



*Helping People Achieve Dignity,
Independence and Their Dreams™*

LOCAL PLAN & NETWORK DEVELOPMENT FY 2011-2012

Lee Brown, 903.237.2341, lee.brown@communityhealthcore.com

PROVIDER NETWORK DEVELOPMENT PLAN

Complete and submit to performance.contracts@dshs.state.tx.us according to prescribed due date:

- ◆ Cohort I: July 27, 2010
- ◆ Cohort II: July 31, 2010
- ◆ Cohort III: August 31, 2010

Refer to Information Item I in the DSHS Performance Contract for a list of LMHAs in each cohort.

Responses should be concise, concrete, and specific.

Use bullet format whenever possible, and note that many sections have character limits.

Provide information for the past two years only (since submission of your first network development plan).

When completing a table, insert additional rows as needed.

Local Service Area

- *Provide the following information about your local service area. Most of the data for this section can be accessed from the following reports in MBOW, using data from the following report: 2010 LMHA Area and Population Stats (in the General Warehouse folder)*

Population	452,094
Square miles	6,906
Population density	65
Number of counties (total)	9
◆ Number of urban counties	1
◆ Number of rural counties	8
◆ Number of frontier counties	0

Major populations centers (add additional rows as needed):

Name of City	Name of County	City Population	County Population	County Population Density	County Population Percent of Total
Longview	Gregg	76,524	119,637	122,993	27.20%

Marshall	Harrison	23,798	64,795	67,673	14.97%
Texarkana	Bowie	36,054	93,964	92,942	20.57%

Using bullet format, briefly note other significant information about your local service area relevant to provider network development. Include population characteristics that are atypical and differentiate your local services area from most other LMHAs. Distinguishing characteristics might include a high proportion of racial, ethnic, or linguistic minorities, the presence of a large military base, or other factors that must be considered in service delivery.

- ♦ Approximately 50% of the population lives in rural areas.
- ♦ A local transit system operates in the cities of Longview and Marshall; no other areas have a city bus system
- ♦ Economically the nine county area falls above the Texas State Average for Poverty.
- ♦ Approximately 6.4% of the population speaks a language other than English in the home; Spanish is the second most spoken language.

Provider Availability

1) Provider Recruitment

Using bullet format, list steps the LMHA took to identify and recruit external providers over the past two years. This includes but is not limited to procurement associated with the 2008 planning cycle.

- ♦ Issued 6 RFPs for the 2008 planning cycle. SP1 Adult for all 3 regions and SP4 Children for all 3 regions – no bids.
- ♦ Worked jointly with two other Community Centers (Andrews & ACCESS) and successfully entered into a contract with Wood Group for Crisis Respite Services using an RFP process.
- ♦ Contacted the two providers who registered on the DSHS statewide Website.
- ♦ Ran ad in Longview and Texarkana paper seeking providers interested in providing services. Held meeting on date and time as advertized and had one local person from Behavioral Hospital of Longview come and ask questions regarding the process. Was given material from DSHS website and its links. To date no defined services except Psychiatric Crisis Stabilization. Community Healthcore will send the organizational contact a link to the posted draft of the Local Plan.

2) Provider Availability

List each potential provider identified during the process described in Item 1 of this section. Include all current contractors, providers who registered on the DSHS website, and providers who submitted written inquiries over the past two years. Note the source used to identify the provider (e.g., current contract, DSHS website, LMHA website, e-mail, written inquiry). Summarize the content of the follow-up contact described in Appendix A. If the provider did not respond to your invitation within 45 days, document your actions and the provider's response. In the final column, note the conclusion regarding the provider's availability. For those deemed to be potential providers, include the type of services the provider can provide and the provider's service capacity.

Provider	Source of	Summary of Follow-up Meeting or Teleconference	Assessment of Provider
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	Identification		Availability, Services, and Capacity
Avail	DSHS Website	Conducted a teleconference follow-up call with Jamie Harwood on Wednesday, May 5. Ms. Harwood shared that in addition to Crisis Hotline, Avail was interested in providing Mobile Crisis Outreach Team (MCOT) services to counties that border Smith County, her base for services. She currently provides MCOT services for Andrews and Coastal Plains Community Centers. She expressed no desire to provide any Service Packages for either Adults or Children.	Provider is available and has provided similar services to other MHAs. Provider limited the amount of MCOT services specific to Region 3 which contains Gregg, Rusk, and Upshur counties all of which adjoin Smith County. Avail does have the capacity to provide some of the MCOT services for Region 3.
Wood Group	DSHS Website	Conducted a teleconference follow-up call with Jerry Parker on Wednesday, May 5. Mr. Parker shared that Wood Group was interested in providing SP3 services. Shared with Mr. Parker the values from the first cycle of planning including the use of 3 catchment areas, providing services in the same city as they are currently received; provided at one location rather than multiple locations, and the use of comprehensive provider. Mr. Parker stated he would need 65 to 75 persons to make it financially work for him. He noted that he would be willing to provide SP1 services for 50 persons in addition to SP3. Mr. Parker noted the difficulty in more rural areas to contract out SP3 as there is not the volume. He also acknowledged that clients would need to choose Wood Group. Mr. Parker is not interested in providing Children Services.	Provider is available and has provided similar services to other MHAs. Provider limited the amount of SP1 services; it was not a proportionate share. Region 3 is the only region that would have sufficient volume for SP 3 services and still retain a choice and safety net for the center.

Local Planning

Guidelines for Gathering Community Input

- CONDUCT THE PROVIDER ASSESSMENT BEFORE GATHERING INPUT FROM THE COMMUNITY.
- The scope and focus of community input will depend on the availability of external providers.
- Seek guidance on network development based on your knowledge of provider availability at the time.
- Information presented in this section of the plan should be specific to the network development plan. Ensure that stakeholders understand the statutory mandate to develop the provider network when qualified providers are available. Community input should be focused on how to use available external capacity based on local needs and priorities.
- If an LMHA has no interested providers, community input should be focused on other elements of the plan (e.g., reducing identified barriers to new providers, on potential strategies for attracting external providers, improving consumer access and choice)
- When gathering input, use the previous plan as the starting point for discussion, including the plans for procurement and the results.
- Before finalizing your plan, review the DSHS website to identify any additional potential providers.

3) **Status of provider availability assessment**

Does the final assessment of provider availability documented above match the information about provider availability on hand at the time of community input?

Yes No

If no, briefly describe the difference.

N/A

4) **Community Engagement**

In the chart below, show the process used to provide information and solicit input about provider network development from stakeholders.

Include specific events as well as activities that take place over a period of time, such as surveys. Note that a variety of communication formats may be used, including telephonic, electronic, and paper. List surveys and similar activities first, including timeframes during which the activities took place, followed by events in date order. Insert additional rows as needed.

Description, Location/Format,	Participating Organizations	Summary of Input Briefly summarize input relating to the network development plan. If the LMHA has	Number of Individuals
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			C	F	O
6/14/09	NAMI Chapter Meeting & Self Advocates	<ul style="list-style-type: none"> Continue to divide the Catchment area into 3 regions provided Provider can apply for all. This would reduce their travel and may increase Provider participation. Each of the 3 counties in a region are a good mix; both city and rural. Support all services provided at same location and receive in same city as now. Do not want to penalize clients or families to drive further than now. Could be closer. Want Provider to have same level of quality as Community Healthcore therefore Joint Commission of the Provider should be expected; don't want to drop a standard. Mixed in that some believed should have at start; others voiced a process with steps with accreditation in a year. Regarding Adult SP1 & SP3 – needs to be patient oriented. Participants believed there needs to be a choice in each region but only Region 3 appears to have volume to provide for two Providers. One suggested the providing 50% of SP3 where others were less forthcoming to put out half of the services in a region. Regarding contracting out MCOT services – would prefer to focus on Adult SP1 and SP3 rather and not include MCOT at this time. 	3	7	1
	Homeless Consortium	<ul style="list-style-type: none"> Did not meet as planned during the Community Input period. 			

5) **PNAC Involvement**

Show the involvement of the Planning and Network Advisory Committee (PNAC) in the table below. PNAC activities should include input into the development of the plan and review of the draft plan. Briefly document the activity and the committee's recommendations.

Date	PNAC Activity and Recommendations
2/4/2010	Reviewed with the Comprehensive Planning and Network Advisory Committee (CPAC) the changes in the revised LPND process. Also discussed the timetable for the LPND process with a submission date of July 27, 2010. Noted that the most feedback from the first cycle came from the NAMI, NAMI Self-Advocates, and Homeless Consortium.
6/3/2010	<p>The CPAC reaffirmed key elements from the first local plan including: use of 3 regions with one larger populated county with two smaller counties, that the Provider must provide all of the services at the same location within the city, and that location would be in the same city as where the client currently receives services.</p> <p>The CPAC discussed the response to the Provider Assessment. They reaffirmed a transition that builds the network over a period</p>

	of time. They supported the inclusion of SP3 with SP1 for this cycle provided they were a qualified provider. They also recommended limiting the number of SP3 in Region 3 (Gregg, Rusk, and Upshur Counties) to 30%; this would shorten the time period for reestablishing services if needed and would support a gradual transition. The CPAC also recommended lowering the SP1 requirement to 20% of persons served to encourage Provider participation.
7/7/2010	The Regional Planning and Network Advisory of the East Texas Behavioral Health Network reviewed the Local Plan at its meeting on July 7, 2010. The only comment was that the Center delivers great services and is in the best position to be the provider of choice. It was explained that, due to the Network Development, we needed to extend invitations to other providers in the community that may be able to provide services to our consumers. The plan was approved with no further comment.
7/8/2010	The CPAC reviewed the plan and noted the one comment received to date regarding the plan. Mr. Brown noted that if there were additional comments that these would be added to page 24. There was no more changes proposed to the plan and a motion was approved to forward the plan to the Board of Trustees for acceptance.

Provider Network Development

6) Contract Expenditures

Complete the table below. Total DSHS funding is the amount described as Total Allocation from Section VIII Budget of the DSHS Performance Contract. The Federal Rehab is equal to the amounts received as 100% payment from Medicaid less the General Revenue that is State match. These amounts should be added to arrive at the total for Adult MH and Child/Adolescent MH Services. For FY 2010 data, provide information from the first six months of the year (September 2009 through February 2010).

SERVICE CATEGOR Y	Total DSHS funding and Federal Rehab 2007*	External provider contract expenditures 2007		Total DSHS funding and Federal Rehab 2008*	External provider contract expenditures 2008		Total DSHS funding and Federal Rehab 2009*	External provider contract expenditures 2009		Total DSHS funding and Federal Rehab 2010* (6 months)	External provider contract expenditures 2010 (6 months)	
		Dollars	%		Dollars	%		Dollars	%		Dollars	%
Adult MH	\$5,604,456	\$1,240,020	22%	\$6,387,978	\$1,285,348	20%	\$6,233,748	\$1,186,069	19%	\$2,911,603	\$450,778	15%
Child/Adol	\$1,407,737	\$206,947	15%	\$1,382,643	\$188,523	14%	\$1,571,191	\$159,680	10%	\$785,791	\$84,754	11%
TOTAL MH	\$7,012,193	\$1,446,967	21%	\$7,770,621	\$1,473,871	19%	\$7,804,939	\$1,345,749	17%	\$3,697,394	\$535,532	14%
Breakout of CONTRACTED												
Medication		\$232,242	16%		\$304,963	21%		\$288,118	21%		\$121,776	23%
Physician		\$526,661	36%		\$459,056	31%		\$352,735	26%		\$160,412	30%
Counselor		\$7,065	0%		\$25,180	2%		\$24,960	2%		\$9,835	2%
Crisis		\$174,034	12%		\$269,539	18%		\$289,915	22%		\$167,604	31%
Residential			0%			0%		\$0	0%		\$0	0%
Inpatient		\$441,819	31%		\$367,105	25%		\$344,232	26%		\$70,596	13%
Other (list):		\$65,146	5%		\$48,028	3%		\$45,789	3%		\$5,309	1%
			0%			0%			0%			0%
			0%			0%			0%			0%
TOTAL		\$1,446,967	100%		\$1,473,871	100%		\$1,345,749	100%		\$535,532	100%

* Total DSHS funding and Federal Rehab amounts includes funding for the Authority functions of the LMHA, as well as the state match for Case Management, which may not be performed by any entity other than the LMHA.

** Include only contracts for physician and counselor services with no other associated services. These will generally be contacts with individual practitioners or groups of individual practitioners. List contracted service packages separately, even though they include physician and counseling services.

Note: The successful management of crisis services through MCOT services and the additional resources in Bowie County has resulted in much lower Inpatient Costs in FY2009 and YTD FY2010. We have also successfully recruited Psychiatrists reducing our Physician costs.

7) FY 2010 Provider Contracts

List your FY 2010 Contracts in the table below. In the Provider Type column, specify whether the provider is an organization or an individual practitioner.

Provider	Service(s)	Provider Type	Dollars Allocated
Salmon Nutrition Concepts	◆ Dietitian	Individual	\$5,620

Louis Morgan Drug #4	♦ Pharmacy Services	Organization	\$160,000
ETBHN	♦ Medical Director	Organization	\$15,000
Harrison Co. Sheriff's Dept.	♦ MH Deputy	Organization	\$27,000
Gregg Co. Sheriff's Dept.	♦ MH Deputy	Organization	\$103,374
Texoma Beh. Health Center	♦ Crisis Stabilization	Organization	\$75,000
Andrews Center	♦ Crisis Respite Beds	Organization	\$6,000
Med. Center of McKinney	♦ Crisis Stabilization	Organization	\$40,000
Ark-Tex Council of Gov.	♦ Client Transportation	Organization	\$1,000
Vickie Sheaffer	♦ Project Evaluation	Individual	\$12,000
Excel Staffing	♦ Temporary Nurses	Organization	\$7,000
Glen Oaks Hospital	♦ Crisis Stabilization	Organization	\$360,000
Champion EMS	♦ Crisis Transportation	Organization	\$25,000
ETMC Beh. Health Center	♦ Crisis Stabilization	Organization	\$300,000
JSA Health, LLC	♦ Telemedicine	Organization	\$4,000
Avail Solutions, Inc.	♦ On-Call Crisis Services	Organization	\$156,000
Imelda Salazar	♦ Spanish Translator	Individual	\$2,000
Brian Ivey	♦ Sign Language Translator	Individual	\$1,000
E.T. Center of Independent Living	♦ Sign Language Translation	Organization	\$2,000
Quest Diagnostics	♦ Lab Testing	Organization	\$10,000
John Hall, MD	♦ Adult Psychiatrist	Individual	\$176,640
David Brown, MD	♦ Children Psychiatrist	Individual	\$215,000
Frank Murphy, DO	♦ Adult Psychiatrist	Individual	\$14,000
Eilene Jones	♦ Counselor	Individual	\$33,000
Caroline James	♦ Counselor	Individual	\$7,280
Maria Carroll	♦ Spanish Translation	Individual	\$5,000

8) Current and Planned Network Development

Complete the following table. Leave cells blank if the percent is 0.

- *Column A: Document current capacity for all service packages, regardless of past or planned contracting. Current service capacity is the average monthly capacity based on service data from FY 2009 and FY 2010 through the most recent closed quarter for services controlled by the DSHS contract. Capacity for service packages is expressed as the number of clients served; use the following DSHS data warehouse report to determine current service capacity: PM Service Target LPND (Enterprise: CA Utilization Mgt: UM Service Delivery: PM Service Target LPND). If projected capacity is significantly different than current capacity, insert a footnote noting the projected capacity.*
- *Column B: State the percent of total capacity contracted to external providers in FY 2009. This is the maximum capacity to be served by external provides according to the terms of the contract.*
- *Column C: Document the percent of capacity served by contractors in FY 2009; this is the actual capacity served by contractors.*
- *Column D: State the current percent of total capacity contracted to external providers for FY 2010. This is the maximum capacity to be served by external provides according to the terms of the contract. .*
- *Column E: Document the percent of capacity served by contractors in the first six months of FY 2010 (September 2009 through February 2010); this is the actual amount paid to external providers during this period. When calculating percentages, use six month figures in both the numerator and denominator.*
- *Columns F and G: If you will be procuring complete service packages in the next biennium, state the percent of current capacity planned for contract in 2011 and in 2012.*
- *Column H: Note the number of available providers based on your provider assessment documented in the previous section.*
- *Column I: Use the following list to identify the number of the applicable condition that justifies the level of service the LMHA will continue to provide internally. Include all conditions that apply. Refer to the Appendix B 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. Use this condition if only one external provider is interested in contracting with the LMHA, and the LMHA will therefore provide up to 50% of the service. This condition does not justify the LMHA providing more than 50% of services.*
 3. *The external network does not provide equivalent access to services. Use this condition if access is the only reason the LMHA will not use all of the available external capacity. Applicability of this condition will probably be made after procurement.*
 4. *The external network does not provide sufficient capacity. Use this condition if the LMHA will use all of the available external provider capacity and directly provide only the balance of current capacity.*
 5. *Critical infrastructure must be preserved during a period of transition. Use this condition if the LMHA will not use all of the available external provider capacity. Instead, the LMHA plans a phased transition to full utilization of external provider capacity, increasing the volume of contracted services over two or more planning cycles.*
 6. *Existing agreements restrict procurement or existing circumstances would result in substantial revenue loss. Use this condition if an external restraint is the controlling factor limiting full use of external provider capacity.*

PAST and CURRENT	PLANNED
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	A	B	C	D	E	F	G	H	I
Service	Current service capacity	Percent of total capacity contracted in FY 2009	Percent total capacity served by contract providers in FY 2009	Percent of total capacity contracted in FY 2010	Percent total capacity served by contract providers in FY 2010 (6 mo)	Percent of total capacity planned for contract in FY 2011	Percent of total capacity planned for contract in FY 2012	Number of available providers	Applicable condition
Adult Service Packages									
Adult RDM SP 1	2395					*12.48%	12.48%	1	2, 5
Adult RDM SP 2	9								1
Adult RDM SP 3	256					**16.02%	16.02%	1	2, 5
Adult RDM SP 4	40								1
Adult RDM SP 0	166								1
Adult RDM SP 5	11								1
TOTAL Adult Services	2877								
Child Service Packages									
Children's RDM SP 1.1	254								1
Children's RDM SP 1.2	17								1
Children's RDM SP 2.1	0								1
Children's RDM SP 2.2	6								1
Children's RDM SP 2.3	2								1
Children's RDM SP 2.4	0								1
Children's RDM SP 4	205								1
Children's RDM SP 0	16								1
Children's RDM SP 5	1								1
TOTAL Children's Services	498								

* SP1 = 20% for Region 3

** SP3 = 30% for Region 3

Use the following table to list any discrete routine services or crisis services with contracting activity (2009, current, or planned) OR interested providers.

- Leave cells blank if the percent is 0.
- Current service capacity is the average monthly capacity based on service data from FY 2009 and FY 2010 through the most recent closed quarter for services controlled by the DSHS contract. Capacity for discrete services is expressed as units of service delivered.

PAST and CURRENT						PLANNED			
	A	B	C	D	E	F	G	H	I
DISCRETE ROUTINE SERVICES And CRISIS SERVICES	Units of service delivered in 2009	Percent of total capacity contracted in FY 2009	Percent total capacity served by contract providers in FY 2009	Percent of total capacity contracted in FY 2010	Percent total capacity served by contract providers in FY 2010	Percent of total capacity planned for contract in FY 2011	Percent of total capacity planned for contract in FY 2012	Number of available providers	Applicable Condition
Psychiatric Crisis Stabilization	596	100%	100%	100%	100%	100%	100%	5	N/A
Crisis Hotline	8,066	100%	100%	100%	100%	100%	100%	1	N/A
Crisis Respite	0	New Service	N/A	100%	100%	100%	100%	1	N/A

9) Rationale for LMHA Service Delivery

- a) Describe the rationale for your plan for network expansion, including the services to be procured and the volume of services to be procured. If only selected services are identified for procurement, explain why those services are being offered for contracting and others are not. Discuss services for adults and for children and adolescents separately.

Community Healthcore's plan is to continue to divide the nine-county area into three regions with a larger county bundled with two smaller counties to help distribute expense but also not to require a Provider to serve all nine counties. Services would be proportional in each of the three counties within a Region so a Provider would share the cost in serving rural areas. So that a person is receiving all of their services through one provider for better coordinated care, all providers would need to provide all services in a SP including add-ons. Given our rural nature and limited transit system, services provided would need to be at the same location within a city and in the same city as the client is currently receiving; i.e. a client currently receiving services in Henderson (Rusk County) would not be forced to drive to Longview (Gregg County) for services. So that providers have the same level of quality as Community Healthcore, providers would need to follow Joint Commission standards immediately and be independently Joint Commissioned within a year. To minimize cost Providers will need to utilize the Anasazi Clinical System for data entry and billing to allow for remote monitoring of client services same as with the internal provider.

Service Package	<u>Region 1</u> Bowie, Cass & Red River	<u>Region 2</u> Harrison, Marion & Panola	<u>Region 3</u> Gregg, Rusk & Upshur	Total
Service Package 1 Adult	659	325	1,497	2,481
Service Package 3 Adult	78	53	137	268
Total Persons	737	378	1634	2,749

Only SP1 and SP3 for Adults will be procured. There was no Provider Availability for Adult SP2 or SP4 or for Children/Adolescents services. Given Provider Availability was for SP3 and a request for 65 only Region 3 provides sufficient numbers to provide and still maintain choice, maintain critical infrastructure, and the ability to reestablish services if needed. Actual numbers are as follows: SP1, 20% = 299; SP3, 30% = 41. These numbers were selected as a fair balance and sufficient enough for a Provider to establish a service.

b) *If the LMHA will continue to provide one or more services because the external network does not provide equivalent access (Condition 3), describe how this determination was made, including the source of data. NOTE: The LMHA must have supporting documentation that can be submitted to DSHS when requested.*

N/A

c) *If the LMHA will continue to provide one or more services because the external network does not provide sufficient capacity (Condition 4), complete the following table. Use this condition if the LMHA will use all of the available external provider capacity and directly provide only the balance of current capacity. External provider capacity is usually determined through the follow-up contacts that take place during the provider availability assessment.*

Service	Capacity Needed	External Provider Capacity	Information and Method Used to Determine External Network Capacity
SP2	9	0	No active response during Provider Assessment Phase
SP4	40	0	No active response during Provider Assessment Phase
SP0	166	0	No active response during Provider Assessment Phase
SP5	11	0	No active response during Provider Assessment Phase
Children Services	498	0	No active response during Provider Assessment Phase

d) *If the LMHA will continue to provide the specified capacity of one or more services in order to preserve critical infrastructure to ensure continuous provision of services (Condition 5), identify the planned transition period and the year in which the LMHA anticipates procuring the full external provider capacity currently available. If the same transition period is planned for all services, only one entry is required. When different transition periods are planned, list each separately.*

NOTE: The rule states that this condition can be used only when the LMHA identifies 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. This timeframe is the LMHA's best estimate based on the limited information currently available, and does not represent a firm commitment. The timeframe will be reassessed during each planning cycle based on the results of procurement, provider performance, and new information. The current estimate should assume that proposed procurement plans are successful and the contractors prove to be stable providers and meet established performance standards.

Service	Transition Period	Year of Full Procurement
SP1 & SP3	2011-2018	2018 for the Provider to achieve 50% of the service capacity in all three regions of both bundled services as only one provider has expressed an interest to date. This achieves the gradual transition planned by the CPAC.

- e) *If the LMHA will continue to provide one or more services because existing agreements restrict procurement or existing circumstances would result in substantial revenue loss (Condition 6), briefly describe each of them, including the end date of any agreement. Describe any steps taken to amend the agreements or alter the conditions to allow contracting. NOTE: LMHA may be asked to submit copies of agreements or other supporting documentation.*
- ♦ N/A

10) Rationale for Volume of Services Provided by the LMHA to Preserve Financial Viability

If the percentage listed for any service is based on a determination that the service provision by the LMHA would not be financially viable at a lower level, explain the budget analysis used to arrive at the specified volume. Enter NA if you have no interested providers or if the volume of services to be provided by the LMHA is not higher than it would otherwise be to ensure financial viability. NOTE: Supporting documentation may be requested.

N/A

11) Strategies to Protect Critical Infrastructure

In bullet format, briefly describe the strategies will you implement to protect critical infrastructure and promote a stable, successful provider network. Enter NA if you have no interested providers.

- ♦ Community Healthcore will continue to provide services until there is a sufficient network of providers to provide all of the needed services.
- ♦ A portion of services will be put out for bid such that (1) choice of two providers is offered and (2) services can be reestablished in a reasonable time since there appears to only be one provider offering services.
- ♦ Provider manuals will be provided to supplement the DSHS guidelines and address Center specific processes.
- ♦ Utilization Management will authorize all services and look for any developing patterns in service requests.
- ♦ Quality Management staff will monitor service delivery through data entered into the Anasazi Clinical System and site visits. Client Outcomes will be reviewed and compared to across providers.
- ♦ Periodic Provider Meetings will be held to discuss system issues and address any concerns either by the Provider or the Center.

12) Time to Re-establish Lost Service Capacity

Estimate the amount of time needed to re-establish the service volume lost if a contract is terminated. If time varies depending on the service type, list each separately. Enter NA if you have no interested providers.

Service(s)	Time Needed to Re-establish Service Volume
Adult SP1 & SP3	<ul style="list-style-type: none"> • A Locum Tenens Psychiatrist (a more expensive model) will be sought immediately and based upon availability should be from 60 to 120 days. A Full-time doctor typically requires 365 days for recruitment, hiring and training. • Other clinical staff will take from 60 days to 120 days to recruit, hire, and train. Existing staff will pick up what capacity they can but for 340 covered lives Center would not have capacity to meet needs without hiring additional staff.

Procurement

13) Structure of Procurement(s)

In the table below, describe how the 2012 procurement will be structured, making a separate entry for each service or combination of services that will be procured as a separate contracting unit. Enter NA if you have no interested providers.

- ♦ Note the method of procurement: competitive procurement (RFP) or open enrollment (RFA).
- ♦ Identify the geographic area(s) in which the service will be procured, and the percent of your clients living in the designated geographic area. Specify whether an external provider will be required to cover the entire area. If an external provider will be permitted to contract for services in only a portion of the identified area, note how the area may be partitioned.
- ♦ Describe the rationale for how the procurement will be structured. In the rationale the following issues must be addressed:
 - Method of procurement (competitive vs. open enrollment)
 - procurement of discrete services rather than service packages (provide a separate rationale for each discrete service)
 - bundling of services or service packages
 - service area (whether the entire local service area is included or only selected counties, and choice of individual counties)

Date(s)	Method (RFA or RFP)	Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Percent of Clients	Rationale
2011	RFP	Adult SP1 & SP3	Region 3: Gregg, Rusk, and Harrison County	SP1/20% SP3/30%	Determined that use of Service Packages was the best for consumers so one entity is providing comprehensive services.

					No expressed interest in Children Services. Provider needs a critical mass, but Center must also maintain a strong presence until Provider fully established i.e. gradual transition. Only Region 3 meets this criterion as it is our largest of our three regions both by population and persons served. Services would be bundled so that SP1 and SP3 services are both provided. Provider must also provide a volume of SP1 services in addition of SP3. Services would also be provided at all three locations within Region 3 so clients would not need to travel from one county to a different county. CPAC determined that 299 persons in SP1 and 41 persons in SP3 in largest region would be best balance in meeting Providers needs and Centers transitional needs. Believed that RFP would allow a better evaluation to select one Provider.
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14) Fidelity and Continuity of Care (complete only if discrete services will be procured).

If you plan to procure discrete services (rather than full service packages), describe how you will maintain fidelity and continuity of care in the provider network. The content of this section describes what changes or additions will be made to your standard process to address the additional fragmentation that can occur when services for a single consumer are provided by multiple contractors, often in multiple locations. Enter NA if you have no interested providers or plan to procure service packages only.

Community Healthcore plans to procure service packages only. Discrete services will be procured for standalone services as listed in Section 8 but not for Service Packages. Community Healthcore does contract out as needed to fill clinical gaps within a service package but the contractor works onsite with other Center staff as a team providing a comprehensive service package.

15) Enhanced Staff Qualifications

Do you require any individual practitioners to meet higher standards than those described in the DSHS performance contract?

Yes No

If yes, identify the practitioner(s) and the specific qualifications. Enter NA if you have no interested providers.

- ♦ To work for an organization that will achieve Joint Commission Accreditation within a year.

Consumer Choice

16) Single Provider

List all services to be provided by a single provider (regardless of provider availability) and the reason(s) for not offering consumers a choice of providers. Identify any economic factors involved in the decision. Enter NA if you have no interested providers.

Service to be Provided by a Single Provider	Reason(s) for Limiting Client Choice
Adult SP2, SP4, SP0, & SP5	Provider Assessment yielded no interested Providers
Children Services	Provider Assessment yielded no interested Providers
Crisis Hotline	Need to have only one central contact to coordinate all Crisis calls
Crisis MCOT	Continue Center responding to calls to facilitate continuity for SP0 and SP5 follow-up, maintain gains from management of Hospital Inpatient services, and to maximize local funds for crisis services.

17) Choice and Access

Using bullet format, briefly describe plans for maximizing consumers' choice of providers and access to services, including relevant procedures, procurement specifications, and contract provisions.

- ◆ Bundle less populated counties together with counties of higher population so every consumer has a choice of a comprehensive provider.
- ◆ Consumer forums will be provided information to facilitate an informed choice by clients.
- ◆ Providers in the network will be listed on the Center's website and printed material in the client's primary language will be made available to support choice. Choice of Provider will also be provided after completion of an assessment and every treatment plan review.
- ◆ Clients may change providers at any time but if a pattern emerges where the client is frequently changing back and forth between providers such that it is interfering with treatment, a time period may be imposed to remain with a provider before a new change will be allowed.
- ◆ Clients will be able to receive their services at one location and not need to travel to multiple locations for their services.
- ◆ Services will also be provided in the same communities as currently provided so clients do not need to travel to a location further away.

18) Diversity

Using bullet format, briefly describe how the LMHA will ensure its provider network meets the diverse cultural and linguistic needs in the local community. Include relevant standards, procedures, procurement specifications, and contract provisions.

- ◆ Cultural competence training will be required and made available through Essential Learning; all clinical staff must demonstrate competence in this area prior to being eligible to provide services and must maintain eligibility as specified in the training guidelines.
- ◆ Provider must provide interpreters meeting any DSHS specified standards when communicating with clients who cannot speak English.

Capacity Development

19) Cost Efficiency

Using bullet format, list steps taken in the past two years to minimize overhead and administrative costs and achieve purchasing and other administrative efficiencies. Do not report efforts included in the 2008 network development plan.

In addition to the significant number of administrative efficiencies mentioned in the Local Plan and Network Development 2009-2010, Community Healthcore has initiated the following administrative efficiencies. In conjunction with the East Texas Behavioral Healthcare Network:

- ◆ A regional Wide Area Network (WAN) and televideo between sites has been installed to allow for less administrative time in traveling to regional oversight committees.
- ◆ The WAN has permitted training to be offered to regional centers with required travel time.
- ◆ Using the WAN for long distance calling between centers.
- ◆ Regional grant writing committees have been actively writing grants for centers in the region.
- ◆ The Region is collaborating on regional grants.
- ◆ SPQM for Utilization Management Services (purchased for each center and a regional model for benchmarking).
- ◆ Using SharePoint for pharmacy communications and storage data.
- ◆ Veteran’s Competitive Grant – ETBHN was awarded two of these (one for our Northern centers and one for the Southern centers).

Community Healthcore has also implemented the following initiatives:

- ◆ Received funding from the Christus Fund and implement a successful crisis treatment approach that reduced the client time in emergency rooms in Bowie County; currently seeking similar funding for Gregg County.
- ◆ Expanded scanning capabilities to utilize more electronic imaging and reducing paper filing and paper records; move closer to a fully electronic medical record.
- ◆ Installing Voice Over IP to improve communication within nine county catchment area and eliminate long distant costs.
- ◆ Working with Clinical Software Vendor to implement Doctors Home Page.
- ◆ Working with two local Federally Qualified Health Centers to create medical homes and provide transition from Center services to local physician services.
- ◆ Collaborating in a Peer Review with other national Mental Health Providers to improve services and system efficiencies.
- ◆ Consultation with MTM Services to improve access and better manage service capacity.

List partnerships with other LMHAs related to planning, administration, purchasing and procurement or other authority functions, or service delivery. Include current, ongoing partnerships (regardless of date established) and time-limited activities that occurred over the past two years.

Start Date	Partner(s)	Functions
July 1997	ETBHN Centers	UM Authorizations, Medication Purchasing, Regional Planning Network Development Committee, Grant Procurement, Regional Medical Director, Training,
2009	Andrews & ACCESS	Created relationship to promote peer relationships, collective brainstorming

		and information sharing, shared cost in staff development, and jointly collaborated and share cost in Crisis Respite services.
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Identify any current efforts and plans to develop new opportunities for working jointly with other LMHAs.

- ◆ As listed above, many activities are underway with ETBHN
- ◆ Exploring website development for all centers
- ◆ Data scanning and storage solutions
- ◆ Creating own telemedicine capability – possible collaboration with JSA Health
- ◆ Possible training partner with a firm in Longview, Texas
- ◆ Email encryption partnering
- ◆ Veteran’s Summit in Round Rock this Fall
- ◆ Exploring combined health insurance for all ETBHN Centers
- ◆ Joint ETBHN retreat to explore additional opportunities

20) Previous Network Development Efforts

In the table below, document your procurement activity over the past two years.

- ◆ *List each service separately, including the percent of capacity and the geographic area in which the service was procured.*
- ◆ *State the results, including the number of providers obtained and the percent of service capacity under contract. If no providers were obtained as a result of procurement efforts, please note under results.*

Procurement (Service, Capacity, Geographic Area)	Results (Providers and Capacity)
Adult SP1, 18%, Bowie, Cass & Red River	No bids
Adult SP1, 18%, Harrison, Marion & Panola	No bids
Adult SP1, 18%, Gregg, Rusk & Upshur	No bids
Children SP4, 30%, Bowie, Cass & Red River	No bids
Children SP4, 30%, Harrison, Marion & Panola	No bids
Children SP4, 30%, Gregg, Rusk & Upshur	No bids

List the comments you received after posting the draft procurement documents during the 2008 planning cycle, and how you responded to the comments, including any modifications made to the procurement document.

Comment or Suggestion	LMHA Response
Provider remains interested in providing Adult Mental Health Services for Service Package 1 - partial or total services in each package and Adult Residential	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

Services.	planning to provide Adult Residential Services either through contract or directly.
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In bullet format, list specific steps taken over the past two years to develop the LMHA's internal capacity to develop and manage the external provider network. The scope of activity should be appropriate to the level of interest from external providers.

- ◆ Established procurement documents for future services.
- ◆ In 2010 collaboratively issued an RFP for Crisis Respite which addressed comment for Adult Residential Services. Currently monitoring services of external provider and evaluating the results.

21) Barriers

Identify the barriers you encountered when trying to recruit external providers, including any local circumstances that make recruitment difficult. Describe how you plan to address each barrier or reduce its impact during the 2012 procurement.

The following barriers were identified by providers during the first LPND cycle.

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.
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 will be based on a fee for service rather than a capitated rate. 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 using a fee for service approach based off of the Medicaid Rates.

Some rural locations have higher costs due to distance from larger cities and lower service volume.	Can only say that Providers must be willing to share the cost of doing business. Did not require a Provider to provide services across nine counties but created 3 geographic regions so a Provider could limit the scope of the geographic region served.
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.	Continue to provide a mix of services to help offset expenses but did reduce the # of SP1 from 30% to 20% to make more profitable.

22) Long Term Planning

Note: Long term plans are based on the limited information currently available, and will be reassessed during the next planning cycle; they do not represent a firm commitment.

If the LMHA is continuing to provide services in order to protect critical infrastructure, briefly describe your plan for transitioning to full utilization of the service capacity being offered by external providers. Assume that proposed procurement plans are successful and the contractors prove to be stable providers and meet established performance standards. The plan must include a target date for the transition and measurable objectives for each procurement period.

If your proposed procurement is successful, what are your current plans for expanding the external provider network during the 2012 cycle? Identify the services and general volume capacity you are considering for procurement in the next planning period. If this information is documented in your critical infrastructure transition plan, simply reference it. Enter NA if you have no interested providers.

- ◆ Community Healthcore will learn much if successful in recruiting a Provider for Service Packages 1 and 3. If we are successful and with the successful performance by the provider(s) we anticipate increasing the % of these services. If we are successful during the second cycle we anticipate adding a larger percentage of services and including other services such as Children Services. Again our success and provider response will drive any final plans.
- ◆ Please revisit the items listed (11) *Strategies in Maintaining Critical Infrastructure*. The expansion of the external network can be a gradual process. Community Healthcore is taking that approach.
- ◆ 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 (12) *Time to Re-establish Lost Service Capacity*, 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 after a successful cycle of contracting out services.

23) Public Comment

Using bullet format, list the steps you will take to publicize and get public comment on the draft network development plan. Include outreach and activities directed to consumers, local advocacy groups, and potential providers.

- ◆ The Draft Plan will be posted on the Community Healthcore Website for public comments.
- ◆ An announcement and link to the plan will be emailed to each provider who expressed interest.
- ◆ An announcement and link to the plan will be emailed to the NAMI and the NAMI Self Advocate respective contact with a request to forward to their membership.
- ◆ The CPAC will review the Draft Plan and any comments received to date.

Implementation

24) Procurement Timeline

Provide your procurement timelines in the following table. Allow at least 14 days for public comment to the draft procurement instrument. If more than one procurement is planned, provide a separate timeline for each (copy and paste additional rows to the table). Enter NA if you have no interested providers.

Date	Key Activities and Milestones
10/15/2010	Draft procurement document (RFP) posted for public comment (at least 14 days)
11/15/2010	Publication of final procurement
1/15/2011	Due date for procurement responses
2/24/2011	Award date by the Board of Trustees
3/1/2011	Begin work with selected Provider for contract, transition of services and provide training.
6/1/2011	Contract start date

25) Consumer Transition

Provide your consumer transition timeline in the following table. If more than one procurement is planned, provide a separate timeline for each (copy and paste additional rows to the table). Enter NA if you have no interested providers.

Date or Timeframe	Key Activities and Milestones
3/15/2011	Date provider list will be posted to website and distributed to consumer and advocacy groups
4/15/2011	Timeframe for hosting provider forums to allow providers to share information with consumers
5/1/2011	Date to begin offering consumers choice of providers in the new network
Initially 30 days, ongoing	Period of time given to consumers to select provider
30 to 90 days	Timeframe for transitioning current clients to new providers

Stakeholder Comments on Draft Plan and LMHA Response

Allow 14 days (minimum) for public comment on draft plan.

In the following table, summarize the public comments received on the draft plan. Use a separate line for each major point identified during the public comment period, and identify the stakeholder group(s) offering the comment. Describe the LMHA's response, which might include:

- ◆ Accepting the comment in full and making corresponding modifications to the plan;
- ◆ Accepting the comment in part and making corresponding modifications to the plan; or
- ◆ Rejecting the comment. Please explain the LMHA's rationale for rejecting the comment.

Comment	Stakeholder Group(s)	LMHA Response and Rationale
<p>There is a misstatement. "A local transit system only operates in the city of Longview; no other area has a city bus system".</p> <p>Currently, the city of Marshall has a public bus system. East Texas Council of Governments in partnership with the city operates a fixed route public bus system within the city limits of Marshall.</p>	<p>CPAC</p>	<p>Accepted the correction and mad change to plan.</p>

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

After a posting of the plan for comment from July 2 – July 16 and having received one comment (above) this plan was presented to the Board of Trustees of Community Healthcore at the July 22, Board Meeting. The Board voted to accept the recommendation from the Comprehensive Planning Advisory Committee; the plan was adopted as presented.

Appendix A

LPND Potential Interested Provider Contact Steps

1. Provider Interest Inquiry form is submitted for posting on DSHS web site.
2. DSHS Staff review information and post form
3. Provider and LMHA are notified via e-mail from DSHS staff that the form has been posted.
4. LMHA contacts provider to schedule a teleconference or site visit.
5. The LMHA may conclude that a provider is not interested in contracting with the LMHA if the provider does not participate in a teleconference or in-person meeting (whichever is requested by the LMHA) within 45 days of the initial LMHA contact.

Through the DSHS website, a provider can submit a Provider Inquiry Form to register interest in contracting with an LMHA. DSHS will notify both the provider and the LMHA when the Provider Inquiry Form is posted.

During its assessment of provider availability, it is the responsibility of the LMHA to review posted information and contact potential providers to schedule a time for further discussion. This discussion, which can take place in person or by phone, provides both the LMHA and the provider an opportunity to share information so that both parties can make a more informed decision about potential procurements.

If the LMHA does not contact the provider, the LMHA must assume the provider is interested in contracting with the LMHA.

The LMHA may request a teleconference or an in-person meeting, and must work with the provider to find a mutually convenient time. If the provider does not respond to the invitation or is not able to accommodate a teleconference or a site visit within 45 days of the LMHA's initial contact, the LMHA may conclude that the provider is not interested in contracting with the LMHA.

An LMHA is not obligated to go through procurement if no providers have demonstrated interested in contracting with the LMHA.

Appendix B

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.