

# SPINDLETOP MHMR SERVICES

## Local Service Area Plan (LSAP)

### FY 2011 – FY 2012

### September 1, 2010 – August 31, 2012

In accordance with requirements of the Texas Department of State Health Services (DSHS), this Local Service Area Plan (LSAP) for Fiscal Years 2011 - 2012 also includes the STMHMR Services Jail Diversion Action Plan, Crisis Services Plan, and Local Planning and Network Development (LPND) Plan. These 3 other planning documents are included at the end of the LSAP.

Comments or inquiries regarding this document are welcome.

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**Spindletop Mental Health and Mental Retardation (STMHMR) Services  
Local Service Area Plan (LSAP) - Fiscal Years 2011 - 2012**

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Note:

Included at the end of this Local Service Area Plan (LSAP) are the STMHMR Services Jail Diversion Action Plan, Crisis Services Plan, and Local Planning and Network Development (LPND) Plan. Each of these 3 planning documents has page numbering separate from the Local Services Area Plan (LSAP).

**Board Approval**  
**Local Service Area Plan (LSAP) for Fiscal Years 2011 - 2012**

The Spindletop MHMR Services Local Service Area Plan (LSAP) for Fiscal Years 2011 – 2012, which includes the STMHMR Services Jail Diversion Action Plan, Crisis Services Plan, and Local Planning and Network Development (LPND) Plan, has been reviewed and approved by the governing board of Spindletop MHMR Services.



Gladdie Fowler, Chair  
Governing Board of Trustees  
Spindletop MHMR Services

7/26/10  
Date



N. Charles Harris, Ph.D.  
Chief Executive Officer  
Spindletop MHMR Services

7/26/10  
Date

## I. Mission / Vision / Values / Philosophy of Service

- Our Mission

Spindletop MHMR Services is a community mental health and mental retardation center. Our mission is to promote independence, recovery, and enhanced quality of life for individuals with mental illness and mental retardation.

- Our Vision

Our vision is to be the premier behavioral health and developmental disability provider in Southeast Texas. We shall ensure access to professional, respectful, and cost-effective services in a supportive, consumer-centered environment.

- Our Values

We value all persons and treat them with dignity and respect.

We develop services that are responsive to the needs, values, and desires of consumers and other stakeholders.

We value and respect families for the important role they play in the effective treatment and delivery of services to consumers.

We embrace self-advocacy as a means of independence.

We measure the success of services by the outcomes of each consumer.

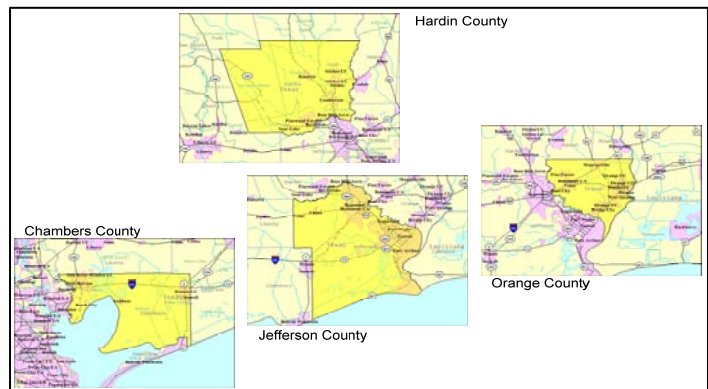
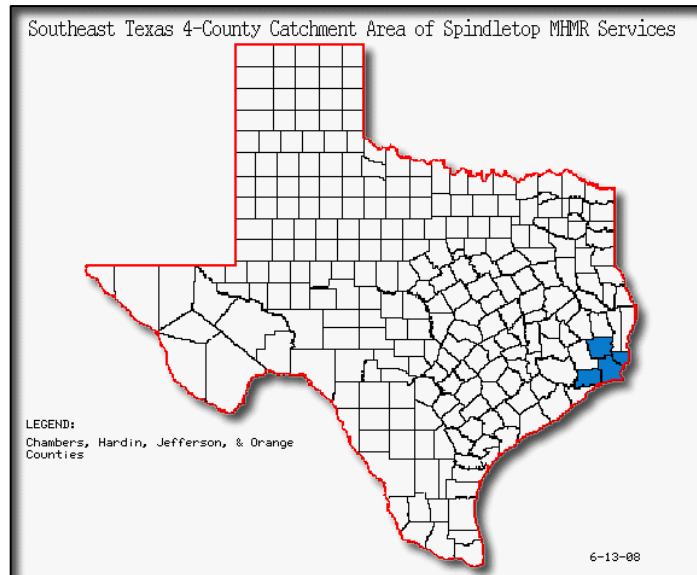
We motivate and empower staff to accomplish the work of the Center with confidence and pride by valuing and respecting them for their contributions in establishing a positive work environment.

We recognize and celebrate best practices among our staff and other network providers.

We promote the Center within the local community to enhance the organization's reputation and to encourage support for consumers.

- Our Philosophy of Service

Each individual possesses a unique capacity for creative and adaptive behavior. He is able to respond constructively to problems and situations and to discover alternatives.



Habilitative services are designed to reflect the principle that persons receiving lifelong training direct those services in accordance with their personal wishes and lifelong goals. This principle is further integrated into daily operations using the Person-Directed Planning model.

An individual's behavior is logical when interpreted within the context of her own perceived choices, behavioral capacities, life situation, and biophysiological makeup.

An individual is capable of acting in her environment to create new possibilities and choices.

Problems in living do not necessarily reflect the manifestation of dysfunction within an individual; problems may reflect interactions among other persons or possible neurological disease.

The willingness and capacity of an individual for coping represent a lifetime of learning and interaction with others.

Dysfunctional behaviors may be defined as learned behaviors based on life experiences.

Treatment interventions are principally conceived as processes designed to assist in the stabilization of biological imbalances, to promote the individual's acquisition of more personally rewarding and socially acceptable behavior, to maintain current adaptive behavior, and to minimize regression.

When biochemical imbalances or neurological diseases cause or contribute to the impairment of an individual's ability to function, medication may be recommended as a part of the treatment program.

Intellectual developmental disability programs and services are developed based upon consumer input during the Person-Directed Planning meeting. Individuals may choose to receive services at the Center or within the community. As with treatment interventions, periodic review of each consumer's progress toward his or her goals occurs frequently.

## **II. Strategic Initiatives**

While long term strategic planning has proven to be of value to business historically, in today's environment the approach to planning for organizations like ours seems more relevant if time is scaled to two years. In the midst of dynamic changes occurring throughout the state and the nation's health care industry, Spindletop MHMR Services develops targeted strategic initiatives to assist the board and staff in clearly focusing on those factors of greatest importance to the near and intermediate range future of the Center and the people it serves. Senior managers and the governing board have agreed to work with the strategic initiatives to provide planning goals in a more reasonable and relevant time period.

### **Consumer Related**

- C1. Increase consumer and family involvement in Center development by supporting consumer councils and peer support groups that regularly meet with management and involve consumers in process designed to determine their level of satisfaction with Center services.
- C2. Assure services are provided in facilities and vehicles that are safe, comfortable, and aesthetically pleasing.

- C3. Upgrade consumer programs and services.
- C4. Provide opportunities for consumers to participate in community projects and efforts that benefit others.
- C5. Develop programs and processes to increase consumer satisfaction and wellness. Create strategies that involve all levels of staff across the center.
- C6. Incorporate public schools' student training expertise into Center consumer training activities by developing relationships with public school special education programs.
- C7. Use both internal and external databases and data management systems to improve and expand services to consumers and to demonstrate positive consumer outcomes.
- C8. Create and develop a resource development department. Establish a separate 501c3 and an independent Foundation and Board with the purpose of raising funds to support Spindletop MHMR programs.
- C9. Develop an array of housing options for consumers looking at various funding alternatives including HUD, tax credits, private donations and other resources. Ultimately create unique development opportunities of all kinds including residential, business and retail options.

#### Provider Related

- P1. Participate in ETBHN Regional Network Advisory Committee's cost-benefit analyses, program evaluations, and service audits.
- P2. Pursue additional funding opportunities via grants, foundations, and other non-traditional sources.

#### Administrative Related

- A1. Review Board and Center policies and practices to increase their effectiveness.
- A2. Review the current compensation plan to assure its success in hiring and retaining valued employees and in providing equitable and competitive salary and benefit packages.
- A3. Increase awareness of Center services and improve the image of the Center by emphasizing written publications, media contacts, and frequent communications with area elected officials, and by participating in community activities and providing a Spindletop MHMR Services speaker's bureau to local groups and businesses. Develop processes to educate the public, referring agencies and stakeholders about Spindletop MHMR and increase satisfaction with ease of accessing services.

- A4. Enhance compliance with all funding and licensing agencies including Medicaid, DADS, and DSHS.
- A5. Implement a set of metrics (key performance indicators such as Business Objects measures, etc.) which will demonstrate the effectiveness of Center services.
- A6. Continue review of Information Services to increase staff efficiency and effectiveness, and review upgrades or additional software which will address anticipated care functions.
- A7. Operate within an approved budget to provide a comprehensive continuum of care while increasing productivity, revenue, and operating efficiencies.
- A8. Promote the Center as the expert in the provision of mental health, IDD services, developmental disabilities, substance abuse, and early childhood intervention services in Southeast Texas through a range of public relations and marketing strategies and activities.
- A9. Utilize resources of the East Texas Behavioral Health Network and pursue increases in administrative efficiencies, improvement of service delivery, and expanded funding opportunities through consolidation of functions or possible mergers of centers among East Texas Behavioral Healthcare Network centers.
- A10. Enhance the competency of Center staff through support of a variety of educational opportunities available at the Center, on the Internet and at a variety of training venues outside the Center.
- A11. Develop on-going programs designed to improve Spindletop MHMR employee wellness and morale. Measure and improve overall employee satisfaction with their work environment. Measure consumer satisfaction to determine if it increases along with employee satisfaction.
- A12. Create opportunities for supervisory staff to develop leadership skills, improve management performance and measure staff productivity.

As with all initiatives, marketplace realities force constant reassessment of these plans. Members of the governing board and the executive management team regularly discuss these strategic initiatives in order to enable the organization to be responsive to these realities. All budgetary requests must be tied to specific initiatives in order to obtain management approval.

The local plan and the initiatives upon which it is based rely upon involvement of all Center stakeholders, including people receiving services and their families, staff, contractors, public advisory committees, as well as the board of trustees in ongoing discussions about key concerns and the commitment to continual service improvement. The Center continually gathers information from external customers, the general public, members of advocacy groups, and people receiving our services in order to understand more clearly the perceptions of these groups and their suggestions for practical improvements. The mental health and mental retardation public advisory committees provide a structured mechanism for obtaining ongoing comments from external customers for inclusion in local plan development.

The board receives monthly reports from senior managers on issues of concern to the Center and staff recommendations for service improvements, investments in resources, or other production ideas. These regularly scheduled discussions are directly connected to the strategic initiatives as agenda items and continually force review of our progress toward major goals. The public advisory committees also directly report to the board at least quarterly, and more often when matters of concern to the committees arise. In addition, a summary of all activities related to the strategic initiatives are presented quarterly to the board.

### **III. Local Service Area Planning Process**

Spindletop MHMR Services structures the planning process that results in the Local Service Area Plan on information from internal data gathering, as well as suggestions and comments from stakeholders concerned about the disabilities of consumers in Southeast Texas. In addition, the Center also considers major forces and expectations outside the center that impact on Center operations. Some of the key factors that impact planning include the many organizational mandates that are attached to the various funding sources that finance services, consumer waiting lists, and the changing demographics of the four-county area served by the Center.

The Center collects internal data that reflect local Center operations for Center managers to use in planning operational activities. The Center's consumer database is also used to generate productivity reports that assist management in making decisions about operational functions, as well as how to best organize and structure the necessary personnel that achieve the objectives. Information about these reports and objectives are regularly reviewed in management meetings to measure progress toward established goals and objectives. Regular Center-wide reports are also reviewed in the monthly meetings of the Center's governing board of trustees.

The Local Service Area Plan is developed based on this regular information review in order to provide Center management and staff the direction and guidance for the functioning of the mental health and developmental disabilities services. The plan document is regularly reviewed and modified based on the changing factors that influence Center operations, including legislative directives and business realities.

The Center supports various committees and councils that provide management with regular suggestions and comments regarding consumer services. Some of these improvement teams include Center staff, while others include participation by external stakeholders from the community. These committees include the Mental Health and Mental Retardation Planning and Network Advisory Committees (PNAC) that each includes consumers, family members, concerned citizens, and staff from other agencies in the community. This group also reviews the results of the community needs assessment surveys and consumer satisfaction surveys that assist management with identifying local needs and priorities, as well as suggest strategies to address these needs.

Formal review of the Local Service Area Plan is completed biannually by the governing board. The plan is also reviewed by the MH and MR Planning and Network Advisory Committees, with an emphasis on the Center's Strengths, Weaknesses, Opportunities, and Threats (SWOT). The governing board has the responsibility for approving changes based on the recommendations and findings of the various survey processes and changes to the Center's main performance contract with its primary funding sources. Goals and objectives that are part of action plans generated by Center management are also reviewed by the board. This ongoing review process ensures that the Center responds to the needs of the consumers.

The Center's planning processes and documents are also reviewed by the Regional Planning and Network Advisory Committee (RPNAC) of the East Texas Behavioral Healthcare Network

(ETBHN). The East Texas Behavioral Healthcare Network (ETBHN) is a network comprised of eleven community mental health and mental retardation centers located in east Texas, and the RPNAC is comprised of representatives from each of the ETBHN member centers. In each of its quarterly meetings, the RPNAC reviews different center programs to assess program quality, identifies regional best practices among the centers, reviews the various plans required of the centers, including the local service area plans, and provides to the local governing boards recommendations on program improvements, budget issues, and other key operational issues.

#### **IV. External / Internal Needs Assessment**

Spindletop MHMR Services develops plans based upon assessments of the needs of diverse segments of the community, as well as reviews of key data elements on mental health and mental retardation prevalence data and state facilities usage. The Center organizes focus groups of consumers, volunteers, consumer advocates, and the citizenry to discuss their concerns regarding the quality of Center services, operational issues within particular program units, managerial recommendations, issues regarding access to services, communication mechanisms, complaints about perceived issues, and ways people can be more involved with staff and the governing board in developing high quality services. These focus groups are conveniently scheduled and are organized based on the unique needs and interests of the different community elements involved in the discussion groups. In addition, the Center formalizes this external input process with questionnaires designed to provide confidential, frank input from people receiving services, staff, and the general public. The governing board annually holds a public hearing to ensure that this communication mechanism is available for direct external input to board members.

These measures support the ongoing needs assessments occurring in all service units. Program unit staff and management regularly receive input from people receiving services regarding their program areas and deal with concerns such as levels of service participation, schedules, activity planning, and individual concerns and preferences.

Center staff summarize these means of input into Center operations and from them develop annual objectives for management implementation. This occurs during the annual budget and service planning cycles, especially when the relevant input results in capital expenditures for such measures as improvements in buildings, facilities, activity items, or other such improvements requiring budgetary support.

The external assessment of services includes regular audits of services by the Center's fund sources, including the Texas Department of State Health Services (DSHS) and the Texas Department of Aging and Disability Services (DADS). In addition, the Center participates in internal and external audits to participate in the data verification process for numerous data elements related to services billed to the Medicaid program. These audits cover all the many requirements in the performance contracts with the fund sources, services provided by the Center that are covered by these funds, as well as a review of operations and processes that are required by the fund source operational standards.

The Center's operations are also assessed by the Joint Commission. The Center is one of only 4 community centers in Texas that are accredited by the Joint Commission. This accreditation includes an extensive onsite evaluation of the Center measured by the numerous Joint Commission standards. This onsite accreditation occurs once every 3 years. In addition to the 3-year onsite review, the Center also must annually complete an internal review of operations based on the Joint Commission standards. This annual Periodic Performance Review (PPR) involves numerous Center leaders in the review of processes and procedures compared to the standards, and each year the Center must complete this PPR in order to maintain accreditation.

The Texas Department of Aging and Disability Services (DADS) oversight of the Center's performance contract expectations include various external methodologies that are used to gather information regarding the many facets of service delivery and business practices in mental retardation services. These include:

- Home and Community Based Waiver Services (HCS)
- Texas Home Living Waiver Services (TxHmL) Provider Services
- Texas Home Living and Quality Assurance Authority Review
- Data Verification Reviews
- Budget and Cost Reports
- Mental Retardation and Behavioral Health Outpatient Data Warehouse (MBOW)

In addition to these assessments, the Center also implements various other reviews. These include:

- Annual Fiscal Audit by External Auditor
- Building Safety Inspection by Texas Risk Management Council
- Three-year accreditation cycle by the Joint Commission

The internal assessment of service delivery and business practices is done through internal reviews and audits, satisfaction surveys, and community needs assessment surveys. The following list summarizes these internal review processes.

- HCS Satisfaction Survey
- Quarterly Consumer Advisory Committee meetings for HCS, TxHmL and GR consumers
- Corporate Compliance/Quality Management Audit
- Bi-Annual Community Needs Assessment
- Utilization Management Reviews of MBOW Data
- Review of Cost Accountability Measures
- Review of Performance Accountability Measures
- Texas Home Living (TxHmL) Waiver Satisfaction Survey

## **V. Stakeholder Involvement in Needs Assessment Process**

In addition to their above described involvement in Center operations, the MH and MR Planning and Network Advisory Committees (PNAC) also aid in the ongoing effort to elicit input from people receiving services and members of the citizenry. Staff request that members of the PNACs review program unit plans and consider possible improvements in Center operations including service alterations, schedule changes, activity scheduling, and involvement in planning by people receiving services.

Members of the two Planning and Network Advisory Committees represent the diversity of the community, and they participate in the ongoing needs assessment process, specifically in identifying and representing the needs of the community in Center plans and operations. The PNAC members review input and feedback data from people receiving services and staff and serve as facilitators in the communication process. This assures that people receiving services, their family members, and representatives of the community feel comfortable expressing their concerns and suggestions regarding Center activities. The process includes specific attempts to target the community to make sure the external community has an opportunity to be involved in the ongoing improvement of services. The PNACs assist staff by reviewing and evaluating this local plan and aid in defining unmet needs, gaps in services, and corresponding priorities of service planning. In addition, the plan is reviewed by the Regional Planning and Network Advisory Committee (RPNAC) of the East Texas Behavioral Health Network (ETBHN).

The Center also supports regular meetings of numerous peer support groups. The Center has budgeted resources for peer support staff to provide technical assistance to people receiving services, to support them in their meetings, to provide transportation to the meetings, to facilitate their decision-making and participation in peer group activities at regional and state levels, and to report their suggestions for service improvements to program unit managers for inclusion in local planning.

The Community Management Team and Community Resource Coordination Groups (CRCG for children and adolescents and CRCGA for adults) also provide ongoing involvement in the planning and development of services to persons in mental retardation, mental health, substance abuse, and early childhood intervention programs.

## **VI. Fiscal Year 2010 Needs Assessment / Satisfaction Survey Results**

The latest assessment of community needs regarding mental health and intellectual developmental disabilities of consumers, and the latest survey of consumer satisfaction with these services reveals areas of opportunity for improvement in Center operations.

The Center also sends staff to other community meetings regarding the mental health and intellectual developmental disabilities concerns of the community, and Center staff presented in these meetings presentations on various Center activities that are in place to improve internal operations and processes.

The key concerns from all these sources of suggestions are provided here.

### **A. Issues Related to STMHMR Services Improvements**

- Dually diagnosed services - mental health and substance abuse issues
- Concerns about future mixing of MH and MR consumers
- Improve quality, quantity, and availability of food prepared for or delivered to Center consumers
- New material and educational resources in ATAR
- Activities in MR program in Anahuac, and transportation to/from Beaumont-based programs
- Professional, respectful behavior by staff with consumers
- New books and magazines in waiting areas
- More social interaction and varied activities and transportation services for Orange MR services
- Improve physician communication skills and awareness of consumer needs
- Transportation for OOPC consumers
- Decrease wait times for appointments, especially physician appointments
- Decrease wait times in Service Coordination to See Physician

- Consumer responsiveness, food service, transportation, and more varied programs and activities in ATAR
- Increase community awareness of available services, with emphasis on toll-free telephone number
- Curriculum updates in MH programs
- Continuity of physicians for the consumers in long term treatment
- Medical community information and awareness of Center services
- Expand staff training in mental health treatment, beyond minimal annual orientation
- Staff cross-training in MH and MR services, especially new intake and crisis screening process
- Continue to assist consumers with applying for Medicaid and disability services

#### B. Issues Related to Ongoing Community Needs

- Dually diagnosed consumers with mental health and alcohol/substance abuse problems
- Funding support from the state, and area local county commissioner courts
- Expand medication support services for those with mental illness
- Increased availability of housing services, especially for consumers with a mental illness and those discharged from state hospital and criminal justice programs, especially since the community has been impacted by 2 major hurricanes in a 5-year period
- Transportation services to and from Center appointments
- Address needs of adults caring for their adult children with mental illness or IDD
- Expand availability of alcohol and substance abuse services in the community
- Mental health consumers with medical conditions needing emergency mental health services
- Children and adolescent mental health and substance abuse treatment
- Emergency inpatient MH services for children and adolescents, especially those with no fund source
- Education and support for families
- Detoxification facilities, especially for children and adolescents
- Increase community awareness of consumers with mental illness or mental retardation

### **VII. Assessment Components**

The target population for adult mental health services consists of adults who have a severe and persistent mental illness, such as schizophrenia, major depression, bipolar disorder, or other

severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment. In providing services to the target population, the choice of and admission to services is determined jointly by the person seeking service and STMHMR Services. Factors used to make these determinations are the level of functioning of the individual, the needs of the individual, and the availability of resources. The Texas Department of State Health Services (DSHS) funding is directed to provide services that meet the needs of the target population.

The children's mental health priority population is defined as including children and adolescents age 3 through 17 years with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who:

- have a serious functional impairment (GAF of 50 or less currently or in the past year); or
- are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
- are enrolled in a school system's special education program because of a serious emotional disturbance. This qualification relates to requirements of the Texas Department of State Health Services (DSHS) and not the Texas Department of Aging and Disability Services (DADS).

Children and adolescents do not meet the DSHS target population criteria if they have a single diagnosis of autism, pervasive developmental disorder, intellectual developmental disability, or substance abuse. The Texas Department of State Health Services (DSHS) funding is directed to provide services that meet the needs of the priority population of children and adolescents.

The priority population for intellectual developmental disabilities services consists of individuals who meet one or more of the following descriptions: mental retardation, as defined by Section 591.003; autism, as defined in the current edition of the Diagnostic and Statistical Manual (DSM); pervasive developmental disorder (PDD), as defined in the current edition of the DSM; children who are eligible for services from the Early Childhood Intervention Interagency Council; persons with related conditions who are eligible for services in Medicaid programs operated by the department, including ICF/MR, waiver programs; and nursing facility residents who are eligible for specialized services for mental retardation or a related condition pursuant to Section 1919(e)(7) of the Social Security Act.

The Center provides the following services through its intellectual developmental disabilities services.

- **Eligibility Determination:** An assessment or endorsement conducted in accordance with the Texas Health and Safety Code, 593.005 and 25 TAC Chapter 415, Subchapter D to determine if an individual has mental retardation or is a member of the TDMHMR mental retardation priority population.
- **Service Coordination:** Assistance in accessing medical, social, educational and other appropriate services and supports to help an individual achieve quality of life and community participation acceptable to the individual.
- **Continuity of Services:** Assistance in placement into or out of a state facility, enrollment or transfers into the HCS or ICF/MR program, or assistance in maintaining an individual's placement or developing another placement for the person.
- **Service Authorization and Monitoring:** Case coordination provided to an individual who is assessed as having a single need.

- Respite: Support Services provided to the consumer in or out of the home to give the family or primary care givers temporary relief.
- Employment Assistance: Assistance in helping a participant locate paid employment in the community by assisting the participant to identify his or her employment preferences, his or her job skills, his or her requirements for work setting and work conditions, and prospective employers offering employment comparative with the participant's identified preferences, skills, and requirements.
- Supported Employment: Supports provided to an individual to assist them in maintaining their job in the community.
- Vocational Services: Services provided away from an individual's home to help the individual develop and refine skills necessary to live and work in the community.
- Day Habilitation: assistance with acquiring, retaining, or improving self help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life.
- Community Supports: Services and supports provided to an individual in the individual's home or community that are necessary to achieve outcomes in the Person Directed Plan.
- Foster Care Services: Services provided to individuals who are in need of a residential setting and are eligible for HCS.
- Special Therapies: OT, PT, Speech, audiologists, and dietary services provided to individuals who have been identified with a need and participate in a Medicaid waiver.
- Behavioral Support: Provides specialized interventions that assist a participant to increase adaptive behaviors to replace or modify maladaptive behavior that prevent or interfere with the participant's inclusion in home and family life or community life.
- Nursing: This service includes treatment and monitoring of health care procedures prescribed by a physician/medical practitioner and /or required by standards of professional practice or state law to be performed by licensed nursing personnel.
- Permanency Planning: This service is for persons under age 22 enrolled in or in the process of being enrolled into an Intermediate Care Facility or HCS residential setting. Spindletop MHMR Services conducts permanency planning every 180 days to assist the person in moving toward residence with either their natural family or a family based alternative.
- In-Home Family Support (IHFS) Grant Program: The IHFS Grant Program serves people who have either mental retardation or who are between the ages of birth-4 years with developmental delays. The program assists people to purchase those items or services that a person needs because of their disability that directly support the person to live in his/her natural home, rather than living in a more restrictive setting at a higher cost and are not available to them through another resource. It is the payer of last resort.
- Ticket to Work (TTW) Program: Persons in the community who receive disability services from the Social Security Administration (SSA) receive tickets from the SSA to assist them in obtaining and maintaining employment in the community. STMHMR

Services supported employment staff assists these consumers with obtaining employment in the community.

The Center is firmly integrated into the community and collaborates with various agencies and local systems in order to provide comprehensive supports to consumers while avoiding duplication of effort.

Examples of these collaborative efforts include but are not limited to the following.

- **State Mental Retardation Facilities:** The Center works closely with the State School to facilitate placements in the community once consumers are identified as needing placement. Collaboration with the admissions department occurs when community based consumers are in need of facility placement.
- **Community Resource Coordination Groups (CRCG's):** Spindletop MHMR Services assigns staff to participate in local CRCG's to assist in planning for consumers that are served by multiple providers.
- **Local School Districts:** Collaboration occurs with transition into and out of the school system. Supports are provided to school aged children who meet priority population criteria.
- **Counties:** Spindletop MHMR Services works closely with the local governance entities that are the sponsoring agencies for the Center. Routinely provide minutes from Board meetings and presentations made to Commissioners courts regarding Center business and needs. Several counties provide physical locations for the Center operations. Staff routinely works closely with county judges, area schools, local medical service providers, local law enforcement, and other social service providers to meet consumer needs.
- **Community MHMR Centers:** Spindletop MHMR Services is a member of the Texas Council of Community MHMR Centers, Inc. through which efforts for collaboration are facilitated. Visits to other centers, sharing of information, and identification of opportunities for efficiencies are just a few examples of the communication and cooperation between centers.
- **Area Law Enforcement and Judicial Officials:** The Center collaborates with area judicial officials in developing and implementing strategies for the treatment and diversion of persons with mental disabilities who interface with law enforcement.

STMHMR Services provides substance abuse services to adult consumers in both outpatient and residential treatment settings. Consumers are referred to these services by the Texas Department of Criminal Justice (TDCJ) substance abuse programs in prisons, and from area probation and parole departments for their consumers with substance abuse problems. In addition, adult substance abuse or alcohol treatment consumers may be committed into residential treatment by local justices. A limited amount of money is available to serve indigent consumers in outpatient or residential programs. Private paying consumers are accepted into all programs.

A prevention and intervention program for youth is offered at local housing authority complexes. These special youth services also include screening, family services and referrals. A treatment program for youth is being developed to serve adolescents with substance abuse or dependency problems.

We will continue to explore ways to expand funds for these and other programs, and to include as many population groups as possible within significant funding limitations. All funds for substance abuse treatment services in our local Region 5 are now managed by a local Outreach, Screening, Assessment and Referral (OSAR) network administrator, the South East Texas Regional Planning Commission (SETRPC), which performs the managed care function for these funds. STMHMR Services participates in the local provider network which advises the Network Administrator on policies and procedures.

Spindletop MHMR Services employs staff that is reflective of the community they serve. This ensures that services are delivered in a culturally sensitive manner.

### **VIII. Involvement of State Facilities**

Spindletop MHMR Services has a close working partnership with existing state hospital and state school facilities in Texas. Analysis of data reflecting the Center's use of state facilities continues to reveal opportunities for improvement in coordination of services with the goal of assuring the appropriateness of referrals to state facilities.

The Center maintains a balanced and effective service delivery system that supports a full range of services and supports to individuals and their families. The continuum of care for individuals with mental and intellectual developmental disabilities may include admission to residential services in state facilities, as well as community-based ICF/MR programs, waiver services, and other appropriate services and supports that may be provided or contracted by the Center. When appropriate, residential services in a state facility are intended to serve individuals with severe or profound mental disorders or disabilities and those individuals with developmental disabilities who are medically fragile or who have behavioral problems.

If an individual or their legally authorized representative chooses services in a state facility, the Center will assist the individual or their legally authorized representative with accessing those services. This occurs when the individual meets the established criteria for admission to a state facility.

Person directed planning begins as soon as a person enters the intake process at Spindletop MHMR Services, and continues through temporary care and discharge planning at the state facilities and into follow-up continuity of care in the community coordinated by Center staff. Clinicians within the Center, in a cooperative venture with clinicians in the state facilities, provide peer review of the clinical necessity of admission to the state facility. The decisions from this clinical peer review process are reviewed and acted upon by clinicians within the Center.

The Center works with the state and area local communities to provide encouragement and support for well-functioning families to ensure that each individual receives the benefits of being a part of a successful permanent family.

For an individual from the catchment area of Spindletop MHMR Services who resides in a state facility, the Center is responsible for the following:

- (1) maintaining a link between the individual and the individual's home community;
- (2) ensuring that the individual, the individual's legally authorized representative, and the state facility are provided with information concerning alternative living arrangements that may be appropriate for the individual;

(3) assisting the individual or their legally authorized representative who decides to seek an alternative living arrangement with accessing their preferred alternative living arrangement, including working with other community centers if the alternative living arrangement being sought is outside the Center's local service area; and

(4) providing the state facility with current, provider-furnished information about services and supports in the Center's local service area.

The Center works with the state facility to provide the supports and encouragement necessary to ensure that each individual or their legally authorized representative is able to exercise their choice and make their own decision in issues related to services and supports.

## **IX. Key Forces**

The major forces influencing STMHMRS policy decisions for fiscal years 2010-2011 include substantial loss of available public sector funds, potential significant reduction in future Medicaid reimbursement, continued increases in medication expense, growing competition from proprietary behavioral health and mental retardation providers, ongoing implementation of resiliency and disease management philosophy and service packages, preparation for pay for productivity and fee for service, and state legislation that requires community centers to increase consumer choice of services provided by external providers. Because of the passage of this legislation, Center management, the public advisory committees, the board of trustees, and other stakeholders must work to improve the cost effectiveness and efficiency of the Center as a public provider, while ensuring that the public safety net is preserved and that adequate contract oversight is maintained to ensure quality of service.

## **X. Choice**

Private providers of IDD services have set up successful enterprises in Southeast Texas over the last several years. However, there continues to be a severe lack of available mental health resources for consumers without a payment source. As the region's intellectual developmental disabilities (IDD) authority, Spindletop MHMR Services informs persons with IDD of the array of provider options available to them. They learn of these options from the point of intake and regularly thereafter through formal and informal discussions with their service coordinators. Several times a year the Center hosts a provider fair during which persons seeking IDD residential placement and their families meet and discuss issues with both public and private providers. Authority staff and private provider staff work together to ensure successful placement for all persons.

To address increased service choice, Spindletop MHMR Services, along with the ten other member centers of the East Texas Behavioral Health Network, participates in formal evaluations and comparisons of programs and services to determine which services to consider in issuing requests for information or requests for proposal on a region-wide competitive bidding basis.

## **XI. Administrative Efficiency**

Efficiency of operations involves many variables impacting the investment in and use of Center resources, including staff, office space and equipment, computer equipment and applications, and other tools necessary to provide quality services. The Center has reduced these internal operational costs by streamlining key processes, reducing the number of staff through attrition, and taking advantage of a large volume in services and requisite supplies necessary to support the direct care processes. Through our association with the East Texas Behavioral Health Network, we pursue savings from consolidation of resources, collaboration on projects, bulk

purchasing, sharing of training, and other regional efforts to reduce operating costs. Our use of the ETBHN pharmacy has resulted in pharmacological cost savings for Spindletop since the pharmacy's inception several years ago.

The Center's Chief Financial Officer works with CFOs from other centers to implement uniform cost accounting methodologies. Center-wide development and monitoring of key performance indicators gives management and the board meaningful data by which to measure the Center's progress towards its goals and strategic initiatives. The cost-benefit analysis and cost accounting projects are part of the many initiatives in which the Center is involved as a member center of the East Texas Behavioral Health Network. The Center's having an experienced Certified Public Accountant as Chief Financial Officer and having access to more timely and accurate financial data via Webcare and Business Objects have proven effective in identifying new opportunities for the Center to increase financial soundness and integrity.

The Center's Human Resource department has computerized parts of its required staff training in order to reduce staff time lost traveling to and participating in sessions away from their home sites.

Spindletop MHMR Services also continues upgrading its information system, increasing the use of information technology, and developing software to meet the specific needs of our own center as well as other community centers throughout the state. The Center has sold its in-house consumer benefits software package to several other community centers. Since implementation of its Electronic Medication Management System (EMMS) software package, program staff have been able to track more effectively sample, stock, and patient assistance medications. The new system allows for identification and transfer of soon-to-expire medications from site to site as well as timely removal of expired meds. Sites manage their medications more effectively, and drug costs have fallen substantially since EMMS was begun.

The Center also is providing the leadership in developing various regional ETBHN projects that will present cost-effective strategies for the 11 member centers. These include the establishment of a regional electronic medical record system, a regional approach to converting documents through the LaserFiche system, and the regional communication and file sharing services in the SharePoint system.

## **XII. Quality**

Efforts to improve the quality of services are described in the STMHMRS Quality Management Plan. The Center's HCS, ICF-MR, and Texas Home Living waiver programs were recently recertified as a result of separate state audits. In 2009, the Center successfully completed its fifth three-year re-accreditation by the Joint Commission, and is now one of only 4 community centers in Texas to be accredited by the Joint Commission. Spindletop MHMR Services continually ranks in the lowest risk group of all Texas community centers in financial ratio indicators, contract performance indicators, and additional risk indicators.

First Steps, Spindletop's early intervention program for infants and toddlers and their families, achieved the highest possible accreditation in its last state audit. These findings provide external validation of the quality of services provided to our consumers. In addition, the internal Compliance Committee provides annual staff training on ethical and legal issues related to day-to-day Center operations. Aspects of the Compliance Committee's operations have been recognized as exemplary by East Texas Behavioral Health Network compliance auditors.

### **XIII. Intellectual Developmental Disabilities (IDD) Services**

Persons of all ages with a diagnosis of mental retardation (intellectual developmental disability) are eligible to participate in employment, residential, habilitative, education, and leisure opportunities and services. Current input from stakeholders indicates need for an increased number of leisure activities, new and expanded services for persons with an intellectual developmental disability who also have a mental illness, expanded opportunities for community employment and leisure activities, additional community residential options for adults, and for increased availability of and training on computer-driven assistive devices for persons with motor or communication limitations. Additionally, in Orange, Jefferson, and Chambers Counties, Spindletop MHMR Services offers early childhood intervention services to families of infants and toddlers who have or are at risk for developmental delays. Planning priorities for all services are based on needs identified by state and local stakeholders and on results from utilization management reviews.

#### XIV. Populations Served

<b>Mental Health, Intellectual Developmental Disabilities, and Substance Abuse Services</b>	<b><u>FY 2006</u></b>	<b><u>FY2007</u></b>	<b><u>FY2008</u></b>	<b><u>FY 2009</u></b>
<b>MH Adult (Priority Pop.)</b>	3,450	3,456	3,217	3,317
<b>MH Children/Adolescents</b>				
Total C & A	569	589	618	688
First Time Offenders	N/A	N/A	N/A	N/A
Juvenile Justice	43	42	43	44
<b>MH Best Practices</b>				
ACT	103	114	124	95
Supported Housing	144	164	185	195
Supported Employment	112	110	108	115
<b>MH Other Services</b>				
Homeless Services – Adult (PATH)	45	108	134	88
In-Home and Family Support (MH & MR)	10	10	6	12
Consumer Peer Support	N/A	N/A	N/A	N/A
Family Support	124	146	164	142
Service Coordination	1,029	1,193	1,514	2,465
Non-General Revenue NGM	1,361	1,571	1,499	1,657
General Revenue (GR) NGM	574	343	211	158
Total	1,935	1,814	1,710	1,815
<b>MR Priority Pop.</b>	883	811	774	645
MR Assessment /Service Coordination	787	414	432	537
MR Supported Employment	137	128	116	114
MR Children	140	114	113	78
MR Vocational Services	90	82	126	84
MR Training and Support	361	337	341	391
<b>Substance Abuse Services</b>				
Treatment	305	312	309	336
Youth Intervention	N/A	N/A	N/A	N/A
<b>Dual Diagnosis (MH / SA)</b>	600	731	983	1302
<b>Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) – Leaving Prison</b>	335	350	313	373

## **XV. Resource Allocation and Development**

Management considers additional, alternative, or reduced services depending on the availability of funds. The board communicates with community service agencies and other advocates in order to be aware of needs beyond the financial capacity of the Center to provide directly and is responsible for working within the community to develop alternative support for these additional needs.

Center efforts to assure that everyone in the state-defined targeted population receives the necessary services depend upon adequate funding support. Those with the most intensive needs require higher-cost services that represent a greater allocation of resources centered around those more complex needs. The Center receives third-party payment from Texas Medicaid funds to support the cost of services for Medicaid-eligible persons. Recent national healthcare reform legislation is expected to increase the Medicaid-eligible population by 1.4 million in 2014, while potential federal legislation reducing Medicaid benefits can have devastating effects on the Center's budget and thus on its efforts to maintain high quality services for everyone within the targeted population.

The Center's operational budget reflects allocation of funds to support designated cost centers designed to address the special needs of people with IDD, children with emotional and mental health needs, adults with mental health needs, adults with crisis psychiatric needs, adults with needs for substance abuse and alcohol treatment, and families of infants and toddlers with or at risk for developmental delays. This budgetary allocation process is driven by community input and feedback as well as by legislative appropriations.

The Center continually invests staff time to seek additional funding sources outside existing contract provisions. A half-time grant writer allows the Center to compete more successfully for limited dollars. In fiscal year 2010, 35 grants were submitted to various fund sources, resulting in approximately \$1.5 million to continue various Center programs or to begin new services. In the Resiliency and Disease Management model of service provision, management continually evaluates the need for reallocation of staff and other resources in order maintain fidelity within all service packages.

## **XVI. Relationships with Other Agencies**

The Center participates with ten other local behavioral health agencies in the East Texas Behavioral Health Network (ETBHN). STMHMR Services receives referrals from all area social, educational, rehabilitation, and health services agencies, and maintains strong relationships with area law enforcement providers and emergency room staff, especially regarding the services provided to persons in psychiatric crises. The Center also supports the Community Resource Coordination Group (CRCG), a ten-agency team of lay persons and professionals who meet regularly to improve services to children and adolescents as well as the newly organized CRCG for adults.

In addition, the Center continues to build strong working relationships with local school districts, advocacy groups, area law enforcement officials, probation and parole departments, the Texas Department of Family and Protective Services, the Texas Department of Assistive and Rehabilitative Services (DARS), the Texas Department of Assistive and Rehabilitative Services (DADS), and other state and federal agencies. Center staff also continue to strengthen collaborative working relationships with area disaster and emergency preparedness functions in all 4 counties served by the Center.

## **XVII. Plan for Review**

Following governing board approval, the local service plan is regularly reviewed by Center management and the governing board for necessary alterations to reflect changing expectations and needs of the people we serve, input from the community regarding its ongoing perceptions of remaining unmet needs, and availability of fiscal resources to support these needs. Findings from operations monitoring of program units by internal and external review are visited regularly by management, the board, and the PACs for input for current and future local plan revisions.

## **XVIII. SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis**

Local planning is a long-term, cyclical, and future-oriented process of assessment, goal setting, and decision-making that presents a path between the present and a vision of the future. The planning process includes a multiyear view of objectives and strategies for the accomplishment of agency goals. Clearly defined outcomes and outputs provide feedback that leads to program performance, which influences future planning, resource allocation, and operating decisions. The strategic planning process incorporates and sets direction for all local authority operations.

A local service area plan is a formal document that communicates to various audiences the Center's goals, directions, and outcomes. These external customers include the Texas Department of State Health Services (DSHS), the Texas Department of Aging and Disability Services (DADS), the Texas Department of Assistive and Rehabilitative Services (DARS), consumer and constituency groups, the general public, and Center employees. The local plan serves as the basis for state agency strategic planning and budget structure. Through local plans, the Texas state authority (DSHS) develops an appropriations request that reflects decisions about how fiscal resources will be allocated.

The local service area plan provides a direction for STMHMR Services operations, and the development of the plan was guided by the suggestions and recommendations from members of the Center's mental health planning and advisory committee (MHPAC), the mental retardation planning and advisory committee (MRPAC), stakeholders, providers, consumers, and Center staff. Board-approved strategic initiatives, analyses of trends identified in internal and external data, and performance contract requirements assist with the direction for STMHMR Services operations. In addition, the Center's local service area plan development process was guided by the involvement of members of the regional planning and network advisory committee (RPNAC) of the East Texas Behavioral Network (ETBHN).

The RPNAC will make reports to each of the East Texas Behavioral Health Network (ETBHN) member center governing boards regarding planning, development, design, management, and evaluation of the local provider network, including but not limited to:

- Client care issues in Network development
- Consumer choice issues in Network development
- Ultimate cost-benefit issues in Network development, and
- Best use of public money in Network development

The Center's performance contract requires that the local authority create a process to develop and report outcome and reporting requirements. For the member centers of ETBHN, the regional planning and network advisory committee (RPNAC) is charged with this evaluation. The ETBHN regional oversight committee selects the services for evaluation and the final recommendations from the RPNAC are compiled for distribution to the respective center boards of trustees.

This evaluation represents part of an ongoing effort to gather information to ensure to the local authority's management team and its governing board that any identified problems are properly understood and addressed. While the purpose of these evaluations is to examine the local authority's needs and capabilities of the current system, it is also important to note that, in time, this process will also allow local authorities to use trends in provider services and consumer utilization. In turn, a local authority can use this data to ensure the proper capacity of its provider network and that the best interests of the consumers are met.

The regional planning and network advisory committee is comprised of members representing each of the eleven member centers of the East Texas Behavioral Healthcare Network, and who are appointed by the local authority's governing board.

The RPNAC members reviewed the Center's plan, its goals and objectives, and assisted with the significant process of analyzing the Center's strengths, weaknesses, opportunities, and threats (SWOT), as well as gaps in services. The RPNAC reviewed the SWOT analysis for all 11 ETBHN member centers, providing valuable comparison of this analysis for each center. The RPNAC discussion of the SWOT analysis is summarized here. The analysis presents a regional evaluation of each member center and provides an excellent regional analysis of the key center operations and functions.

### **Strengths:**

1. Low staff turnover
2. Audio / video teleconferencing, a solid infrastructure for communication, great organizational depth, and a variety of services, not just the traditional services
3. Good working relations with the communities and governmental officials
4. Staff are assessable and approachable. Most centers do not have an automated system and consumers talk to a real person, which makes a lot of difference to consumers
5. Good relations with law enforcement
6. Great data systems
7. Using the ETBHN Pharmacy has been a major impact on centers in a good way
8. Telemedicine expansion
9. Implementing business approaches to be more competitive
10. Proven to be adaptable and flexible
11. Centers continue to provide services with limited financial resources

### **Weaknesses:**

1. Under funded
2. Lack of doctors
3. Long waiting list, especially for a first appointment
4. Lack of options for transitioning from adolescence services
5. Difficult to attract outside providers due to lack of funding
6. Lack of beds in State Hospitals
7. Lack of private psychiatric hospital beds
8. Lack of LPC's
9. Low pay scale leads to shortage of some professional staff
10. Lack of enough safe, affordable housing

### **Opportunities:**

1. Ability to diversify to other services to serve the needs of our community

2. Educate the general public on our services and behavioral health and Intellectual disabilities
3. Veterans services
4. Group homes transitioning to smaller facilities
5. Integrated healthcare
6. New service coordination model
7. Person-directed planning
8. Geriatric services
9. Autism services
10. ETBHN collaboration and staff communication
11. ETBHN continuing to build more infrastructure for the future

**Threats:**

1. Funding cuts
2. Not on level playing field with private providers
3. CAM data still not useful for a good comparison between Centers
4. Unknown future landscape
5. Economy
6. Possible cuts coming out of next Legislative Session
7. Possible Northstar expansion
8. Due to possible budget cuts, we could lose qualified staff
9. Stakeholder overload (being asked too much)
10. Substance abuse funding is still a question

**Gaps in Services:**

IDD Gaps:

1. Intellectual developmental disability services for adults
2. Public transportation limitations
3. Group housing that fits individual needs
4. Autism funding
5. Cost prohibitive to hire professionals for DMR's
6. Lack of resources for IDD adolescents in the community
7. Lack of transitional services from school into IDD programs
8. Summer programming for children
9. Lack of services for adult daycare

Adult Mental Health Service Gaps:

1. Day habilitation services
2. Transitional housing
3. Lack of psychiatric hospital beds
4. Resources for people being discharged from state hospitals
5. Jail diversion funding
6. Jail diversion intervention
7. Employment
8. RDM limits services

Mental Health Services for Children:

1. Limited availability of child psychiatrists

2. State hospital bed availability
3. Crisis respite
4. Parent education
5. Mentoring services
6. Summer programs
7. Youth employment services

The center liaisons and ETBHN staff compiled this information and the RPNAC completed its evaluation of services on May, 11, 2010. Committee members and center liaisons identified many areas of strengths and reviewed last year's SWOT analysis for a comparison. Findings for FY10 were compiled in list format for each of the four categories.

Based on the findings from the service evaluation of Spindletop MHMR Services, the ETBHN RPNAC recommends that the board of trustees of Spindletop MHMR Services discuss and take action when deemed appropriate regarding: (1), Review all components of the document, and (2), Work to strengthen any weaknesses, while planning for the listed threats.

### **XIX. Goals and Objectives**

The Center's goals and objectives provide the focus for quality improvement efforts, serve as the basis for process improvement efforts, and ensure that sufficient staff, fiscal, and information resources are allocated to meet those priorities. The following planning goals reflect the requirements of the Texas "Guidelines for Local Service Area Planning" and contain objectives that are products of current external and internal stakeholder input, quality improvement analyses, and data from the many other sources mentioned throughout this plan.

**Goal A: Spindletop MHMR Services will ensure accountability for, cost effectiveness of, and relative value of service delivery options.**

- Objective 1: Executive management will implement efficient processes for successful operations in a fee-for-service environment
- Objective 2: Directors will analyze Resiliency and Disease Management fidelity measurements, WebCare, MBOW, CAM, and internal data for trends and outliers.
- Objective 3: Executive management will assure financial viability is maintained.
- Objective 4: The Center will maintain accreditations and certifications with the Joint Commission, Home and Community-Based Services, Early Childhood Intervention, Intermediate Care Facility-Mental Retardation, and Texas Home Living Waiver.
- Objective 5: Executive management will emphasize strategic initiatives that stress accountability, cost effectiveness, and service options value.
- Objective 6: Staff will participate in East Texas Behavior Health Network and Texas Council consortia.
- Objective 7: The Center will increase billable hours.
- Objective 8: Staff will maintain community collaboration with Community Resource Coordination Group, the local jail diversion task force, National Alliance on

Mental Illness, the Arc, Mental Health Association, and other local interagency networks in order to identify and alleviate gaps in service.

**Goal B: Spindletop MHMR Services will ensure that a person with an intellectual developmental disability is placed in the least restrictive environment appropriate to the person's care.**

Objective 1: The Center will continue its collaboration with the Arc, Community Resource Coordination Group, and the Golden Triangle Self-Advocates.

Objective 2: The Center will include elements for identifying least restrictive environments within its public and private provider training curriculum.

Objective 3: The Center will include the full array of options available in its service area in publications available to persons with mental retardation and their families.

Objective 4: Both in-home and out-of-home respite options will be available for families of persons with intellectual or developmental disabilities.

Objective 5: Articles relating to least restrictive environment will appear in the MR Public Advisory Committee newsletter that is distributed to all local public schools and to persons with intellectual developmental disabilities receiving Spindletop MHMR Services.

Objective 6: The Center will provide transportation to persons with intellectual developmental disabilities who wish to participate in community activities.

**Goal C: Spindletop MHMR Services will ensure that it communicates to all potential and incoming persons with intellectual developmental disabilities about the availability of services of state schools.**

Objective 1: The Center will perform in-house Determinations of Mental Retardation (DMR) to assure that knowledgeable staff presents a thorough discussion of all available service options.

Objective 2: Public schools will be represented strongly on the Public Advisory Committee for intellectual developmental disabilities services.

Objective 3: Service options for persons with mental retardation will be addressed during community collaborative meetings with the Arc, Golden Triangle Self-Advocates, Community Resource Coordination Groups, and other organizations.

Objective 4: Initial and annual planning meeting documentation will contain discussion of the state school placement option.

Objective 5: The Public Advisory Committee newsletter will contain articles on state school placement options.

**Goal D: Spindletop MHMR Services will develop innovative services and service delivery options.**

Objective 1: The Center will continue its grant writing to increase and expand services and to assist with infrastructure.

- Objective 2: The Center will present speakers of note to the community through joint ventures with National Alliance for Mental Illness, the Arc, public schools, and local hospitals.
- Objective 3: Staff will share their expertise with the community through the Center's speakers' bureau.
- Objective 4: The Center will volunteer to participate in specific scientific studies, i.e., cell phones through which reminders for medications and appointments can be programmed for persons with mental illness.
- Objective 6: Executive management will explore ways of integrating mental health services into health care settings such as Federal Qualified Health Clinics.
- Objective 7: The Center's information services staff will develop new computer programs to meet changing needs of internal and external stakeholders, i.e., electronic medication management system, consumer benefits system, and internal RDM system.
- Objective 8: The Center will support new self-directed activities by persons receiving Center services.

## **XX. Network Planning**

The primary goal supporting the development of a network of service providers is to improve access, choice, and quality of services and supports while obtaining the best value for the public dollar. Toward this aim, the Spindletop MHMR Services governing board endorses the ongoing formal involvement of the Center with the East Texas Behavioral Health Network. The regional planning and network advisory committee (RPNAC) of the East Texas Behavioral Healthcare Network (ETBHN) focuses on consumer choice, accessibility, quality management, and resource availability as factors in building its regional network of providers.

The following presents a summary of the key outcomes of the network.

- Closed Door Pharmacy
- Pharmacy and Therapeutics Committee
- Utilization Management Committee (quarterly meetings)
- Regional Planning and Advisory Committee (RPNAC)
- Wide Area Network (WAN)
- Sharepoint
- Legislative Education (as needed)
- Collaborative Projects (as needed) – MCOT, Crisis Re-design, LPND, etc...
- Discipline Director meetings (as needed)
- Board of Trustee Trainings and Retreats
- Business Opportunities Committee
- Grant Workgroup
- Information Services Workgroup
- Trainings

## Menu Plan Consolidation projects:

These consolidations are made by choice of each individual Center.

- **Authorizations (7 Centers participating)**  
Participating Centers have saved money by using regional staff to authorize services for their Center, instead of having to dedicate master level clinicians for this function at their individual Center.
- **Medical Director (3 Centers participating)**  
These three Centers use the Medical Director for a minimum of 8 hours monthly for consulting, supervisory duties, and administrative functions. This has been a very successful program.
- **CFO Consolidation (3 Centers participating)**  
Under exploration and planning right now. Once in place, we will offer this to other member Centers. Some back office consolidation would be expected as an outcome.
- **Utility Purchasing (5 Centers participating).**  
All de-regulated utility areas that our member Centers have were put up for bid and we were able to get a tremendous savings on utility costs with a long-term contract.
- **Service Code matching Workgroup (6 Centers participating)**  
This group is working on matching all service codes for Anasazi Centers. Once completed, it will make it easier for any future consolidations, trainings, and comparison data.
- **Human Resource Director (2 Centers participating)**  
The list of menu items can and, most likely, will grow. If any 2 (or more) Centers are interested in participating, we will develop the capacity on a regional level. The purpose is cost efficiency and quality improvement.

Three centers have been added to the network, bringing the total size of ETBHN to 11 centers that cover 70 counties of Texas.

As a local mental health and mental retardation authority, the Center continues to focus on expansion of its local network of public and private providers. Spindletop MHMR Services has existing contractual or collaborative agreements with area service providers including private providers of residential services, community agencies, school districts, hospitals, and licensed independent clinicians consisting of physicians, psychiatrists, physician assistants, psychologists, dietitians, and others.

As mental retardation authority, the Center hosts provider fairs several times a year so that persons seeking residential placements can get to know the public and private staff members and make informed decisions regarding their choice of providers. Service coordinators provide ongoing informal information about the provider networks throughout the year.

Spindletop MHMR Services continues to utilize various mechanisms to involve persons receiving services, their families, and advocacy organizations in Center planning, including active participation by the Center's public advisory committee members in the East Texas Behavioral Health Network's (ETBHN) Regional Planning and Network Advisory Committee (RPNAC).

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

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

- o A system of service delivery that is managed by the Center and that provides consumers choice from among multiple service providers;
- o A system that provides ultimate cost benefit, quality consumer care, and the best use of public money in assembling with public involvement a network of service providers;
- o A system of service delivery that meets the needs and preferences of the local community;
- o A system that demonstrates prudent stewardship of public dollars;
- o A system that has operational controls in place to provide the best possible consumer outcomes;
- o A system that protects the rights of consumers to exercise their control over and make decisions regarding their health; and
- o A system that demonstrates the greatest return on public investment in mental health services.



**Spindletop MHMR Services**  
**Jail and Detention Diversion Action Plan – Fiscal Year 2010**  
**Update on Strategy Implementation – November 2009**

**Note:**

The specific strategies and activities included in this update can be found in section VIII.

The following plan was originally developed in 2005 and was updated in fiscal year 2009 in accordance with the Texas Health and Safety Code (THSC) §533.0354(d), as amended by the Texas State Legislature, 78<sup>th</sup> session, in House Bill 2292, and in accordance with THSC §533.108. This plan focuses on jail and detention diversion action strategies for both adults with serious mental illnesses and juveniles with serious emotional disturbances who are served by Spindletop MHMR Services (the “Center”).

**I. Goal:**

The goal of this Diversion Action Plan is to develop and maintain:

- a process for early and ongoing identification of consumers with serious mental illness and serious emotional disturbances in the criminal and juvenile justice systems;
- a protocol for providing crisis screening and assessments for inpatient hospitalization for juveniles in detention, boot camp, and intermediate sanction facilities including inpatient admission criteria and procedures and continuity of care requirements upon discharge;
- identification of high risk consumers;
- matching of jail and detention records with CARE system reporting within 72 hours of receipt of booking records from jail;
- procedures for receiving law enforcement, juvenile probation, and Texas Youth Commission (TYC) referrals;
- pre-booking diversion strategies that focus on diverting consumers with serious mental illness and serious emotional disturbances before arrest;
- services while the consumer is in jail or juvenile detention including advocacy efforts that continue to ensure recommendations for mental health or personal recognizance bond or release to a community treatment alternative;
- services after release focus on the provision of appropriate services upon release from jail, juvenile detention, TYC, or prison to ensure continued mental health and support services;
- integration of community resources including use of any state appropriated funds;
- processes for ongoing collaboration and coordination among stakeholders; and
- specific action steps, timelines for implementation, and resources to support the plan and responsible parties.

## **II. Identifying High Risk Consumers and Intervention Techniques**

### **A. Co-occurring psychiatric and substance abuse disorders.**

Spindletop MHMR Services (the "Center") recognizes that consumers who have serious mental illnesses or serious emotional disturbances and who are currently on probation or parole, or who have co-occurring psychiatric and substance abuse disorders are at risk for involvement with law enforcement. Therefore, the Center has trained staff to recognize and provide intervention services to consumers who are both mentally ill and have drug or alcohol abuse problems or who are involved with the criminal justice system. The Center trained existing staff in 2004 and 2005 on co-occurring psychiatric and substance abuse disorders, and this training is annually repeated. The goal of the ongoing training is to address dual symptoms which often trigger behaviors that result in intervention by law enforcement. In 2008, the Center's intake and crisis administrator and its community support services administrator designed a jail diversion screening process that is used by the Center's crisis and intake unit to more accurately assess appropriate clients who may be diverted.

### **B. Texas Correctional Office on Offenders with Medical or Medical Impairments Grant**

A major method of identifying high-risk persons occurs through ongoing communication with the local probation office. Each year the Center receives two grants from the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). Under these grants both agencies share specialized caseloads of adult offenders with mental illness and juvenile offenders who have an emotional disturbance.

The probation offices initially refer adult offenders who are considered to be at high risk of having a mental illness. If the results of an intake assessment determine that the person is eligible for the grant program, the person is placed on the specialized TCOOMMI caseload. Staff and the person determine the appropriate level of need for supervision. At each level of supervision the person receives a minimum of two face-to-face contacts each month. There is intensive tracking regarding compliance with treatment, and observable measures are developed for the probation officer to monitor. There are also regular treatment team meetings to review the person's treatment progress and compliance with their treatment plan. The goal of the agencies is to work together to support and assist the individual in managing their mental illness, including medication management, and to remain in compliance with probation office requirements in order to prevent recidivism.

The TCOOMMI grant for Jefferson County juveniles who are on probation funds a full time Qualified Mental Health Professional (QMHP-CS) from the Center and a full time probation officer from Jefferson County. These staff meet two to three times a week to discuss the intensive intervention for their mutual caseloads of twelve to fifteen youth. A Center consumer benefits specialist works with the families to ensure that they have access to all other appropriate funding sources. The goal of the agencies in working with this juvenile population is the same as for adults: to support and assist the person to manage their mental illness and medication and to remain in compliance with probation office requirements in order to prevent recidivism.

The Center's two TCOOMMI grants require ongoing cross training among adult and juvenile probation departments and Spindletop staff. The cost of this training is included in the grants.

### **III. Pre and Post Booking Strategies**

#### **A. Pre-Booking Strategies:**

A major strategy of this plan is to train center staff, law enforcement, adult probation, juvenile justice staff, and other first responders to understand each other's operating procedures, as well as to be able to distinguish mental illness from criminal behavior. In the course of their duties, these professionals are often the first to make a determination regarding whether a person's behavior is criminal. That initial assessment may determine if a person becomes involved in the criminal justice system, the mental health system, or both. Beginning in March 2005, Spindletop MHMR Services began training criminal justice staff in the four-county area on methods of identifying and communicating with persons with mental illness. Jefferson County law enforcement agencies served as pilots in implementing the jail and detention diversion task force's pre-booking strategies, and the other three counties provide valuable input through their task force representatives. The Center's intake and crisis staff make available training for all area jails on how to use the jail diversion screening process and how to identify symptoms of mental illness.

A major pre-booking strategy involves the appointment of one judge to hear all the arraignments of Jefferson County residents whom law enforcement believes may qualify for mental health services. A Jefferson County judge volunteered for this specialized caseload, and implementation began in fiscal year 2005. The Spindletop MHMR Services Chief Operating Officer is the chair of the jail and detention diversion task force, and the task force developed an arraignment flow chart that the task force is presenting to all affected law enforcement personnel.

A pre-booking strategy has been implemented for clients in a psychiatric crisis who are charged with a misdemeanor. The police officer at the scene contacts the STMHMR Services Mobile Crisis Outreach Team (MCOT) if the law enforcement officer believes the individual is a candidate for pre-booking diversion. If the client is new to the Spindletop MHMR Services system, then the client is transported to The Wood Group's Crisis Respite Center (CRC) and placed in a respite bed. The respite bed provides a limited placement of up to 48 hours, with the goal of having the individual complete the crisis intake process the next business day. In addition, the client has their initial psychiatric evaluation completed within 2 business days of their admission to the respite bed. For existing clients in the STMHMR Services Service Pack 1 or Service Pack 2, the MCOT is the primary server for these individuals during the crisis episode and is responsible for the individual until the crisis episode has abated. For individuals in Service Pack 3, the MCOT immediately notifies the person's case worker and assists the caseworker with crisis intervention as long as necessary. If the individual has a current Service Pack 4 assignment, then the MCOT immediately notifies the caseworker and remains at the scene until a member of the Center's Assertive Community Treatment (ACT) team arrives to assume the role of primary crisis responder.

#### **B. Post Booking Strategies**

##### **1. City and County Jails:**

Having been trained by Spindletop staff to recognize behaviors exhibited by persons with mental illness as opposed to criminal behavior, law enforcement personnel interact with the STMHMR Services crisis intake unit on a daily basis. The Center has presented to the area jails a process to improve the post booking jail diversion process. This process would include jail staff identifying a potential STMHMR Services consumer, completing a forensic pre-booking packet, and faxing this information to the STMHMR Services crisis intake department. Once the packet was received, the Center's crisis intake team would complete an intake assessment within 24 hours by using the Center's

telecommunication equipment. The proposal currently remains under consideration by two of the area jails and one county jail has rejected the proposed process.

One treatment alternative involves placement in the Spindletop MHMR Services contracted inpatient psychiatric treatment facility (Memorial Hermann Baptist Hospital Behavioral Health). This is for adults who present an imminent danger to themselves or others due to their psychiatric symptoms and who cannot be safely maintained in a custodial setting. The Center's commitment to law enforcement is to detain no officer longer than thirty minutes when escorting a person to the facility. Another treatment alternative is for patients who need services that are more intensive than routine outpatient services, but who do not require inpatient hospitalization. This treatment includes the Spindletop MHMR Services contracted crisis respite unit (The Wood Group CRC). Staff from private hospitals and law enforcement regularly meet with STMHMR Services staff to refine the referral process for consumers who meet exclusionary criteria for the contract inpatient facility or for any persons whose most appropriate, least restrictive placement is questionable but urgent. Spindletop MHMR Services has created a Memorandum of Understanding (MOU) that addresses post-booking strategies, and this has been signed by the Center, Jefferson County jails, probation and parole departments, the Jefferson County district attorney's office, and private hospital representatives.

In accordance with jail standards and requirements of the Texas Juvenile Probation Commission, all juveniles are screened for mental illness, suicidal ideations, or mental retardation, regardless of known or unknown history. Based on the screening results, Center staff determine the level of risk that the individual presents. If the juvenile consumer is determined to be a high risk, the jail or detention staff contact the Center for a more in-depth evaluation.

Telecommunication equipment currently set up at the detention center and at the Center allow Center psychiatrists and other Center staff to provide timely evaluations to determine if the individual meets the requirements for psychiatric services. If these consumers are found to be in need of services, they are transported to the Center by the criminal justice facility. Immediate intervention by the center helps ensure that placement in the most therapeutic treatment setting occurs.

Adults or juveniles who do not present an imminent danger to themselves or others may receive either:

- an intake appointment, if they are not currently a consumer;
- an appointment with their service coordinator; or
- an appointment with a psychiatrist for an evaluation

The Center provides psychiatric and medication related services to incarcerated consumers who have an open assignment. The Center projects that in fiscal year 2010 it will provide approximately one hundred and twenty (120) psychiatric evaluations for adult and adolescent individuals who are in county jails or detention centers.

## **2. CARE Matching**

Upon request, or notification from the jails or detention facilities, Spindletop MHMR Services now cross matches inmates to individuals in the CARE system within seventy-two hours of the receipt from jails of the booking records. Any detained person who is identified as a member of the priority population is immediately referred for mental

health services. If the person is presently in services, they are staffed to determine the most appropriate therapeutic treatment options available. The Center cross matches with the jails, juvenile detention facilities, parole offices, and probation agencies. Interconnectedness among jails, parole offices, detention facilities, and the center and individual systems for each county have been developed. All detained populations now are accurately cross matched in a timely manner. The STMHMR Services crisis and intake administrator works with the Center's information technology staff to update reports in the CARE jail match database in order to allow these records to be sorted by unit and subunit. These reports are daily distributed to the clinical administrators and other appropriate Center staff. When a match is made to an existing STMHMR Services client, the jail diversion screening will be completed by a TCOOMMI QMHP who will make an appropriate referral for necessary crisis or outpatient services.

**3. Court / Jail Liaison**

In order to facilitate post booking release, TCOOMMI will use its Continuity of Care (CoC) worker as liaisons between the courts, the Jefferson county jail, and STMHMR Services. The CoC staff will attend court for clients that meet diversion criteria in order to facilitate their transition into appropriate STMHMR Services mental health services and to ensure that any relevant legal charges are filed or dismissed.

**IV. Procedures for Referrals from Criminal Justice System**

**A. Law Enforcement:**

A Center liaison staff person regularly meets with the local police, sheriff and jail personnel to make sure that these law enforcement staff are always aware of how to contact Spindletop MHMR Services. When law enforcement makes a referral to STMHMR Services, Center staff obtain information regarding the person through an initial screening and schedule an intake evaluation of the person. In 2005, telecommunication equipment was successfully connected between the Center and the Jefferson County juvenile detention facility. This equipment supports video conferencing, including teleconference psychiatric evaluations. T-1 telephone lines were also installed, and the Center and the detention facility share the cost of the service. Video conferencing allows the Center's mental health professionals to more quickly evaluate the mental health needs of incarcerated individuals with no travel time and with fewer officers necessary for transportation. During fiscal year 2010, the Center plans to upgrade the telecommunications equipment used in the facilities. The Center's community support services administrator purchased additional telecommunications equipment for the local jails and the equipment was purchased in fiscal year 2009. This equipment is presently being installed and connected to the Center. When jail staff complete a jail diversion screening that meets the appropriate criteria, a Center crisis intake assessment is conducted, either face-to-face or via the new telecommunications equipment, and appropriate internal and external referrals are made.

**B. Adult and Juvenile Probation:**

Spindletop MHMR Services and the area adult probation departments work cooperatively through the TCOOMMI grants. For adult or juvenile offenders, the probation officer makes referrals to STMHMR Services that result in the offenders completing the intake process. If the consumer is determined to be eligible for Center service programs, the adult is placed on a specialized caseload, and the juvenile is assigned to a special resiliency package based upon their particular needs.

Spindletop MHMR Services maintains a Memorandum of Understanding with area county juvenile probation departments which outlines mutual and individual agency responsibilities for

establishing and maintaining a continuity of care system for juvenile offenders with mental illness.

Spindletop MHMR Services has also established a Memorandum of Understanding (MOU) with the Jefferson County adult probation department. The MOU outlines the mutual and individual agency responsibilities for establishing and maintaining a continuity of care system for adult offenders with mental illness. Also all agencies outlined in the recently amended Texas senate bill 839, that became effective September 1, 2007, now comply with the agency responsibilities for continuity of care processes as explained in the legislation.

**C. Texas Youth Commission (TYC) Referrals:**

If a child incarcerated by the Texas Youth Commission (TYC) has a mental illness or emotional disturbance and is nearing discharge, the child's parents or legally authorized representatives have the option of referring the child to Spindletop MHMR Services or obtaining their own private psychiatrist. If the parents wish for the child to receive Center services, TYC staff contact STMHMR Services to provide prescreening information and the child's TYC release date. Center staff review the information and contact TYC and the parents to arrange the intake appointment.

**V. Crisis Screening and Assessment Protocol for Detained Juveniles**

Youth detention officials contact Center staff when they believe a detainee may be eligible for Center services. If the youth is expressing suicidal or homicidal ideations or is in crisis, Spindletop MHMR Services staff assess the child in person, or in Jefferson County through telecommunications equipment. Detention center officials usually transport the person to the Center. Frequently Center staff go to the detention facility to complete the assessment. The Center and the juvenile probation departments in the area jointly function under procedures pursuant to Texas Administrative Code (TAC) 37, Chapter 343, Subchapter B 343:10. Based on the results of the crisis assessment, Center staff determine if placement at the Austin State Hospital or a local private psychiatric hospital is needed. If the child is hospitalized, then upon their release from the hospital, the child returns to the detention facility. Upon discharge from the detention facility, the child is referred to STMHMR Services for continuity of services. If the child is not expressing suicidal or homicidal thoughts or intent, detention facility staff recommend that the child's parents contact STMHMR Services upon the child's release from the detention facility.

**VI. Law Enforcement Training**

An ongoing strategy of STMHMR Services is to continue providing training for area law enforcement personnel on the early identification of persons with mental illness, appropriate intervention techniques, and expedited access to the mental health system. The Center works with police departments and sheriff's departments to provide refresher training to reinforce their growing knowledge base. In fiscal year 2006 Spindletop MHMR Services spent \$3,200 for Mental Health Peace Officer training for area law enforcement units, including the Beaumont Police Department. This extensive training pays for material, travel, and compensates officer time, and is noticeably costly. In addition, the Center continues to investigate additional funding sources for law enforcement training activities. In 2006, STMHMR Services jail diversion staff expanded their expertise by attending the GAINS-TAPA Center for Jail Diversion Workshop: Successfully Working with Adults with Mental Illness Involved in the Criminal Justice System.

**VII. Stakeholder Collaboration, Coordination and Integrated Funding:**

**A. Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Collaboration and Integrated Funding**

Individuals who have been served through the two TCOOMMI grants have been identified by the Center and criminal justice agencies as individuals at the highest risk of future criminal justice involvement. A team consisting of a probation officer and a Center mental health specialist jointly serves these targeted populations. These specialized caseloads receive intense supervision and treatment. The contract amount for the two grant programs in fiscal year 2010 will not exceed \$1,068,260.

**B. Community Resource Coordinating Groups (CRCG)**

In Jefferson and Orange counties, there are Community Resource Coordinating Groups for children and a special Adult Protective Services Task Force for adults. These groups are comprised of community service agencies that include Spindletop MHMR Services, the Texas Department of State Health Services Health Department Services, probation and parole officers, school representatives, children and adult protective services, and representatives from the South East Texas Regional Planning Commission's Area Agency on Aging. These groups address specific cases in which intensive services and creative interventions are needed. At these meetings the agency representatives discuss various ideas on how to collaborate and coordinate services and supports to meet the challenging needs of the individuals being discussed.

**C. Task Force**

A task force comprised of consumers, family members, local judges, district attorneys, key hospital personnel, police department, sheriff department, probation and parole office representatives, and Spindletop MHMR Services personnel has existed for two years. This group discusses barriers to services within the various service agencies, identifies concerns or problems that may have occurred since the last meeting, and shares ideas and methods for reducing recidivism, improving treatment options, and enhancing access to community services and supports.

**VIII: Status of Strategy Implementation as of November 30, 2009**

Strategy	Due Date	Responsible Party(s)	Action	November 2009 Update
I. Pre- and Post-Booking Memorandum of Understanding Signed by All Parties	12-15-05	Gary Hidalgo, COO, STMHMR	Ongoing discussions with Hermann Memorial Baptist Hospital, Jefferson County District Attorney, and judges.	Letters of Agreement have been signed with the Jefferson County District Attorney's office. Center in process of finalizing agreement with Jefferson County Sheriff's Department – due date 9-1-06.
II. Juvenile Detention Memoranda of Understanding Updated	9-1-05	Sally Walden, UM/QM Dir. STMHMR	MOUs updated and submitted to juvenile probation chiefs in four counties for signatures.	Action Completed.

III. CARE Cross Match System Refined to include all Jail Populations	12-31-05	Jerry Carnley, CIO, STMHMR	Outpatient clinic cross matching in CARE every day for Jefferson County, every other day for Hardin and Orange Counties	Action completed.
IV. Law Enforcement Training	Ongoing	STMHMR Services liaison staff	a. Informal training continues as liaison performs screenings in four counties. b. Sally Walden facilitated training with Beaumont Police Department - add'l trainings scheduled with department in other three counties. c. Sally Walden educated dispatchers in four counties on mental health issues.	Ongoing
<b>ADDITIONAL STRATEGIES FOR FY 2006</b>				
V. Submit grant for Mental Health Peace Officer for Jefferson County	12-05	Contract Grant Writer	Two grants submitted; another pending submission	Grants not awarded or received.
VI. Assist Police Academy administration in developing strategies on mental health issues for inclusion in Police Academy curriculum of FY 08	9-06	Police Academy and STMHMR staff	Initial discussion completed	Follow-up discussions ongoing.
<b>ADDITIONAL STRATEGY FOR FY 2006-2007</b>				
VII. Request funding from Jefferson County for mental health screeners to be assigned at the county jail on the 3-11 p.m. shift to divert detainees brought in on misdemeanor charges who present with mental illness.	10-06	Gary R Hidalgo, COO	Center has submitted letter of request to Jefferson County Commissioners Court.	Request denied.
<b>ADDITIONAL STRATEGY FOR FY 2007-2008</b>				
VIII. Request funding from TCOOMMI for additional telecomm. equipment for the local jails.	10-07	Robin Meek	Center will submit letter of request to TCOOMMI	Center continues to work on installation of the equipment in all counties


IX. Request funding from TCOOMMI to change the open full time QMHP position to a part-time contract LPC position to be used for Jail Intakes.	10-07	Robin Meek	Center will submit letter of request to TCOOMMI	Due to changing needs in the program, the position was not funded
X. STMHMR will begin using its TCOOMMI COC staff as court/ jail liaison	1-08	Robin Meek Garrett Craver	Robin & Garrett will begin to prepare training/ met with court jail personnel	The court liaison was hired in May 2009
XI. STMHMR will develop implement a Jail Diversion Screening training on the assessment.	1-08	Robin Meek Garrett Craver	Robin & Garrett will begin to prepare new assessment training.	Jail chose to use their own assessment tool
XII. STMHMR will develop new report(s) from the jail/ CARE match database to be used to identify clients.	10-07	Robin Meek, Garrett Craver Cathy Hartlieb	The group will begin to design useful reports targeted at jail diversion staff	An automated Internet-based reporting system is now in place.
<b>ADDITIONAL STRATEGY FOR FY 2009-2010</b>				
XIII. STMHMR Services will upgrade the telecommunications equipment located in the juvenile detention center	01-10	Garrett Craver, Jerry Carnley	The Center will purchase and install the equipment.	Ongoing
XIV. STMHMR Services will meet with jail diversion task force to propose eliminating misdemeanor 46B commitments	02-10	Garrett Craver	The purpose is to better use community resources to serve in the least restrictive environment incompetent consumers	Meeting to be held February 2010
XV. STMHMR Services will complete installation of telecommunications equipment in adult jails in Hardin and Orange County jails	03-10	Jerry Carnley, Robin Meek	Center staff will ensure that the new telecommunications equipment functions to enhance the jail diversion process	Equipment to be installed by March 2010

## **JAIL DIVERSION TASK FORCE MEMBERSHIP**

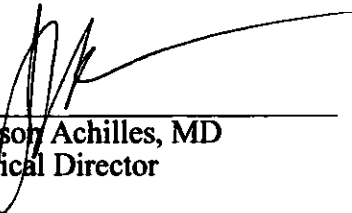
**Gary R Hidalgo, COO, Spindletop MHMR Services, Task Force Chair**  
**Ed Cain, Hardin County Sheriff's Department**  
**Tom Maness, Jefferson County District Attorney**  
**Claude Guidroz, NAMI, family member**  
**Melissa Ownby, Beaumont Policy Department**  
**Annie Bell, Adult Protective Services, TDRS**  
**C. Lopez, Adult Protective Services, TDRS**  
**James M. "Bubba" Martin, Jefferson County Juvenile Probation**  
**Frank Coffin, Chief, Beaumont Police Department**  
**Charles Harris, CEO, Spindletop MHMR Services**  
**Don Harmon, Orange County Sheriff's Office**  
**Keith Merritt, Orange County Sheriff's Office**  
**Mike Langley, Orange County Sheriff's Office**  
**Jennifer Esclovon, Jefferson County Jail Liaison to STMHMRS**  
**Betty Reynolds, Director of Adult Outpatient & Children Services, STMHMRS**  
**Sally Walden, Director of Network Services, STMHMRS**  
**Mario Watkins, Jefferson County Precinct 4**  
**Bradford Lowe, Captain, Jefferson County Sheriff's Office**  
**Ed Cockrell, Jefferson County Juvenile Probation Department**  
**Jan Tobias, Jefferson County CSCD**  
**Judge G.R. "Lupe" Flores, Jefferson County Court at Law # 2**  
**Gladdie Fowler, Chair, STMHMRS Board of Trustees**  
**Diane Perkins, Hardin County Sheriff's Office**  
**David Burrous, Hardin County Sheriff's Office**  
**Tommy Smith, Orange County Sheriff's Office**  
**Robin Meek, Program Administrator, STMHMRS**  
**Glenn Durst, Beaumont Police Department**  
**Ken Corona, Port Arthur Police Department**  
**Darrell Bush, Chief, Nederland Police Department**  
**Garrett Craver, STMHMR Services Staff Liaison**  
**Zena Stephens, Chief Deputy, Jefferson County Sheriff's Department**  
**Mitch Woods, Jefferson County Sheriff**  
**Joe Larive, Chambers County Sheriff's Department**

**Spindletop MHMR Services**  
**Jail and Detention Diversion Action Plan – Fiscal Year 2010**  
**Update on Strategy Implementation – November 2009**

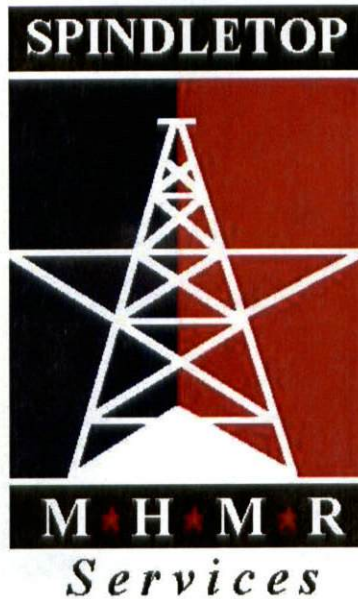
The STMHMR Services Chief Executive Officer (CEO) and Medical Director have reviewed and approved the Jail and Detention Diversion Action Plan for fiscal year 2010 (Latest Update – November 2009).

  
\_\_\_\_\_  
N. Charles Harris, Ph.D.  
Chief Executive Officer

2-10-10  
Date

  
\_\_\_\_\_  
Jackson Achilles, MD  
Medical Director

9 ES 10  
Date



## **Spindletop MHMR Services**

**Crisis Services Plan - Fiscal Year 2010  
Update on Strategy Implementation – November 2009**

## **I. Introduction:**

This Crisis Services Plan is developed in order to outline plans to increase crisis services at Spindletop MHMR Services (“the Center”). An increase in funding for crisis services was appropriated by the 80<sup>th</sup> and 81<sup>st</sup> Texas Legislature. For the biennial fiscal years 2009-2010, approximately \$82 million was allocated for crisis services throughout Texas to be distributed by the Texas Department of State Health Services (DSHS). The 81<sup>st</sup> Texas Legislature continued funding for crisis services for the biennial fiscal years 2009-2010. Additional funding was also provided to support intensive ongoing and transitional crisis services for consumers in a psychiatric crisis. The allocation of funds to Texas community mental health and mental retardation centers is distributed through a variety of methods, including equity distribution (approximately 32%), proportional allocations (approximately 36%), and a community investment incentive (approximately 30%), with 1.5% going towards state expenditures for implementation expenses. Spindletop MHMR Services (STMHMR Services) received \$294,567 in fiscal year 2008, \$354,567 in fiscal year 2009, and \$354,567 in fiscal year 2010 for its current crisis redesign project.

In addition, in May 2008 Spindletop MHMR Services also received \$1,008,000 to fund 48-hour extended observation services, and these funds were renewed in May 2009 for the biennial fiscal years 2010-2011. For the fiscal years 2010-2011, the Center received an additional \$205,381 for intensive ongoing and transitional crisis services.

## **II. History:**

The Texas Department of State Health Services (DSHS) assessed the crisis services needs of local communities over the past few years, and a panel of crisis service stakeholders from throughout the state of Texas met to develop a Texas Crisis Redesign Plan. The plan outlined the need for basic “core” crisis services. These include the following.

- 24 Hours Crisis Hotline
- Mobile Crisis Outreach Teams
- Crisis Outpatient Services
- 23-48 Hour Observation
- Community Residential Services
- Law Enforcement Crisis Intervention Teams and Mental Health Deputy Programs

The first priority for funds that are distributed to each Local Mental Health Authority (LMHA) is to use crisis funds for Crisis Hotline Services and Mobile Crisis Outreach Teams (MCOT). The DSHS standards require that crisis hotlines be continuously available 24 hours a day, 7 days a week, and that the hotlines be staffed by trained personnel, including Qualified Mental Health Professionals (QMHP). The hotlines must also be accredited by the American Association of Suicidology (AAS). The MCOTs must meet requirements that vary according to whether the LMHA is considered an urban or a rural center. Spindletop MHMR Services (STMHMR Services) has been classified as a rural center. The STMHMR Services MCOT must provide face-to-face assessments and crisis services 24 hours a day, 7 days a week. The goal is to provide emergency care, urgent care, and crisis follow up using a team approach, and the team must be able to provide face-to-face assessments within one hour of a request for eligible services.

If LMHAs receive enough funds through their state-based allocation from DSHS, these centers may develop additional local funding to provide additional services. These services may be developed with local stakeholder input and the services may be supported by funding through the crisis redesign funds and local matching funds.

These other crisis services include:

- Crisis Walk In Services
- Children's Outpatient Crisis Services
- Crisis Respite Treatment
- Crisis Stabilization Unit
- Emergency Crisis Psychiatric Services with Extended Observation
- Transportation Offsets for Local Law Enforcement

Initially, the allocation of crisis services funds received by Spindletop MHMR Services allowed for only the core service requirement to establish a Mobile Crisis Outreach Team (MCOT).

Spindletop MHMR Services has worked extensively over the past several years to increase and improve crisis services and crisis response in our catchment area. Numerous improvements, upgraded services, and staffing changes have been made in order to assure rapid response to crises, appropriate documentation of provided services, and to increase the number of available inpatient and residential crisis beds. An ongoing dialog continues with the Texas Department of State Health Services (DSHS) via reporting and auditing to monitor these enhancements. Once Spindletop MHMR Services was apprised of the allocation of additional funding and resources to be made available through the last legislative session, planning began to continue adding to the array of crisis services available in our community.

### **III. Stakeholder Input and Meetings:**

Spindletop MHMR Services views stakeholder education and input as essential components of a successful improvement process. The Center invites all crisis services stakeholders in our region to participate in this process and works to consider their feedback and contributions as the redesign of crisis services is implemented. Stakeholders who are unable to attend the meetings receive a follow-up letter that asks their feedback either by mail or individual phone call to the Center's Administrator of Crisis Services in order to ensure that every point of view is considered in the planning process. All stakeholders continue to be invited to stakeholder planning meetings regardless of their record of attendance at past meetings.

As required by the Crisis Services Planning guidelines, a comprehensive list of all area stakeholders was developed, and these agencies, providers, and individuals were invited to attend initial planning meetings at STMHMR Services. The first meeting to discuss the potential for new funding occurred with law enforcement representatives from all the agencies in our four county area. This meeting was held on September 18, 2007 and the executive staff from the Memorial Hermann Baptist Beaumont Hospital Behavioral Health Center (MHBH) was included. The emphasis of this meeting was on obtaining feedback regarding the contract between Spindletop MHMR Services and the Behavioral Health Center for crisis inpatient beds, notifying law enforcement agencies about the new funding, and requesting feedback for planning and implementing new services. The consensus from the meeting was that a Mobile Crisis Outreach Team (MCOT) would be a valuable asset to the region that would help to reduce the strain on law enforcement personnel, decrease jail admissions for people in psychiatric crisis, and divert people from emergency room and inpatient admissions. In addition, the area county sheriffs, chiefs of police, others agreed that the new system for psychiatric inpatient treatment has greatly improved their wait time for people brought in on an involuntary warrant and has made the access to inpatient treatment far less cumbersome for law enforcement officers.

Two more meetings were held on October 25, 2007 for community stakeholders and law enforcement. During these meetings, Spindletop MHMR Services staff educated the meeting participants about the new crisis funding and discussed the array of new potential services which could be added if future funding would support these services. The funding allocation to STMHMR Services was discussed and the requirement for starting a

Mobile Crisis Outreach Team was reviewed. Center staff explained that a MCOT is all that the initial new funding allows at this time. The feedback and support of the stakeholders was solicited in order for us to include their suggestions into the plan. The participants were also asked to submit their views on where they see gaps in crisis services in our community and to identify barriers that currently exist for people seeking crisis psychiatric services. The Center continues to hold ongoing meetings with crisis service stakeholders to continue keeping them apprised of progress as well as soliciting feedback on the implementation of the plan.

On December 7, 2007, the Center mailed a letter to the stakeholders who could not attend the initial stakeholder meetings. The letter explained the concept of the Mobile Crisis Outreach Team (MCOT) process and requested the stakeholders to send the Center their comments or feedback for consideration as the Center worked to implement the new MCOT. STMHMR Services received positive feedback about the need for the MCOT team from the CEO of Family Services, and a Jefferson County Commissioner from Precinct 4.

On August 13, 2009, the Center held another crisis services stakeholder meeting. In this meeting, the participants reviewed various issues and concerns, including the release authority of local judges, what happens after a local jail releases an inmate from jail, how to handle requests from the psychiatric hospital to local jails for information regarding consumers in a psychiatric crisis, assessments of inmates in local jails, and the status of the plan to install telecommunications equipment in the local corrections facilities.

#### **IV. Identified Gaps in Local Crisis Services:**

Current gaps in crisis service in our area identified by many of the stakeholders include a lack of inpatient detoxification programs for insured and uninsured individuals. While the local behavioral health center at the Memorial Hermann Baptist Beaumont Hospital does offer detoxification for people admitted when they present a danger to themselves, this is usually done in the behavioral health unit rather than in a designated substance abuse program.

Additionally, besides the Spindletop MHMR Services crisis services, law enforcement officers, and the area hospital emergency rooms, there are no other crisis systems or services in place in this region. Furthermore, in the STMHMR Services four-county catchment area of Chambers, Hardin, Jefferson, and Orange counties, there is only one private or public hospital that offers any behavioral health programs. This creates extremely limited referral options and a dearth of opportunities for consumer choice.

Another gap identified by the stakeholder group as an obstacle for recovery for people in a psychiatric crisis is the lack of affordable housing or supervised living placements that can be offered for people coming out of inpatient or residential treatment programs. This frequently and unnecessarily increases their length of stay.

Another consistently mentioned gap in services is the lack of public transportation in our region. Currently, the only public transportation system is a bus route in only in the one City of Beaumont. Even this service has limited routes and hours of operation. This issue is of great concern for all those who have a desire to comply with treatment and keep appointments, but who do not have the financial means or support system to get where they need to go. Since the only psychiatric inpatient hospital is located in Beaumont, this poses a significant challenge for people seeking to be voluntarily assessed, but who lack their own transportation.

Law enforcement officers uniformly identify a lack of personnel in their departments, which makes it extremely difficult to devote officers to the difficult and challenging issues created by people experiencing a psychiatric crisis. This shortage of officers, combined with the time it takes to transport people to the closest inpatient facility or state hospital (about a 4-5 hour drive from this region), creates a significant burden on law enforcement, especially the smaller departments that may have only two officers on patrol at any given time.

Family members added that they often feel their input and relevant information is not taken into consideration by professional staff or law enforcement. At times, the federal patient and record confidentiality requirements in the new Health Insurance Portability and Accountability Act (HIPAA) regulations prevent families from getting information or participating in treatment when their loved one does not consent to their inclusion, even if the family members believe they have a valuable contribution to make in the treatment and decision making process. Financial resources continue to be noted as a gap in accessing and providing enough services for people in need.

Local stakeholders were unanimous in their perception that existing resources are not adequate based on the size of our population and the prevalence of mental illness and substance abuse needs. The stakeholders also agreed that the new allocation of crisis funding is a good beginning, but they continue to urge leaders at the state level to continue their commitment to add financial resources to fully address the crisis response system.

## **V. Current Array of Crisis Services at Spindletop MHMR Services:**

The current array of crisis services offered by Spindletop MHMR Services includes the following.

1. **Crisis Hotline:** Spindletop MHMR Services currently contracts with the Harris County Mental Health and Mental Retardation Services helpline to respond to calls 24 hour per day, 7 days per year. This hotline is accredited by the American Association of Suicidology, and Spindletop MHMR Services regularly reviews with the Harris County MHMR Services administrators the telephone hotline staffing patterns. The psychiatric crisis hotline staff may call the Spindletop MHMR Services on-call QMHP to conduct a face-to-face assessment, or law enforcement to intervene in situations where there is perceived danger. In addition, the hotline staff may also refer consumers to next day appointments and then follow-up with STMHMR Services staff when the situation is not emergent. They may also request the person or their family to proceed to the Memorial Hermann Baptist Beaumont Hospital Behavioral Health Center for an assessment and inpatient screening.
2. **Crisis Inpatient Psychiatric Beds:** STMHMR Services has implemented a contract with the Memorial Hermann Baptist Beaumont Hospital Behavioral Health Center for inpatient hospitalization for both voluntary and involuntary beds. The contract is based on a per diem rate and the number of paid daily beds fluctuates based on consumer need and the availability of beds. Currently, our Center averages 6.9 patients per day that are paid for by the contracted funds. The contract with Memorial Hermann Baptist Beaumont Hospital specifies that the hospital will accept all appropriate Spindletop MHMR Services consumers regardless of a source of payment and who demonstrate a medical need for crisis inpatient services.
3. **Crisis Respite Beds:** In April, 2006, STMHMR Services contracted with The Wood Group to provide a 16 bed Crisis Respite Center (CRC). This respite center is located on the campus of STMHMR Services in an existing Spindletop MHMR Services building that was renovated to operate as a respite center. The 16 beds are used to provide 48-hour crisis respite services for any consumer in a crisis situation. After the 48-hour period, consumers are reassessed to determine if an additional stay in the crisis respite program is necessary. When no additional respite service is needed, consumers are referred to other appropriate STMHMR Services programs and other community service agencies. When determined clinically appropriate, consumers may stay in the crisis respite program up to 14 days, and after this 14 day period consumers are referred to other services. The STMHMR Services current allocation of funds for this program does not allow for any additional funding in this area at this time.
4. **Mobile Crisis Outreach Team:** STMHMR Services began the new mobile crisis outreach team (MCOT) in 2006, and the Center now has 6 full time professionals and 2 part-time professionals on the team. The team includes 5 Qualified Mental Health Professionals (QMHP), 1 Licensed Masters Social Worker (LMSW), who is the team leader, 1 half-time psychiatrist (MD), and a part-time Registered Nurse (RN). The MCOT team continues work in fiscal year 2010-2011.

5. **Extended Observation Service:** The Center began a new extended observation service in 2008, and this service continued into 2009. For fiscal years 2010-2011, this new service will continue with funding provided by DSHS. This service is provided through a contract with STMHMR Services and the Memorial Hermann Beaumont Baptist Hospital Behavioral Health Center facility. This service provides special observation by mental health professionals of consumers who may be in a psychiatric crisis but who may not necessarily need intensive treatment. During the extended observation period that can last no longer than 48 hours, professional staff interact with the consumer to determine the severity of their psychiatric emergency and the staff may also provide for the consumer stabilizing mental health medications when necessary. If the consumer's psychiatric crisis cannot be stabilized during the 48-hour extended observation time period, the consumer may then be admitted to the Behavioral Health Center for further inpatient treatment. This dynamic extended psychiatric observation program prevents these consumers from tying up hospital emergency staff who need to focus their attention and energies on patients with serious medical emergencies.

## **VI. Staff Training:**

All newly hired Spindletop MHMR Services employees are required to complete extensive initial training for one week prior to working in any program. This training includes a curriculum on crisis intervention. In addition, any professional clinician who works in the crisis intake unit completes an additional week of training in the unit as they also shadow an experienced crisis intake clinician. This training includes reviewing and conducting risk assessments, education regarding all Spindletop MHMR Services inpatient and outpatient services, the Texas Resiliency and Disease Management program requirements, the Texas Recommended Assessment Guidelines (Adult-TRAG), verification and documentation of medical necessity, all available community resources (for inpatient, outpatient treatment, referral sources, community programs such as Salvation Army, food kitchens, shelters, etc.), and observing assessments for voluntary and involuntary admissions for outpatient and inpatient services.

For the mobile crisis outpatient team, additional training is required, including one day of advanced crisis resolution training, one day of advanced risk assessment training, one day of shadowing a staff member at The Wood Group, and two days spent at the Memorial Hermann Baptist Beaumont Hospital Behavioral Health Center, including a staff person on the acute unit and another staff person in the screening and admissions unit.

All crisis intake staff attend daily meetings. In these meetings, new developments that have occurred overnight or the day before are reviewed, as well as all admissions to the Behavioral Health Center, The Wood Group, and any Texas state hospital admission. Each day, the crisis intake clinical administrator reviews all the crisis logs and assessments from the prior day and provides individual guidance and support to any clinician who requests it, or any clinician whose documentation suggests a need for more direct supervision.

Upon development of the new mobile crisis outpatient team, additional training curriculum was developed to include additional in-depth training on signs, symptoms, and crisis response to trauma, including sexual, physical, and verbal abuse and neglect. Additionally, crisis intake staff receive more training on signs, symptoms, and crisis response to substance abuse issues, and assessment and intervention with children and adolescents.

A training curriculum was developed and written by the crisis intake program administrator. The training includes 4-hours of training in the following classroom modules.

- Session I: Introduction to Crisis Counseling
- Session II: Advanced Crisis Assessment (includes children and adolescents)
- Session III: Lethality and Risk Assessment (includes substance abuse issues)
- Session IV: Advanced Crisis Intervention (includes trauma, abuse, neglect)

## **VII. STMHMR Services Crisis Services Budgets:**

Mobil Crisis Outreach Team (MCOT)	\$354,567
Extended Observation Crisis Services	\$504,000
Intensive Ongoing and Transitional Services	\$205,381

## **VIII. New Funding Use:**

Participants in the various crisis stakeholder meetings suggested that Spindletop MHMR Services use the first and second year of funding to develop a Mobile Crisis Outreach Team (MCOT). The Center has implemented a contract with the Harris County Mental Health and Mental Retardation Authority to provide a crisis telephone hotline service. This service began in April 2006. The Harris County MHMRA helpline has been accredited by the American Association of Suicidology, and the service answers all calls made to the Spindletop MHMR Services crisis hotline 24 hour a day, 7 days a week. In addition, in March 2006, the Center began a new contract with the Memorial Hermann Baptist Beaumont Hospital Behavioral Health Center. The Center reimburses the hospital for crisis psychiatric inpatient beds for indigent consumers. Also, in April 2006, Spindletop MHMR Services began a contract with The Wood Group to provide a 16 bed crisis respite program for voluntary admissions.

Center staff and crisis services stakeholders agreed that a mobile crisis outreach team would enhance existing services, reduce the burden on law enforcement agencies, and divert potential jail admissions by offering immediate and on-site crisis intervention and follow up. With the allocated funds STMHMR Services received in fiscal years 2008-2009, the Center implemented the new mobile crisis outreach team. In addition, the Center began the new extended observation program with special funds received in May 2008. The program was continued with renewed funds for fiscal years 2009, 2010, and 2011. In fiscal year 2010, the Center's crisis services were redesigned to accommodate the funds received from the Texas Department of State Health Services (DSHS) and to implement the DSHS requirements regarding intensive ongoing and transitional psychiatric services.

Additional psychiatric services were secured by increasing the time of a Center psychiatrist who moved from part-time to full time in crisis services. This allowed the Center to rearrange the crisis psychiatrist schedule to accommodate same-day, next-day treatment. In addition, this has allowed for more frequent follow-up appointments with the psychiatrist for consumers in crisis situations.

The Center also moved an existing intake eligibility therapist position into crisis services, which added an additional full time equivalent (FTE) position in these services. This position has enabled the Center's crisis services to more efficiently triage consumers who walk in with a psychiatric emergency, provide crisis intervention in a more timely manner, handle urgent and emergent phone callers who have not called the crisis hotline, and improve the continuity of care for consumers in a psychiatric crisis.

The new crisis services funds also enabled the Center to fund and add another caseworker position in crisis services. This position provides intensive ongoing crisis services to consumers who are being underserved in the Texas Resiliency Disease Management (RDM) service package 1. In addition, this position provides transitional services to consumers in RDM service package 5 for up to 90 days.

Of the new crisis services funds, \$45,000 were allocated for crisis service beds to be made available for consumers who require crisis respite and who are receiving intensive ongoing or transitional services.

The remaining new crisis services funds were used to complete minor renovations to the crisis unit to enable the unit to safely and efficiently serve consumers who walk into the unit. This included installing a new magnetic lock door and moving the reception area closer to the entrance to the unit. This was completed in response to concerns regarding safety and security of staff and consumers as the Center added these additional crisis services.

If additional funds are allocated in the future, other services will be added based on community need and local match.

#### **IX. Comparison of Current and Proposed Crisis Services:**

Since Spindletop MHMR Services has limited new funds allocated for crisis services, the Center has been able to add only intensive ongoing and transitional crisis services to the current array of crisis services. There will be no remaining funding to implement enhanced services. Any additional crisis services funding will be used to improve or enhance current crisis services.

#### **X. Coordination of the New Crisis Response System:**

Members of the Spindletop MHMR Services crisis services unit coordinate their services with the array of crisis service providers in our region. These include the Memorial Hermann Baptist Beaumont Hospital Behavioral Health Center for crisis inpatient admissions, The Wood Group crisis respite program, the Rusk and Austin state hospitals, and the local outreach screening and assessment referral (OSAR). Since Spindletop MHMR Services already has contracts with the only inpatient psychiatric hospital in the region and with The Wood Group, no additional agreements or memoranda of understanding will be necessary for these referrals.

STMHMR Services staff schedule biweekly meetings, as well as other more frequent meetings, with staff of the Memorial Hermann Baptist Beaumont Hospital's Behavioral Health Center and The Wood Group to discuss coordination of care between the Center and these behavioral health contractors. The meetings enable the staff to discuss the care and expected outcomes of consumers admitted for services, as well as provide opportunities for discussion of any possible issues or concerns regarding the referral, admission, and treatment of consumers.

In January 2008, Spindletop MHMR Services hired a new public information officer, and this professional is creating a marketing effort to ensure that the community is educated about and aware of the new mobile crisis outreach team and all the other psychiatric crisis services that are available in the region.

#### **XI. Implementation Timeline:**

The implementation of the new intensive ongoing and transitional crisis services began in October 2009, and these services will be fully implemented by January 2010.


#### **XII. Program Oversight:**

Oversight of the STMHMR Services crisis program includes data monitoring that focuses on the required performance measures identified in the Texas Department of State Health Services (DSHS) performance contract with the Center. Crisis services stakeholder input and satisfaction are also monitored on an ongoing basis through community meetings that are sponsored by Spindletop MHMR Services. Community stakeholders continue to be asked for their input regarding their needs and are kept apprised of progress with the benchmarks that are identified in the DSHS performance contract and of the implementation of the crisis services, as well as the likelihood that new funding may be allocated which might allow the Center to increase crisis response services in the future.

The Center's quality management department and its executive management team review the ongoing implementation of crisis services and data to determine the effect of the crisis services on psychiatric hospitalizations and repeat hospitalizations within 30 days after the end of the crisis episode. These internal functions also review the number and percentage of people who are linked to appropriate community services.

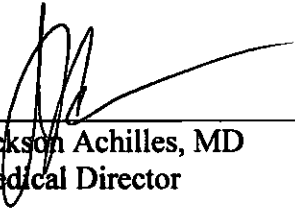
For example, the review process might include discussion of a typical consumer in a psychiatric crisis and their assigned level of care, or their service encounter at a substance abuse treatment facility. In addition, the teams might review the outreach, screening, or assessment and referral services provided to the consumer within 14 days of the crisis episode. Also reviewed is the transition from crisis assessment to crisis follow up services within 30 days of a crisis assessment. Finally, the percent of people who have a crisis inpatient hospitalization and who had a crisis assessment within 5 days prior to their admission will be monitored. The number of crisis relapses, the number of consumers in crisis who were served, and other relevant outcome measures are reported for consumers who receive intensive ongoing and transitional services.

The STMHMR Services Chief Executive Officer (CEO and Medical Director have reviewed and approved the Crisis Services Plan.



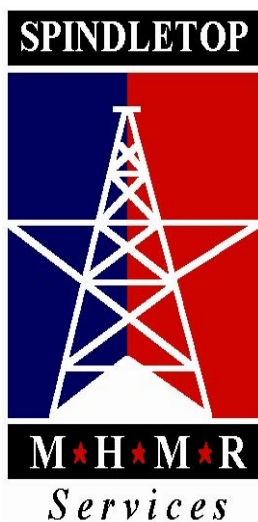
N. Charles Harris, Ph.D.  
Chief Executive Officer

2-10-10  
Date



Jackson Achilles, MD  
Medical Director

9 Feb 10  
Date



# LOCAL PLANNING & NETWORK DEVELOPMENT (LPND) Fiscal Years 2011 – 2012

For More Information, Please Contact:

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## TEMPLATE FOR PROVIDER NETWORK DEVELOPMENT PLAN

Complete and submit to [performance.contracts@dshs.state.tx.us](mailto: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.

### **Local Service Area**

Characteristics	Chambers County	Hardin County	Jefferson County	Orange County
<b>Population</b>	35,845	52,181	242,826	84,911
<b>Square miles</b>	629	897	990	380
<b>Population density</b>	57 per sq m	58 per sq m	245 per sq m	223 per sq m
<b>Male</b>	18,108	25,778	123,574	41,655
<b>Female</b>	17,737	26,403	119,252	43,256
<b>Anglo</b>	26,092	45,602	100,839	70,182
<b>Black</b>	3,716	4,374	89,876	8,747
<b>Hispanic</b>	5,665	1,881	39,177	4,340
<b>Other</b>	372	324	12,934	1,642

<b>Number of counties (total)</b>	4
◆ <b>Number of urban counties</b>	2
◆ <b>Number of rural counties</b>	2
◆ <b>Number of frontier counties</b>	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
Beaumont	Jefferson	110,553 (2008 - U.S. Census)	242,826 (Jefferson County)	245 – Jefferson County	45.52%
Port Arthur	Jefferson	55,910 (2008 – U.S. Census)	242,826 (Jefferson County)	245 - Jefferson County	23.02%
Orange	Orange	19,494 (2008 – U.S. Census)	84,911 (Orange County)	223 – Orange County	22.95%
Silsbee	Hardin	6,879 (2008 – U.S. Census)	52,181 (Hardin County)	58 – Hardin County	13.18%
Winnie	Chambers	3,200 (2007 – U.S. Census)	35,845 (Chambers County)	57 – Chambers County	8.93%

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.

- ♦ Jefferson County - Vietnamese (Asian) Population – 6,654 (2008 U.S. Census) – 14.2% Families Below Poverty level (2008 U.S. Census) – 17.6% Individuals Below Poverty Level (2008 U.S. Census)

## **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.

#### 2008 Planning Cycle

- ♦ The Center distributed to providers a copy of the draft LPND planning document, and requested comments on the plan.

January 1, 2010

- ◆ The Center posted at its extranet home page a public link to the draft LPND planning document.
- ◆ The Center distributed to providers a copy of the final version of the LPND planning document.
- ◆ The Center posted at its extranet home page a public link to the final version of the LPND planning document.
- ◆ The Center distributed to providers a copy of the draft Request For Application (RFA) procurement document, and requested comments on the document.
- ◆ The Center posted at its extranet home page a public link to the draft RFA document.
- ◆ The Center distributed to providers the final version of the RFA document. This includes sending providers via surface postal mail a paper copy of the RFA document, as well as an email message that included as an attachment an electronic Word file that contained the RFA document.
- ◆ The Center posted at its extranet home page a public link to the final version of the RFA document.
- ◆ The Center made telephone contacts with providers to inform them of the LPND planning document and the RFA document, and to discuss their interest in possibly procuring services.
- ◆ Providers have been invited to attend past STMHMR Services Local Planning and Network Development advisory council meetings, and providers are included as members of this advisory council.
- ◆ STMHMR Services presently has 2 contracts with private psychiatrists to provide services to consumers, and in the past the number of contract psychiatrists has varied from 6 – 8, and now numbers 2.

2009 Planning Cycle

- ◆ In FY 2010, the Center distributed to 13 private provider businesses, 7 private provider psychiatrists, and 3 consumer advocacy organizations a request for interest (RFI) package to determine level of interest in possible contracts for services
- ◆ In FY 2010, the Center held telephone meetings with private provider businesses to discuss their level of interest in possibly contracting for services

**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.*

<b>Provider</b>	<b>Source of Identification</b>	<b>Summary of Follow-up Meeting or Teleconference</b>	<b>Assessment of Provider Availability, Services, and Capacity</b>
The Wood Group (TWG Investments, LTD)	DSHS Website	No Follow-up Response To All Contacts in FY 2008	Indicated No Interest In Procuring Services

Sunwest Behavioral Health Organization	DSHS Website	No Follow-up Response To All Contacts in FY 2008	Indicated No Interest In Procuring Services
National Smart Healthcare Services	DSHS Website	No Follow-up Response To All Contacts in FY 2008	Indicated No Interest In Procuring Services
Family Services of Southeast Texas	RFI Response	No Follow-Up Response To All Contacts in FY 2008	Indicated No Interest In Procuring Services
Family Services of Southeast Texas	RFI Response	In Teleconference Discussion, Provider Expressed Interest in Traditional Counseling That STMHMR Services Does Not Provide	Provider Interested in Service Not Provided by Center
The Wood Group (TWG Investments, LTD)	DSHS Website & RFI Response	In Teleconference Discussion, Provider Expressed Interest in Continuing to Provide Services Already Under Contract with Center	Provider Interested in Continuing Providing Services Already Under Contract
Beaumont Psychological Services	RFI Response	RFI Response Indicated Interest in Continuing to Provide Psychological Testing Already Under Contract with Center and Traditional Counseling That STMHMR Services Does Not Provide	Provider RFI Indicated Interest in Continuing Providing Services Already Under Contract and Failed to Respond to Center Staff Attempts to Discuss RFI Response
National Smart Healthcare Services	DSHS Website & RFI Response	Provider Failed to Respond to Center Staff Attempts to Contact to Discuss RFI Response and Failed to Attend Face to Face Meeting. Staff Provided Provider a 45-Day Response Time Frame	After Provider Submitted RFI, Center Staff Contacted Provider via Telephone and E-Mail. Provider Expressed Preliminary Interest in Providing SP 2 Services. Following Initial Contact, Attempts Were Made to Set Up Face to Face Meeting via 3 Telephone Calls and 2 E-Mail Contacts. Provider Failed to Respond to All Attempts During 45 Day Period.

## 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.*

### 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, and Date or Timeframe	Participating Organizations (List)	Summary of Input Briefly summarize input relating to the network development plan. If the LMHA has identified interested providers, include recommendations for how the LMHA should implement the mandate to develop the provider network.	Number of Individuals		
			Consumers	Family	Other
Mental Health Planning and	Beaumont Hope Center, Jefferson	Summarized process of development of next 2010 LPND plan. Identified providers that indicated in 2009 at the DSHS website possible interest in procuring services for	1	3	5

Advisory Council February 18, 2010	County Probation Department, Mental Health Association	all Texas centers. Explained process of soliciting interested providers through a RFI to be issued in March – April. Explained process for procurement if interested providers respond to the RFI. Discussed concerns of the MHPAC regarding providing choice of providers that may not be in locations convenient for consumers and that may not continue to provide services over the long term.			
East Texas Behavioral Health Network (ETBHN) Regional Planning and Advisory Council March 11, 2010	Members Come From 11 Member Centers of ETBHN	Summarized process of development of next 2010 LPND plans. Explained process of soliciting interested providers through a RFI to be issued in March – April. Discussed results of LPND planning process. Discussed concerns of the local Center MHPACs regarding providing choice of providers that may not be in locations convenient for consumers and that may not continue to provide services over the long term.	3	7	4
East Texas Behavioral Health Network (ETBHN) Regional Planning and Advisory Council May 11, 2010	Members Come From 11 Member Centers of ETBHN	Summarized status of development of next 2010 LPND plans. Reviewed strengths, weaknesses, opportunities, and threats (SWOT) facing the 11 ETBHN member centers, and existing gaps in adult and children services. Reviewed for RPNAC the number and type of RFI responses.	3	7	4
Mental Health Planning and Advisory Council May 27, 2010	Beaumont Hope Center, Jefferson County Probation Department, Mental Health Association	Reviewed the 11 ETBHN member center SWOT analyses and the development of the local network plans. Reviewed RFI responses and attempts being made to contact prospective providers to discuss their RFI response.	1	3	5
Public Meeting May 28, 2010, 10:00 am, STMHMR Services Board Room	Existing Consumers and Community Were Targeted via Notices Posted in all Locations	No one showed up for this scheduled meeting.	0	0	0
East Texas	Members Come	Reviewed and approved the STMHMR Services 2010 LPND plan	3	7	4

Behavioral Health Network (ETBHN) Regional Planning and Advisory Council July 7, 2010	From 11 Member Centers of ETBHN				
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**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.*

<b>Date</b>	<b>PNAC Activity and Recommendations</b>
February 18, 2010	Summarized process of development of next 2010 LPND plan. Identified providers that indicated in 2009 at the DSHS website possible interest in procuring services for all Texas centers. Explained process of soliciting interested providers through a RFI to be issued in March – April. Explained process for procurement if interested providers respond to the RFI. Discussed concerns of the MHPAC regarding providing choice of providers that may not be in locations convenient for consumers and that may not continue to provide services over the long term.
March 11, 2010	Summarized process of development of next 2010 LPND plans. Explained process of soliciting interested providers through a RFI to be issued in March – April. Discussed results of LPND planning process. Discussed concerns of the local Center MHPACs regarding providing choice of providers that may not be in locations convenient for consumers and that may not continue to provide services over the long term.
May 11, 2010	Summarized status of development of next 2010 LPND plans. Reviewed strengths, weaknesses, opportunities, and threats (SWOT) facing the 11 ETBHN member centers, and existing gaps in adult and children services. Reviewed for RPNAC the number and type of RFI responses.
May 27, 2010	Reviewed the 11 ETBHN member center SWOT analyses and the development of the local network plans. Reviewed RFI responses and attempts being made to contact prospective providers to discuss their RFI response.
July 7, 2010	Reviewed and approved the 11 ETBHN member center LPND plans

## 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 CATEGORY	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 Services	\$7,126,669	\$1,957,884	27%	\$7,556,410	\$2,375,211	31%	\$7,832,942	\$2,120,127	27%	\$4,106,221	\$1,165,717	28%
Child/Adol MH Services	\$2,184,606	\$130,807	6%	\$2,532,418	\$150,104	6%	\$2,827,988	\$132,539	5%	\$1,459,302	\$46,370	3%
TOTAL MH Services	\$9,311,275	\$2,088,691	22%	\$10,088,828	\$2,525,315	25%	\$10,660,930	\$2,252,666	21%	\$5,565,523	\$1,212,087	22%
<b>Breakout of CONTRACTED SERVICES:</b>												
Medication and Labs		\$576,437	28%		\$643,297	25%		\$572,310	25%		\$327,330	27%
Physician Services**		\$423,699	20%		\$504,586	20%		\$191,754	9%		\$95,223	8%
Counselor Services**			0%			0%			0%			0%
Crisis Services			0%		\$126,715	5%		\$434,985	19%		\$252,000	21%
Residential Services		\$234,495	11%		\$462,422	18%		\$467,471	21%		\$233,034	19%
Inpatient Services		\$854,060	41%		\$788,295	31%		\$586,146	26%		\$304,500	25%
Other (list):			0%			0%			0%			0%
			0%			0%			0%			0%
			0%			0%			0%			0%
TOTAL		\$2,088,691	100%		\$2,525,315	100%		\$2,252,666	100%		\$1,212,087	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.

Complete the table below. For FY 2010 data, provide information from the first six months of the year (September 2009 through February 2010), using six month figures in both the numerator and denominator when calculating percentages.

**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.

<b>Provider</b>	<b>Service(s)</b>	<b>Provider Type</b>	<b>Dollars Allocated</b>
MHMRA of Harris County	◆ Crisis Hotline (Adults & Children)	Organization	\$52,500
Baptist Hospital of Southeast Texas	◆ Crisis Stabilization ◆ Extended Observation	Organization	\$1,200,000 \$504,000
The Wood Group	◆ Crisis Respite	Organization	\$463,500
Victor Fermo, MD	◆ Medication Services (Adults & Children)	Individual	\$54,000
Sudheer Kaza, MD	◆ Medication Services (Children)	Individual	\$85,000
Dorothy Henges, LPC	◆ Counseling (Adults & Children)	Individual	\$15,000

**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			
	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
<b>Adult Service Packages</b>									
Adult RDM SP 1	1,969	0%	0%	0%	0%				
Adult RDM SP 2	32	0%	0%	0%	0%				
Adult RDM SP 3	247	0%	0%	0%	0%				
Adult RDM SP 4	60	0%	0%	0%	0%				
Adult RDM SP 0	24	0%	0%	0%	0%				
Adult RDM SP 5	5	0%	0%	0%	0%				
TOTAL Adult Services	2,337	0%	0%	0%	0%				
<b>Child Service Packages</b>									
Children's RDM SP 1.1	233	0%	0%	0%	0%				
Children's RDM SP 1.2	1	0%	0%	0%	0%				
Children's RDM SP 2.1	1	0%	0%	0%	0%				
Children's RDM SP 2.2	115	0%	0%	0%	0%				
Children's RDM SP 2.3	0	0%	0%	0%	0%				
Children's RDM SP 2.4	0	0%	0%	0%	0%				
Children's RDM SP 4	99	0%	0%	0%	0%				
Children's RDM SP 0	7	0%	0%	0%	0%				
Children's RDM SP 5	0	0%	0%	0%	0%				
TOTAL Children's Services	456	0%	0%	0%	0%				

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 FY 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
Crisis Hotline (Adults & Children)	7,782 Total Hotline Calls 945 Urgent / Emergent	100%	100%	100%	100%	100%	100%	1	
Crisis Stabilization	1,081 Days	100%	100%	100%	100%	100%	100%	1	
Extended Observation	14,527 Hours	100%	100%	100%	100%	100%	100%	1	
Crisis Respite	197 Admissions	100%	100%	100%	100%	100%	100%	1	
Medication Services	870 Unduplicated Consumers	32%	32%	23%	23%	23%	23%	2	
Counseling (Adults & Children)	32 Unduplicated Consumers	100%	100%	100%	100%	100%	100%	1	

## 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.

Spindletop MHMR Services (the Center) delivered to possible providers a request for interest package of information regarding the current LPND planning cycle. The package described the possible services that might be procured by the Center in fiscal years 2011 – 2012. One provider indicated interest in continuing to provide psychological testing services already under contract, one provider indicated interest in providing a type of

counseling that the Center does not procure, and one provider failed to respond to repeated requests for an onsite face to face meeting to discuss their experience and qualifications to procure services. Therefore, no additional services will be procured in fiscal years 2011 – 2012.

- 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 – Does Not Apply

- 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.*

<b>Service</b>	<b>Capacity Needed</b>	<b>External Provider Capacity</b>	<b>Information and Method Used to Determine External Network Capacity</b>
N/A - Does Not Apply			

- 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.*

<b>Service</b>	<b>Transition Period</b>	<b>Year of Full Procurement</b>
N/A - Does Not Apply		

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 – Does Not Apply

**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.*

NA – No qualified, experienced providers

**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*

- ♦ NA – No qualified, experienced providers

**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
NA – No qualified, experienced providers	NA

**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)*

<b>Date(s)</b>	<b>Method (RFA or RFP)</b>	<b>Service or Combination of Services to be Procured</b>	<b>Geographic Area(s) in Which Service(s) will be Procured</b>	<b>Percent of Clients</b>	<b>Rationale</b>
NA	NA	NA	NA	NA	NA – No experienced, qualified providers

**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.*

NA – No experienced, qualified providers

**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.*

- ♦ NA – No experienced, qualified providers

## 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
NA – No experienced, qualified providers	NA

### 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.

- ◆ NA – No experienced, qualified providers

### 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.

NA – No experienced, qualified providers

## 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.

- ◆ 4-County telemedicine continues to be developed
- ◆ Automated human resource functions, including payroll and benefits management
- ◆ Automated Center billing through insurance carriers for services provided to consumers
- ◆ Centralized SharePoint file sharing
- ◆ Converting paper records into electronic medical records
- ◆ Regionalized utilization management to control admission of consumers for services
- ◆ Implement regional wide area network with 10 other member centers of ETBHN
- ◆ Joined regional ETBHN veterans service initiative
- ◆ Continue to support and participate with ETBHN regional planning and network advisory committee (RPNAC)
- ◆ Continue to consolidate staff functions when Center staff resign or retire

- ◆ Participated in regional ETBHN purchasing functions for regular operational supplies
- ◆ Telemedicine has been implemented in all jails
- ◆ Reduced FTEs in administrative roles of human resource and financial services
- ◆ Developed productivity standards and measures for clinical staff
- ◆ Providing fund development consultation to ETBHN centers as revenue generating opportunity
- ◆ Implemented standardized office design and equipment material
- ◆ Implemented a performance improvement team to decrease no-show rates and reduce wait time between request for service and appointment for service

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
9-1-09	11 member centers of ETBHN	Regional utilization management
9-1-09	11 member centers of ETBHN	Regional file sharing
9-1-09	11 member centers of ETBHN	Regional medical records conversion
9-1-09	11 member centers of ETBHN	Regional pharmacy
9-1-09	11 member centers of ETBHN	Regional audio/video teleconferencing

Identify any current efforts and plans to develop new opportunities for working jointly with other LMHAs.

- ◆ Working with ETBHN centers on regional veterans services initiatives
- ◆ Working with ETBHN centers on collaborative fund development initiatives
- ◆ Developing joint collaborative human resource functions and staff training

## **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)
NA – No interested providers	NA – No interested providers

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

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.

- ◆ Other than existing contracts for discrete services, the Center will not be adding additional provider services until a network of providers to manage is established.

**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.

Barriers	Plans
Relatively Small Community	Continue to market the Center to the community
Close to Harris County	Enhance the general awareness of the community’s attractions
Shortage of Licensed Providers	Improve relationship with area university to produce more licensed

	professionals, and continue to work with nearby medical school to attract more clinical residents to the area
Providers Reluctant To Meet DSHS Contract Requirements	Work with DSHS and private providers to streamline regulations and contract requirements
Shortage of Reasonably Priced Office Space	Work with local chambers of commerce to obtain reasonably priced office space and consider the option of sharing existing Center office space with external providers.
Lack of Public Transportation	Work with area transportation providers to expand public transportation.
Center Catchment Area is in a Hurricane Area of Texas	Assist providers with storm preparation and evacuation planning Given that the Center has been impacted by 2 major hurricanes within the past 5 years, major emphasis in the Center and in the community has been placed on recovery and restoration.
3,260 Total Square Miles in the 4-County Catchment Area	Possibly expand telemedicine services to alleviate MD travel expense
Rising Cost of Gasoline Makes Traveling to the Different Areas of the 4-County Catchment Area Difficult, if not Cost-Prohibitive	Work with providers to ensure service locations are near bus routes when possible
Relatively High Rate of Uninsured in Southeast Texas	Work with elected officials to make it easier for small businesses to obtain more affordable insurance by enforcing current law that allows small businesses to form cooperatives to purchase health insurance
Typical Service Reimbursement Rate of Payment not Attractive to Providers	Medicaid rates are again expected to be reduced in the next biennium due to legislative budget deficit. Continue to lobby to maintain sufficient funding. Plan to work with local FQHCs and other healthcare entities to integrate behavioral health services with medical services and take advantage of new Medicaid eligible consumers that are likely to need services as a result of national healthcare reform

## **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.*

NA – No Interested Providers

This is the second planning cycle that has resulted in no experienced, qualified providers interested in contracting for services. In the next procurement cycle, the Center will continue to reassess the availability of providers, as well as the implications of the national healthcare reform legislation in order to determine availability and viability of future procurement efforts. The Center will continue to evaluate its operations and functions in order to increase cost effectiveness and reduce administrative overhead costs.

### **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.*

- ◆ Draft plan will be posted at STMHMR Services extranet for public comment for the required 14-day period
- ◆ Draft plan will be sent to local NAMI group and the local Mental Health Association
- ◆ Draft plan will be distributed to members of the MHPNAC

## **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.*

NA – No experienced, qualified providers

### **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.*

NA – No experienced, qualified 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.*

<b>Comment</b>	<b>Stakeholder Group(s)</b>	<b>LMHA Response and Rationale</b>
STMHMR Services received no comments on this LPND plan.	N/A	No response necessary

**COMPLETE AND SUBMIT ENTIRE PLAN TO [performance.contracts@dshs.state.tx.us](mailto:performance.contracts@dshs.state.tx.us) AS REQUIRED.**

## 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.