"Helping People Achieve Dignity, Independence and Their Dreams"

LOCAL PLAN & NETWORK DEVELOPMENT

FY 2009-2010

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Mission, Vision & Values

Mission

The mission of Community Healthcore is to help people achieve

Dignity,

Independence and

Their Dreams

Our Mission is accomplished by ….

- Serving as mental health and mental retardation governing authority for Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk and Upshur Counties.
- Helping people and their families heal the consequences of mental illness.
- Assisting people with mental retardation and their families achieve maximum independence in all aspects of their lives.
- Providing programs and services in greater East Texas that help people lead lives free from addictions.
- Helping people access appropriate community resources through information and referral services.
- Networking with other group and organizations that share our goal.
- Demonstrating our commitment to our vision and mission in all we say and do.

Vision

- We envision a world in which all people have the opportunity to make choices for themselves that will lead to the highest quality of life possible.
- We envision a world in which all people are independent and free from poverty, pain and despair.
- We envision a world in which there is no stigma associated with seeking treatment or assistance for mental illness, mental retardation and substance abuse.
- We envision a world in which all people receive supportive, nurturing care appropriate to their needs in the least restrictive environment possible.
- Through the efforts of our hearts and hands, Community Healthcore dedicates itself to the achievement of this vision…………….

Values

- We value cooperation and teamwork within the agency and between agencies
- We value diversity
- We value the pursuit of excellence by every employee
- We value the judicious and effective use of and access to, available resources
- We value community concerns, ideas and opinions
- We value creativity, innovation and empowerment of consumers and employees
- We value the abilities of our consumers
- We value the successes of our consumers and employees
- We respect the value of change
- We value continuous quality and performance improvement
- We value respect and confidentiality for our consumers and employees

Agency History

Agency History

Community Healthcore is a combined effort of two major community forces, Sabine Valley Regional MHMR Center and Northeast Texas MHMR, which affiliated on December 1, 2006. This affiliation has produced a powerful community influence with a combined sixty (60) plus years of serving community needs. In the Gregg and Harrison county region as a result of a year of planning and development by a coalition of community groups Community Healthcore began operation as the Gregg-Harrison Mental Health Mental Retardation Center on January 1, 1970. The County Commissioner's Court of Gregg and Harrison Counties appointed the first nine members of the Board of Trustees. Gregg Harrison Mental Health Mental Retardation Center became the Sabine Valley Regional Mental Health Mental Retardation Center on September 1, 1979 due to an expansion of services into Marion, Rusk, and Upshur Counties and later into Panola County. On February 1, 1984, the Board of Trustees accepted the challenge to become the Mental Health-Mental Retardation Authorities for the six-county service area. On November 9, 1993, an Assumed Name Certificate was executed by the Executive Director, which authorized the Center to conduct and transact business as Sabine Valley Center.

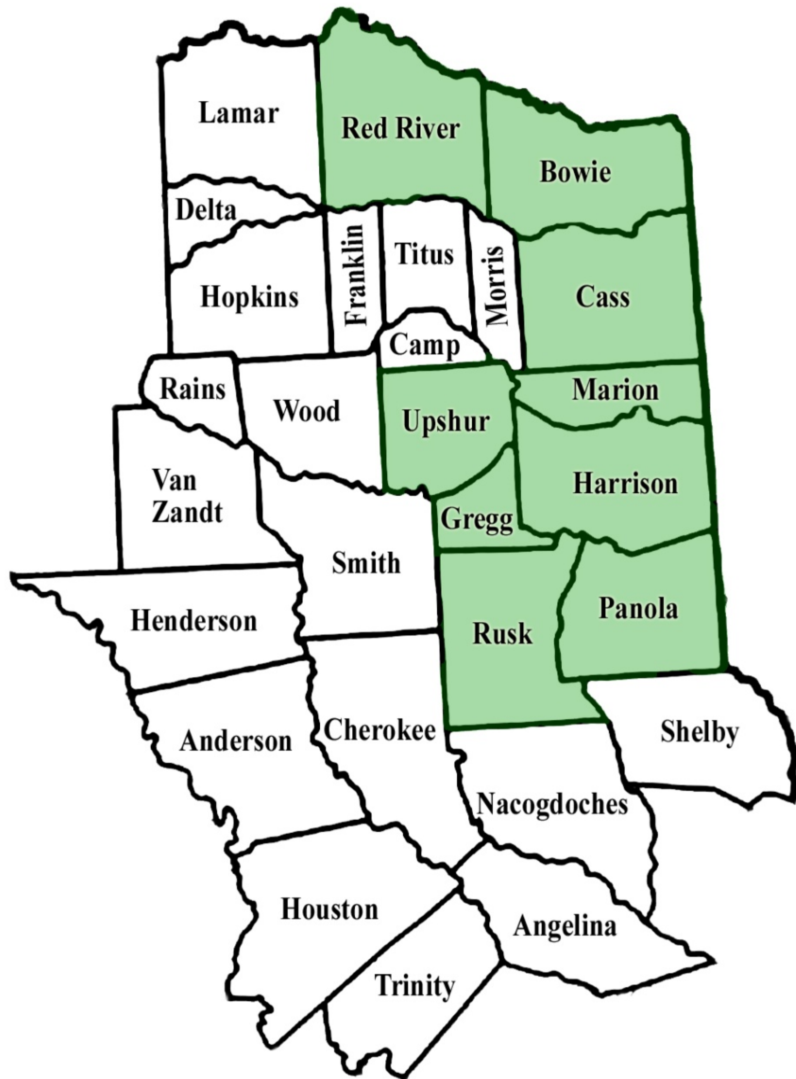
After the enactment of H.B.3, THE GREATER TEXARKANA MENTAL HEALTH ASSOCIATION was instrumental in convincing both the City Council of Texarkana Texas and the Commissioners Court of Bowie County to appoint a Board of Trustees, creating the Bowie County Mental Health Center. This was the first local legal effort that enabled the Board of Trustees to be eligible for State "Grant-In-Aid (GIA)". In May, 1967 the Texas Department of Mental Health and Mental Retardation (TDMHMR) approved the required "Intergovernmental Agreement", and requested a local "Plan of Operation and Budget". Local Volunteers could not accomplish this second document and were advised to raise local monies, retain a planner to develop the Plan and Budget and if approved, the Local Board of Trustees would then be eligible for State GIA. This was accomplished during the FY 69 and in October 1968 the Local Board of Trustees received $19,718.55 in State GIA to develop a "Comprehensive Plan." In FY 70 the Texarkana Regional MHMR Center was formed as a Bi-State

agency serving both Texas and Arkansas counties. In FY73 the Center separated into two different agencies and Northeast Texas MHMR on May 1, 1974 serving Bowie and Red River counties, and later adding Cass County. Northeast Texas MHMR Center served those three counties until its affiliation with Sabine Valley Regional MHMR Center on December 1, 2006 with Sabine Valley Regional MHMR Center (dba Community Healthcore) the surviving entity.

The Center has expanded from a service system of 12 staff members with a budget of $2,180,000 in 1970 at Sabine Valley Regional MHMR Center and Northeast Texas MHMR Center in 1974 with a budget of $477,264 to approximately 450 employees and a budget in excess of $25.8 million at the beginning of September 2007. Since its beginning, the Community Healthcore has provided services to over 80,000 people who were experiencing problems associated Mental Health, Mental Retardation and Related Conditions, and/or Substance Abuse.

Service Area & Demographics

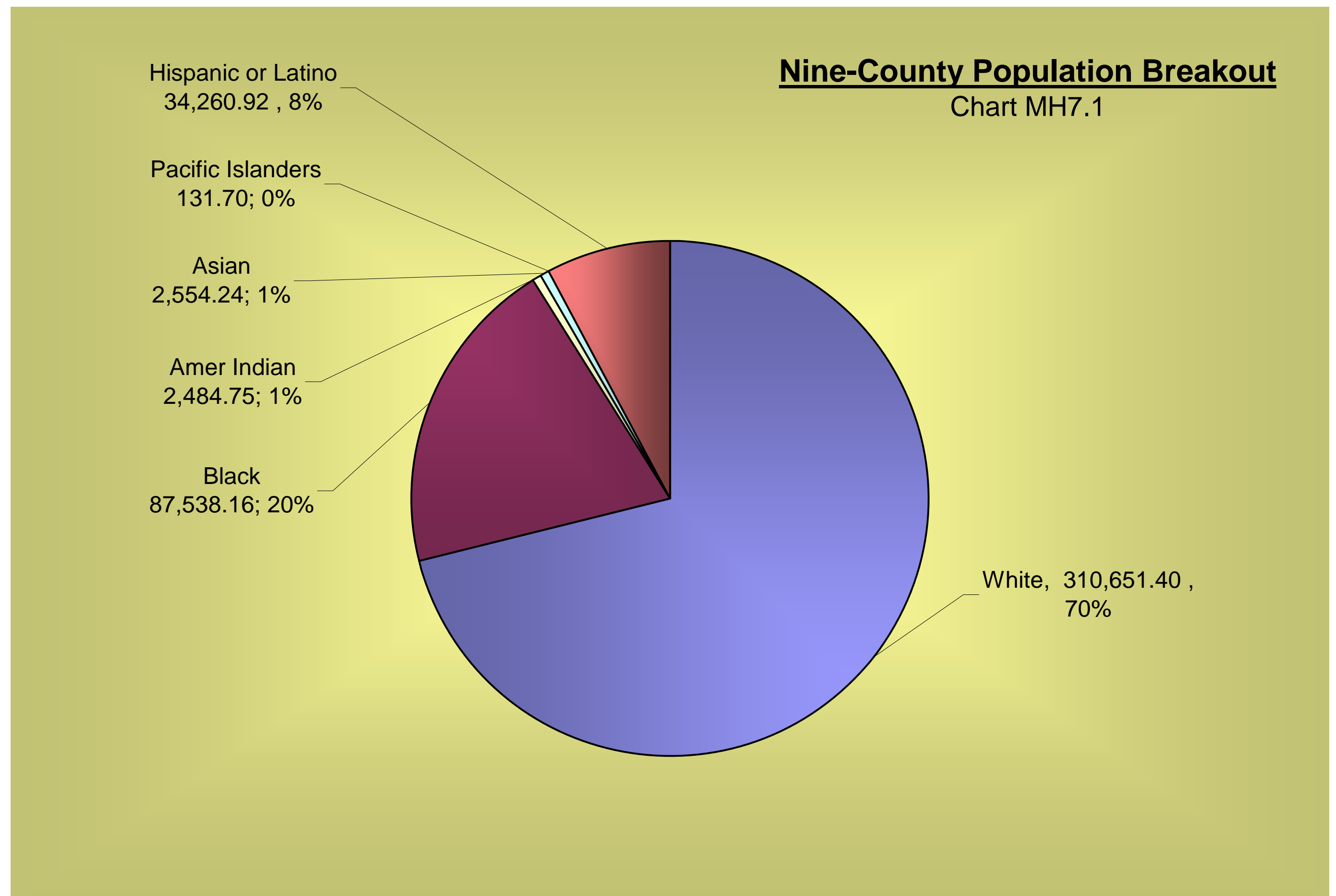
Community Healthcore's Service Area



Community Healthcore currently provides services in twenty-eight counties through its various contracts and grants. Only in nine of these counties (shaded in green) is Community Healthcore the Mental Health Authority and Mental Retardation Authority. In these nine counties Community Healthcore has the responsibility for local planning and network development for general revenue services provided through State Contracts with the Department of State Health Services and the Department of Aging and Disability Services.

Demographic Information for DSHS & DADS Catchment Area

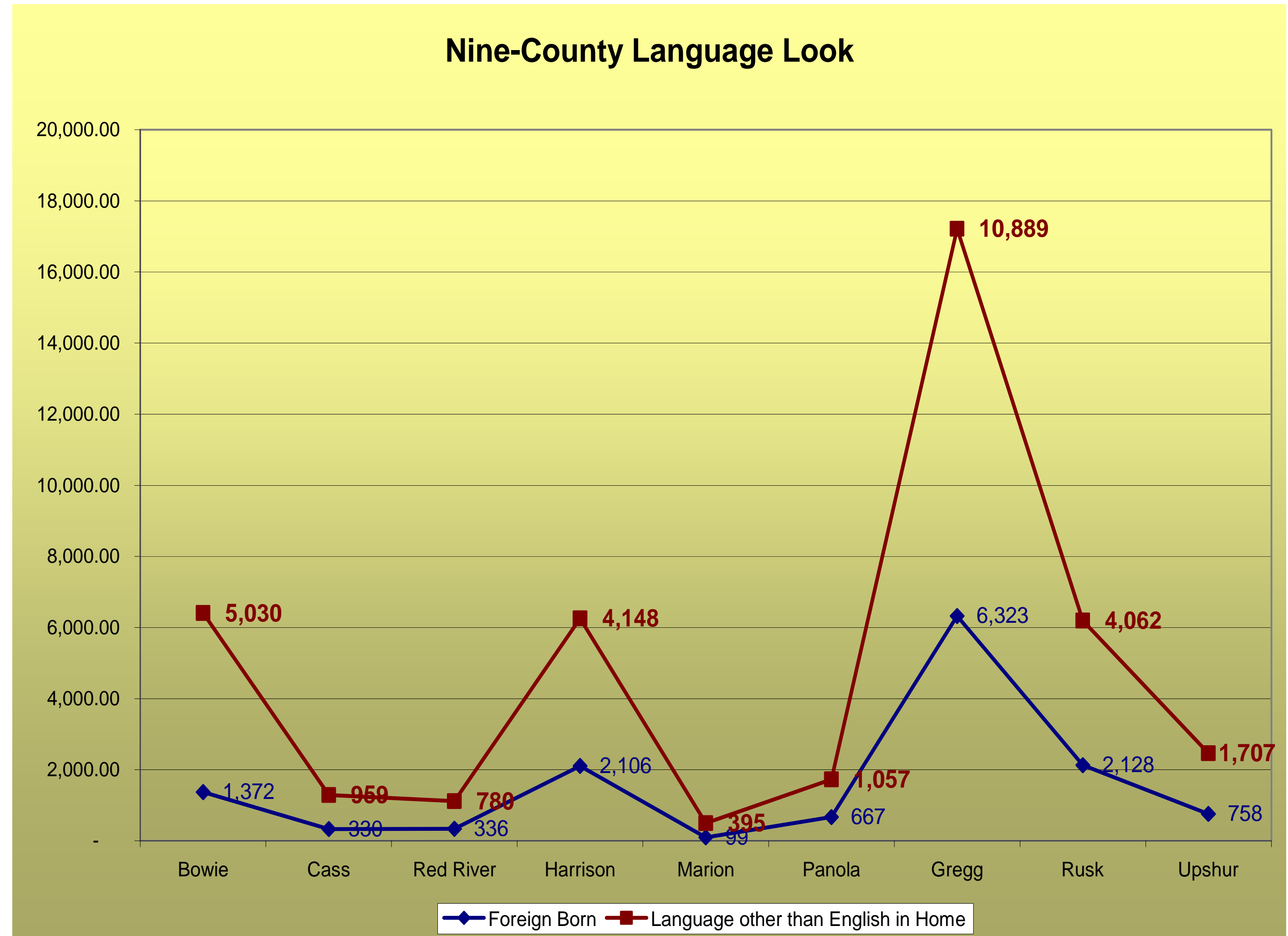
Community Healthcore provides one or more services of a large 30 county area. However it retains the contractual responsibility for local planning for only nine of those counties as illustrated on the prior page. All demographic information presented is specific to those nine-counties in which Community Healthcore serves as the Mental Health Authority (MHA) and the Mental Retardation Authority (MRA).



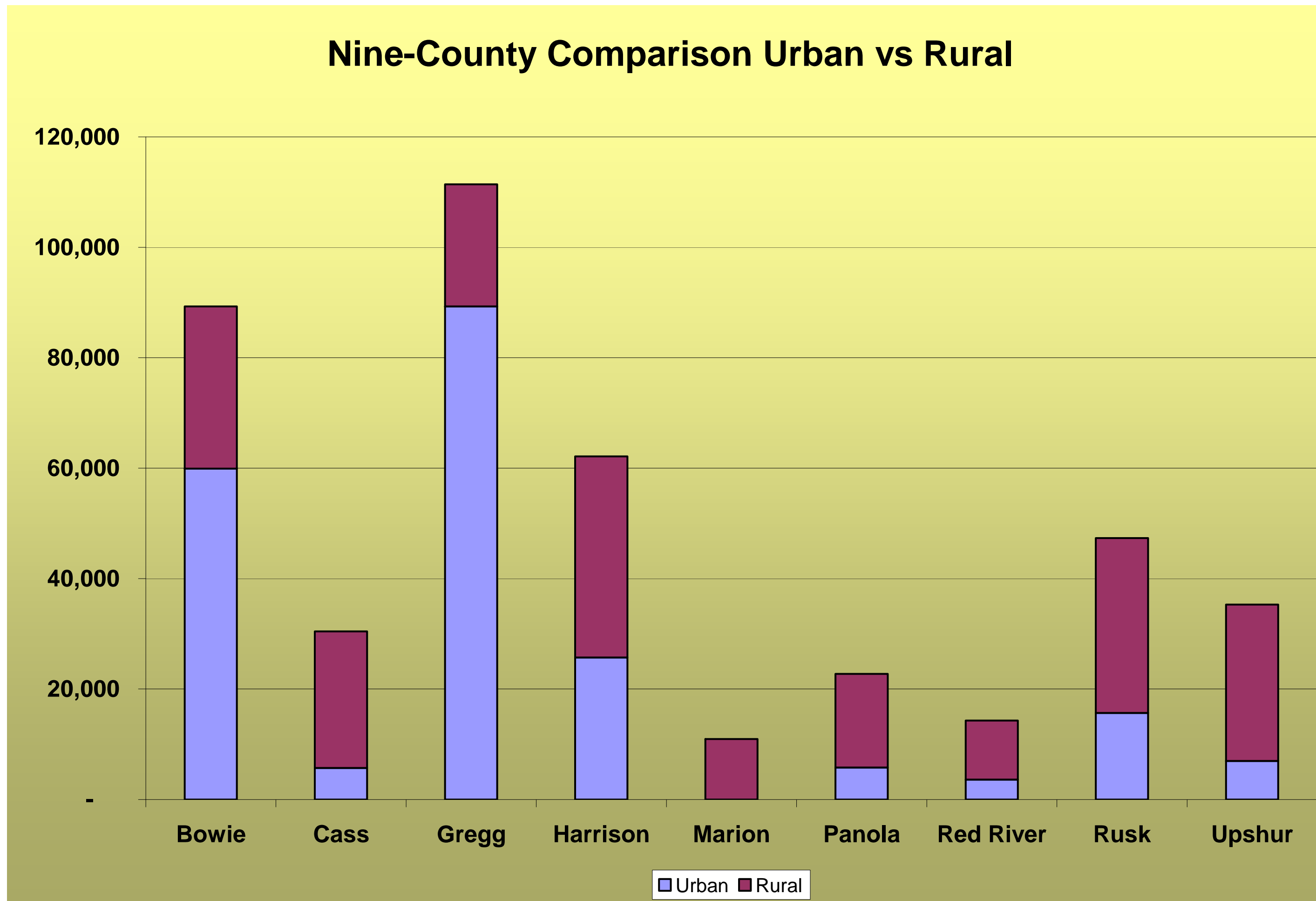
According to the 2006 American Community Survey (US Census Bureau) the combined population for the Community Healthcore MHA Service Area is 435,995. This can be further broken down into the following population groups as seen in MH Chart 7.1.

Of the 435,995 residents, approximately 14,000 report that they were foreign born.

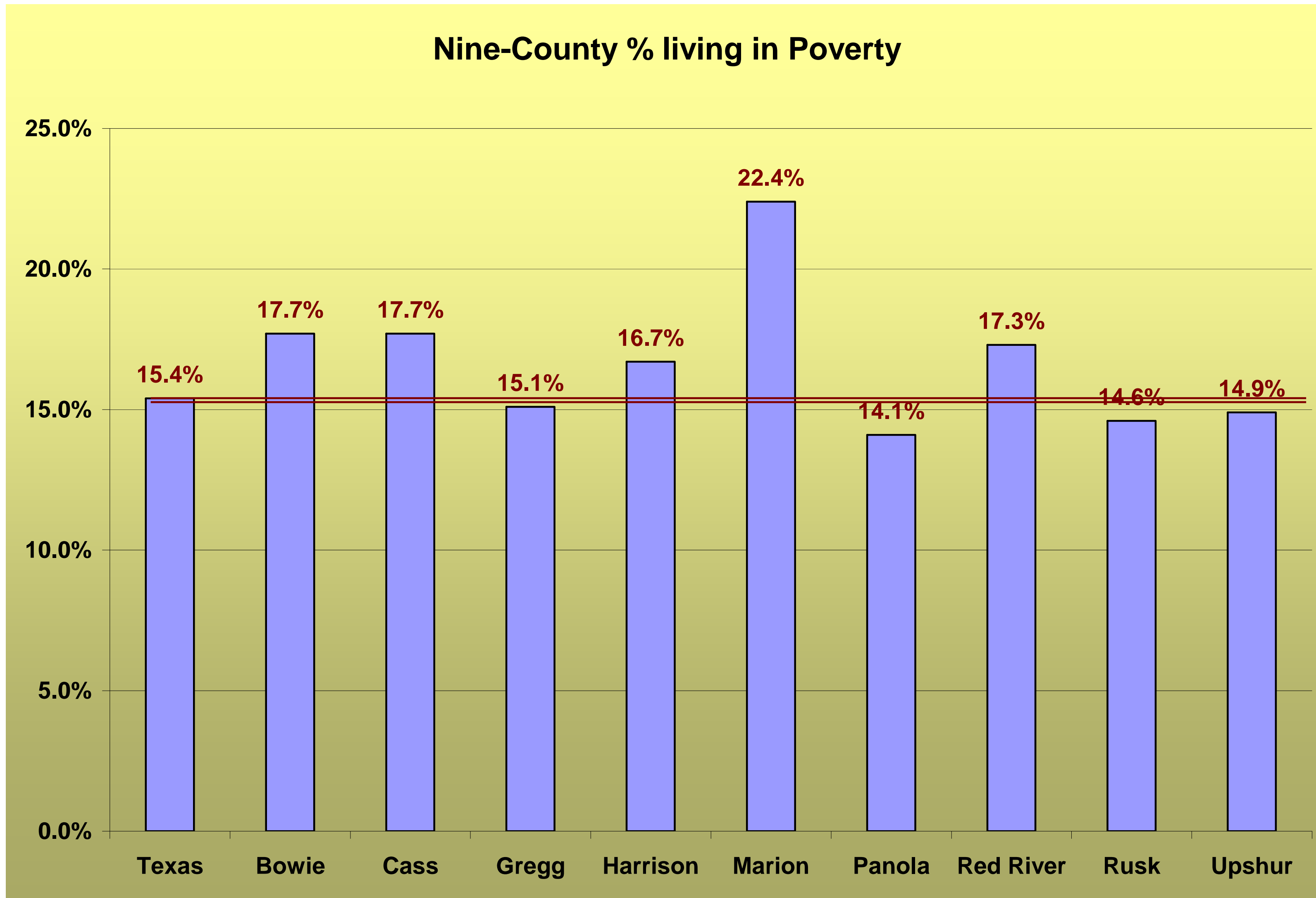
Also 29,000 report that they speak a language other than English in the home. Spanish is the second most spoken lanuage in the area.



Another view of the population is illustrated in the chart Urban vs Rural. Community Healthcore is considered a rural MHA and MRA. Although there are 3 mid-sized cities: Longview in Gregg County, Texarkana in Bowie County and Marshall in Harrison County, approximately 50% of the nine-county residents live in rural areas.



Economically the area overall falls above the Texas State Average for Poverty with the highest level found in Marion County.



Mental Health Services
(DSHS funded)

Local Planning Process

1. Planning Process Used to Identify and Solicit Input

PLANNING EFFORTS & STAKEHOLDER OPPORTUNITIES

In the spring of 2007, prior to the implementation of Local Planning Network Development (LPND), Community Healthcore participated in a regional informational gathering project with the eight Community Centers that make up East Texas Behavioral Health Network. As a part of that project, service needs and gap information was gathered. Only responses specific to Community Healthcore's service area are included here.

Since the onset of LPND Community Healthcore has utilized a multi-Method approach to provide community education regarding the new Rule and the opportunities that stakeholders have in providing input in the decisions found within the local plan. The primary methods for providing community education are through Community Forums, Other Stakeholder Meetings, Surveys, and the Community Healthcore Website.

Community Forums have been held in our two largest cities with announcements in the local newspaper, posted on the website and in one case on the marquee three days in advance. Each time the room setup provided for the audience to watch the DSHS Presentation "You Have a Voice", the training for consumers and family members. Surveys with a cover letter from Community Healthcore on one side and "You have a Voice" on the other side were distributed. Finally an easel with a tablet was used to capture comments and questions. Refreshments in the form of cookies, bottled water and soft drinks were also presented for participants to enjoy. Unfortunately these efforts were not well attended by the general public. The topic **Mental Health Service System - Community Forum** with the byline "Come join us in a community forum initiated by Community Healthcore the local Mental Health Authority and learn how the Texas system is changing" did not compete well in the busy lives of the public.

Other Stakeholder Meetings which includes consumer groups, advocacy groups, judicial work groups, etc were much more productive as participants had a vested interest in the 'changing Texas system'. The set up for these meetings was identical to the Community Forums unless noted otherwise. The viewing of the DSHS "You have a Voice" was well received although it created different levels of anxiety for some persons who receive services. After the viewing a question and answer session was initiated. Individuals raised questions and the facilitator dialogued for several minutes writing down key ideas or comments. Some times when there were breaks in the questions/comments the facilitator posed questions for the audience to respond to. This method by far seems to be the most effective method in capturing public input.

Surveys were our third source of community education/input. The Consumer/Family survey and the Official survey, both developed by the Texas Council, were adopted by our Comprehensive Planning Advisory Committee. The Consumer/Family surveys in addition to being distributed in Community Forums and Other Stakeholder Meetings were placed in the outpatient clinics throughout our nine counties during the month of May. The cover letter and "You have a Voice" message provided some education regarding the changes in the Texas system. It also encouraged them to go the Community Healthcore or other websites to access additional information including the DSHS presentations. The Survey could be completed and mailed back to the Center or collected at the clinic. The Survey for local officials was mailed out to key officials and stakeholders in our nine counties. Information from both sets of surveys were collected and summarized to the CPAC.

The Community Healthcore's Internet Website is our fourth method for Community Education and input. It has a link on the front page of the Center's Website to a section devoted to the LPND Rule and changes in the Texas System. From the LPND Synopsis page, readers can choose to view Upcoming events, Take the Survey, Access DSHS created Modules and other websites, Contact the Center for Questions or provide Input, or view and comment of the Local Plan. The Community Healthcore's website is www.communityhealthcore.com.

PLANNING & ADVISORY COMMITTEES INVOLVEMENT

There were three advisory groups that participated in the development of this plan: the Regional Planning Advisory Committee, the Comprehensive Planning Advisory Committee, and the Organizational Planning Committee.

Regional Network Advisory Committee

Assist the Board of Trustees in an advisory capacity, making recommendations regarding the development of the regional network plan and the subsequent development, design, management, and evaluation of the provider network.

Comprehensive Planning Advisory Committee

The functions of the Comprehensive Planning Advisory Committee are to assist the Board of Trustees in an advisory capacity, making recommendations concerning local service delivery and the development of the local strategic plan. The Comprehensive Planning Advisory Committee also identifies community needs, makes recommendations for new programs, services, or improvements of services and stimulates financial support and public interest in the community for the Center. The Comprehensive Planning Advisory Committee provides local, state and federal governmental bodies with information in support of the Center and educating the community about the kinds of services offered and how to access those services. The Comprehensive Planning Advisory Committee also recommends and participates in special studies at the request of the Board of Trustees. The Comprehensive Local Planning Advisory Committee, which is part of the Center feedback loop and supports the infrastructure, reviewed the mental health and mental retardation services and produced reports and/or surveys, which form the basis for this Local Planning Strategy.

Organizational Planning Committee of the Board of Trustees

This three member board committee provides organizational oversight to all of the local planning efforts of the Center. This group typically meets monthly prior to each Board of Trustee Meeting and reviews reports and recommendations from other committees prior to presentation to the full Board.

Combined Committee Schedule with LPND Discussion

With the implementation of LPND, the following groups met to discuss the development of the Local Plan.

Planning Meetings

- RPNAC – Wednesday, March 20, 2008 (training)
- CHC CPAC – Thursday, May 1, 2008 (training)
- Board Training - Thursday, May 8, 2008 (training)
- CHC CPAC Workgroup – Thursday, June 12, 2008 (needs & service gaps)
- ETBHN RPNAC – Thursday, June 19, 2008 (review essential elements)
- Organizational Planning Committee – Thursday, June 26, 2008 (Update)
- CHC CPAC – Thursday, July 10, 2008 (review essential elements)
- CHC CPAC – Thursday, Aug 7, 2008 Follow up Meeting

2. Stakeholder Participation

The following chart reflects the efforts in both community education and in gathering information specific to the DSHS template for the local plan. It also identifies the type of stakeholders who had an opportunity to participate and the actual response.

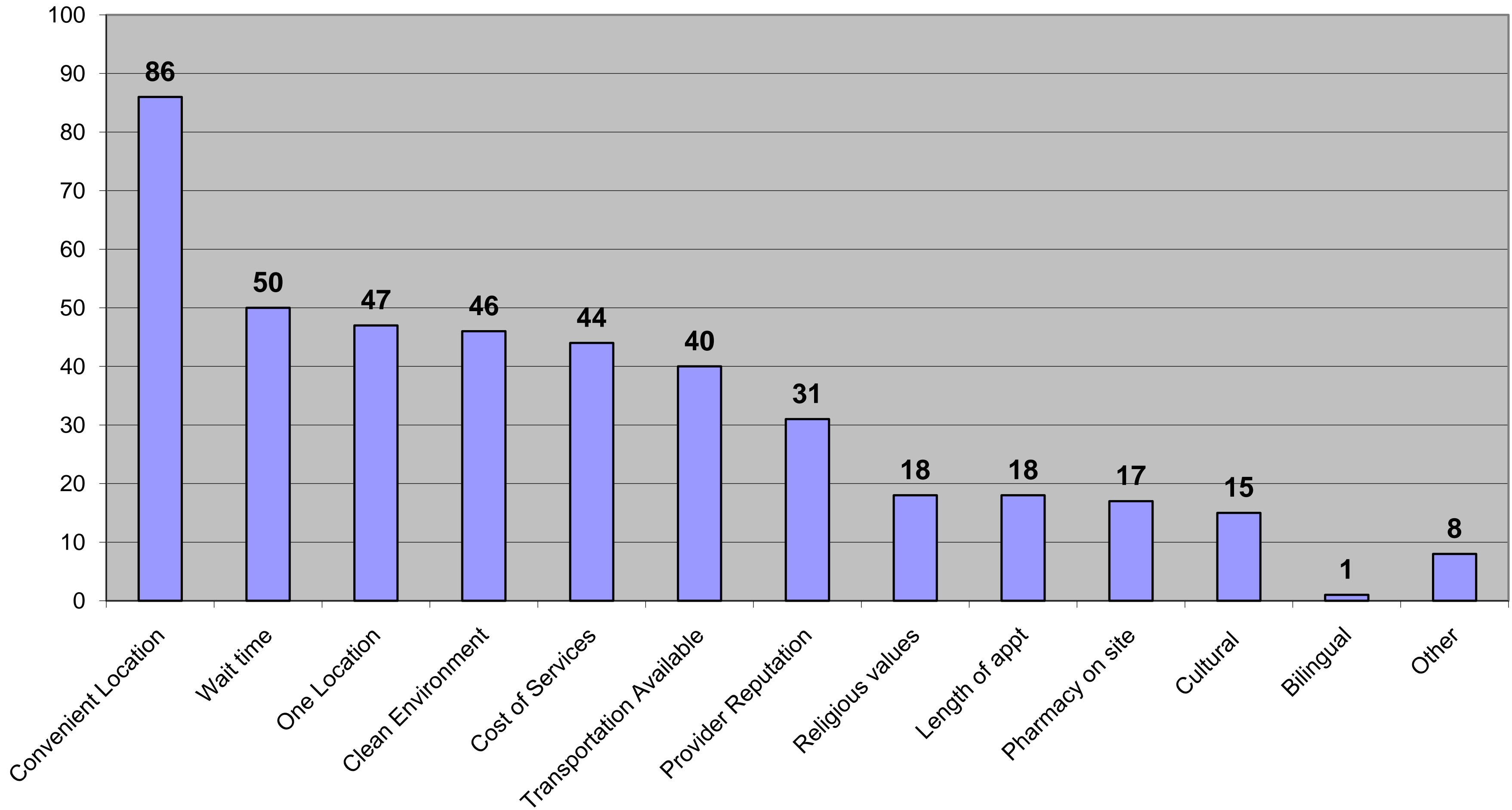
Description And Date or Timeframe	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
2007 Consumer & Family Surveys	Consumers, family members	**286**	**128**	**26**
2007 Local Official Surveys	Judges, local law enforcement, volunteers	**0**	**0**	**63**
Meeting, 9/12/07 Crisis Redesign, Texarkana	Hospitals, local law enforcement, Juvenile, Probation, Judges, NAMI, Advocacy Incorporated, Community Healthcore	**0**	**2**	**24**
Meeting, 9/13/07 Crisis Redesign, Longview	Judge, local law enforcement, hospitals, Community Healthcore	**0**	**0**	**21**
Meeting, 11/27/07 Crisis Redesign, Texarkana	Judge, local law enforcement, hospitals, Community Healthcore	**0**	**0**	**5**
Meeting, 11/28/07 Crisis Redesign, Longview	Hospitals, local law enforcement, Juvenile, Probation, Judges, NAMI, Advocacy Incorporated, Consumers, Family members, Community Healthcore	**1**	**2**	**16**
Meeting, 1/15/08 Crisis Redesign, Texarkana	Judge, local law enforcement, probation, hospitals, PAC, Community Healthcore,	**0**	**0**	**14**
Consumer / Family Satisfaction Surveys	Available at all Outpatient Clinics during the month of May and early June; over 500 distributed.	**102**	**39**	**14**
Community Stakeholder Surveys	Mailed out to community stakeholders including: Advocacy Incorporated, NAMI, area hospitals, law enforcement, OSAR, County Officials; sixty-nine mailed out.	**0**	**0**	**4**
Public Forum, Texarkana, 5/5/08	Advertised and conducted at a Texarkana Community Building	**0**	**0**	**1**
Meeting, Longview, 5/12/08	NAMI Membership Meeting	**3**	**15**	**3**

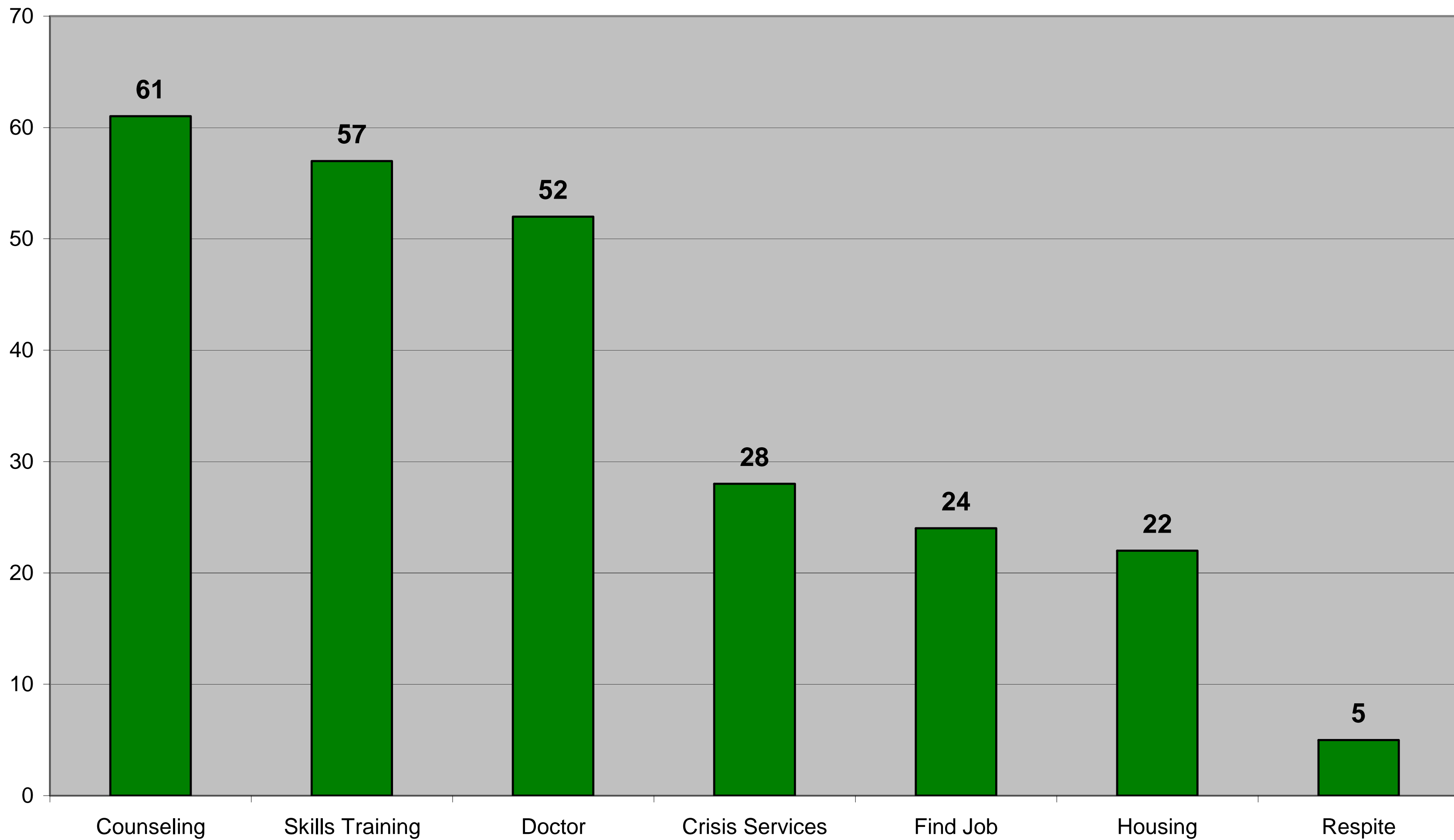
Description And Date or Timeframe	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
Meeting, Longview, 5/14/08	Homeless Advocacy Network	**5**	**2**	**8**
Public Forum, Longview, 5/15/08	Advertised and conducted at the Longview Public Library	**0**	**0**	**1**
Informational Meeting, Longview 5/21/08	Information shared at Judge Sage's Family Court monthly meeting with key agency stakeholders including juvenile probation and other stakeholders.	**0**	**0**	**11**
Public Forum, Longview, 7/7/08	Final forum. Posted in 3 major newspapers and 6 smaller papers (each primary paper of every county). Also fifty-three invitations mailed out to potential providers.	**1**	**1**	**4**

3. Summary of Input Received from Stakeholders

Service Needs and Priorities

Surveys and comments gathered at stakeholder meetings along with prior efforts in identifying local needs was used. From the 151 returned surveys two responses are graphed below.


Most Important Factors in Choosing a Provider
LPND FY2008 Surveys
100
90
80
70
60
50
40
30
20
10
0
86
50
47
46
44
40
31
18
18
17
15
1
8
Convenient Location
Wait time
One Location
Clean Environment
Cost of Services
Transportation Available
Provider Reputation
Religious values
Length of appt
Pharmacy on site
Cultural
Bilingual
Other



Other useful information was captured and incorporated into the service needs and priorities listed below.

Crisis Response System

Community Stakeholder meetings were reconvened in Texarkana, November 27, 2007 and Longview, November 28, 2007 to prioritize needs identified at meetings earlier in the fall. Fourteen persons attended the meeting in Texarkana and nineteen persons attended the meeting in Gregg County.

The top two priorities in the Texarkana region were:

1) Observation in a short term location for persons to wait in a safe and secure environment for further evaluation.

2) Transportation for persons in crisis

The two top priorities in the Longview region were:

1) Observation for further assessment, 23 hour hold, and Crisis Stabilization

2) Transportation

Development of an External Provider Network

Although Community Healthcore scored a high level of satisfaction by the responders of the survey, an average of 4.54 on a scale from 1 to 5 (n=140), most responders indicated that choice of provider was also an added value. However what was clearly perceived as a gain would quickly become a loss if access to the services was less than the one currently available. This is indicated both in the high scores for Convenient Location #1, One Location #3, and Transportation Available #6. In Stakeholder Meetings consumers and family members spoke to the issue that having choice in the same town in which they were getting services was extremely important and traveling to another city or even county was a serious concern. Consumers also spoke to the issue of getting all of their services at one location. Having a choice of providers was good but they did not want more than one location to get their services. All of the services clustered together (with the exception of those services that come to their home or work location) were important.

Other Significant Issues and Concerns

There are three categories of other significant issues and concerns that were captured in this process: Potential Providers, Operational, and Bundling.

Potential Providers expressed the need for:

- Technical Assistance for Providers
- A well developed Provider Manual
- Specific Billing Guidelines
- Concern that the MHA does not run out of money during the year
- Request for strong guidance for discharges
- Clear Communication channels and processes to revise treatment plans and for additional authorizations.

Operational Issues identified in the planning process include:

- Extending current authority functions to external providers who are not on Community Healthcore property
- Expanding the utilization processes to external providers
- Claims adjudication processes for external providers
- Managing resources effectively to pay all claims
- No new money to implement changes

Bundling Issues

- Need for Choice in all areas not just more populated areas
- Inability of Center to operate only remote areas which have a higher cost and external providers serving more populated areas with lower cost
- Unfair to external providers to originally not bundle more remote counties and then add remote areas as requirements in future procurements

4. Community Healthcore's Priorities for FY2009 & FY2010

A CPAC workgroup met June 12 to review and discuss five data sets to help identify service delivery needs, gaps and priorities. Data sets include:

- Focus group input from Local Plan 2005
- Consumer/Family & Community Stakeholder survey responses FY2007
- Crisis Redesign needs and priorities FY2008
- LPND Surveys FY2008
- Strategic Vision FY2008-2010

This information was then shared at the Public Forum on July 7 and presented to the CPAC on July 10. Both groups added previously unidentified items so that the final list is represented as follows:

- A safe place for persons in crisis to be in observation and better assess their needs.
- A detoxification evaluation at different locations to assess if atypical behavior is the result of a substance issue or a mental health episode.
- Locally funded inpatient services or other safe alternative to help stabilize a crisis.
- Single location for individuals to travel to receive services rather than going to multiple locations to receive their services.
- Services provided directly in Marion County without the need to travel to a different county to access services.
- Transportation to either public or service locations in a convenient location.
- Specialized services to assist children with behavioral needs in the home and school.
- Increased supports to children and adolescents with mental health needs who are in the criminal justice system.

- More funding to address waiting list needs.
- Local funding resources for Children at Risk whose parents earn 'too much' to qualify for Medicaid and Medicare.
- Trained Clinicians and Support Staff who are bilingual.
- Benefits assistance for persons who do not meet the target population.
- Patient Assistance Program (PAP) for persons outside the target population
- Assistance with Medication costs.

Operational Priorities also identified in the planning process include:

- Serve more individuals at or nearer their LOC-R and with more authorized specialty services; this will result in a reduction of total persons served (would still exceed the minimum target established by DSHS contract).
- Increase the existing authority infrastructure to oversee an increase in external providers
- Expanding the utilization processes to external providers
- Claims adjudication processes for external providers
- Managing resources effectively to pay all claims
- Seek ways to fund expanding authority with no new money to implement changes

5. Changes in the Service Delivery System for FY2009 & FY2010 for Crisis Redesign

Due to the Crisis Redesign initiative started in the fall of 2007 Crisis Services will not be placed out for bid except where indicated under discrete services to continue the existing plan. Features of the improved system include:

- Crisis Hotline Certification by American Association for Suicidology
- Upgrade and expand the two Mobile Crisis Outreach Teams operating out of Longview and Texarkana

- ❖ Monthly meetings with County Judges, Hospital Administrators, and Crisis Staff to share results and address new issues.
- ❖ Receipt of a grant from the CHRISTUS Fund for $183,000 for crisis needs in two major hospitals' emergency departments in the Texarkana community
- ❖ Utilization of national consultants to help Community Healthcore further improve its mental health services including Crisis Services

The full plan can be viewed on the Community Healthcore website – www.communityhealthcore.com

Current Services and Providers

The following is an overview of and rational for the methodology used to calculate the amounts listed in the columns entitled "Dollars Spent on Direct LMHA Services" and "Dollars Spent on the 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***. Costs (as opposed to revenues) were utilized because of their direct relationship with the services delivered. The rationale to use cost is summarized as follows – the costs are the costs regardless of the funding source.

To utilize the methodology, the Center isolated the costs associated with the services delivered under contract by External Providers during FY07. 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 picture of the Center's service delivery network for that 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.

Tips for Understanding the table below:

- *An "X" in the column labeled "LMHA" means the LMHA provides the service* ***directly.***
- *LMHA means Local Mental Health Authority and in this case is Community Healthcore.*
- *If the service is provided (in whole or in part) through contract with an external provider, the name and address of the external provider and the LMHA's expenditures for external provider contracted services in FY 2007is listed.*
- *If the Service is not provided an N/A is listed in the first column.*
- *An "External Provider" is an organization or individual who is not an employee of Community Healthcore, who provides mental health services via contract with Community Healthcore.*

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	609,635	N/A	N/A	N/A
Routine Case Management (Adult)	X	494,479	N/A	N/A	N/A
Routine Case Management (Child/ Adolescent)	X	188,733	N/A	N/A	N/A
Respite Services	N/A		N/A	N/A	N/A
Supplemental Nursing Services	X	0	John L. Hall, M.D. P.O. Box 3542 Longview, Texas 75606 Byron R. Wadley, M.D. 2020 Bill Owens Pkwy, Suite 250 Longview, Texas 75604 Gregory Montoya, M.D. Collom & Carney Clinic Association	181,163	

			1902 Galleria Oaks Texarkana, Texas 75503 Mark A. D'Eramo, M.D. 3800 Paluxy Dr., Suite 425 Tyler, Texas 75703 David L. Brown, M.D. 911 NW Loop 281, Suite 111 Longview, Texas 75604 Dennis R. Flores, M.D. 500 Hospital Drive New Boston, TX 75570-2301		
FY2008 Contract Experience			Contracted with same individuals in FY08; one ended during FY08		
Pharmacological Management	X	336,488	John L. Hall, M.D. P.O. Box 3542 Longview, Texas 75606 Byron R. Wadley, M.D. 2020 Bill Owens Pkwy, Suite 250 Longview, Texas 75604 Gregory Montoya, M.D. Collom & Carney Clinic Association 1902 Galleria Oaks Texarkana, Texas 75503 Mark A. D'Eramo, M.D. 3800 Paluxy Dr., Suite 425 Tyler, Texas 75703 David L. Brown, M.D. 911 NW Loop 281, Suite 111 Longview, Texas 75604 Dennis R. Flores, M.D. 500 Hospital Drive New Boston, TX 75570-2301	375,739	9/1/2006 8/31/2007
FY2008 Contract Experience			Contracted with same individuals in FY08; one ended during FY08		

Provision of medication	N/A		Mike Holbert Louis Morgan Drug #4 110 Johnston St. Longview, TX 75601 East Texas Behavioral Healthcare Network 4101 South Medford Dr. Lufkin, TX 75901-5699 McKesson PO Box 841838 Dallas, TX 75284	651,467	9/1/2006 8/31/2007
	FY2008 Contract Experience		Contracted with same individuals in FY08; one ended during FY08		
Psychiatric evaluation	X	67,274	John L. Hall, M.D. P.O. Box 3542 Longview, Texas 75606 Byron R. Wadley, M.D. 2020 Bill Owens Pkwy, Suite 250 Longview, Texas 75604 Gregory Montoya, M.D. Collom & Carney Clinic Association 1902 Galleria Oaks Texarkana, Texas 75503 Mark A. D'Eramo, M.D. 3800 Paluxy Dr., Suite 425 Tyler, Texas 75703 David L. Brown, M.D. 911 NW Loop 281, Suite 111 Longview, Texas 75604 Dennis R. Flores, M.D. 500 Hospital Drive New Boston, TX 75570-2301	36,584	9/1/2006 8/31/2007
	FY2008 Contract Experience		Contracted with same individuals in FY08; one ended during FY08		
All Rehabilitation Services (Adult)	X	2,348,750	N/A	N/A	N/A

Service Type	LMHA	Dollars Spent on Direct LMHA Services	External Provider (Name/address)	Dollars Spent on External Provider Services	External Provider Contract Start and End Dates
All Rehabilitation Services (Child/Adolescent)	X	480,869	N/A	N/A	N/A
Supported Employment	X	65,704	N/A	N/A	N/A
Supportive Housing	X	16,947	N/A	N/A	N/A
Assertive Community Treatment	X	470,181	N/A	N/A	N/A
Inpatient services	N/A		East Texas Medical Center PO Box 700 Tyler, TX 75711 Glen Oaks 301 East Division St Greenville, TX 75402 Arcadia Pathways 22 Bermuda Lane Longview, TX 75605	439,551	9/1/2006 8/31/2007
	FY2008 Contract Experience		Contracted with all three facilities but one closed and another was added		
Residential Treatment	N/A		N/A	N/A	N/A
Intensive Case Management (Child/Adolescent)	X	19,495	N/A	N/A	N/A
Counseling (Adult)	X	165	N/A	N/A	N/A
Counseling (Child/Adolescent)	X	33,326	N/A	N/A	N/A
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)	X	281,014	N/A	N/A	N/A
Flexible Community Support (Child/Adolescent)	X	1,149	N/A	N/A	N/A
Multi-Systemic Therapy (Child/Adolescent)	N/A				
Consumer Peer Support	X	13,856	N/A	N/A	N/A
Service Type	LMHA	Dollars Spent	External Provider	Dollars Spent	External Provider

		on Direct LMHA Services	(Name/address)	on External Provider Services	Contract Start and End Dates
CRISIS & OTHER DISCRETE SERVICES					
Crisis Hotline	N/A		Janie L. Harwood, President Avail Solutions, Inc. P.O. Box 60811 Corpus Christi, Texas 78466	112,912	9/1/2006 8/31/2007
FY2008 Contract Experience			Continued throughout FY08		
Crisis Intervention Services	X	501,343	N/A	N/A	N/A
Mobile Outreach	N/A	The Crisis Services Redesign initiative began September 1, 2007 and enhanced plans completed December 31, 2008; just prior to this local planning initiative which began on 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 Planning Network Development Rule for FY08. Also the Service Types listed on the left hand column pertain to new service definitions as a result of the Crisis Redesign initiative and they did not exist in FY07 which is the basis for this table.			
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		Quest Diagnostic PO Box 841725 Dallas, TX 75284-1725	36,477	9/1/2006 8/31/2007
FY2008 Contract Experience			Changed to another vendor during FY08		

Provider Network Development

1. Provider Availability

The following narrative summarizes the three-pronged process Community Healthcore used to assess the availability of current and potential external providers. In the spring of 2004 a Request for Information (RFI) was issued by Community Healthcore. Four responses were received expressing interest in providing services to Adults and / or Children with Mental Health Needs. Of these four, two became contractors and one continues as a contractor for FY08. The information provided by the other two interested providers has been maintained for future procurement opportunities. All three providers not currently under contract by Community Healthcore have been contacted during the LPND planning phase. Of the three, one respondent specifically provides advocacy services and peer-to-peer services. Another one has registered on the DSHS Website to provide services for Community Healthcore. The third provider received a mailed invitation to attend the July 7th Public Forum but did not attend. Calls have been placed with this provider who is out of the area and information will be updated as to their interest to provide services in the Community Healthcore MHA.

The second method utilizes the Department of State Health Services statewide website in which providers may register as one method to express their interest. As of the posting of the draft Local Plan, two providers have expressed their interest in providing services and the areas of interest are listed further below in the section **3. Service Capacity and Procurement**. At the Texas Council for Mental Health and Mental Retardation Centers, Inc Annual Conference in May 2008, both providers were sought out and visited with. They were encouraged to check our website for dates and locations of public forums and a business card was provided with the name, telephone number and email address for the LPND contact at Community Healthcore. Both were mailed specific invitations to the Public Forum on July 7, 2008 but neither attend; it should be recognized that both are located a considerable distance outside the catchment area. Handouts from that meeting have recently been sent to them. The Wood Group has verified its continued interest in becoming a member of the Community Healthcore Network as contained in their original Provider Inquiry Request Form. Sunwest Behavioral Health Organization has received a similar contact and is reviewing the handout. Any new information will be reflected in the plan.

The third method utilized specific invitations to local providers of mental health services. In addition to the public forums held in Longview and Texarkana which utilized the website and local newspaper announcements to attract the public, an invitational letter was mailed out to fifty-three local providers of mental health services. In addition to the respondents to the RFI and providers who completed online Provider Interest Inquiry Forms, letters were sent to Psychiatrists, Counseling groups, hospitals, and other medical providers operating in the Longview, Texarkana, and Marshall Areas. These invitations were in addition to the announcements in multiple papers and the website. Although this was not intended to be an exclusive provider meeting it was hoped that there would be substantial provider participation and dialogue. At the July 7, 2008 meeting, four potential providers participated in the forum. Many of their comments are captured further below in section **12. Barriers**.

2. Provider Inquiries

Below is a summary of all written inquires from providers interested in providing services received over the previous four years by the LMHA. Written inquiries include regular mail service, e-mail, fax, or website and include services each provider wishes to provide.

Date of Inquiry	Summary of Inquiry	LMHA Response
Spring 2004	Texas Mental Health Consumers responded to RFI issued spring of 2004.	Contacted them by telephone. Followed up by mailing them through the US Mail specific information regarding current process.
Spring 2004	Adapt of Texas, Inc. responded to the RFT issued spring of 2004.	Mailed specific invitation regarding public forum and included website information. More recently contacted them by telephone and left a message; no response as of this date.
Spring 2004 Spring 2008	The Wood Group responded to RFI issued spring of 2004. The Wood Group also submitted on the DSHS website a Provider Interest Inquiry Form for Community Healthcore.	Spoke with president at Texas Council Annual Conference in May, 2008 and provided contact information. Mailed specific invitation regarding public forum and included website information. More recently emailed handout from the forum and contacted office by telephone and left a message. President returned call and verified continued interest as reflected below in section **3. Service Capacity and Procurement**.

Date of Inquiry	Summary of Inquiry	LMHA Response
Spring 2004	Avail Solutions, Inc. responded to RFI issued spring of 2004.	Currently contract with Avail Solutions for Crisis Hotline and some Crisis Follow Up. Regarding this new procurement cycle spoke with representative at Texas Council Annual Conference in May, 2008 and provided contact information. Mailed specific invitation regarding public forum and included website information.
Spring 2008	Sunwest Behavioral Health Organization, LLC submitted on the DSHS website a Provider Interest Inquiry Form for Community Healthcore	Spoke with representative at Texas Council Annual Conference in May, 2008 and provided contact information. Mailed specific invitation regarding public forum and included website information. More recently emailed handout from the forum and contacted office by telephone and left a message. Have spoken with their office by telephone but awaiting verification of continued interest. Their interest is reflected below in section **3. Service Capacity and Procurement**.

3. Service Capacity and Procurement

To better understand the table below please note the following:

a) *Document the current service capacity (for a one-year period) using data from the LPND Web page [http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/default.shtm]. If the service is not provided, enter N/A.*
b) *Document the projected service capacity. The current and projected capacity will often be the same number. However, if service minimums and RDM targets are not being met, the projected capacity may be lower than the current capacity.*
c) *Briefly state the LMHA's assessment of the availability of current and potential external providers.*
d) *Indicate (Yes/No/NA) if the LMHA will procure each service package/service during FY 2008-2009.*
e) *If a service will be procured, state the capacity to be procured during FY 2008-2009.*
f) *Document the method of procurement, e.g. request for proposal or open enrollment.*
g) *NOTE: RDM services packages are identified as the primary units of procurement, but LMHAs may determine that it is most appropriate to procure discrete services from within one or more service packages. If this decision is made, state "No, except for (insert the discreet service)" in column 3d. Leave the last two columns blank. Then, enter the discrete service(s) to be procured in one of the blank rows at the bottom of the table (enter additional rows if needed), and fill out the remaining columns as described above. Also, item 4 must be completed.*

Please notice that there is a difference between the Current Capacity and Projected Capacity. Community Healthcore has historically served beyond the service target established by the Department of State Health Services which are 1,882 for adults and 341 for children. Therefore the current capacity as reported below is 2,454 for adults (130%) and 605 for children (177%). Independent of this effort, Community Healthcore is moving closer to its service target number in order to maintain compliance with the state guidelines.

	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	2099	1650	Wood Grp = 200; Sunwest 100	Yes	18%*	RFP
RDM SP 2	12	15	Wood Grp = 25; Sunwest 100	No	0%	NA
RDM SP 3	240	220	Wood Grp = 100; Sunwest 100	No	0%	NA
RDM SP 4	38	40	Wood Grp = 75; Sunwest 100	No	0%	NA
RDM SP 5	3	Unknown, new service definition	Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts: 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 Planning and Network Development rules for FY08. Important to note: Centers are not required to repeat the process of local planning for crisis services when considering the Network Development Plan, thus crisis services are not subject to further procurement at this time. For more information regarding Community Healthcore's Crisis Services Plan please visit the website: www.communityhealthcore.com/plans			
RDM SP 0	62	Unknown, new service definition				
CHILD/ADOLESCENT SERVICES						
RDM SP 1.1	151	125	Sunwest 50	No	0%	NA
RDM SP 1.2	31	30	Sunwest 50	No	0%	NA
RDM SP 2.1	1	2	Sunwest 50	No	0%	NA
RDM SP 2.2	8	8	Sunwest 50	No	0%	NA
RDM SP 2.3	1	2	Sunwest 50	No	0%	NA
RDM SP 2.4	2	2	Sunwest 50	No	0%	NA
RDM SP 4	404	175	Sunwest 50	Yes	30%*	RFP
RDM SP 0	7	Unknown, new service definition	Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts: 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 Planning and Network Development rules for FY08. Important to note: Centers are not required to repeat the process of local planning for crisis services when considering the Network Development Plan, thus crisis services are not subject to further procurement at this time. For more information regarding Community Healthcore's Crisis Services Plan please visit the website: www.communityhealthcore.com/plans			
RDM SP 5	0	Unknown, new service definition				

<table>
<thead>
<tr><th>Service</th><th>Current Capacity</th><th>Projected Capacity</th><th>Availability of Current and Potential External Providers</th><th>Procurement Planned?</th><th>Capacity to be Procured</th><th>Method of Procurement</th></tr>
</thead>
<tbody>
<tr><td>CRISIS & OTHER DISCRETE SERVICES</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Pharmacological Management</td><td>225 hours per mo</td><td>200 hours per mo</td><td>Area Physicians to work within one or more comprehensive provider of one or more services.</td><td>Yes</td><td>50%</td><td>RFP</td></tr>
<tr><td>Psychiatric evaluation</td><td>30 hours per mo</td><td>30 hours per mo</td><td>Area Physicians to work within one or more comprehensive provider of one or more services.</td><td>Yes</td><td>33%</td><td>RFP</td></tr>
<tr><td>Supported Housing</td><td>14 hours per mo</td><td>14 hours per mo</td><td>No known interest</td><td>No</td><td>0%</td><td>NA</td></tr>
<tr><td>Supported Employment</td><td>29 hours per mo</td><td>29 hours per mo</td><td>No known interest</td><td>No</td><td>0%</td><td>NA</td></tr>
<tr><td>Inpatient Services</td><td>112 bed days avg per mo</td><td>15 bed days avg per mo</td><td>ETMC; Glen Oaks;</td><td>Yes</td><td>100%</td><td>Open Enrollment</td></tr>
<tr><td>Crisis Hotline</td><td>645 calls / mo</td><td>645 calls / mo</td><td>Avail; Sunwest</td><td>Yes</td><td>100%</td><td>RFP</td></tr>
<tr><td>23-Hour Observation</td><td>NA</td><td>NA</td><td colspan="4" rowspan="11">Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts:
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 Planning and Network Development rules for FY08. Important to note: Centers are not required to repeat the process of local planning for crisis services when considering the Network Development Plan, thus crisis services are not subject to further procurement at this time.
For more information regarding Community Healthcore's Crisis Services Plan please visit the website: www.communityhealthcore.com/plans</td></tr>
<tr><td>Day Program for Acute Needs</td><td>NA</td><td>NA</td></tr>
<tr><td>Crisis Stabilization Unit</td><td>NA</td><td>NA</td></tr>
<tr><td>Crisis Respite Services</td><td>NA</td><td>NA</td></tr>
<tr><td>Crisis Residential Treatment</td><td>NA</td><td>NA</td></tr>
<tr><td>Mobile Outreach</td><td>230 face to face crisis assessments per mo</td><td>230 face to face crisis assessments per mo</td></tr>
<tr><td>Intensive Crisis Residential</td><td>New in FY08</td><td>Unknown, insufficient data</td></tr>
<tr><td>Safety Monitoring</td><td>New in FY08</td><td>Unknown, insufficient data</td></tr>
<tr><td>Crisis Follow-Up and Relapse Prevention (SP5)</td><td>New in FY08</td><td>Unknown, insufficient data</td></tr>
<tr><td>Crisis Transportation</td><td>New in FY08</td><td>Unknown, insufficient data</td></tr>
<tr><td>Crisis Flexible Benefits</td><td>New in FY08</td><td>Unknown, insufficient data</td></tr>
</tbody>
</table>

* The percentage reflected "**3e Percentage of Procurement Planned**" is based on the Projected Capacity. Due to the fluctuation of this figure and the actual # served, please know that Community Healthcore will attempt to procure services for 300 adults in SP1 and 50 children in SP 4.0.

4. Justification for procurement of discrete services

Although Community Healthcore is primarily seeking comprehensive external providers of service packages, it does describe below needed single-service providers for specialty areas and additional external contractors to supplement Community Healthcore's staffing. In the latter case the contractor works on-site with Community Healthcore employees in providing the necessary services in a given service package.

Discrete Service to Procure	Rationale
Physician Services for Pharmacological Services and Psychiatric Evaluation	In Rural East Texas there is a need to supplement Physician services. However this service must be provided within a comprehensive array for one or more service packages through a more comprehensive provider (either internal or external) and provided at the same location as with the other services with that package.

Plan for Fidelity and Continuity of Care
Fidelity is accomplished over time through training, supervision, and continuous reassessment to prevent movement away from principles and practices for the duration of the provision of service(s). In order to ensure that consumers receive the necessary services from within the designated service package the provider will: Providers shall be required to attend specified mandatory meetings (as identified or at a minimum quarterly), staffing, and/or training programs. The Provider will be notified by the Center of such meeting or training program prior to the date of the meeting or training program. The Provider will be notified by the Center of any staffing prior to the date of the staffing. Notwithstanding the meetings and trainings, the Provider shall be subject to on-site audits, desk reviews, data entry, provider assessments, surveys and profiling, credentialing and compliance with in applicable federal, state laws and contract requirements. In addition, provider will make available data selected for review by accredited organizations as applicable (Joint Commission) Case Managers will work to ensure continuity of care by monitoring services provided by external providers. They shall be responsible for ensuring that individuals are receiving services from within the designated service package that are appropriate to their level of need. Authority Quality Management will monitor services provided by external providers. Providers will be responsible for corrective action plans

and implementation of corrective deficiencies noted within timeframes identified in audit results. Failure to implement corrective action plans may result in possible vendor hold or non-payment.

All client data collected by all providers will be entered and maintained in the authority clinical data system. Utilization Management will monitor data on a routine basis to ensure compliance and performance on outcomes of service delivery. Providers will ensure data is entered in accordance to CHC guidelines to ensure this process is proactive.

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, 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	90%	4, 5*	The Planning Advisory Committee decided to begin with the greatest service volume and establishing a network of qualified providers in the first cycle; this is SP 1 for adults. However, there is not enough system capacity at this time to meet the need for this service package. Also the need to gradually develop the network so it can establish stable providers, strong authority processes, and maintain a safety net while the network develops further supports the need for Community Healthcore to provide SP 1 services.	50%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area, SP 1 services will be increased in successive cycles.
RDM SP 2	100%	5*	The Planning Advisory Committee decided to begin with the greatest service volume and establish a network of qualified providers during the first cycle. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.	0%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 2 services will be procured.
RDM SP 3	100%	5*	The Planning Advisory Committee decided to begin with the greatest service volume and establish a network of qualified providers during the first cycle. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.	50%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 3 services will be procured.

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
RDM SP 4	100%	5*	Given both the small number of adults in this SP and the intensity of the service delivery, it was decided by the Planning Advisory Committee to procure services in a less intensive and greater service volume. Procurement of SP 4 would necessitate contracting out 100%. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.	0%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 4 services will be procured.
RDM SP 0	100%	Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts: 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 Planning and Network Development rules for FY08. Important to note: Centers are not required to repeat the process of local planning for crisis services when considering the Network Development Plan, thus crisis services are not subject to further procurement at this time. For more information regarding Community Healthcore's Crisis Services Plan please visit the website: www.communityhealthcore.com/plans			
RDM SP 5	100%				
CHILD/ADOLESCENT SERVICES					
RDM SP 1.1	100%	2, 4, 5*	There is not enough system capacity at this time to meet the need for this service package. Only one external provider has requested providing this service at a capacity well below the actual need. The Planning Advisory Committee decided to begin with the greatest service volume and establishing a network of qualified providers as a part of the first cycle. This will allow for good relationships and processes to be established between the authority and the comprehensive external providers.	50%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 1.1 for children will be procured.

Service	Percent Capacity provided by the LMHA	Condition 1–6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
RDM SP 1.2	100%	5*	Given the small number of children in this SP, it was decided by the Planning Advisory Committee to procure services in the service package with the most volume. Procurement of SP1.2 would necessitate contracting out 100%. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.	0%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 1.2 for children will be procured.
RDM SP 2.1	100%	5*	Given the small number of children in this SP, it was decided by the Planning Advisory Committee to procure services in the service package with the most volume. Procurement of SP2.1 would necessitate contracting out 100%. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.	0%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 2.1 for children will be procured.
RDM SP 2.2	100%	5*	Given the small number of children in this SP, it was decided by the Planning Advisory Committee to procure services in the service package with the most volume. Procurement of SP2.2 would necessitate contracting out 100%. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.	0%	It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 2.2 for children will be procured.

<table>
<tr><th>Service</th><th>Percent Capacity provided by the LMHA</th><th>Condition 1–6 (listed above)</th><th>Explanation</th><th>Percent Capacity necessary for LMHA Viability</th><th>Rationale for this Volume</th></tr>
<tr><td>RDM SP 2.3</td><td>100%</td><td>5*</td><td>Given the small number of children in this SP, it was decided by the Planning Advisory Committee to procure services in the service package with the most volume. Procurement of SP2.3 would necessitate contracting out 100%. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.</td><td>0%</td><td>It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 2.3 for children will be procured.</td></tr>
<tr><td>RDM SP 2.4</td><td>100%</td><td>5*</td><td>Given the small number of children in this SP, it was decided by the Planning Advisory Committee to procure services in the service package with the most volume. Procurement of SP2.4 would necessitate contracting out 100%. Given the need to establish a stable external provider network with strong authority processes, and in consideration of the safety net concern until a stable provider network exists, it was determined to defer procuring this service during this cycle.</td><td>0%</td><td>It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, SP 2.4 for children will be procured.</td></tr>
<tr><td>RDM SP 4</td><td>90%</td><td>2, 4, 5*</td><td>The Planning Advisory Committee decided to begin with the greatest service volume and establishing a network of qualified providers in the first cycle; this is SP 4. However, there is not enough system capacity at this time to meet the need for this service package. Only one external provider has requested providing this service at a capacity well below the actual need.</td><td>50%</td><td>It is anticipated that as external service providers demonstrate their ability to provide services within the Community Healthcore catchment area and as authority infrastructure is established designed for an external provider providing full service packages, procurement for SP 4 for children will be increased.</td></tr>
<tr><td>RDM SP 0</td><td>100%</td><td rowspan="2" colspan="4">Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts: 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 Planning and Network Development rules for FY08. Important to note: Centers are not required to repeat the process of local planning for crisis services when considering the Network Development Plan, thus crisis services are not subject to further procurement at this time.
For more information regarding Community Healthcore's Crisis Services Plan please visit the website: www.communityhealthcore.com/plans</td></tr>
<tr><td>RDM SP 5</td><td>100%</td></tr>
</table>

<table>
<tr><th>Service</th><th>Percent Capacity provided by the LMHA</th><th>Condition 1–6 (listed above)</th><th>Explanation</th><th>Percent Capacity necessary for LMHA Viability</th><th>Rationale for this Volume</th></tr>
<tr><td>CRISIS & OTHER DISCRETE SERVICES</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mobile Outreach</td><td>100%</td><td colspan="4" rowspan="10">Per the October 31, 2007 memo from Rod Swan, DSHS Unit Manager of MH Contracts:
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 Planning and Network Development rules for FY08. Important to note: Centers are not required to repeat the process of local planning for crisis services when considering the Network Development Plan, thus crisis services are not subject to further procurement at this time.
For more information regarding Community Healthcore's Crisis Services Plan please visit the website: www.communityhealthcore.com/plans</td></tr>
<tr><td>23-Hour Observation</td><td>NA</td></tr>
<tr><td>Day Program for Acute Needs</td><td>NA</td></tr>
<tr><td>Crisis Stabilization Unit</td><td>NA</td></tr>
<tr><td>Crisis Respite Services</td><td>NA</td></tr>
<tr><td>Intensive Crisis Residential</td><td>NA</td></tr>
<tr><td>Safety Monitoring</td><td>100%</td></tr>
<tr><td>Crisis Follow-Up and Relapse Prevention</td><td>100%</td></tr>
<tr><td>Crisis Transportation</td><td>0%</td></tr>
<tr><td>Crisis Flexible Benefits</td><td>100%</td></tr>
<tr><td>Pharmacological Management</td><td>50%</td><td>4, 5*</td><td>Currently there is a shortage of physician time to provide this service so additional physician time is to be contracted out. Service provision would be at the same location. The service would be provided at the same one location of the other services and would work with the provider employees as a part of an integrated team.</td><td>50%</td><td>Pharmacological Management is not a discreet service but a part of a comprehensive service package. However, even after a stable service volume has been established it may well be necessary for a provider to supplement their staffing to meet the full array of service provision required in one or more service packages.</td></tr>
<tr><td>Psychiatric evaluation</td><td>66%</td><td>4, 5*</td><td>Currently there is a shortage of physician time to provide this service so additional physician time is to be contracted out. Service provision would be at the same location. The service would be provided at the same one location of the other services and would work with the provider employees as a part of an integrated team.</td><td>50%</td><td>Pharmacological Management is not a discreet service but a part of a comprehensive service package. However, even after a stable service volume has been established it may well be necessary for a provider to supplement their staffing to meet the full array of service provision required in one or more service packages.</td></tr>
<tr><td colspan="6">5* - Please see the section <u>Long Term Planning</u> at the end of the document for a discussion regarding Preserving Critical Infrastructure</td></tr>
</table>

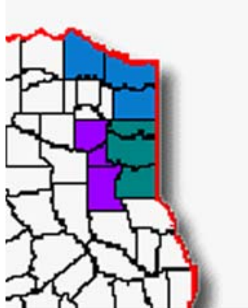
6. Structure of Procurement(s)

The table below describes how the procurement is structured with its rationale. There is a separate entry for each service or combination of services that will be procured as a separate contracting unit. The geographic area(s) are identified and shown in the map below. As noted in section "3 Service Capacity and Procurement" only 18% of adult SP1 and 30% of children SP4.0 is being procured. This extends to the geographic regions below. For example only 18% of the Adult SP1 is being procured in each region. This allows for a more effective ability to reestablish service if needed until stability of the network is established.

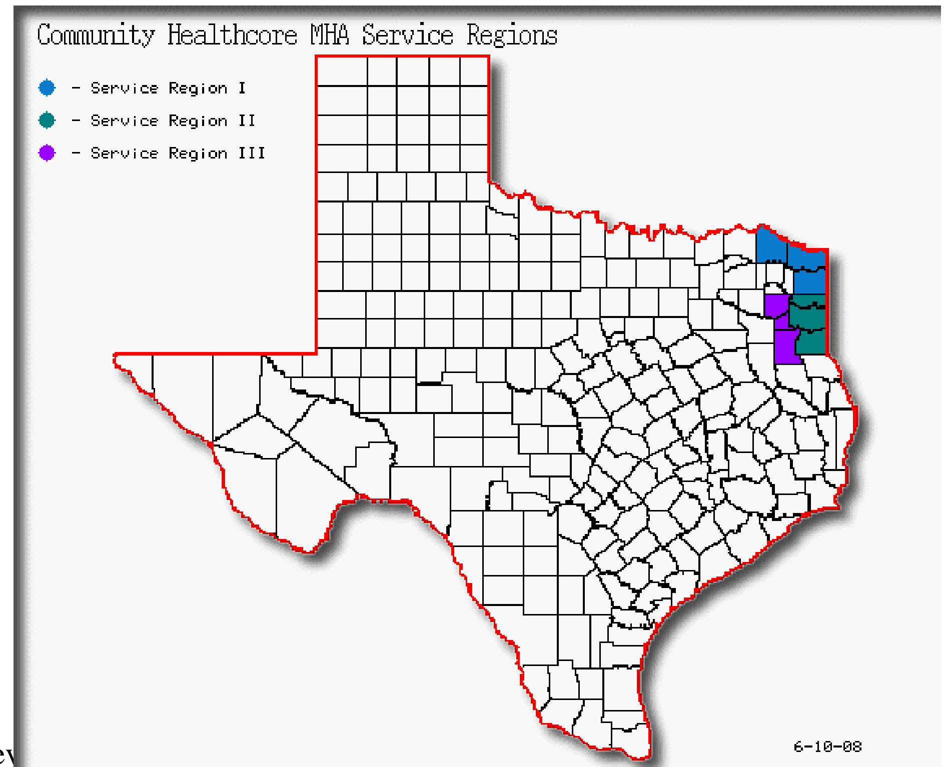
Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
Adult SP 1	Bowie, Cass & Red River	Bundle two adjoining rural counties with one larger in population.
Adult SP 1	Gregg, Rusk, & Upshur	Bundle two adjoining rural counties with one larger in population.
Adult SP 1	Harrison, Marion, & Panola	Bundle two adjoining rural counties with one larger in population.
Children SP 4	Bowie, Cass & Red River	Bundle two adjoining rural counties with one larger in population.
Children SP 4	Gregg, Rusk, & Upshur	Bundle two adjoining rural counties with one larger in population.
Children SP 4	Harrison, Marion, & Panola	Bundle two adjoining rural counties with one larger in population.

The nine-county area for Community Healthcore's MHA Service Area has been divided into the following three Regional Service Areas:

- Region I: Bowie, Cass, and Red River
- Region II: Harrison, Marion, and Panola
- Region III: Gregg, Rusk, and Upshur



This is reflected in the Maps shown to the left and right.



7. Choice and Access

Consumer choice is one of the driving reasons for LPND. It is one reason why Community Healthcore is bundling less populated counties together with counties of higher population centers. Community Healthcore desires every consumer to have choice of a comprehensive provider. After the procurement phase, Community Healthcore will work with both internal and external providers to review the choice process. As noted below under the Procurement & Transition Timeline consumer forums will be provided so individuals or their legally authorized representative are provided the information necessary to make an informed choice. Providers in the network will be listed on Community Healthcore's website and printed material in the consumers' primary language will be made available to support informed choice. After the initial transition is complete, Choice of Provider will also be provided after:

- Completion of an assessment
- Every treatment plan review

Consumers or their legally authorized representative may request a change of providers at any time.

At a minimum access will remain at the same level as currently provided by Community Healthcore. Individuals will be able to receive their services at one location and not need to travel to multiple locations to obtain their services. Services will also be provided in the same communities as currently provided. Individuals who receive their services in smaller rural settings will not be required to travel to larger communities but will be able to receive services in the same community. Individuals who may work in other regions can choose to receive their services from that location. For example, if a person lives in Panola County but works in Harrison County, they may choose whether to obtain their services in Panola or Harrison. It is also hoped that through the procurement process, external providers will open a clinic in Marion County which has been identified as a need through the needs assessment

8. Single Provider

Community Healthcore acknowledges that there are some services that will 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______

The services Community Healthcore proposes to be provided by a single provider due to economic factors which prevent the LMHA from offering consumers a choice are reflected in the table below.

Service to be Provided by a Single Provider	**Economic Factors Preventing Consumer Choice**
Crisis Hotline	Both practically and economically, it is not viable to have multiple Crisis Hotline providers.
Service Package 4 (ACT)	Community Healthcore provides services to approximately 40 persons under service package 4. The intensive service delivery model for self-contained, comprehensive wrap-around program for the number of persons served does not support providing choice of multiple providers; the cost per client is too high. The determination at this time is that with our current numbers to have only one provider available not multiple providers in one area.

9. Diversity

An essential requirement for any provider is being culturally competent. Terry Cross in his seminal monograph Towards A Culturally Competent System of Care, 1989, states "Cultural Competency is having a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable that system, agency, or professionals to work effectively in cross-cultural situations." Cultural competence is an important trait of any provider to effectively treat persons. Likewise the need for cultural competence is vital for engagement. Clear evidence of Cultural Competence will be a part of the procurement process and a requirement for any contracts. Community Healthcore will augment its ability to ensure cultural competency through the use of assessments that are available. Although no single tool has been selected yet, A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument developed by the National Center for Cultural Competence, Georgetown University Center for Child and Human Development is an example of a tool that may be used. Cultural competence training will be made available to external providers through Essential Learning or other training module used by the Center and required of all contractors. Potential

contractors must also demonstrate the ability to access necessary interpreters and translators so that linguistic diversity is not a barrier to treatment. As noted in the demographic section of this plan, the Community Healthcore nine-county catchment area has a large Hispanic or Latino population. The US Census Bureau estimates that of this 34,000 people group almost 23% (7,820 persons over the age of 5) cannot speak English well or cannot speak it at all. Therefore clear evidence that an external provider is culturally competent is important. Community Healthcore will ensure that all contractors describe in their response to an RFP how they will meet cultural competence and the MHA will monitor the compliance of their own plan.

10. Cost Efficiency

Cost efficiency has always been a part of the organizational culture at Community Healthcore. It is addressed on two fronts – efficiencies within its own operations and efficiencies gained jointly working with other organizations. Community Healthcore efficiencies are found through its organizational structure, technology, purchasing, use of grants, and consumer benefits. Its organizational structure groups mental health, addiction recovery, and children's services under one Director. This allows for more sharing of resources and an effective service delivery system. The uses of teams to effectively manage programmatic requirements and service delivery have proved useful for the day to day service needs. One such team is the CORE Team which meets on a weekly basis reviewing hospitalizations and efforts to receive a person from the State Hospital back to the community. Effective use of technology is another area of efficiency. As an early TIF grant recipient, Community Healthcore has utilized Video Conferencing to connect persons through the nine-county region for a variety of purposes. Some examples include a physician video conferencing with an addiction recovery setting, members of the Planning Advisory Committee who come to Longview video conferencing with members meeting in Texarkana, and the CORE team video conferencing with a staff person at Rusk State Hospital, team members in Texarkana, and team members in Longview. Community Healthcore utilizes a purchasing agent and accesses many different state contract programs to obtained needed goods at the best possible price. It seeks out grants that provide needed services and supports to members of our target population. Such FY08 mental health related grants include: SAMSHA = $394,590; TCOOMMI = $405,963; Dual Diagnosis = $233,496; SSA Housing = $127,845; and Emergency Shelter Grant = $57,200 for a total of $1,219,094; there are additional grants in the areas of criminal justice and developmental disabilities not included with these figures. Community Healthcore also effectively uses the Patient Assistance Program to control medication costs. Its three-person staff has assisted individuals in

obtaining a value of $1,401,260 in medications from participating pharmaceutical companies in FY07. Our benefits assistance program likewise works with consumers in helping them apply for Medicaid and other benefits. In a recent three month period, sixty-seven applications were submitted with twenty resulting in benefits to date.

Community Healthcore also works jointly with others in achieving cost efficiencies. Two primary partners are the Texas Council of Mental Health and Mental Retardation Centers, Inc. (Texas Council) and East Texas Behavioral Health Network (ETBHN). The Texas Council is our trade organization and provides needed support in effectively conducting our role as both the local mental health authority and as a provider of mental health services. Texas Council helps coordinate with other Centers and the Department of State Health Services on a number of topics including but not limited to contracts, human resources, behavioral health, quality management, and information technology. Collectively it is able to bring some of the best minds together on an issue and then share that information to members of the Texas Council. Perhaps the best use of efficiency has been Texas Council's role in supporting the new LPND initiative. Through work groups and weekly conference calls, the LPND effort has been supported saving additional costs by attempting to meet the new requirements independently of Texas Council. East Texas Behavioral Health Network is another collaborating partner that is made up of eight community centers located in East Texas. Examples of cost efficiencies through this joint effort include:

- ❖ Regionalization of Authorization Process – ETBHN completes authorization of services for Community Healthcore as well as six other services through the effective use of staff and access to each center's clinical system.
- ❖ Regionalization of Medical Director – Currently, Community Healthcore and two other centers in ETBHN share a Medical Director.
- ❖ Regional Planning and Advisory Committee – Community Healthcore participates with the other members in utilizing a stakeholder group that views issues from a regional level. This gives a broader perspective on community impact and allows consumers and their families to learn about services of other Community Centers.
- ❖ Regional Utilization Management Committee – Community Healthcore participates with other centers on the ETBHN UM Committee. This allows for more comparison between Centers and benchmarking.

- ❖ Pharmacy – The ETBHN Closed Door Pharmacy has saved Community Healthcore hundreds of thousands of dollars in reduced medication costs. In February, 2008 alone, Community Healthcore saved $15,106 through the use of the ETBHN pharmacy. Annualized this is a $190,648 savings.

Within this section on cost efficiencies it should be noted that some efficiencies are achieved through the design of the network of providers though the administrative cost are increased under LPND. External providers will be required to enter data into the Anasazi Clinical Software utilized by the center. This will allow for monitoring of service delivery, review of progress notes, and other contract requirements from anywhere that the clinical software is connected. Likewise all office-based services being provided at one location in a community will increase the ease of on-site visits at one location in a community rather than at multiple locations to review charts and verify needed documentation. Bundling services also has the benefit of sharing the cost of providing services to more rural locations across providers.

11. Previous Efforts

Community Healthcore has contracted with external providers for years albeit for discreet services or to supplement existing staffing. As noted above in ***Current Services and Providers,*** $1,190,025 was paid out to external providers in FY07. This represents 23 % of DSHS dollars spent in that same year. The current effort marks the first time Community Healthcore will be seeking comprehensive external providers who would provide a full set of services based upon service packages.

Prior efforts in building a network include a Request for Information request that was released in the spring of 2004. Four of the nineteen responses indicated an interest in providing mental health services for adults; no one expressed interest in providing mental health services for children. Of those four interested providers, one, Avail Solutions, Inc., is a current provider of Crisis Hotline and related services, and another, the Wood Group, who has contracted before with Community Healthcore, has registered through the DSHS website. The other two providers have been contacted and sent information regarding Community Healthcore's latest planning effort. As of the posting of this draft, no written interest has been submitted by either of these organizations.

12. Barriers

The dialogue at the July 7th Public Forum that included four local providers and one telephone call with an interested provider is summarized below in the shaded green section. The non-shaded areas are potential barriers identified by the Center.

Barriers	Plans
Procurement by Service Packages rather than a discreet service. Concern particularly for specialty services such as supported housing and supported employment.	Encouraged providers to develop strong alliances with other partners and perhaps develop a group. Also encouraged external providers to seek out purchasing services from specific area vendors who provide that specialty service.
Requested need for clarity regarding the billing of services. Would the external provider bill for all services or would the Center bill for all services or something in between.	In the procurement documents have clear expectations and guidelines as to what services the Center would bill on behalf of the provider and what services the external provider would bill directly. As shared at the July 7th meeting it is anticipated that Community Healthcore would only bill for on behalf of the provider those Medicaid rehabilitation services. Other services would be in the system for contract monitoring but the provider would be responsible for the direct billing.
Concerns regarding Consumer Choice i.e. is it a level playing field?	Ensure clear protocols and processes that are consistent with the rule and provide this in the procurement documents.
Expressed need for a clear Provider Manual that includes state requirements and discharge criteria and technical assistance.	Effectively communicate in the procurement documents the resources and tools that will be provided during the initial training and through ongoing training. Did assure providers that these are areas under development but that the best and official resources would be the already existing DSHS materials that the provider would be utilizing in addition to what was Center specific in its application.
Questioned if funding would be provided to the external provider for transportation to assist the individual in accessing services.	Funding is anticipated to be based on a fee for service rather than a capitated rate but this has not finalized. Funding for transportation would only be available if it was a part of the individuals plan under flexible funds. Encouraged to locate business near bus lines where available and the use of other community resources.
Questions regarding reimbursement rates, the amount of the reimbursement, and if it would be a fee for service or a capitated rate.	In the procurement documents clearly address the amount of the reimbursement and the approach. Anticipate a fee for service rather than a capitated rate but this has not been finalized. No plans to address the current Medicaid Rate established by the state of Texas.

Barriers	Plans
Some rural locations have higher costs due to distance from larger cities and lower service volume.	Future procurement cycles will increase the service volume across the geographic areas.
Procuring Service Package 1 services will result in external providers earning a low to no profit as these services typically have a high cost / low reimbursement rate. Service Packages 3 & 4 are more attractive to external providers as they better cover actual costs in service provision and can yield a profit.	In this first cycle of LPND, Service Package was selected as it has the highest service volume. This will allow for the establishment of a stable external provider network while the Center further develops its authority role for monitoring comprehensive providers. Subsequent cycles will include higher Service Packages and increase the percentage of services.

13. Attraction of Providers

Community Healthcore recognizes that a large rural catchment area with three mid-size communities (none exceeding 75,000 persons) may not be the most attractive setting for comprehensive external providers to serve. This may improve with plans for a new interstate running North and South through this area over the next twenty years. Such projects have resulted in greater growth in these areas particularly when they cross other interstate highways such as I-20 in Marshall and I-30 in Texarkana.

In public forums Community Healthcore has encouraged local providers to join together with other local disciplines to become a comprehensive service provider able to provide the full array of services necessary in a service package. This could be as a new legal entity or as a primary provider who subcontracts out specialty services. The full complement of required services as defined in the Resiliency and Disease Management and other DSHS documents, the implied complexity of the system as viewed through the DSHS documents, and the current reimbursement rates for Texas services does not appear to be a sufficient incentive at this time. Perhaps increases in the reimbursement rates and DSHS workshops that provide basic training in understanding the Texas Mental Health System held in regional locations could help offset the initial response.

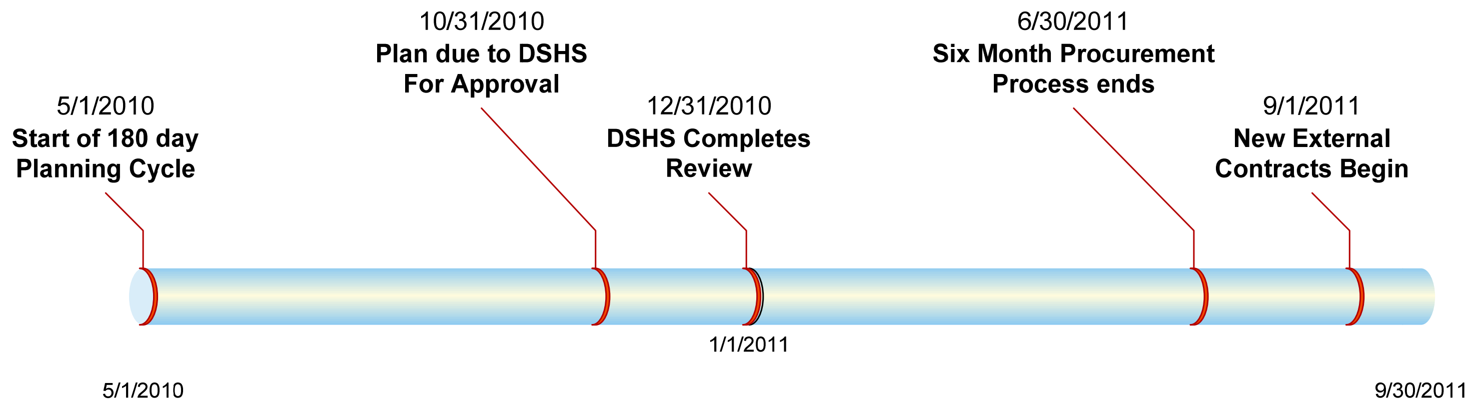
14. Long Term Planning

Community Healthcore anticipates it will learn much during the remainder of the first cycle of the new Local Planning Network Development Rule. As already described Community Healthcore will begin with SP1 for Adults and SP4 for Children. If we are successful we anticipate increasing the % of these services and contracting out SP 3 for Adults and SP 1.1 and 2.1 for Children. If we are successful during the second cycle we anticipate adding a larger percentage of services and including SP 4 for Adults in the third cycle. Again our success and provider response will drive any final plans.

Many of the items listed in the Table *Rationale for Keeping Services* utilize the reason #5 Maintaining Critical Infrastructure. The expansion of the external network can be a gradual process. Community Healthcore is taking that approach. Currently it does not conduct any Medicaid business "under arrangement". It also shares a Utilization Management Authorization Group that continues to refine its processes. Successful monitoring of external providers offsite is another benchmark. But also the Provider Network needs to prove up its ability to provide the full array of services contained within one or more service packages in rural East Texas. As reflected in the section *Time Needed to Re-establish Service Volume* some positions require a lengthy time to re-recruit during which Community Healthcore has both a legal and community responsibility to provide services. Community Healthcore will explore cooperative agreements between the MHA and external providers in re-hiring staff. However in an area in which such professionals are sought by many businesses our experience has been that staff whose employment ends due to reduced service demands move on to more secure jobs that would be outside the Center and any local comprehensive external providers. Employees have choice too and they often move to security. Our best estimate at this time for a time frame in which critical infrastructure would no longer be an issue is 10 years.

LPND Cycle for FY2010-2011

We are looking to the Department of State Health Services to help define the next cycle but anticipate that it will begin in the late spring of 2010. This cycle may look something like the timeline below.



Procurement Timeline

The table below lists the milestones in the procurement process.

Date	Key Activities and Milestones
November 1 – 30, 2008	Respond to any requests by DSHS following DSHS plan review (if needed)
May 29, 2009	Publicize draft procurement document (Public comment period – 14 day minimum)
July 15, 2009	Publication of final procurement document
October 29, 2009	Final Contracts awarded by the Board of Trustees
February 1, 2010	Services begin

NOTE: The dates highlighted in yellow have been modified per a letter dated January 30, 2009 from the Department of State Health Services.

Consumer Selection of Providers and Transitioning

The table below reflects target dates for consumer choice and selection of providers and transition activities to support this change.

Steps	Time Frames For Completion
Develop internal procedures and forms for consumer selection of providers	November 3, 2009
Develop consumer information materials relating to selection of providers	November 3, 2009
Develop a provider list	November 3, 2009
Verify provider information	November 3, 2009
Post Provider list to website and distribute to consumer and advocacy groups	November 8 – 26, 2009
Provide training to external providers re RDM, procedures, protocols, data entry system and other necessary activities for an external provider to provide services in our system.	November 1 – December 31, 2009
Ensure external providers are trained on consumer selection requirements and procedures	December 31, 2009
Conduct provider forums to allow providers to share information with consumers, LARs, and other stakeholders.	January 1, 2010 – March 31, 2010

Steps	Time Frames For Completion
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, 2010
Develop and implement continuity of care plans for transitioning individual clients to new providers	January 1, 2010 – June 30, 2010
Consumer transition complete	July 31, 2010

NOTE: The above highlighted dates have been adjusted from the original submission to match the modified procurement timeline.

Re-establish Service Volume

The table below clarifies Community Healthcore's position on re-establishing service volume in the event a provider gives notice to terminate the contract or the Center determines the need to terminate the contract.

Service	Time Needed to Re-establish Service Volume
Service Packages Adult 1 Children 4.0 All Discrete Services	Community Healthcore has established a ninety-day period to reestablish all services. Historically when clinical staff leave, Community Healthcore works quickly to continue services often by shifting existing staff and contracting for additional help including locum tenens doctors and contracting with recruiting firms. Such efforts create added workloads and unexpected costs. One of the challenges when contracting out larger portion of services in rural east Texas is the ability to reestablish services, particularly when the size of the provider side of Community Healthcore is smaller to provide choice for additional external providers. Our experience over the last two years in hiring for LPHA is an average of 20 weeks and for Physicians is an average of 18 months. This has the added feature of potential financial penalties paid to DSHS when our collective provider network effort fails to meet contractual minimums. Therefore until a strong base of external providers is established that can assist the MHA in covering unexpected lapses in service, this will remain a challenge and is not fully reflected in a "90 day standard to reestablish services".

Staff Qualifications

In addition to meeting all required qualifications as established by the Texas Administrative Code and the Department of State Health Services, individual practitioners whether employees of Community Healthcore or External Providers must meet the following:

Practitioner	Qualifications
All	Be in compliance with standards required for Community Healthcore's accreditation through the Joint Commission..

Stakeholder Comments on Draft Plan and LMHA Response

The table below summarizes the public comments received on the draft plan during the comment period. Community Healthcore posted its plan on its website beginning August 12, 2008 and accepted comments through Aug 26, 2008.

A separate line is used for each major point identified during the public comment period and the stakeholder group(s) offering the comment. Community Healthcore's response follows in the third column which results in one of three outcomes:

- ❖ Acceptance of the comment in full and subsequent corresponding modifications to the plan;
- ❖ Acceptance of the comment in part and subsequent corresponding modification to the plan; or
- ❖ Rejection of the comment. In these cases Community Healthcore will explain its rationale for this action.

Comment	Stakeholder Group(s)	LMHA Response and Rationale
Provider remains interested in providing Adult Mental Health Services for Service Package 1 - partial or total services in each package and Adult Residential Services.	Provider	Community Healthcore accepts in part comment and will send any RFP developed later in the LPND process for SP1. At this time Community Healthcore is not planning to provide Adult Residential Services either through contract or directly.

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

Appendix 25 TAC §412.758 LMHA Provider Status

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

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

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

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

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

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

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