p> <p>The Crisis Services Redesign initiative was completed just prior to this local planning initiative which began March 1, 2008. The development of local crisis service plans occurred using then existing planning and procurement 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.</p> <p>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.</p>				
<i>Extended Observation</i>					
<i>Day Program for Acute Needs</i>					
<i>Crisis Stabilization Unit</i>					
<i>Respite Services</i>					
<i>Inpatient/Hospital Services</i>					
<i>Crisis Residential Treatment Services</i>					
<i>Safety Monitoring</i>					
<i>Crisis Follow-Up and Relapse Prevention</i>					
<i>Crisis Transportation</i>					
<i>Crisis Flexible Benefits</i>					
<i>Laboratory Services</i>	0%	N/A	Current Provider (CPL) provides 100% of service capacity	0%	N/A
<i>Supported Housing</i>	100%	1	Captured as part of SP3 and SP-4 based on authority authorization	100%	No providers have expressed interest in this service at this time
<i>Supported Employment</i>	100%	1	Captured as part of SP-3 and SP-4 based on authority authorization	100%	No providers have expressed interest in this service at this time

6. Structure of Procurement(s)

The table below describes how procurement will be structured and the rationale. The table also identifies the area(s) in which the service will be procured, and MHMRABV’s expectation of external provider(s) to cover the entire area.

Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
Service Package 1,2,3,and 4	Madison, Leon and Robertson Counties	RFA seeking multiple (at least 2) providers in the Northern Counties of the Brazos Valley. Goal is obtain a provider in Madison, Leon and Robertson Counties with an ability to provide 100% of the procured services allowing greater access to individuals residing in these counties.

7. Choice and Access

MHMRABV agrees that maximizing choice of those who receive services is a primary goal of this Plan. Obviously one of the strategies will be attempting to increase the number of external providers in certain service areas to increase the choice of providers. *More providers, more choice.* However, there is a realistic expectation of a shortage of willing and qualified providers available for rural service delivery areas. While we may not initially be successful in developing a large external provider network during this planning cycle, we are cognizant that choice can also occur and be maximized at an organizational level. Strategies to increase choice at the organizational level include:

- Having more than one physician available at each medication clinic facility. This may be accomplished through the utilization of Tele-medicine/Tele-psychiatry in the event that finding a physician to travel to the rural counties is fruitless.
- Allowing consumers to choose his/her service coordinator/case manager instead of being auto assigned to a caseload. There may still be a limitation of choice as staffs caseloads fill.
- Allowing consumers to switch internal or external providers upon request.

Access to psychiatrists and prescribed psychiatric medications is a critical mental health treatment element. Over the past several years, MHMRABV has taken considerable action to expand and improve greater access to psychiatrists and prescribed psychiatric medications. These include the submission of multiple additional funding requests specifically for the support of prescribed psychiatric medications; increased and enhanced direct assistance to consumers in applying for available benefits and maximized patient assistance programs. MHMRABV contracts with US Scripts pharmacy program; which provides effective and efficient pharmacy services, and assures best cost value of medications – maximizing limited resources. MHMRABV is continuing to evaluate

ways to assure immediate access to services for those adjudicated within the criminal justice system; yet maintain capacity and assure continued service. MHMRABV has expanded staffing support to the local jails, to complement previously existing mental health support and services there. To facilitate access to physician services, MHMRABV is furthering its use of telemedicine; currently providing physician service via telemedicine in Brazos County.

Due to the success of this telemedicine site and the increasing difficulty to obtain physician services, MHMRABV is expanding telemedicine activities at rural service locations. With regards to the External Provider Network, MHMRABV shall ensure that: service hours are the same if not greater than the Centers. MHMRABV operates Monday through Friday from 8:00a.m. to 5p.m. External Providers shall have the same or extended hours. At a minimum clinic locations shall remain in the geographic areas of Brazos, Burlson, Madison, Leon, Robertson, Grimes, and Washington counties. Being that there are clinics in all of the rural areas of the Brazos Valley, geographic service location will be considered when selecting a service provider. Procurement of services shall not cause individuals who receive services to have a decreased level of access to services. Access to services shall be equivalent to or better than the level of access currently provided by MHMRABV services.

8. 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
Routine and Intensive Case Management	Only the LMHA may provide this service
Crisis Hotline Services	Only one provider is necessary to effectively provide this service
Inpatient/Hospital Services	The only psychiatric facility is within 75 mile radius. Contracting with a facility that is further is cost prohibited when providing continuity of care services.

9. Diversity

In order to better understand the diversity of MHMRABV's local community, the following information was obtained from the US Census Bureau:

According to the 2000 American Community Survey (Census Bureau) for populations less than 65,000 and 2006 for population greater than 65,000 the percentage of residents residing in the Brazos Valley region who were foreign is 11% Brazos, 3% Burleson, 5% Grimes, 5% Madison, 4% Leon, 3% Robertson and 5% Washington Counties. Among the people residing in this region, 13 percent speak a language other than English at home.

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

Cultural competence occurs in the mental health service delivery system when cultural issues are acknowledged and addressed at all levels of an organization: administration, service delivery, and clinician.

MHMRABV also strives to ensure that individuals receive effective, understandable, and respectful care from its internal staff. As with many entities, recruitment of bi-lingual staff is sometimes difficult. With the need on occasion often greater than our internal resources, we have a contract in place for interpreter services as well as translation services when needed. MHMRABV proactively tries to ensure that care and information is received in the individual's preferred language.

MHMRABV provides refresher training on individual rights information annually. Staff are required to access the Essential Learning training module at least annually to ensure competency in this area:

- Cultural Diversity - This course is an introduction to understanding the various components of cultural competence and how they apply to providing mental health and other human services to various groups of people and to individuals from within those groups.

Overall in developing a network of providers, MHMRABV desires to maintain a network which meets the needs of the local community, improves access to treatment by minorities, reduces disparities in treatment and improves quality of care.

10. Cost Efficiency

MHMR Authority of Brazos Valley (MHMRABV) continually explores opportunities that help us achieve optimal efficiencies, while at the same time ensuring that there is adequate oversight of operations and that maximum dollars are preserved for direct services. MHMRABV consistently looks at partnerships with other local agencies that serve the same consumers we serve and work proactively to establish relationships that are positive to the consumers and the community. Numerous staff of MHMRABV also serve on various committees locally and statewide to further our commitment to the consumers and the community. Examples of these are: Special Mental Health Commission through the School of Rural Public Health at Texas A&M, and Health & Safety Matter and Families Matter Impact Solutions Team through the United Way of the Brazos Valley to name a few.

Examples of current purchasing efficiencies:

- Through the use of Requests for Proposals, we procure/lease vehicles from major automakers that gives us governmental pricing. We use the TXMAS contract to purchase vehicles from vendors that are approved through the State of Texas bidding process. We also work through our local Brazos Valley Transit system in our purchasing needs of wheelchair equipped vans.
- The agency receives governmental discounts for office supplies through Staples.
- The agency receives governmental discounts from US Scripts for drug purchasing. In recent years, drug purchasing was explored with the East Texas Behavioral Network, but the program didn't meet our local needs and actually cost the agency more.

MHMRABV will explore the following ideals in order to continue our path of efficiency:

- Explore possibilities of joining with like agencies to further our purchasing power and cost efficiency. Options could be county, independent school districts, or the East Texas Behavioral Health Network, which is a combination of various local authorities in East Texas.
- Analyze buildings owned by the agency in the outer counties and either look into leasing out vacant space or possibly joining other like agencies in their buildings and selling the agency buildings.
- Explore the possibility of contracting out direct services in some of our outer rural counties that may be closer geographically to another community MHMR center.
- Explore grant/foundation monies and collaborate with other entities to enhance and/or expand our service delivery system.

Though MHMRABV will continue its efforts toward efficiency and maximizing direct service dollars, we will also need to take into consideration that if there are willing and qualified providers coming to our area, we will have to strengthen our administrative and authority functions in order to meet the new burden being placed on our local system.

11. Previous Efforts

In March 2004 a Request for Information (RFI) process was developed and initiated as a means of determining interest in a comprehensive treatment network for people with mental illness and mental retardation. Respondents were asked to provide information on various service packages and include any topics or questions the respondent or any other interested parties believes important to address in any future Request For Proposal (RFP). The RFI document included a geographic description of the local service areas, thus giving the respondents the opportunity to indicate the preference to serve the entire local service area or a portion thereof. The RFI document included the verbatim service descriptions from Local Authority's FY'04 TDMHMR Performance Contract, Attachment IX-Exhibits A, B, and C. Respondents were given an opportunity to express interest in providing the entire service package or individual services within the package. MHMRABV's deadline to respond to its RFI was April 9, 2004 and we received a total of 6 unduplicated respondents.

Summary

MHMRABV received 8 respondents for MR services. MHMRABV started an Open Enrollment Network for MR Services in FY 2002 and has continued to expand the network which now includes all MR services except service coordination. The Local Authority has no other services to procure under MR services at this time but does plan to publish its RFA as required as a means of increasing its network of providers, thereby increasing choice for consumers. While providers can submit an Open Enrollment Application at anytime, MHMRABV does schedule publication of the Application at least every 2 years.

MHMRABV received 6 respondents for MH-Adult services. MHMRABV does contract services for MH-Adult but not at the same degree it has developed a network for MR Services. Two factors which primarily contribute to this are previous stakeholder input requesting the Local Authority hire an additional psychiatrist to decrease the potential of consumers seeing different psychiatrist at each visit which will enhance continuity of care and thereby increase care and satisfaction.

In 2004, procurement within the framework of Disease Management presented several challenges which needed further analysis before an intelligent and informed decision could be made in regards to contracting additional services. A few of the initial queries included:

- With the requirement of the Local Authority to provide service coordination, how does this effect rehab services which may be provided by this individual?
- In instances where rates have not been previously established, the Local Authority runs the risk of creating a network with providers and limited resources or limited providers and limited resources. Would the logical resolution include, developing an efficient Disease Management Delivery system and then in FY06 meet with the Regional Network Advisory Committee to evaluate MH services to determine which services could reasonably be procured using the requirements of public input, ultimate cost benefit and client care?
- Does contracting services or a portion thereof for Service Packages 3 and 4 affect the integrated team structures for which they are designed? this was only a few of the unknowns which made developing a solid procurement plan involving MH-Adult services challenging at that time.

Note: Of the 6 respondents who responded to the MH services portion of the RFI, 1 responded to providing the entire service packages. There were no respondents for Mental Health Child services. The Local Authority does contract a small portion of its services for MH Child. Currently psychiatric evaluations and med management are done by contract psychiatrist through our UTMB Children’s Services contract. For the most part, all other services are performed by MHMRABV staff.

12. Barriers

The chart below identifies potential barriers anticipated when attracting external providers and specific plans to address each identified barrier.

Barriers	Plans
Shortage of Providers	Continue to partner with University of Texas Medical Branch Department of Psychiatry; explore expanding telemedicine
Rates not attractive to external providers	Continue supporting legislation and lobbying efforts to improve funding
5,109 Square miles of service area, gas prices continue to soar	Expand telemedicine service to rural areas to alleviate MD travel expense
Providers reluctant to meet DSHS Contract Requirements	Continue to work with DSHS regarding contract requirements and potential to streamline regulations
Limited Public Transportation	The Center will continue to collaborate with Brazos Transit and seek additional funding to support transportation needs.

13. Attraction of Providers

MHMRABV recognizes that there are barriers and challenges to attracting external providers to this market and its service area as depicted above. Increased funding for mental health services by the State is the surest means for attracting both internal and external qualified providers to the Brazos Valley. 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. However there are many positive aspects to living and working in the Brazos Valley communities which one should consider:

- Central location to the four metroplexes of Dallas, Austin, San Antonio and Houston
- Home to Texas A&M University, George Bush Presidential Library, and the future home of the new Health Science Center campus of Texas A&M
- Increased employment opportunities due to natural resources (i.e., Lignite Mines in Leon County)
- Well established city amenities such as parks and other recreational facilities, shopping sites of major department stores, specialty shops and nation wide discount stores
- Entertainment resources such as movie theaters, athletic events and cultural festivals along with close to 200 restaurants and fast food outlets are located in this area

14. Long Term Planning

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

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

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

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

As MHMRABV progresses through this initial 2 year plan and its associated procurement, MHMRABV will analyze and assess the system of providers obtained to determine the stability of the current network as well as the cost effectiveness of provider contracts in order to ensure that the proper shift of overhead and administrative costs is financially sound. During FY09, Phase 1 will begin with procurement of adult services in Leon, Madison, and Robertson counties for service packages 1-4. MHMRABV shall also use this time period to evaluate certain operations and functions of the Network Development Department. The importance of this evaluation is to gauge the stability and effectiveness for increasing the Network Providers during the next planning cycle starting for FY11. The evaluation shall include but not be limited to:

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

MHMRABV plans to start its second input gathering stage approximately 6 months prior to the submission of its next Network Development Plan for the 2 year cycle including FY2011 and 2012. During FY11, Phase 2 will consist of procurement of children/adolescent services in Leon, Madison, and Robertson counties for all service packages and procurement of adult services in Burleson, Grimes, and Washington counties for service packages 1-4. There is an expectation that MHMRABV will have gained some added expertise so as to procure more services during the second cycle. There is also the expectation that consumers will be more familiar with choosing a provider, thus the input gathered on where they may want more choice in the future may be more focused, direct and meaningful, thus resulting in better meeting the needs and priorities of the Brazos Valley region.

Beginning in FY 2011, MHMRABV will evaluate the prior two years, including a review of experience with newly established external providers into our network. Based on that evaluation and successful achievements of outcomes, the plan will be updated to continue expanding the external provider network into our local service area. Some factors that will play a very important role into the continuation of expanding our external provider network will include, but is not limited to future priorities of stakeholders, legislation at the National and State level in regards to funding, Medicaid Reform and the Deficit Reduction Act. Not knowing what the landscape will look like that far out, it is the intention of MHMR Authority of Brazos Valley to review experiences and latest data and update the plan accordingly. Once the services/packages are identified for further contracting, then an appropriate method of procurement will be used to further our activities towards an expanded external provider network with procurement of children/adolescent service packages in Burleson, Grimes and Washington counties and procurement of adult and children/adolescent service packages in Brazos County during FY13.

III. Procurement and Transition Timelines

MHMRABV's procurement timelines is depicted in the following table. At least 14 days was allowed for public comment to the draft procurement instrument. The procurement time frame is projected based on approval of the plan within 60days. Timeframes may be adjusted due to circumstances outside MHMRABV's control.

Date	Key Activities and Milestones
December 1, 2008 – May 27, 2009	Develop draft procurement document for Phase 1 of the northern counties (Leon, Madison, and Robertson) Adult Services
May 28, 2009 – June 12, 2009	Publicize draft procurement document (Public comment period – 14 day minimum)
June 13, 2009 – July 14, 2009	Timeframe for LMHA to consider all public comment and revise procurement document
July 15, 2009	Publication of final procurement document
August 19, 2009	Due date for procurement responses
September 24, 2009	Award date
September 25, 2009 – October 31, 2009	Contract Development and Negotiation Phase
December 4, 2009	Final Contracts approved by Board of Trustees
February 1, 2010	Implementation of Contract/Service Delivery

An important part of the development of an external provider network is that it expands choices available to consumers. The specific steps for consumer's selection of a provider and the timelines for transitioning consumers to new providers are noted below.

Steps	Time Frames For Completion
Develop a provider list	October, 2009
Verify provider information	October 1-31, 2009
Post Provider list to website and distribute to consumer and advocacy groups	November 1, 2009
Conduct provider forums to allow providers to share information with consumers, LARs, and other stakeholders.	November 1 – December 31, 2009
Develop internal procedures and forms for consumer selection of providers	October 1 – December 31, 2009
Develop consumer information materials relating to selection of providers	October 1 – December 31, 2009
Train internal staff on consumer selection procedures	November 15 – December 31, 2009
Ensure external providers are trained on consumer selection requirements and procedures	January 1 – 31, 2010
Implement provider selection procedures for new intakes	February 1, 2010

Implement provider selection procedures for current clients (in conjunction with treatment plan reviews)	January 1 – January 31, 2010
Develop and implement continuity of care plans for transitioning individual clients to new providers	February 1 – May 31, 2010
Consumer transition complete	June 1, 2010

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
Service Package 1	180 days
Service Package 2	180 days
Service Package 3	180 days
Service Package 4	180 days
<p>MHMRABV has established a 180 day period to reestablish all services. Historically when clinical staff leave, MHMRABV works quickly to continue services often by shifting existing staff and contracting for additional help including locum tenens doctors and contracting with recruiting firms in certain cases. Such efforts create added workloads and unexpected costs. One of the challenges when contracting out larger portion of services in rural areas of Texas is the ability to reestablish services, particularly when the size of the provider side is limited in providing choice for additional external providers. Therefore, until a strong base of external providers is established who can assist in covering unexpected lapses in services, this will remain a challenge and is not fully reflected in a “180 “day standard to reestablish services”.</p>	

IV. Staff Qualifications

MHMRABV does not currently exceed the standards set forth in the DSHS performance contract in regards to qualifications of individual practitioners.

V. Stakeholder Comments on Draft Plan and LMHA Response

MHMRABV did not receive any public comments on the draft plan, however, during the 14 day comment period the following changes were received from DSHS in relation to the LPND template and incorporated into the Local Plan during the comment period.

DSHS Funded Services

- “Supportive” was changed to “Supported.”
- Some of the names of Crisis Services were changed to be consistent with the Performance Contract.
- “Crisis Stabilization Unit” kept the same name but changed within the template

Service Capacity and Procurement

- Adult Services and Child/Adolescent Services each were changed to include RDM SP 0 and RDM SP 5.
- Crisis Services was changed and the order on the form was changed within the template

After reviewing additional guidance and clarifications provided by DSHS, the following modifications were made to ensure that the plan is understandable and reflective of the Centers intent:

- Provider Availability section modified to include providers who expressed interest on the DSHS website. Also F/U comments were added to the Provider Inquiry Table section.
- “Plan for Fidelity and Continuity of Care for the Service Package(s)” section modified to include the additional detail regarding specific process of implementation involved in client care.
- “Rationale for Keeping Services” table section modified to include better use of the 6 conditions for keeping services.

COMPLETED PLAN SUBMITTED TO performance.contracts@dshs.state.tx.us AS REQUIRED.

Local Planning and Network Development FY 2009 Post-Procurement Survey and Amendment Form

The rules governing provider network development require plan amendments when procurement does not achieve the desired results:
§412.756(m) Post procurement plan amendment. If the results of a procurement alter the type or volume of services to be provided by the LMHA as described in its local network development plan, the LMHA shall submit a plan amendment to DSHS and update all publicly available copies of the plan after receiving approval from DSHS.

Please complete the table below.

Column A: List each procurement activity proposed in your approved network development plan (service, capacity, and method).

Column B: Document the number of applications received. If the procurement is not yet complete, enter N/A.

Column C: Document the results (capacity successfully procured and number of contracts). If the procurement is not complete, note the projected date of completion and the current status (e.g., RFP posted, evaluating applications).

Proposed Procurement (service, capacity, RFA vs. RFP)	Number of Bids	Results (capacity procured and number of contracts) OR projected date of completion and current status
Service Packages 1,2, 3, and 4 in Madison, Leon, and Robertson Counties Service Package 1 capacity - 182 Service Package 2 capacity - 2 Service Package 3 capacity - 41 Service Package 4 capacity - 1 Procurement Method – RFA	0	