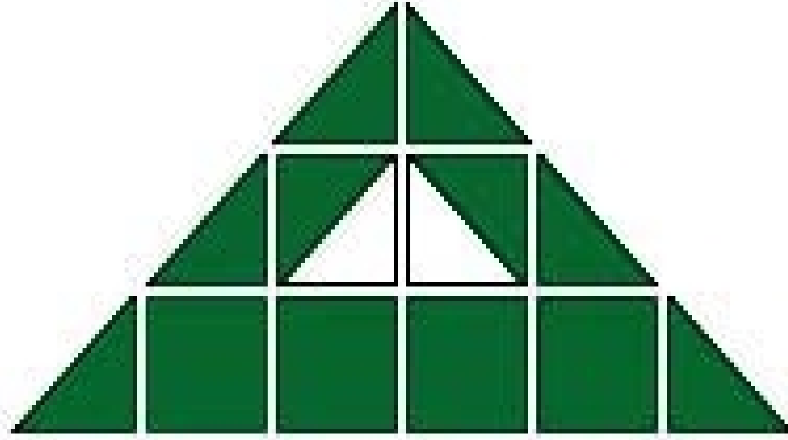

Andrews Center

Behavioral Healthcare System

THE LOCAL SERVICE AREA PLAN

FY 2011 – FY 2012

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ANDREWS CENTER
TEMPLATE FOR
PROVIDER NETWORK DEVELOPMENT PLAN
Fiscal Years 2011 - 2012

Local Service Area

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

Population	397,603
Square miles	3,412
Population density	107
Number of counties (total)	5
◆ **Number of urban counties**	0
◆ **Number of rural counties**	5
◆ **Number of frontier counties**	0

Major populations centers (add additional rows as needed):

Name of City	Name of County	City Population	County Population	County Population Density	County Population Percent of Total
Tyler	Smith	83,650	206,781	218	52%
Whitehouse	Smith	5,346	206,781	218	52%
Lindale	Smith	2,954	206,781	218	52%

Athens	Henderson	11,297	81,314	86	20%
Canton	Van Zandt	3,292	53,658	62	14%
Mineola	Wood	4,550	44,888	64	11%
Emory	Rains	1,021	10,962	42	3%

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.

- Hispanic persons make up the largest minority population (16% of total population)
- Most persons who are non-English speaking communicate in Spanish
- There is a large medical community in Tyler (Smith County) and Athens (Henderson County)

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.

- Posted Andrews Center's interest in contracting services on Andrews Center Website (2008 & 2010)
- Placed public notice in regional newspaper to notify potential external providers of the opportunity to document their interest on the DSHS Website (2008 & 2010)
- Contacted professional organizations and notified them of our interest in contracting services. (2008)
- Issued RFA for Pharmacological Services and Counseling Services in 2009
- Posted Andrews Center's interest in contracting for Crisis Respite Services on Andrews Center Website in 2010
- Issued RFP for Crisis Respite Services in 2010 (posted on website and notice in paper)

2) Provider Availability

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

Provider	Source of Identification	Summary of Follow-up Meeting or Teleconference	Assessment of Provider Availability, Services, and Capacity
The Wood Group	DSHS Website	Teleconference with Jerry Parker – 3/25/10 – Primarily interested in providing discrete Psychosocial Skills Training services from SP3. Also interested in providing Supported Housing and Supported Employment services. Would need a minimum of 50 consumers to make this viable. Would consider doing complete service packages if there were enough SP3 services available. Would not do SP1 or SP2 services unless they also got SP3 services. Would need a minimum of 75 SP3 consumers to do 25 to 100 SP1s and up to 4 SP2s. If there were sufficient numbers, could provide doctor services and medications. Also interested in providing some MR services such as planned respite and community support.	Provider has a good track record with other LMHAs with the services they are interested in. Discrete services could be provided within 30 to 60 days. Complete service packages would depend on doctor services and number of SP3 consumers who were available. Would need a minimum of 50 persons in discrete skills training services to be interested. Did not have an upper capacity limit.
Avail Solutions, Inc.	DSHS Website	Face-to-face meeting with Janie Harwood – 4/13/10 – Primary interest is in continuing to provide Crisis Hotline and MCOT services. Has the ability to provide telephone intake screening and make appointments for assessment if we need these services at some point.	Provider has fulfilled her contracts with us and done a good job with these over the years. Can provide needed services immediately. No problem with capacity as they are already doing these jobs for us.
Ava Weaver	e-mail notice from Tamara Allen (DSHS)	Face-to-face meeting with Ava Weaver – 6/3/10 – Primary interest is CBT and Assessments with a special interest in child and adolescents but has experience with adults. Has LPC Texas NCC certification. Does not have own office location for services. Would need to use	Will need to check with other LMHAs this provider has worked for but seems to have credentials and experience needed. Is available now

		Andrews Center site. Wants to work primarily in Tyler office and maybe Mineola. Does not currently live in Tyler or any of our counties and would have to drive in for appointments. Would need enough consumers to make this viable but had no particular requirement for minimum #s. Has worked for Lakes and Hunt County previously. She is already on provider panel for some HMO's.	to provide services but does not have location. Not sure as to capacity as this is a single provider who is currently working on another contract with the center for autism services.
Melinda Bird	e-mail notice from Tamara Allen (DSHS)	Teleconference with Melinda Bird – 6/9/10 – Primary interest is in providing services for the IDD population. Currently has an associate degree in liberal arts and working on bachelors. Did not know that this current network development effort was for the MH consumer population.	Does not have the educational background needed to provide MH services and the provider is focused on IDD services. Does not seem to be a viable candidate for contracting.

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 _X___ No

If no, briefly describe the difference.

Two providers expressed interest late in the process. The Regional PNAC met earlier and was apprised of the two potential providers that had made contact at that time. Interagency Meetings were held in all counties during May which was prior to the two additional interested providers being identified. The Local Advisory Committee will be met on 6/23/10 and was advised of the additional provider contacts at that time. Consumer and Stakeholder surveys were reviewed and their guidance was solicited at that time regarding contracting possibilities that meet the needs of the community.

4) <u>Community Engagement</u>

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**
Consumer Survey was solicited at all MH Clinic sites	All consumers who presented at the each MH	Surveys distributed to all consumers who entered the MH Clinics during this week period. Postage paid envelopes were offered to those who wished to take the survey home to complete. 210 surveys were returned representing all five counties in our	152	55	32

from 5/10/10 thru 5/14/14 from 8:00 a.m. to 5:00 p.m.	Clinic during the time frame listed previously.	service area. 73% or the returned surveys were from current consumers. 77% of the returned surveys indicated that choice of providers was somewhat or very important. Counseling and Psychiatric services were the top selections when asked which services were most important to have choice and were also selected as the top two when asked what services were most important. 70% of the respondents preferred to have all of their services provided in a single location and 62% preferred to have these services provided by a single organization. The biggest problems identified to accessing MH services were lack of insurance (Medicaid/Medicare/Private Insurance) and the wait time for the first physician visit. 70% or the respondents stated that they were satisfied or very satisfied with the services they are currently receiving.			
Community Stakeholder Survey was presented during interagency meeting at all MH Clinics during May 2010	Private Provider Government Official Interested Citizen Judicial System Law Enforcement Employee	Surveys and postage paid envelopes distributed to all representatives from other agencies in attendance at this meeting. Extra surveys and postage paid envelopes were also provided for agencies to take to representatives who were not in attendance. 18 surveys were returned representing Henderson, Smith and Van Zandt Counties. Respondents represented Governmental Officials, members of the Judicial System, Law Enforcement, Local Private Providers and Interested Citizens. As in the consumer survey, Counseling services and Psychiatric services were the two most important services for the community that were identified by this group. In addition, this survey also identified Crisis Services (Hotline, Mobile Outreach, Stabilization, and Transportation) as very important services. Stakeholders identified the following as important factors in contracting for service providers in this community: ◆ All services in the same location ◆ Convenient location ◆ Cost of services ◆ Length of time for the appointment ◆ Transportation available The two most identified gaps on current services were access to services for those persons not in crisis and transportation.			18
Interagency Meeting – Van	Andrews Center Employees	Discussed LPND process and the two potential providers who have expressed interest in providing services under contract with the Center. Stakeholder surveys were			11

Zandt County 5/12/2010	Van Zandt Co. Commissioner Rep. Cosby Germany Hosp. Rep. Van Zandt Co. Sheriff's Office	provided to the agencies present along with postage paid envelopes. Representatives were asked to take the surveys back and ask others in their organizations to complete and return them.			
Interagency Meeting – Henderson County 5/18/2010	East Texas Medical Center-Athens East Texas Medical Center-Behavioral Health Center Henderson County Sherriff's Office Terrell State Hospital Henderson County Atty's Office Henderson County Gov. Interested Citizen	Discussed LPND process and the two potential providers who have expressed interest in providing services under contract with the Center. Stakeholder surveys were provided to the agencies present along with postage paid envelopes. Representatives were asked to take the surveys back and ask others in their organizations to complete and return them.			29
Consumer Meeting – Henderson County	Interested Citizen	No consumers attended this meeting. Only one person representing a local church did attend this meeting. Local planning was discussed and ways in which the church could assist in meeting the needs of citizens in the community. Meeting notice was posted on			1

5/18/2010		Andrews Center Website and posted in several locations in the MH Clinic Office.			
Consumer Meeting- Van Zandt County 5/18/2010	No Attendance	No consumers attended this meeting. Meeting notice was posted on Andrews Center Website and posted in several locations in the MH Clinic Office.			
Interagency Meeting – Wood-Rains County 5/19/2010	Andrews Center Staff TCOOMMI Staff Avail Solutions Staff Terrell State Hospital Staff	Discussed LPND process and the two potential providers who have expressed interest in providing services under contract with the Center. Stakeholder surveys were provided to the agencies present along with postage paid envelopes. Representatives were asked to take the surveys back and ask others in their organizations to complete and return them.			9
Consumer Meeting- Wood-Rains County 5/19/2010	No Attendance	No consumers attended this meeting. Meeting notice was posted on Andrews Center Website and posted in several locations in the MH Clinic Office.			
Consumer Meeting- Smith County 5/19/2010	No Attendance	No consumers attended this meeting. Meeting notice was posted on Andrews Center Website and posted in several locations in the MH Clinic Office.			
Interagency Meeting – Smith County 5/25/2010	Andrews Center Staff Smith Co. Sherriff's Office Tyler Police Department TCOOMMI Trinity Mother Francis Hospital ETMC-	Discussed LPND process and the two potential providers who have expressed interest in providing services under contract with the Center. Stakeholder surveys were provided to the agencies present along with postage paid envelopes. Representatives were asked to take the surveys back and ask others in their organizations to complete and return them.			19

	Behavioral Health Center				

5) PNAC Involvement

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

Date	**PNAC Activity and Recommendations**
Regional PNAC Meeting – 3/11/2010	Discussed LPND planning for the current cycle. Planning timelines from each member center was presented to the committee for review. Both members representing Andrews Center were present and participated in this meeting.
Local MH Advisory Committee Meeting – 3/18/2010	Discussed LPND planning for the current cycle. Planning timeline was presented to the group. Discussed Wood Group who had expressed an interest in contracting for discrete Rehab services, supported employment and supported housing. Discussed plans for consumer and stakeholder meeting. Draft consumer/family survey was presented for review and suggestions for change. Some suggestions for changes were made and incorporated in document.
Regional PNAC Meeting – 5/11/2010	Local plan development was discussed with the RPNAC members. During the meeting, the committee members developed a SWOT analysis for regional services that will be provided to the Boards of Trustees of each member center. This SWOT analysis was provided to each center liaison for use with development of the LMHAs LPND development. Both members representing Andrews Center were present and participated in this meeting.
Local MH Advisory Committee Meeting – 6/23/2010	Results of the Consumer and Stakeholder Surveys were review with the committee. Four providers who have expressed interest in contracting with the Center were discussed along with their areas of interest. Results of the Consumer/Stakeholder surveys were reviewed. LPND Template was shared with the committee for review, comment and suggestions for change. Committee members were notified that the completed template would be posted on the Andrews Center website for a 14 day review and comment period and they would be notified when it was uploaded.

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	$4,521,076	$1,146,841	25%	$4,789,162	$1,192,357	25%	$4,872,188	$1,204,718	25%	$2,417,640	$505,929	21%
Child/Adol MH Services	$1,414,890		0%	$1,354,628		0%	$1,361,515		0%	$731,014		0%
TOTAL MH Services	$5,935,966	$1,146,841	19%	$6,143,790	$1,192,357	19%	$6,233,703	$1,204,718	19%	$3,148,654	$505,929	16%
Breakout of CONTRACTED SERVICES:												
Medication and Labs		$1,006,692	88%		$864,297	72%		$725,784	60%		$301,534	60%
Physician Services**			0%			0%		$66,275	6%		$0	0%
Counselor Services**			0%			0%		$19,584	2%		$7,820	2%
Crisis Services		$16,501	1%		$220,435	18%		$222,000	18%		$111,000	22%
Residential Services			0%			0%			0%			0%
Inpatient Services		$123,648	11%		$107,625	9%		$171,075	14%		$85,575	17%
Other (list):			0%			0%			0%			0%
			0%			0%			0%			0%
			0%			0%			0%			0%
TOTAL		$1,146,841	100%		$1,192,357	100%		$1,204,718	100%		$505,929	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.*

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

Provider	Service(s)	Provider Type	Dollars Allocated
Avail Solutions	◆ Crisis Hotline ◆ MCOT	Organization	$222,000
East Texas Behavioral HealthCare Network	◆ Pharmacy ◆ TRAG Authorizations	Organization	$450,428
Behavioral Health of Longview	◆ Community Inpatient	Organization	$40,000
ETMC Behavioral Health Center	◆ Community Inpatient	Organization	$89,950
LabCore	◆ Patient Lab	Organization	$91,449
*JSA	◆ Tele-Psychiatry	Organization	$27,109
*The Wood Group	◆ Crisis Respite	Organization	$358,000

*These Providers did not begin services at the first of the fiscal year and there were no payments made in the first six months of FY'10 so these expenditures do not show up in the Contract Expenditure Table above.

8) <u>Current and Planned Network Development</u>
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**
Adult Service Packages									
Adult RDM SP 1	1444	0	0	0	0	0	0	1	*1
Adult RDM SP 2	93	0	0	0	0	0	0	1	*1
Adult RDM SP 3	111	0	0	0	0	0	0	1	*1
Adult RDM SP 4	9	0	0	0	0	0	0	0	1
Adult RDM SP 0	70	0	0	0	0	0	0	0	1
Adult RDM SP 5	18	0	0	0	0	0	0	0	1
TOTAL Adult Services	1745	0	0	0	0	0	0	0	1
Child Service Packages									
Children’s RDM SP 1.1	272	0	0	0	0	0	0	0	1
Children’s RDM SP 1.2	46	0	0	0	0	0	0	0	1
Children’s RDM SP 2.1	0	0	0	0	0	0	0	0	1
Children’s RDM SP 2.2	34	0	0	0	0	0	0	0	1
Children’s RDM SP 2.3	12	0	0	0	0	0	0	0	1
Children’s RDM SP 2.4	3	0	0	0	0	0	0	0	1
Children’s RDM SP 4	107	0	0	0	0	0	0	0	1
Children’s RDM SP 0	7	0	0	0	0	0	0	0	1
Children’s RDM SP 5	1	0	0	0	0	0	0	0	1
TOTAL Children’s Services	482	0	0	0	0	0	0	0	1

- Provider (Wood Group) wants to provide adult rehabilitation services as discrete services but would consider providing the complete service packages if they are not allowed to contract for this discrete service. Only willing to do SP1 and SP2 packages if he can get enough SP3 consumers to make doing 1s and 2s financially viable.

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

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

PAST and CURRENT						PLANNED			
	A	B	C	D	E	F	G	H	I
DISCRETE ROUTINE SERVICES And CRISIS SERVICES	**Units of service delivered in 2009**	**Percent of total capacity contracted in FY 2009**	**Percent total capacity served by contract providers in FY 2009**	**Percent of total capacity contracted in FY 2010**	**Percent total capacity served by contract providers in FY 2010**	**Percent of total capacity planned for contract in FY 2011**	**Percent of total capacity planned for contract in FY 2012**	**Number of available providers**	**Applicable Condition**
Rehab/Skills Training	585					25%	25%	1	2,3
Psychotherapy (CBT Counseling)	5188					10%	10%	1	3,4
Crisis Hotline Services	4189	100%	100%	100%	100%	100%	100%	1	N/A
Crisis Intervention (Face-to-Face Assessment)	1343	*50%	40%	*50%	40%	*50%	*50%	1	2

***Contract provider provides all face-to-face crisis interventions after regular business hours and on holidays and weekends.**

9) <u>Rationale for LMHA Service Delivery</u>

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.*

Only four providers expressed interest in contracting as providers in the Andrews Center's Network. One of these providers was interested in contracting for complete service packages only if there were enough SP3 consumers to make it financially viable. In FY'10, this center is serving only 69 patients with any GR funding in SP3. This provider indicated that they would need a minimum of 75 to be interested. One provider wanted to contract for Rehabilitation Services, one was interested in Crisis Hotline and MCOT service, one was interested in providing CBT counseling services, and the fourth was not a viable provider based on education, experience and lack of certification/licensure. We are planning to offer services under contract where we have a willing provider and the client census which meets the providers requirements.

Adult Services – One provider interested in rehabilitation services, one in CBT counseling and one in Crisis services specified above.

Children/Adolescent Services – One provider interested in CBT counseling and one in Crisis services specified above.

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.*

One prospective contract provider (Wood Group) stated that they would consider providing services in more than one county if they were contiguous counties and the number of potential consumers made the service viable (Discrete Rehab/Skills Training). One prospective contract provider (Ava Weaver) was only interested in providing CBT counseling in Smith County. Therefore the Center is planning to continue providing these services to assure equivalent access to services for consumers.

Andrews Center will provide Crisis Hotline services under contract only and will provide MCOT services after hours and on weekends/holidays under contract only because Avail has the ability to provide equivalent access to services at these times.

c) *If the LMHA will continue to provide one or more services because the external network does not provide sufficient capacity (Condition 4), complete the following table. Use this condition if the LMHA will use all of the available external provider*

capacity and directly provide only the balance of current capacity. External provider capacity is usually determined through the follow-up contacts that take place during the provider availability assessment.

Service	Capacity Needed	External Provider Capacity	Information and Method Used to Determine External Network Capacity
CBT Counseling	5188 services FY'09 2708 services FY'10	Not Specified	Only one provider with no others working with her. Only wants to work in one county (Smith).

d) *If the LMHA will continue to provide the specified capacity of one or more services in order to preserve critical infrastructure to ensure continuous provision of services (Condition 5), identify the planned transition period and the year in which the LMHA anticipates procuring the full external provider capacity currently available. If the same transition period is planned for all services, only one entry is required. When different transition periods are planned, list each separately. NOTE: The rule states that this condition can be used only when the LMHA identifies a timeframe for transitioning to an external provider network, during which the LMHA procures an increasing proportion of the service capacity of the external provider network in successive procurement cycles. This timeframe is the LMHA's best estimate based on the limited information currently available, and does not represent a firm commitment. The timeframe will be reassessed during each planning cycle based on the results of procurement, provider performance, and new information. The current estimate should assume that proposed procurement plans are successful and the contractors prove to be stable providers and meet established performance standards*.

Service	Transition Period	Year of Full Procurement
N/A		

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

- N/A

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

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

- **N/A**

11) Strategies to Protect Critical Infrastructure

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

- Pursue contracting with prospective provider for 25% of our discrete Adult Rehabilitation/Skills Training with the aim to increase to 50% in the preceding year. If additional contractors are identified, this percentage may be increased.
- Pursue contracting with prospective provider for as much of the CBT counseling as they are willing to provide in Smith County and as the consumers make this choice. If additional contractors are identified, this percentage may be increased.
- Establish monitoring activities and provider relations interactions with these providers to support their entry into our network, insure fidelity with the services to be provided, and identify any problems before they become critical and destructive to the network.

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
Discrete Rehabilitation and Skills Training	30 to 60 days
CBT Counseling	30 to 60 days
After hours and weekend/holiday MCOT	30 days
Crisis Hotline	30 days

Procurement

13) Structure of Procurement(s)

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

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

Date(s)	Method (RFA or RFP)	Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Percent of Clients	Rationale
3/1/11	RFP	Rehab/Psycho social Skills Training	Smith County Henderson County	25%	In order to get the needed numbers for this provider they would have to provide services in more than one county. The greatest percentage of our consumers receiving these services reside in these two counties.
3/1/11	RFP	CBT Counseling	Smith County	25%	The only interested provider is a single person who does not have an office. She will have to negotiate for office space to do these services.

9/1/10	RFP	Crisis Hotline	Complete 5 county service area	100%	Continuing a successful contracting practice
9/1/10	RFP	After hours, weekends & Holiday MCOT services	Complete 5 county services area	100%	Continuing a successful contracting practice

14) <u>Fidelity and Continuity of Care</u> (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. <u>Enter NA if you have no interested providers or plan to procure service packages only</u>.

- **Private provider will be added to our monthly record monitoring process to assure accurate documentation and billing.**
- **A survey will be developed for consumers seen by LMHA providers as well as contract providers to assess satisfaction with access and the services provided. The survey will be mailed to a random selection of these consumers on an annual basis.**
- **Private providers will be entering their documentation into the LMHAs IS and data will be reviewed quarterly for accuracy.**
- **Service coordinators will document consumer satisfaction with providers as a part of their monthly contacts.**
- **Each consumer will have an Andrews Center Rehab Specialist assigned to them who will provide the continuity of services to persons who may be receiving their services from multiple providers and/or multiple locations. These Rehab Specialists will assist the individuals in developing their treatment plans and monitoring to see that services are being provided as planned.**

15) <u>Enhanced Staff Qualifications</u>
Do you require any individual practitioners to meet higher standards than those described in the DSHS performance contract?

_____Yes __X__ No

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

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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.

The only services we had interested providers for were Rehab/Psychosocial Services and CBT Counseling in addition to Crisis services we are already contracting for. There will be an effort to provide choice in services where there are interested providers.

Service to be Provided by a Single Provider	Reason(s) for Limiting Client Choice
N/A	

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.

- At assessment and re-assessment, consumers in areas where there are other providers will be provided the opportunity to select or change providers from those available.
- Providers will be required to provide the LMHA with information describing their services and providers to inform the consumers about them.
- The contract with provider will have a non-discrimination clause that providers must adhere to.
- Ability to provide services in Spanish will be required which may include providing interpreter services as needed.

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.

- **The provider contract will inquire into the provider's written policies, staffing patterns, use of interpreters, written translation materials and grievance procedures.**
- **Prospective providers will be asked to address how they will provide an initial and annual training for themselves or other providers within their organization that addresses at a minimum: 10 cultural diversity; 2) general clinical cultural issues in mental health treatment; and 3) prejudice and stereotyping.**
- **The LMHA provides training on consumer rights and cultural sensitivity at hire and annually. If providers do not provide such training, they will be required to attend training at the LMHA.**
- **LMHA's training includes cultural diversity, general clinical cultural issues in mental health treatment, direct support providers client cultural competency.**

Capacity Development

19) <u>Cost Efficiency</u>

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.

- Developed Wide Area Network (WAN) which includes all LMHAs (11) who participate in the East Texas Behavioral HealthCare Network. This minimizes travel costs and increases the contact between these LMHAs when jointly working to provide additional services or solve problems.
- Established Sharepoint through ETBHN – assists staff in staying connected between LMHAs especially helpful with workgroups and committees.
- Establishment of Business Opportunities Committee (ETBHN) – working on establishing additional opportunities for LMHAs which are in keeping with the mission or our organizations.
- Grant Workgroup through ETBHN – focuses on grants that can benefit the region as a whole.
- Regional Training through ETBHN – includes everything from CEU credit trainings, free trainings from other sources (drug companies, etc.) to train-the trainer initiatives coming from the state. These regional trainings reduce LMHA costs for training because it can be provided locally with minimal workshop fees, mileage, lodging, and meal expenses.
- Regional purchase of SPQM for Utilization Management Services which is now available to all ETBHN member centers.
- Utility Purchasing opportunities through ETBHN group purchasing.

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
4-1-2010	Community HealthCore & ACCESS	Provide a 13 bed crisis respite facility in Tyler to facilitate the prevention of inpatient services if appropriate.
1997	ETBHN (11 LMHAs in the East Texas Region)	Minimize overhead and administrative costs and achieve purchasing and other administrative efficiencies. (see above)

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

-

20) <u>Previous Network Development Efforts</u>

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)
Crisis Hotline – Smith, Henderson, Van Zandt, Wood, Rains Counties – Capacity = as needed	Avail Solutions provided 100% of this services
MCOT – Afterhours, weekends & Holidays - Smith, Henderson, Van Zandt, Wood, Rains Counties – Capacity = as needed	FY'09 & '10 – Avail Solutions provided 100% of this service
Inpatient Psychiatric Care -Smith, Henderson, Van Zandt, Wood, Rains Counties – Capacity = as needed	ETMC – Behavioral Health Center – Had 220 admissions in FY'09 and 175 admissions in FY'10 YTD. 93% of FY'09 service and 98% of FY'10 YTD.
Inpatient Psychiatric Care -Smith, Henderson, Van Zandt, Wood,	Behavioral Health Care of Longview – Had 16 admissions in FY'09

Rains Counties – Capacity = as needed	and 3 admissions in FY'10 YTD. 7% of FY'09 service and 2% of FY'10 YTD.
Telepsychiatry –Henderson County	JSA – provides 4 hrs per week of psychiatric services
Crisis Respite – Capacity = as needed	The Wood Group – 13 bed crisis respite facility – 100% of this service.
CBT Counseling – 10% - All five counties	No interested providers
Pharmacological Management/Psychiatric evaluations – 10% - All five counties	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**
We received no comments on our RFP draft procurement for the CBT Counseling and Psychiatric Services	

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.

- There have been no interested providers in the previous two years for the services we chose to put out for bid in the last network development plan.
- We have contracted for Tele-medicine in one of our clinics and have managed this contract for about eight months.

- We have contracted for staffing and operating a 13 bed crisis respite facility which has been in operation since April, 2010.

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
Rate not attractive to external providers	Continue to lobby to improve funding
Five county catchment area, 3,412 sq. miles, largely rural service area, gas prices	Increase use of telemedicine and other services that can be appropriately provided by televideo or other uses of technology.
Limited public transportation	The LMHA continuously seeks additional funding to enhance the current Medicaid transportation program to reach those without personal transportation.
Limited professional opportunities for providers' significant others.	Continue to investigate the use of technology.
Providers reluctant to meet DSHS Contract Requirements	Continue to work with DSHS regarding contract requirements and potential to streamline regulations. Advocate with the state for less prescriptive treatment and service expectations.

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.

- As contract providers prove to be successful and reliable their percentage of services will be expanded.
- It is anticipated that we will expand our volume considered for procurement to 50% for those services that have only one willing and qualified provider.
- Expansion of the network of providers is currently limited by those available to participate.
- If available funding rates are increased full implementation should be accomplished within the next 10 years.

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.

- Post on Center website
- Post notices in clinics
- Make copies available in clinic offices for persons to review
- Present to the regional and local advisory committees
- Present the draft network plan to the local NAMI at their meeting and have copies available for review.
- Present at interagency meetings with stakeholders and have copies available for review.

Implementation

24) Procurement Timeline

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

Date	Key Activities and Milestones

12/1/10	Draft procurement document (RFA/RFP) posted for public comment (at least 14 days)
1/1/11	Publication of final procurement
2/15/11	Due date for procurement responses
3/1/11	Award date
5/16/11	Contract start date

25) Consumer Transition

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

Date or Timeframe	Key Activities and Milestones
3/1/11	Date provider list will be posted to website and distributed to consumer and advocacy groups
3/1/11 – 5/16/11	Timeframe for hosting provider forums to allow providers to share information with consumers
6/1/11	Date to begin offering consumers choice of providers in the new network
6/1/11 – 9/30/11	Period of time given to consumers to select provider
9/30/11	Timeframe for transitioning current clients to new providers

Stakeholder Comments on Draft Plan and LMHA Response

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

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

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

Comment	Stakeholder Group(s)	LMHA Response and Rationale
The Center delivers great services and is in the best position to be the provider of choice.	Regional Planning and Network Advisory Committee	Due to Local Planning and Network Development requirements and the need to develop choice for our consumers, we will continue to extend invitations to other providers in the community that may be able to provided services of value to our consumers.
You guys have put a lot of quality effort into the process and have very little to show for it. Given our situation it may indicate that the whole idea of pursuing a Provider network is not going to be a very fruitful endeavor. It is a shame our work could not go towards more productive efforts.	Local Citizen's Advisory Committee	While we have been somewhat unsuccessful in attracting large numbers of providers to join our network to date, we have been successful in contracting for Tele-medicine, Crisis Respite Facility staffing, Hotline and MCOT services, etc. We have had some interest from providers for other services this year. If we continue to work toward choice, we will one day find that our network has expanded and consumers are empowered to be more involved with their treatment.

COMPLETE AND SUBMIT ENTIRE PLAN TO 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.