



MENTAL HEALTH MENTAL RETARDATION

AUTHORITY OF HARRIS COUNTY

MHMRA of Harris County

Mental Health Network Development Plan FY '08



HARRIS COUNTY LOCAL SERVICE AREA PLAN

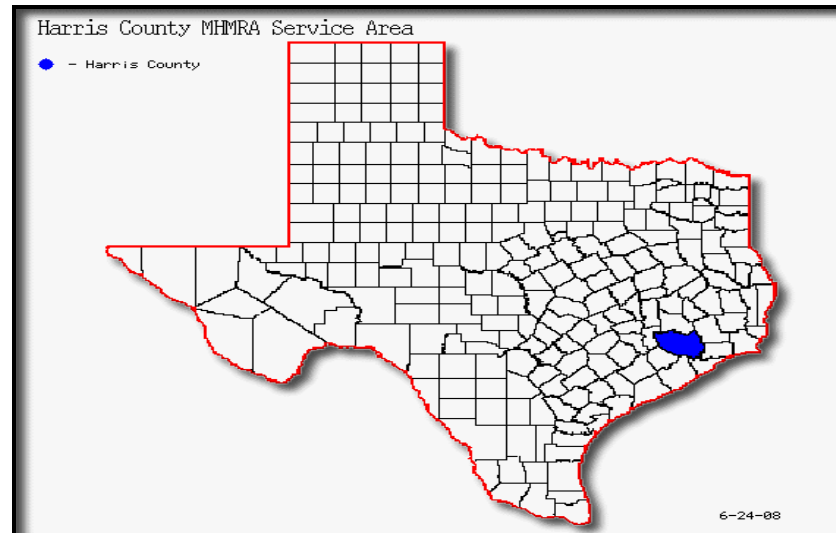
MHMRA MISSION STATEMENT

It shall be the mission of the Mental Health and Mental Retardation Authority of Harris County (MHMRA), within the resources available, to provide or ensure the provision of services and supports in a respectful fashion that are high quality, efficient, and cost effective such that persons with mental disabilities may live with dignity as fully functioning, participating, and contributing members of our community as possible, regardless of their ability to pay or third party coverage.

- Persons with severe mental illness should be able to live in homes of their own, develop relationships, work, and remain out of hospitals and jails.
- Persons with intellectual or developmental disabilities should be able to acquire the skills and access community resources to develop networks of human relationships, learn, work, and live in environments of their choosing.
- Children and adolescents with serious emotional disturbance should be able to live in homes with families, develop normal relationships with their peers, attend school, and remain out of hospitals and juvenile justice facilities.

Service Area:

Harris County



LOCAL NETWORK PLAN- OBJECTIVES

Mental Health and Mental Retardation Authority (MHMRA) of Harris County as the designated Mental Health Authority for the Harris County service area, has the responsibility to ensure that funds received from the Department of State Health Services (DSHS), are utilized appropriately and efficiently in Harris County, ensuring quality service provision to residents of Harris County as defined in the DSHS contract. As of June 2007, MHMRA has developed a Network Development Advisory Committee (NDAC) to assist the Agency in the development and the implementation of a community provider network.

The objectives of this plan are to ensure:

- A system of service delivery in which consumers have choice from among multiple service providers and in which MHMRA's role is to provide management and oversight.
- A system which demonstrates ultimate cost benefit, quality client care, and the best use of public money in assembling a network of service providers with public input.
- A system of delivery which meets the needs and preferences of the local community.
- A system which demonstrates prudent stewardship of public dollars.
- A system which has controls in place to ensure the best possible consumer outcomes, inclusive of continuity of care options.
- A system which protects the rights of consumers to exercise control and to make decisions regarding their health.
- A system which demonstrates the best return on public investment in mental health services.

This plan applies to funds allocated to MHMRA of Harris County by DSHS as "department federal and department state funds" through the DSHS performance contract. This includes Federal Mental Health Block Grants and State General Revenue funds.

Local Planning Process

1) Describe the process used to identify and solicit input from stakeholders, including efforts to ensure that:

a) Planning efforts are inclusive and participants represent the diversity of opinion, culture, and ethnicity of local service area-

To ensure that input received in the development of our local plan is inclusive of our community as a whole, we have-

- Posted a description of the Network Development Initiative on our local website with links to surveys, and contact information for our community to directly submit feedback
- Presented the Network Development Surveys to:
 - Network Development Advisory Committee (NDAC)
 - Medical Provider Advisory Committee
 - Jail Diversion Planning Committee
 - One Voice- Local Community Collaborative
 - BEHAV- Local Community Collaborative
 - Local NAMI chapters
 - Gathering Place- Local Consumer Clubhouse
 - MHMRA service locations (Clinics and Eligibility Center)
 - MHMRA service locations (Crisis Stabilization Unit)
 - Local Law Enforcement Officers - Houston Police Department, Sheriff
 - Both Sides Now – Local Group for Interested Consumers, Citizens, Family Members
 - Side by Side – Local Group for Spanish Speaking Family Members
 - The Houston Galveston Trauma Institute DID and Psychotherapy Course Group – Therapists Group
- Posted “You have a Voice” flyers and posters in local MHMRA service sites with local and state contact information
- Opened the door to our community to circulate the surveys requesting feedback~ surveys and general legislative information were sent electronically to local stakeholders and they were requested to not only respond to the survey but also to forward it to their distribution lists and post in their programs/facilities in order to further our outreach efforts

b) Stakeholders have opportunities to participate effectively in the planning process-

In addition to the above efforts of getting the word out and requesting input, we have allowed providers the capability of submitting feedback in various ways to encourage participation:

- Electronically to our Network Management email address,
- Calling in to a Network Management call box or direct to staff,

- Dropping written information off at our physical address and/or any MHMRA location, or
- Faxing information into our dedicated fax line
- In addition- we have held many community meetings in order to get direct feedback from the community at large. These NDAC meetings were open to our community

c) The Planning and Network Advisory Committee (PNAC) is actively involved in the planning process-

MHMRA has held all NDAC meetings as open meetings to the public. Invitations were sent individually to targeted stakeholders to participate in this process. MHMRA identified 60 stakeholders who received direct invitations and this number has since grown to 146 interested parties as of May 2008.

All interested parties are invited to committee meetings and are kept up-to-date on NDAC developments electronically via an email distribution list. Meetings are usually attended by about 25% of our participant list and others provide feedback electronically. The current NDAC distribution list consists of:

- 14 (10%) Public providers/provider groups
- 23 (16%) Private providers/provider groups
- 4 (3%) Consumers Advisory Council Representatives (representing over 12,000 consumers across Harris County)
- 40 (27%) Additional Consumers
- 26 (18%) Family Members/ Advocacy Organizations
- 14 (10%) Other Stakeholders (governmental entities, police, courts, local precinct representatives, etc)
- 13 (9%) Federally Qualified Health Care Centers (FQHC's)
- 3 (2%) Substance Abuse Providers
- 13 (9%) MHMRA staff

NDAC meetings (2 hour community meetings) were held for Network Development planning on:

- June 26, 2007
- July 9, 2007
- July 27, 2007
- August 2, 2007
- August 15, 2007
- August 31, 2007

Communications since the initial community planning was completed on August 31, 2007 have been via electronic communications. The NDAC will reconvene in August 2008 to review public comment on the final draft.

In addition, MHMRA tracks all provider contract inquiries on a tracking log with disposition as well as adding all interested providers to our mailing list for procurement notices as such contacts are received. MHMRA will also mail procurement notices to those individuals/groups listed with DSHS as interested providers for the Harris County service area.

MHMRA attends other community meetings as requested and provides presentations on Network Development activities as a way to reach out to the community and ensure a wide spread awareness of NDAC activities, hence promoting wide public input prior to Network Development (ND) implementation. All presentations are logged and public comments added to our tracking and response logs for incorporation within the ND planning process.

The draft ND Plan and all subsequent updates will be posted on the MHMRA website for public comment as well as circulated to the NDAC distribution list electronically. For stakeholders, requesting to receive updates, who do not have email access, MHMRA will mail hardcopies as requested. The Final ND plan will also be posted on the website upon approval and updated as needed but at least every 2 years.

2) List the names of organizations who have participated since the last planning cycle in each of the information gathering methods, including:

- Advocacy organizations
- Local governmental entities
- Other public and private stakeholder organizations.

Organizations Represented:

Advocacy, Inc.	Good Neighbor Healthcare Center	MHA of Greater Houston
Baylor College of Medicine	H.C.C.S	Memorial Herman Hospital
Houston Police Academy	Harris County Budget Office	Memorial Hermann Crisis Response Team
Care for Elders	Harris County Healthcare Alliance	MHMRA of Harris County
CBHS/Phoenix House	Harris County Hospital District	NAMI - Metropolitan Houston
Children At Risk	Harris County Protective Services	Neighborhood Ctrs
Children’s Assessment Center	Harris County Psychiatric Center	NeuroPsychiatric Center
Houston City Council	Harris County Sheriff Department	ProSalud
Commissioner Radacks Office	Health Center S.E.Tx	Ripley Center
Consumer Advisory Council- MHMRA	Healthcare for the Homeless-Houston	South Central Houston CHC Riverside Satellite
Cypress Creek-West Oaks Hospital	Heart of Montgomery	Spring Branch Com. Health Center
CBHS/Phoenix House	HHSC	TCADA
DBSA of Greater Houston	Hope Clinic	The Community Clinic
Department of Family & Community Medicine~ Baylor College of Medicine	Houston Community Health Centers, Inc	The Council on Alcohol and Drugs, Houston
Depelchin Children's Center	Houston Psychiatric Society	TOMAGWA Ministries Medical Clinic
El Centro de Corazon	IntraCare Hospital	University of Houston- Clear Lake
Evercare	Judge Emmett’s Office	University of Texas Houston
Family Services of Greater Houston	Legacy Community Health Services	UT Medical School
FUUSA	MD Anderson	We Are Caring Hearts, CDC
Gateway to Care	Menninger Foundation	West Oaks MAT

- In addition, identify the number of individuals who have participated since the last planning cycle in each information gathering event or method, including;

In the following chart, specify the method of information gathering in the first column: Focus Group, Meeting, Public Hearing, Survey, or Other. If other, specify method. List events in date order.

Description And Date or Timeframe	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
NDAC meeting 06/26/07	Consumer Advisory Council Members, MHMRA, Gateway to Care, El Centro de Corazon, Harris County Psychiatric Center, West Oaks Hospital, UT Medical School, Baylor College of Medicine, Ripley Center, Intracare Hospital, Depelchin Children’s Center, Harris County Hospital District, Constables Office, Judge Emmet’s Office, University of Texas- Houston, (J.DeCubellis)	2	1	20
Gateway to Care Meeting- July 2007	ProSalud, Health Center SE, Neighborhood Centers, MD Anderson, Gateway to Care, We are Caring Hearts, HHSC, South Central Houston, El Centro de Corazon, Legacy, Care for Elders, Heart of Montgomery, TOMAGWA Ministries, The Community Clinic, City Council, NBHP, CBHS, Evercare, FUUSA (J.DeCubellis)	unk	unk	24
NDAC meeting 07/09/07	Consumer Advisory Council Members, Harris County Hospital District, Healthcare for the Homeless, El Centro de Corazon, Harris County Constables Office, Harris Co Psychiatric Center, Memorial Herman Crisis Response Team, DBSA, Depelchin Children’s Center, Advocacy Inc, NAMI, TCADA, Intracare Hospital, (J.DeCubellis)	3	2	18
NDAC meeting 07/27/07	Judge Emmet’s Office, MHMRA, Advocacy Inc, Consumer Advisory Council Members, TCADA, Gateway to Care, Harris CO Budget Office, El Centro de Corazon, Intracare Hospital, Mental Health Association, HCHD Healthcare for the Homeless Program, The Council on Alcohol and Drugs, (J.DeCubellis)	4	2	16
NDAC meeting 08/02/07	Children’s Assessment Center, Commissioner Radack’s Office, Harris County Protective Services, Children at Risk, Consumer Advisory Council Members, Disability Services, HCCS, DBSA, Univ. of Houston- Clear Lake, MHMRA (J.DeCubellis)	3	1	11
NDAC meeting 08/15/07	MHMRA, Consumer Advisory Council Members, Intracare Hospital, Family Services, NAMI, Constables Office, Advocacy Inc, Harris County Psychiatric Center (J.DeCubellis)	4	1	9
NDAC meeting 08/31/07	MHMRA, NAMI, Children at Risk, Consumer Advisory Council Members, El Centro de Corazon, Harris County Psychiatric Center,	1	1	11

	Mental Health Association (J.DeCubellis)			
4/1/08-4/30/08 Meeting, survey	Community Stakeholders (J. DeCubellis)			34
4/7/08 – 4/30/08 survey - Spanish	Family to Family – Spanish (J. Lee)		1	1
4/9/08 930 – 1030 Meeting, survey	MHMRA Consumer Advocacy Group (J.Lee)	8		
4/9/08 -4/16/08 survey	MHMRA NW Clinic (CAG – J. Lee)	25	1	
4/9/08-4/24/08 survey	MHMRA SE Clinic (CAG – J.Lee)	7	3	
4/9/08-4/24/08 survey	MHMRA SW Clinic (CAG – J.Lee)	16	4	3
4/9/08 – 4/30/08 survey	MHMRA Ripley Clinic (CAG – J.Lee)	9		
4/10/08 – 4/30/08 survey	UT Outpatient Clinic (J. Lee)	10		
4/16/08 11 – 1230 Focus group, survey; 4/30/08 10:30	Gathering Place (J. Lee)	13		18
4/17/08 11 – 12 Meeting, survey	Jail Diversion Committee (J. DeCubellis)			28
4/17/08 11 – 12 Meeting, survey	Medical PAC (J. DeCubellis)			12
4/21/08 Focus group & survey	NAMI West (presented by Dr. S. Schnee)	2	6	18
4/21/08 8 – 1130 P Outreach, survey	MHMRA Eligibility Center (J. Lee)	9	9	5
4/27/08 Focus group, survey	Both Sides Now (J. Lee)	2		3
4/24/08 – 4/30/08 survey	MHMRA Crisis Stabilization Unit (J.Lee)	7		
4/24/08 – 4/30/08 survey	Houston Police Dept at CSU (J. Lee)			3
5/9/08 Focus Group, survey	HG Trauma Institute – DID course group (J. Lee)			20

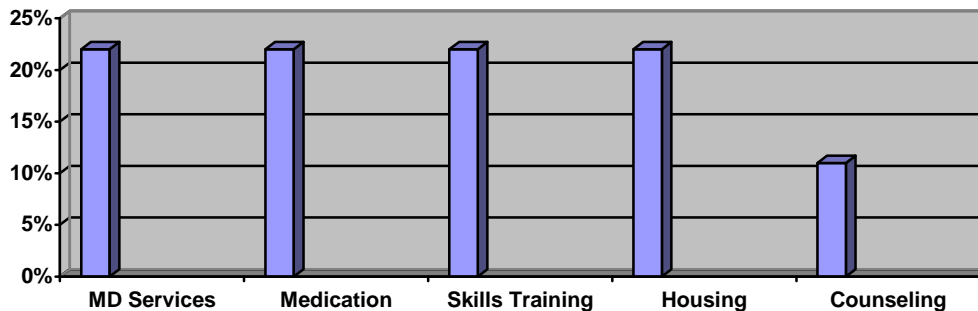
3) Summarize the input received from stakeholders regarding:

- **Service needs and priorities for children, adolescents, and adults,**
- **Crisis response system and services,**
- **Development of an external provider network, and**
- **Other significant issues and concerns.**

Service needs and priorities for children, adolescents, and adults:

The most important service needs and priorities for children, adolescents, and adults from the input received on stakeholders survey's are:

- MD services (22%),
- Medication (22%),
- Skills Training (22%),
- Housing (22%), and
- Counseling (11%).



65% of Stakeholders surveyed reported provider choice as very important.

Crisis response system and services:

Follow-up care after crisis services was the stakeholders' main concern due to the long waitlist to see a Psychiatrist and the cost of follow up care. In our community it was felt that we have expanded crisis services and are better identifying the needs; however, there is not sufficient inpatient/ acute care options for indigent care and hence emergency services are often on diversionary status. In addition, our community has received additional

Crisis funding, however without comparable increases in outpatient services, those consumers receiving crisis intervention continue to have limited options for on-going treatment, resulting in many being placed on a waitlist and reoccurring crises. It is anticipated that this will increase

as more crisis redesign services are implemented in the next fiscal year, more cases will be identified but there are not corresponding expansions (due to funding limitations) in our community for outpatient treatment, hence the concern is that consumers will be treated and stabilized but not connected to on-going outpatient maintenance, due to resource limitations.

An additional crisis related concern is the increasing population of consumers seen in crisis services with non-target (priority population only) diagnosis. Without the ability to bridge services from crisis care to outpatient care, many of these consumers have great difficulty accessing outpatient services which results in a high recidivism rate through our more expensive crisis care services due to lack of resource to maintain stability in our community. Consumers discharging from Jail, Local inpatient units, State Mental Health Facilities (SMHF), etc. do not receive any medications to bridge them into the community, so even if providers are available to see consumers not otherwise served outpatient by MHMRA, there is a significant gap in an inability to obtain medications to bridge them to care.

The important areas in the development of external provider network per the survey responses were:

Survey respondents focused on the priority of:

- Convenient location to home (30%),
- Cost of services (17%),
- Transportation availability (15%),
- Wait time to see the doctor (14%),
- All services at the same location (13%), and
- Pharmacy on site (10%).

Services to be contracted out per the survey responses were:

- Skills Training (28%),
- Counseling (26%),
- Psychiatrist/Medication Management services (23%), and
- Supported Employment (22%).

Other significant issues and concerns per the survey responses were:

There was significant concern around:

- Not enough psychiatric hospital beds for inpatient needs,
- The need for more therapists,
- The need for more family education,
- Cost of services, and
- The need of more residential/maintenance treatment centers for substance dependent consumers.

4) Describe the LMHA's (Local Mental Health Authority) priorities and gaps with regard to services. This description should be based on community input and any internal or external analysis which may have been completed. Please include any opportunities and challenges projected for the biennium. Describe the LMHA's service delivery needs and priorities for the biennium, including significant gaps in services:

LMHA's priorities and gaps with regards to services:

Services Gaps were noted by stakeholders as:

- Transportation (60%),
- Counseling (21%), and
- Housing (19%).

It is seen in the number of case closures that are coded as: inability to locate, no follow through with treatment, treatment noncompliance, etc. Harris County serves a very transient population and a very poor population where housing and transportation needs (Maslow's basic needs) are not being met due to a lack of resources. A significant % of our State Hospital and Local Hospital discharges as well as our Jail discharges, are released to shelters due to not having benefits for housing placement. As a result of no income, they also do not have transportation means to follow-up with needed care. Though Harris County MHMRA assists them in applying for public benefits as applicable, there are not immediate options and we often "lose" the consumer before engaging them in care which begins the cycle of recidivism. Harris County will continue its efforts to try and identify funding sources for transitional housing and has submitted several plans to fund such activities over the past several years. Releasing from acute care settings such as these and not having supportive transitional housing options which could provide skills training/supports and housing/transportation resources and ensure consumers are connected to needed behavioral health care and physical health care is a serious flaw in our service delivery system, yet it requires a funding source for implementation.

Counseling requests in the gap analysis from community input was specifically related to limitations posed by Resiliency and Disease Management (RDM) service packages which only allow therapy services to a select group based upon diagnosis. Consumers and Families request that this definition be widened to include other populations as there is a larger need for this service level and historically improvements in functioning were noted when receiving this service level even when time limited. Harris County has submitted this request to DSHS in the past and been informed that an expansion would not be funded under the DSHS contract, hence Harris county MHMRA continues efforts to identify other such resources which would allow for such service enhancements.

An additional gap in services identified by stakeholders includes but is not limited to:

- Limited detox beds in Harris County, though crisis funding assisted in expanding some residential treatment beds, the capacity for substance abuse treatment comparable to the need is greatly discrepant and specifically around the need for detox. MHMRA of Harris County will attempt to address these needs in their Crisis Redesign Plan since this is not a service funded currently under Resiliency and Disease Mgmt.
- Lack of service locations in areas convenient to consumer's homes which is compounded by lack of transportation resources to get to services.

- Secondary to lack of funding, non MHMRA clients are being discharged from local hospitals including HCPC without MHMRA services. In addition, the majority of Harris County Jail mental health patients are being released without MHMRA appointments. As many of these individuals also do not have health benefits, follow-up care is limited and access often difficult to obtain without long waits which increases the likelihood for high recidivism levels.

Opportunities and challenges projected for the biennium:

Challenges projected for the biennium will be procuring providers who will provide:

- ❖ Physician services, Medications, and Counseling/Skills training in 1 location which is,
- ❖ In a convenient location near the consumers' home/work,
- ❖ With less wait time,
- ❖ Which is at the same or a lower cost,
- ❖ Where transportation is accessible,
- ❖ While maintaining quality of care and DSHS contractual compliance.

MHMRA of Harris County is serving consumers in four main clinic locations and at several co-location sites. The main clinic locations are centers complete with Psychiatric medication services, Medication (pharmacy), Labs, Counseling, and Rehab services that include skills training, housing assistance, and employment assistance all encompassed at the same location. This is the ideal model per survey results; however, how to make the contract requirements feasible for the private providers is the first challenge for the next biennium. Based on community meetings with our private and public providers- there was extreme concern expressed related to the increased cost of doing business under the DSHS contract, as rates were generally at Medicaid rate levels; however, the requirements for documentation, patient follow-up, staff training, outcome measurements/reporting, etc where much more expansive than traditional Medicaid and/or Managed Medicaid. These extensive requirements make the cost of doing business under contract with the MHMRA's more difficult and in many cases cost prohibitive unless there was already an extensive administrative structure in place to manage the business oversight of such an extensive contract. Our challenge is to assist Providers in finding ways to overcome these barriers and find creative means to make such a contractual arrangement feasible for the benefit of our community and the consumers we serve.

Per our experience in bringing in external providers under the DSHS contract, it is very costly upfront for both the MHMRA and the Provider Group due to the extensive training and learning curve around the DSHS contract requirements, expectations, and performance targets. MHMRA has attached 3 employees for over 1 year to implement 1 large provider now which is a high cost for the Authority. However, this support level is needed to ensure the financial viability of the contractor through the initial learning curve and the quality of services for the consumers. Our challenge is to learn from this first large roll-out ways to best expedite the contract learning and start up of future programs.

Additionally, inflationary costs for services occur each year, although funding from DSHS has not increased overtime. MHMRA is challenged with complying with additional requirements and ensuring cost effective care in an increasingly costly market with no changes in baseline funding even though costs and service requirements increase incrementally each year.

Opportunities go hand in hand with these challenges. Harris County has the opportunity under the new crisis funding to provide more outreach and more expansive services to our community and through Network Development efforts we will hopefully identify more opportunities for consumer care to reduce waitlists and improve continuity for our consumers and families.

LMHA's service delivery needs and priorities for the biennium:

Provided that consumers are able to choose providers, current trends show the following needs:

- Convenient location to home (24%):
 - MHMRA has software to geoplot service availability. It is our goal to identify service options within 30 minute travel time from Consumers homes and/or place of employment. This includes locations which are on public transportation routes. Our challenge is provider interest in the DSHS contract matching service area needs.
 - MHMRA has initiated in the past year, several co-location programs (6 as of July 2008) which focus on co-locating MHMRA services with Primary Care services to better meet the consumer's needs and expand service locations into school based clinics, Federally Qualified Health Care Centers and other City/County program sites. MHMRA will continue to evaluate service locations to best meet the Community needs.
- Minimal wait time to see MD (18%):
 - MHMRA currently goes on waitlist if provider appointments reach greater than 30 days out as no show rates at that point become excessive neither meeting the patient needs nor maximizing limited resources. Our goal is to develop a provider system that minimizes such occurrences so that our only limitation is the consumer service numbers we are funded for not Provider capacity.
- Transportation needs (16%):
 - MHMRA has worked with Metro transportation to solicit discounted travel rates for our disabled population to reduce the burden of transportation.
 - MHMRA has noted for consumers, bus routes attached to provider locations for ease of selection of providers when this is of concern.
 - MHMRA provides limited transportation and works with consumers on identifying longer term solutions to getting to medical services such as attending closer service locations, allowing staff to come to their homes for certain services, identifying family and friends who can be resources, etc.
- Low cost of services (15%):
 - MHMRA continues to educate consumers and families on public benefits when eligible, pharmacy benefits as applicable (such as Medicare part D, PAP benefits), and how to request a financial review in times of hardship and/or payment plans as applicable. The goal is to ensure that payment for services is not a barrier to patient care.
- Pharmacy on site (14%):
 - MHMRA has had this benefit available for indigent consumers at our four main clinic sites; however, as we look at external providers this poses challenges- indigent consumers will need to come to MHMRA locations for medications as this is not an option at other sites. MHMRA has looked into contracting with retail pharmacies; however, this option has proven cost prohibitive. MHMRA is

exploring whether fax and fill, mail options are feasible with our population, and how to best explore some other creative opportunities.

- All services in same location (13%) (services, labs, pharmacy, etc):
 - The same issue as above related to pharmacy applies and in addition, most external providers do not have lab services on site. MHMRA has contracted with CPL labs and our goal is to have lab sites though not necessary at the service provider location 100% but at least within 30 minute travel of the provider location. CPL labs are located through-out our community and will be geoplotted against provider locations to ensure, as much as possible, county wide coverage. As provider volume reaches a certain point, it may also be feasible for us to have onsite lab draws under our CPL contract; however, this is based on patient volume so it would take time to implement based on consumer choice trends. MHMRA hears this concern and will continue efforts to accommodate as able. In summary, if external providers are chosen, it may create a 3-stop shopping approach (Doctor, Lab, Pharmacy) versus the 1-stop shopping which occurs at MHMRA clinic locations.

These provider choice decision points will also be included in our Provider Choice Matrix which is shared with Consumers when selecting a provider and details out not only the Provider name and location but also whether transportation is provided, whether labs/meds are on site, bus routes, hours of operations, etc. This will help consumers to make informed choices when selecting providers based upon their own particular needs/preferences.

5) Briefly describe changes you will be making to your service delivery system in the next biennium, including those resulting from Crisis Redesign:

- New Crisis Redesign Programs:
 - Mobile Crisis Outreach Team (MCOT) Expansion- Mobile Crisis Outreach Team
 - Expansion of MCOT services to the North side of Harris County
 - Crisis Intervention Response Team (CIRT)
 - Program in conjunction with Houston Police Department. Trained Mental Health workers ride-along with Crisis Intervention Team (CIT) officers to assist in interventions with persons experiencing potential Mental Health crisis. Targeting high incident areas.
 - Critical Time Intervention (CTI)
 - Provide Intensive Case Management services to connect patients to housing and on-going treatment services. Housing subsidy available for up to 3 months pending benefits and/or employment.
 - Dual Diagnosis (mental health and substance abuse) Residential Treatment program- 40 beds available under contract for residential treatment for dual disorders. 20 beds are allocated for the Jail population and 20 beds from CPEP services.
 - Outpatient Competency Restoration program- Potential development of an outpatient model
 - Peer Support program expansion
 - Respite and Transitional Living programs
 - Expansion of local Inpatient Provider Network for crisis stabilization when HCPC has no bed availability, with the goal of reducing the occurrence of diversionary status for Comprehensive Psychiatric Emergency Programs (CPEP)

- Enhancement of Back Door Functions:
 - Development of transition team to help identify consumers who are transition ready and assist them through the transition process to other community services to ensure treatment needs are met and stability maintained through 90 day transition period. This will enable us to move consumers to less acute care, when clinically appropriate, in a more fluid manner and ideally lessen the number of consumers waiting for services at the front door.
- External Network Development:
 - Consumers will be offered choice from our provider panel of internal and external providers
 - Provider panel is updated with each new contractor
- Co-Location Programming:
 - Expanding services further throughout the community through collaborations with School Districts, City Health Department, County Health Department, Local Hospital District, Harris County Sheriff's Office, and Federally Qualified Health Centers
- Shared Eligibility Processes:
 - Expediting service eligibility determinations through collaborations with the City Health Department, Harris County Public Health and Environmental Services, MHMRA, and Harris County Hospital District
- Expansion of Psychiatric Emergency Services (PES):
 - Preliminary discussions are occurring around the feasibility of expanding PES services to LBJ hospital as a means to decompress the Emergency rooms and expand service locations for crisis care to best meet the community's needs.

Current Services and Providers

1. Mark "X" in the column labeled "LMHA" if the LMHA provides the service directly, and in the second column list the LMHA's direct service expenditures for the service in FY 2007.
2. In the third column list the name of the provider and the LMHA's expenditures for external provider contracted services in FY 2007.
3. If the service is not provided, enter N/A in the first column.

DSHS-Funded Services					
Service Type	LMHA	Dollars Spent on Direct LMHA Services	External Provider*	Dollars Spent on External Provider Services	External Provider Contract Start and End Dates
			(Name/address)		
ROUTINE SERVICES					
Intake (Screening, Pre-admission Assessment)	X	\$ 1,872,514	N/A	\$ 0	N/A
Routine Case Management (Adult)	X	\$ 974,247	N/A	N/A	N/A
Routine Case Management (Child/ Adolescent)	X	\$ 1,403,726	N/A	N/A	N/A
Respite Services	N/A	\$ 0	N/A	\$ 0	Pending Contracts in '08/'09
Supplemental Nursing Services	X	\$ 27,476	N/A	\$ 0	N/A
Pharmacological Management	X	\$ 3,073,327	Harris County Psychiatric Center- Outpatient Program 3610 Willowbend, Suite 1000 Houston, TX 77054	\$ 5037	Harris County Psychiatric Center- 09/01/07-8/31/08 (Note: numbers reflect only 2 months utilization in FY '07 when program first initiated)

			Continuum Healthcare 2001 Cedar Bayou Drive Baytown, TX 77520		Continuum Healthcare- Contract Pending
Provision of medication	N/A	\$ 0	**Note: PAP program	\$ (7,599,166)	N/A
Psychiatric evaluation	X	\$ 832,994	Harris County Psychiatric Center- Outpatient Program 3610 Willowbend, Suite 1000 Houston, TX 77054 Continuum Healthcare 2001 Cedar Bayou Drive Baytown, TX 77520	\$ 11,755	Harris County Psychiatric Center- 09/01/07-8/31/08 (Note: numbers reflect only 2 months utilization in FY '07 when program first initiated) Continuum Healthcare- Contract Pending
All Rehabilitation Services (Adult)	X	\$ 8,754,655	N/A	\$ 0	N/A
All Rehabilitation Services (Child/Adolescent)	X	\$ 1,375,371	N/A	\$ 0	N/A
Supported Employment	X	\$ 38,867	N/A	\$ 0	N/A
Supportive Housing	N/A	\$ 0	N/A	\$ 0	Note: Service captured within other service array
Assertive Community Treatment	N/A	\$ 0	N/A	\$ 0	Note: Service captured within other service array
Inpatient services	N/A	\$ 0	Harris County Psychiatric Center- 2800 S. McGregor Way, Suite 2B43 Houston, TX 77021	\$ 22,852,076	Renewed Annually each August Pending contract expansion currently (open enrollment)
Residential Treatment	N/A	\$ 0	Menninger 2801 N. Gessner	\$ 0	Affiliation Agreement 2/18/04 with annual

			Houston, TX 77080		auto-renewal, no expiration (charity care bed)
Intensive Case Management (Child/Adolescent)	X	\$ 223,489	N/A	\$ 0	N/A
Counseling (Adult)	X	\$ 139,935	N/A	\$ 0	N/A
Counseling (Child/Adolescent)	X	\$ 125,491	N/A	\$ 0	Foster Care- Rehab contracts pending (open enrollment)
Parent/Family Support Activities (e.g., family case management, family training, family partner, parent support group)	X	\$ 44,034	National Alliance for the Mentally Ill (NAMI) Multiple locations	\$ 0	Note: Not under contract- open to the public
Flexible Community Support (Child/Adolescent)	X	\$ 48,000	N/A	\$ 0	Note: FY 08 numbers
Flexible Community Support (Adults)	X	\$ 108,000	N/A	\$ 0	Note: FY 08 numbers
Multi-Systemic Therapy (Child/Adolescent)	N/A	\$ 0	N/A	\$ 0	N/A
Consumer Peer Support	N/A	This service is provided within another service code (not a discrete service) hence unable to report separate dollars at this time	N/A	\$ 0	Note: Pending Expansion with Crisis redesign
CRISIS & OTHER DISCRETE SERVICES					
Crisis Hotline	X	\$ 105,449	N/A	\$ 0	Note: This is FY08 Crisis redesign allocation numbers
Crisis Intervention Services	X	\$ 0	N/A	\$ 0	Note: County funded
Mobile Outreach	X	\$ 2,053,344	Memorial Herman 9801 Southwest Freeway Suite 370 Houston, TX 77074	\$ 78,600	9/1/07-8/31/08 Note: County funded
23 Hour Observation	X	\$ 2,345,616	N/A	\$ 0	N/A

Extended Observation Unit	N/A	\$ 0	N/A	\$ 0	N/A
Crisis Residential Services	X	\$ 0	<p>Bay Area Substance Abuse Facility 4316 Washington Dickinson, TX 77539</p> <p>Santa Maria Hostel, Inc. 7807 Longpoint Rd., Ste. 375 Houston, TX 77055</p> <p>Zebra Inc. dba Cheyenne Center P.O. Box 11627 Houston, TX 77293</p> <p>Volunteers of America 1424 Hemphill St. Ft. Worth, TX 76104</p>	\$ 0	<p>Co-Occurring Substance Abuse Residential Treatment contracts started in May 2008- Hence no dollars reported in FY'07</p> <p>Note: Primary MH CRU is County Funded, hence no dollars reported in FY'07</p>
Crisis Respite Services	N/A	\$ 0	N/A	\$ 0	Contract Discussions pending
Crisis Stabilization Unit	X	\$ 447,301	N/A	\$ 0	N/A
Crisis Follow-Up and Relapse Prevention	X	\$ 0	N/A	\$ 0	New code in FY' 08- Not available in FY' 07 reporting
Crisis Transportation	N/A	\$ 0	Best Care EMS 4040 Willowbend Houston, TX 77025	\$ 2,268	9/1/07-8/31/08 Note: County funded
Crisis Flexible Benefits (see Adult and CAS flex funds above)	N/A	\$ 0	N/A	\$ 0	Included in General Flex funds above
Laboratory Services	N/A	\$ 0	Memorial Herman 9401 Southwest Freeway Suite 1132 Houston, TX 77074	\$ 1,723,603	Memorial Herman 9/1/07-8/31/08

			Pretty Quick Delivery 10106 Kinney Road Houston, TX 77099 Clinical Pathology Laboratories, inc (CPL) 9200 Wall Street, Austin, TX 78754 Pharmatech, Inc 10151 Barnes Canyon Rd San Diego, CA 92121		Pretty Quick Delivery 9/1/07-8/31/08 CPL labs 9/1/07-8/31/08 Pharmatech 9/1/07-8/31/08
ADDITIONAL SERVICES PER LMHA DEFINED NEEDS					
Intensive Outpatient Programming (IOP)	N/A	\$ 0	Harris County Psychiatric Center- Outpatient Clinic 3610 Willowbend, Suite 1000 Houston, TX 77054 Continuum Healthcare 2001 Cedar Bayou Drive Baytown, TX 77520	\$ 1317	Harris County Psychiatric Center- Outpatient Clinic Started June 2007- Annual renewal each August Continuum Healthcare- Contract Pending
Intensive In-Home Counseling	N/A	\$ 0	Depelchin Children's Ctr (not a direct contract)	\$ 0	Costs covered by TRIAD

*An organization that provides mental health services that is not an LMHA; or an individual who provides mental health services who is not an employee of an LMHA.

** The PAP program has resulted in a critical pharmacy savings which allows us to funnel these dollars directly into services instead of medications. As such, this is a critical component to maintain in the development of external providers, in order to meet DSHS contract expectations and requirements.

Note: In FY '08 external provider contracts have been expanded, however the above table reflects FY'07 costs, hence where new contracts are noted, there will be a cost shift in FY' 08- not reflected here.

Provider Network Development

1) Provider Availability:

Describe the process used to assess the availability of current and potential external providers.

MHMRA completed a review of previous contract attempts and responses (see pg 45), reviewed provider inquiries trends (see below) and reviewed applicants expressing interest in the current process on the DSHS website. The latter being the most recent information, we had respondents interested in all levels of care (CAS, Adult, and Crisis services) and with sufficient capacity for network development. As such, we do not see provider availability as a barrier for procurement at this time. The only noted restraint is that currently only 1 provider (from the DSHS interested provider list) is located in Houston, hence the start up time for service contracts may be longer as providers bring up services here locally.

2) Provider Inquiries:

Provide a summary of all written inquiries from providers interested in providing services received over the previous two years by the LMHA. Written inquiries include regular mail service, e-mail, fax, or website and include services each provider wishes to provide. Describe the LMHA’s response to each inquiry.

Date of Inquiry	Summary of Inquiry	LMHA Response
7/7/06	Letter received from ADAPT expressing interest in contracting services.	Conference Called with Beth Epps from ADAPT on several occasions to discuss contract potential. ADAPT expressed interest but would not initiate services in Harris County unless other business lines were also obtained- they agreed to contact us when ready to discuss further.
12/12/06	Letter received from the Wood Group expressing interest in providing services in Harris County (Crisis and Residential Services).	Responded to the Wood Group that currently these services are not open for enrollment but that they were added to our Provider Notice list and would receive future notices as services are contracted out.
Jan 2006-Dec 2006	13 provider inquiries for service contracts in response to RFA (see past contract efforts) 1 provider requesting CAS contract 3 providers requesting other service contracts (MR/Intern)	Instructed providers on how to complete the contract applications. Took contact information for future Network notices Referred providers to appropriate department
Jan 2007-Dec 2007	<u>31 provider inquiries:</u> 2- interested in CAS service contracts 6-interested in Adult service contracts	MHMRA added providers to Network Mgmt contact list for future notices and communications. For those services open for enrollment (IOP, SP-1)-

	<p>5- interested in general service contracts/not specified 4- interested in other service levels (non-licensed providers) 1- interested in PHP contract 3- interested in IOP contracts 2- interested in contracting as CMHC 8- requesting referrals to private practices</p>	<p>educated providers on how to apply for contracts. Directed CMHC requests to Exec Dir office. Added providers to referral panels as requested.</p>
<p>Jan 2008-May 2008</p>	<p><u>20 provider inquiries:</u> 1- interested in counseling services 2- interested in IOP/PHP services 4- interested in general services/not otherwise specified 10- interested in Foster Care Open enrollment 2- interested in Residential/Respite services</p>	<p>MHMRA added providers to Network Mgmt contact list for future notices and communications. For those services open for enrollment (IOP, SP-1, Foster Care)- educated providers on how to apply for contracts.</p>

3) Service Capacity and Procurement:

Complete the following table.

- a) Document the current service capacity (for a one-year period) using data from the LPND Web page [<http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/default.shtm>]. If the service is not provided, enter N/A.
Note: Harris County Service Capacity based on FY 2007 and Qtrs 1&2 of FY 2008
- b) Document the projected service capacity. The current and projected capacity will often be the same number. However, if service minimums and RDM targets are not being met, the projected capacity may be lower than the current capacity.
- c) Briefly state the LMHA’s assessment of the availability of current and potential external providers.
- d) Indicate (Yes/No/NA) if the LMHA will procure each service package/service during FY 2008-2009.
- e) If a service will be procured, state the capacity to be procured during FY 2008-2009.
- f) Document the method of procurement, e.g. request for proposal or open enrollment.
- g) **NOTE: RDM services packages are identified as the primary units of procurement, but LMHAs may determine that it is most appropriate to procure discrete services from within one or more service packages. If this decision is made, state “No, except for (insert the discreet service)” in column 3d. Leave the last two columns blank. Then, enter the discrete service(s) to be procured in one of the blank rows at the bottom of the table (enter additional rows if needed), and fill out the remaining columns as described above. Also, item 4 must be completed.**

	3a	3b	3c	3d	3e	3f
Service	Current Capacity	Projected Capacity	Availability of Current and Potential External Providers	Procurement Planned?	Capacity to be Procured	Method of Procurement
ADULT SERVICES		(-2.5% decrease)				
RDM SP 1- Basic Medication Services	6779	6610	Currently- 2 External Provider Groups provide this service level 4 additional Provider groups report interest on the DSHS website	Currently under open enrollment	Up to 20%	Open Enrollment
RDM SP 2- Cognitive Behavioral Therapy	200	195	4 Provider groups report interest on the DSHS website 2 Additional Provider Groups currently under contract for other services report interest	Yes	Up to 30%	Open Enrollment
RDM SP 3- Rehabilitation Services	1246	1215	4 Provider groups report interest on the DSHS website 2 Additional Provider Groups	Yes	Up to 20%	Open Enrollment

			currently under contract for other services report interest			
RDM SP 4- Assertive Community Treatment (ACT)	379	348	4 Provider groups report interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of team model and efficiencies (rationale # 5 & 6)	N/A	N/A
RDM SP 0- Crisis Services	820	900	3 Provider groups report interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of model and efficiencies (rationale # 5 & 6)	N/A	N/A
RDM SP 5- Crisis Follow-up	140	210	3 Provider groups report interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of model and efficiencies (rationale # 5 & 6)	N/A	N/A
CHILD/ADOLESCENT SERVICES		(-26 % decrease)				
RDM SP 1.1- Brief Externalizing Disorders	1461	1080	3 Provider groups report interest on the DSHS website	Yes	Up to 20%	Open Enrollment
RDM SP 1.2- Brief Internalizing Disorders	407	300	3 Provider groups report interest on the DSHS website	Yes	Up to 20%	Open Enrollment
RDM SP 2.1- MultiSystemic Therapy (MST)	N/A	N/A	N/A	No	N/A	N/A

RDM SP 2.2- Intensive Externalizing Disorders	246	180	2 Provider group reports interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of model and efficiencies (rationale # 5 & 6)	N/A	N/A
RDM SP 2.3- Intensive Internalizing Disorders	20	15	2 Provider group reports interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of model and efficiencies (rationale # 5 & 6)	N/A	N/A
RDM SP 2.4- Bipolar/Schizo/Psychotic	5	7	2 Provider group reports interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of model and efficiencies (rationale # 5 & 6)	N/A	N/A
RDM SP 4- Aftercare	404	299	3 Provider groups report interest on the DSHS website	Yes	Up to 20%	Open Enrollment
RDM SP 0- Crisis Services	80	90	3 Provider groups report interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3-4 based on costs of model and efficiencies (rationale # 5 & 6)	N/A	N/A
RDM SP 5- Crisis Follow-up	30	45	3 Provider groups report interest on the DSHS website	Not in the first 2 years- will reevaluate for year 3 based on	N/A	N/A

				costs of model and efficiencies (rationale # 5 & 6)		
CRISIS & OTHER DISCRETE SERVICES						
Crisis Hotline	20,000 calls/mo	20,000 calls/mo	Number includes all calls, not just crisis. Provided internally also as a Contractor for 6 other Centers. 1 of 5 respondents on DSHS website are interested in contracting for this service; however, since Harris County is serving as contractor for 6 other Centers, will not contract out at this time due to revenue generation and economy of scale	No	N/A	N/A
Mobile Outreach	180 individuals/mo	260 individuals/mo	<p>Per the Memo from Rod Swan, DSHS Unit Manager of MH Contracts dated October 31, 2007.</p> <p>The Crisis Services Redesign initiative completed just prior to this local planning initiative which began March 1, 2008. The development of local crisis services plans occurred using then existing planning and procurement requirements. The efforts related to crisis services are not subject (at this time) to the new Local Network Planning and Development rules for FY08. Current crisis service planning efforts are summarized within this plan.</p> <p>Important to note: Centers are not required to repeat the process for local planning for crisis services when considering this Network Development Plan, thus crisis services are not subject to further procurement at this time.</p>			
Extended Observation	100 individuals/mo	100 individuals/mo				
Day Program for Acute Needs	900 individuals/mo in the PES and 35 individuals/mo in Crisis Counseling	900 individuals/mo in the PES and 35 individuals/mo in Crisis Counseling				
Crisis Stabilization Unit	16 beds	16 beds				
Crisis Respite Services	0	~ 4 beds				
Inpatient Services	132 beds	142 beds	Currently, this service is 100% contracted out; however, there are legislative requirements which do not allow us to put this funding out to other entities. Will utilize some new crisis redesign dollars to expand capacity by ~ 10 beds	Yes	100%	Open Enrollment

Intensive Crisis Residential	18 beds- CRU	18 beds	<p>Per the Memo from Rod Swan, DSHS Unit Manager of MH Contracts dated October 31, 2007.</p> <p>The Crisis Services Redesign initiative completed just prior to this local planning initiative which began March 1, 2008. The development of local crisis services plans occurred using then existing planning and procurement requirements. The efforts related to crisis services are not subject (at this time) to the new Local Network Planning and Development rules for FY08. Current crisis service planning efforts are summarized within this plan.</p> <p>Important to note: Centers are not required to repeat the process for local planning for crisis services when considering this Network Development Plan, thus crisis services are not subject to further procurement at this time.</p>			
Safety Monitoring	Internal to PES and MCOT programs	Internal to PES and MCOT programs				
Crisis Follow-Up and Relapse Prevention	180 individuals/mo	340 individuals/mo				
Crisis Transportation	\$5,000	\$5,000				
Crisis Flexible Benefits	\$10,000	\$10,000				
Laboratory Services	\$55,200	\$55,200	Currently contracted out 100% to Memorial Herman, CPL, Pharmatech, and Pretty Quick Delivery	Yes	100%	RFP
Supported Housing	Treatment Plan specific- not reported as a discrete service- incorporated into Rehab services	Treatment Plan specific- not reported as a discrete service- incorporated into Rehab services	See RDM sp 3 for rehab services	Yes- note will ensure providers stable in rehab service delivery before expanding consumer choice to this population due to the expanded clinical needs	Up to 20%	Open Enrollment
Supported Employment	Treatment Plan specific- not reported as a discrete service- incorporated into Rehab services	Treatment Plan specific- not reported as a discrete service- incorporated into Rehab services	See RDM sp 3 for rehab services	Yes- note will ensure providers stable in rehab service delivery before expanding consumer choice to this population due to the expanded clinical needs	Up to 20%	Open Enrollment

4) Justification for procurement of discrete services:

If procuring discrete services from one or more service packages, provide the rationale for procuring the service(s) separately. Provide a separate rationale for each discrete service to be procured. Add additional rows as needed.

Discrete Service to be Procured	Rationale
Therapy Services	<p>Therapists are independent practitioners</p> <p>Therapy has historically been a stand alone program, which can be separated from Medication services without great consequence as long as contractually the providers of care are required to coordinate care/case staffings to ensure the best outcomes for the patient. This will be a contract stipulation with audits and proven (documentation) that such coordination occurs. This service package is time limited with the hope that the patient can be stepped down to Medication only services upon completion. If needing a higher level of care during the course of therapy, the patient would need to be referred to an MD that has rehab providers under MHMRA contract.</p> <p style="text-align: center;"><i><u>Services Available: Counseling (CBT)</u></i></p> <p><i><u>Plan:</u></i> This population can be served in an <u>unbundled</u>, stand alone program as services are provided by a Therapist and potentially a Psychiatrist in collaboration. Both are independent practitioners and could be held to case collaboration under contract stipulations.</p>

In addition, state your plan for maintaining fidelity and continuity of care for the service package(s).

Plan for Fidelity and Continuity of Care
<p>This will be a contract stipulation with audits and proven (documentation) that such coordination occurs. Both are independent practitioners and could be held to case collaboration under contract stipulations.</p> <p>The challenge will be for the MD to complete the Medication Training and Support Services if working without nursing or other clinical staff and for both providers to ensure minimum hours and outcome requirements are met. This will be monitored through data submissions.</p>

5) Rationale for Keeping Services:

According to the Texas Administrative Code (TAC), the rationale for the decision to continue providing services at any level for any of the services listed above must be based on:

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

For each service in the table below, describe the rationale for a decision to continue providing service at any level. For each service the LMHA will be providing, state the percent capacity to be provided by the LMHA, identify the condition from 25 TAC §412.758(a) that applies if the LMHA will continue to provide services at any level, and provide an explanation of why the condition from 25 TAC §412.758(a) is applicable. In addition, state the percent capacity of service necessary to make service provision by the LMHA financially viable and the rationale for arriving at this volume.

If discrete services are being procured separately from one or more service packages, enter them in the blank rows at the end of the table (enter additional rows as needed) and follow the instructions above.

Service	Percent Capacity provided by the LMHA	Condition 1-6 (listed above)	Explanation	Percent Capacity necessary for LMHA Viability	Rationale for this Volume
ADULT SERVICES					
RDM SP 1	~80% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks-hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~25% Approximately	In the first 2 years as external providers are training up to provide this service, it is prudent that the internal network remain operational as a safety net. Per our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reducing the internal network. In years 3-4 areas which have successfully contracted and stabilized services will have an increased % contracted out. (Graduated approach)
RDM SP 2	~70% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks-hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~10% Approximately	In the first 2 years as external providers are training up to provide this service, it is prudent that the internal network remain operational as a safety net. Per our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reducing the internal network. In years 3-4 areas which have successfully contracted and stabilized services will have an increased % contracted out. (Graduated approach)

RDM SP 3	~80% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks-hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~25% Approximately	In the first 2 years as external providers are training up to provide this service, it is prudent that the internal network remain operational as a safety net. Per our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reducing the internal network. In years 3-4 areas which have successfully contracted and stabilized services will have an increased % contracted out. (Graduated approach)
RDM SP 4	100%	5	Critical infrastructure must be preserved-. It is expected in years 3-4 that the % provided by the LMHA decreases 20-30%, if procurement at the lower levels of care are successful. MHMRA is procuring and stabilizing the step down packages first to ensure proper supports are in place for this population prior to procurement of the intense service levels.	~50% Approximately	In the first two years as external providers learn the DSHS system, it is critical for us to keep the most fragile population with internal providers for continuity of care, quality of care, and for cost efficiencies due to the highly prescriptive model of ACT services and related staffing. Will re-examine provider basis and competencies in years 3-4 for potential procurement of this level of care.
RDM SP 0	N/A	N/A	N/A	N/A	See specific crisis programs for contract status
RDM SP 5	N/A	N/A	N/A	N/A	See specific crisis follow-up programs for contract status

CHILD/ADOLESCENT SERVICES					
RDM SP 1.1	~80 Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks- hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~25% Approximately	In the first 2 years as external providers are training up to provide this service, it is prudent that the internal network remain operational as a safety net. Per our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reducing the internal network. In years 3-4 areas which have successfully contracted and stabilized services will have an increased % contracted out. (Graduated approach)
RDM SP 1.2	~70% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks- hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~20% Approximately	In the first 2 years as external providers are training up to provide this service, it is prudent that the internal network remain operational as a safety net. Per our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reducing the internal network. In years 3-4 areas which have successfully contracted and stabilized services will have an increased % contracted out. (Graduated approach)
RDM SP 2.1	N/A	N/A	N/A	N/A	No current service provision for this level of care
RDM SP 2.2	100%	5	Critical infrastructure must be preserved-. It is expected in years 3-4 that the % provided by the LMHA decreases 20-30%, if procurement at the lower levels of care are successful. MHMRA is procuring and stabilizing the step down packages first to ensure proper supports	~30% Approximately	In the first two years as external providers learn the DSHS system, it is critical for us to keep the most fragile population with internal providers for continuity of care, quality of care, and for cost efficiencies due to the highly prescriptive model of these services and related

			are in place for this population prior to procurement of the intense service levels.		staffing. Will re-examine provider basis and competencies in years 3-4 for potential procurement of this level of care.
RDM SP 2.3	100%	5	Critical infrastructure must be preserved-. It is expected in years 3-4 that the % provided by the LMHA decreases 20-30%, if procurement at the lower levels of care are successful. MHMRA is procuring and stabilizing the step down packages first to ensure proper supports are in place for this population prior to procurement of the intense service levels.	~25% Approximately	In the first two years as external providers learn the DSHS system, it is critical for us to keep the most fragile population with internal providers for continuity of care, quality of care, and for cost efficiencies due to the highly prescriptive model of these services and related staffing. Will re-examine provider basis and competencies in years 3-4 for potential procurement of this level of care.
RDM SP 2.4	100%	5	Critical infrastructure must be preserved-. It is expected in years 3-4 that the % provided by the LMHA decreases 20-30%, if procurement at the lower levels of care are successful. MHMRA is procuring and stabilizing the step down packages first to ensure proper supports are in place for this population prior to procurement of the intense service levels.	~25% Approximately	In the first two years as external providers learn the DSHS system, it is critical for us to keep the most fragile population with internal providers for continuity of care, quality of care, and for cost efficiencies due to the highly prescriptive model of these services and related staffing. Will re-examine provider basis and competencies in years 3-4 for potential procurement of this level of care.
RDM SP 4	~50% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks- hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~25% Approximately	In the first 2 years as external providers are training up to provide this service, it is prudent that the internal network remain operational as a safety net. Per our experience; training, quality monitoring and fiscal stability need to be assessed over a 1-2 yr time span prior to further reducing the internal network. In years 3-4 areas which have successfully contracted and stabilized services will have an increased % contracted out. (Graduated approach)
RDM SP 0	N/A	N/A	N/A	N/A	See specific crisis programs for contract status.
RDM SP 5	N/A	N/A	N/A	N/A	See specific crisis follow-up programs for contract status.

CRISIS & OTHER DISCRETE SERVICES					
Crisis Hotline	100%	6	Existing Circumstances would result in substantial revenue loss- Currently MHMRA of Harris County is the Contractor for 6 other LMHA's for this service. Due to this being a revenue generator for Harris County MHMRA and due to economy of scale savings. There would be a substantial loss of revenue in us contracting this service out.	N/A	Crisis services need to be provided by 1 service provider for consistency and economy of scale.
Mobile Outreach	~90% Approximately	5	Critical infrastructure must be preserved-Since Crisis services have recently developed/expanded, it is not cost effective to contract these services out at this time. Programs were recently developed, staff hired, and trained internally and it would not be prudent to procure this level of care at this time. Crisis services need to stabilize first from recent roll-outs. Will re-evaluate all crisis services for possible procurement in years 3-4	~50% Approximately	Mobile Crisis Outreach Team (MCOT) services is closely tied into our local Police Department and Local Hospital systems and has taken years to build relationships and work flows to effectively manage this high cost service and ensure positive outcomes for consumers (hence overall cost of care reductions). It is critical that we do not destabilize this system hence we are taking a graduated approach to contracting out this service to ensure program integrity is maintained. No further procurement planned- maintain at current contract levels.
Extended Observation	100%	6	Existing Circumstances would result in substantial revenue loss- This service is incorporated into our PES services. The build out for such service provision is extensive and costly and Harris County has expended these funds already. Funding is maximized by incorporating this into our PES services so not staffing two levels of care 100%. Economy of scale in keeping this as 1 service currently helps to reduce costs. If service volume is expanded to make it feasible to bring up a secondary site, MHMRA will consider procurement of such expansion.	50%	23-hour observation is integrated into the Psychiatric Emergency Services (PES) system noted below as (Day Program for Acute Needs) hence we have bundled these two services together.
Day Program for Acute Needs	100%	6	Existing Circumstances would result in substantial revenue loss- This service is incorporated into our PES services. The build out for such service provision is extensive and costly and Harris County has expended these funds already. Funding is maximized by	~50% Approximately	The Psychiatric Emergency Services (PES) system (noted as Day Program for Acute Needs) and 23 hr observation (above) are bundled in 1 service array, as patient flow from one to the other and hence both are needed to maximize

			incorporating this into our PES services so not staffing two levels of care 100%. Economy of scale in keeping this as 1 service currently helps to reduce costs. If service volume is expanded to make it feasible to bring up a secondary site, MHMRA will consider procurement of such expansion.		resources and minimize costs.
Crisis Stabilization Unit	100%	5 & 6	Existing Circumstances would result in substantial revenue loss- This service is also incorporated into our PES and 23 hr observation units. As such 24 hour staffing can be maintained at lower costs as staff coverage across units occurs. At this level of care having such fluid staffing maximizes resources and would not be feasible if services were separated. Critical infrastructure must be preserved- MHMRA operates a 16 bed unit- at this time there is not funding for additional beds. It would be difficult to staff a safety net if this was contracted out as this is the minimum unit size for fiscal feasibility. Fiscally, we cannot support an internal and external unit due to limited bed size and staffing costs.	100%	MHMRA operates a 16 bed unit- at this time there is not funding for additional beds. It would be difficult to staff a safety net if this was contracted out as this is the minimum unit size for fiscal feasibility. Fiscally, we cannot support an internal and external unit due to limited bed size and staffing costs. Will re-evaluate this in years 3-4 as new providers enter our system- currently there are no existing CSU beds with which to contract outside of our system.
Crisis Respite Services	0%	N/A	N/A	0%	Not currently providing this level of care under DSHS contract- however under contract discussions to possibly contract capacity for 4 beds in FY 09- so would have 100% in an external provider model.
Inpatient Hospital Services	0%	N/A	N/A	0%	Currently this is 100% contracted to Harris County Psychiatric Center (HCPC)- under legislative restrictions these funds are passed through MHMRA of Harris County but are restricted for HCPC only. These cannot be bid out to other providers; however, MHMRA has requested some Crisis redesign dollars for additional overflow beds to be contracted for times that HCPC does not have bed capacity available. This will be 100% contracted out under these additional funds in FY 09.
Crisis Residential Treatment Services	100%	N/A	N/A	N/A	MHMRA of Harris Counties Crisis residential unit is 100% county funded and does not utilize DSHS service dollars at this time. The new dual disorders (MH and substance abuse) programs utilizing crisis redesign dollars

					are 100% contracted out.
Safety Monitoring	N/A	N/A	N/A	N/A	This service is included in our other CPEP service programs and is not a stand alone discrete service- refer to MCOT, CIRT, CTI, CPEP programs for contractual status
Crisis Follow-Up and Relapse Prevention	~90% Approximately	5 & 6	See Mobile Outreach Section	~50% Approximately	See Mobile Outreach Section
Crisis Transportation	~80% Approximately	6	Existing Circumstances would result in substantial revenue loss- This service is not a stand alone service (incorporated into crisis service array- hence will be contracted out with those services as they are procured. The stand alone transportation (i.e., ambulance) is 100% contracted out and will remain so but typically transport is provided by service providers of crisis care hence this only makes up about 20%. Contracting this out separate from service provision would	~80% Approximately	Costs of this are wrapped into program costs and only in limited cases is this pull-out funding (i.e., ambulance transport). Will maintain current contract status.
Crisis Flexible Benefits	100%	6	Existing Circumstances would result in substantial revenue loss- The local authority would have to oversee this process and since already reviewing and authorizing this level of care, it would not make sense fiscally to contract it out versus contain this function within current UM procedures.	100%	There are minimal funds and minimal management costs to implementation of this resource. Due to its small size, it is not cost effective to contract this function out. Contracting out would result in increased costs of contracting and oversight versus maintaining this function internally.
Laboratory Services	0%	N/A	N/A	0%	100% contracted out currently and this will continue under arrangement
Supported Housing	~80% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks- hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~25% Approximately	Due to the specialized nature of this service- it will follow Sp-3 procurement (same providers yet must prove rehab expertise prior to taking on this population and enhanced service provision)

Supported Employment	~80% Approximately	5	Critical infrastructure must be preserved- Since this initiative is not funded with any new dollars-the transition to an external network must be gradual as MHMRA cannot reduce internal staffing until external providers are fully operational under the contract and have proven clinical and financial stability. As such, there is not enough funding to support both networks-hence MHMRA is taking a graduated approach and will slowly contract a higher service percent out each biennium as able and downsize the internal network accordingly as costs and consumer flow shift. It is expected in years 3-4 that the % provided by the LMHA decreases another 20-30% if procurement is successful.	~25% Approximately	Due to the specialized nature of this service-it will follow Sp-3 procurement (same providers yet must prove rehab expertise prior to taking on this population and enhanced service provision)
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For more information on service packages- please see the DSHS websites:

Adult UM Guidelines-

http://www.dshs.state.tx.us/mhprograms/RDM/documents/Adult_UM_Guidelines_Revised20080527.pdf

Children and Adolescent UM Guidelines-

<http://www.dshs.state.tx.us/mhprograms/doc/ChildrensUMGuidelinesDec2007.doc>

How did the LMHA determine the type and volume of services that must be retained to protect critical infrastructure? What factors were considered, and what data was used? Please attach any supporting documentation.

Harris County took three factors into consideration when setting these numbers:

- a) Consumer Impact- Looking at procurement numbers, we needed to ensure that we did not procure out such a high volume initially that we risked destabilizing our internal system and impacting consumer services. If too many dollars go out the door early on before we can offset our staffing, we risk not being able to cover internal costs which can interrupt care for those consumers still under the LMHA. In addition, procuring out services too fast may result in a quick loss of staff, again destabilizing this system before consumer transition has safely occurred. Many providers interested in Harris County business are from other areas and will need to hire staff locally. Currently, there is a shortage of behavioral Health care providers in our service area and if too many providers come in too fast with high staffing needs; the risk is that the LMHA staff are hired by external providers prior to their readiness to take on business, which could have a negative impact on patient care very quickly. On the flip side, we wanted to ensure by service package that there was enough volume being procured out to allow providers to staff "experts" in RDM. If a business cannot dedicate their staff to this business contract due to low numbers, it will be a challenge for them to have these staff become experts in RDM (if mixing business lines and not seeing enough volume to gain proficiencies in the detailed contract requirements). This would likely have a negative impact on patient care, patient outcomes, and fidelity.
- b) External Provider Impact- Looking at procurement numbers by service package, we went higher on service packages which had lower numbers served to ensure that this would be cost effective for providers to engage in a contract. If the numbers are too small, we understand that it quickly becomes cost prohibitive for a provider to comply with such a detailed contract and administrative/business office functions without sufficient consumer volume. Though consumer choice may still drive this to be a challenge, we wanted to ensure capacity restrictions were not a deterrent to contracts.

- c) LMHA Impact- As mentioned above, the LMHA ensuring that the cost shifts in internal staffing can occur in increments to ensure that financial stability of the LMHA is intact is critical in this plan's implementation. If staff are lost too quickly in a market where providers are lower than consumer demand, it places the safety net at risk. Alternatively, if staff costs are not offset incrementally as more business goes to the private providers, than again it places the LMHA at financial risk. Hence, it is imperative that this is in planned increments so as one system grows, the other is able to downsize appropriately.

Harris County took the above factors and looked at the planned numbers served by service package for FY 09 as a means to determine a balance. We started with looking at current staff vacancies and related caseloads as a means to shift these to an external network without adding additional costs and then factored in how much higher could we go in procurement prior to our having to downsize internally and then finally looked at the numbers/percentages to see if this was feasible for an external provider to start a new business line.

6) Structure of Procurement(s):

In the table below, describe how procurement will be structured and provide a rationale. Make a separate entry for each service or combination of services that will be procured as a separate contracting unit. Identify the geographic area(s) in which the service will be procured, and 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 service area, describe how the area may be partitioned.

Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Rationale
Adult SP-1 services	Harris County (at least 20 mi radius)	This population can be served in an unbundled stand alone program as services are provided by a Psychiatrist with no requirement (or minimal requirement) for additional auxiliary staff.
Adult SP- 2 services	Harris County (at least 20 mi radius)	This population can be served in an unbundled stand alone program as services are provided by a Therapist and potentially a Psychiatrist. Both are independent practitioners and could be held to case collaboration under contract stipulations.
Adult SP- 3 services/Combined with SP-1	Harris County (at least 20 mi radius)	This population must be served in a <u>bundled</u> program as services require additional auxiliary staff whom are trained in rehabilitation services in addition to the Psychiatrist. In addition, the staff providing these additional services are not independent practitioners and are in need of close clinical supervision. Finally, the acuity level of these patients warrants close collaboration by a treatment team model versus partitioned services to ensure that the consumer's needs are met, care is coordinated and medically necessary, and care is cost effective in that it is not duplicated between providers. Step down to SP-1 is a natural progression, so contractors are required to provide both levels of care to ensure continuity of care for consumers.
Adult SP-4 services/Combined with SP-3 and SP-1	Harris County (at least 20 mi radius)	This population must be served in a <u>bundled</u> program as services require fidelity to the ACT model of treatment. Step down to SP-3 is a natural progression (and eventually to SP-1), so contractors are required to provide all levels of care to ensure continuity of care for consumers.
CAS SP-4	Harris County (at least 20 mi radius)	This population can be served in an <u>unbundled</u> , stand alone program as services are provided by a Psychiatrist with no requirement or minimal requirement for additional auxiliary staff.
CAS SP-1.1 /Combined with SP-4	Harris County (at least 20 mi radius)	This population must be served in a <u>bundled</u> program as services require additional auxiliary staff whom are trained in rehabilitation services in addition to the Psychiatrist. In addition, the staff providing these additional services are not independent practitioners and are in need of close clinical supervision. Finally, the acuity level of these patients warrants close collaboration by a treatment team model versus partitioned services to ensure that the consumer's needs are met, care is coordinated and medically necessary, and care is cost effective in that it is not duplicated between providers.

CAS SP-1.2	Harris County (at least 20 mi radius)	This population can be served in an <u>unbundled</u> , stand alone program as services are provided by a Therapist and potentially a Psychiatrist in collaboration. Both are independent practitioners and could be held to case collaboration under contract stipulations. The challenge would be for the MD to complete the Medication Training and Support Services if working without nursing or other clinical staff and for both providers to ensure minimum hours and outcome requirements are met.
CAS SP-2.2 /Combined with SP-4 and SP-1.1	Harris County (at least 20 mi radius)	This population must be served in a <u>bundled</u> program as services require additional auxiliary staff whom are trained in rehabilitation services in addition to the Psychiatrist. In addition, the staff providing these additional services are not independent practitioners and are in need of close clinical supervision. Finally, the acuity level of these patients warrants close collaboration by a treatment team model versus partitioned services to ensure that the consumer's needs are met, care is coordinated and medically necessary, and care is cost effective in that it is not duplicated between providers.
CAS SP-2.3 /Combined with SP-4 and SP-1.2	Harris County (at least 20 mi radius)	This population must be served in a <u>bundled</u> program as the acuity level of these patients warrants close collaboration by a treatment team (ACT model) versus partitioned services to ensure that the consumer's needs are met, care is coordinated and medically necessary and the services are cost effective in that it is not duplicated between providers.
CAS SP-2.4/Combined with SP-4, SP-2.2, and SP-2.3	Harris County (at least 20 mi radius)	This population must be served in a <u>bundled</u> program as the acuity level of these patients warrants close collaboration by a treatment team model versus partitioned services to ensure that the consumer's needs are met, care is coordinated and medically necessary, and cost effective in that it is not duplicated between providers. These patients once stabilized quickly move into either counseling or rehab/skills training services and it would be less disruptive to care if both 2.2 and 2.3 services were available within the same provider practice for continuity purposes.
Crisis Services	Harris County	Pending Procurement in years 3-4

7) Choice and Access:

Describe how consumer choice and access will be maximized.

The consumer (and legally authorized Representatives -LAR's) will then be provided with a Network Provider Listing (NPL) to allow them to choose a Provider that best meets their needs. In order to ensure consumer choice is maximized, MHMRA of Harris County will be maintaining a provider panel with basic service, location, transportation, and language information in order to educate consumers and offer choice in service provider. MHMRA of Harris County plans to conduct open enrollments and to keep procurements open in order to ensure all interested providers have ample opportunity to apply as a subcontractor for services. MHMRA will ensure access to services by targeting to have provider options within 30 min travel time from consumers homes throughout Harris County and that appointment availability is maintained within our agency standards

based on urgent, emergent, routine needs. MHMRA of Harris County will geo-plot service providers as a means to focus recruitment in any underserved areas.

8) Single Provider:

Will any services be provided by only one provider (internal or external) because it would not be financially viable to fund two or more providers?

Yes No

If yes, specify which services will be provided by a single provider and identify the economic factors which prevent the LMHA from offering consumers a choice.

Service to be Provided by a Single Provider	Economic Factors Preventing Consumer Choice
Crisis Hotline	It is not cost effective to break this service across multiple providers. Economy of Scale is present with a Crisis Hotline since location is not prudent. MHMRA of Harris County currently is the contractor for 6 other Centers in providing this service. Consistency is also imperative and best maintained with operation by one provider for this type of service.
Crisis Residential Unit	This service is currently County funded. It is funded for limited numbers of beds and is not cost effective to split this amongst multiple providers at this time. If funding and/or bed numbers increase, it may be feasible in the future. Will re-evaluate in years 3-4.
Crisis Stabilization Unit	This service is incorporated into the PES service array and is limited to 16 beds. With this low volume it is not cost effective to contract this across multiple providers and yet due to its critical nature, we need to ensure it remains operational (safety net). Will re-evaluate in years 3-4 to see if other crisis service have been contracted out and if feasible to expand this into other External provider contracts (tier 2 contracting)

9) Diversity:

How will issues of cultural and linguistic diversity in the local community be addressed by the LMHA? Include any contract issues regarding use of external providers and how a plan to ensure that cultural and linguistic diversity will be addressed by external providers contracting with the LMHA.

Cultural and Linguistic Diversity Issues-

All new providers will engage in cultural diversity training prior to provision of services and will receive this training at least annually. In addition, cultural respect language is included in all provider contracts and will be monitored through consumer complaints as well as consumer satisfaction surveys.

In addition to the Provider training, Authority staff will be trained, when assisting a consumer to choose a provider, to be mindful of these needs.

All providers will be listed with any cultural/linguistic specializations so as to easily match a consumer requesting such preferences with appropriate providers.

Translation services for Monolingual consumers, will be made available if needed, at both MHMRA internal provider offices as well as at external provider locations. This is a contractual requirement of all providers in the network to accommodate such needs. The Agency will first attempt to place consumers with providers who speak the needed language; however, when that is not feasible translation services will be coordinated. This is inclusive of sign language and other hearing impairment accommodations as well. MHMRA is anticipating a cost increase for language services in a decentralized provider network

10) Cost Efficiency:

How will the maximum possible service dollars be preserved while maintaining required authority functions? The response must include a discussion of:

- ❖ **Administrative costs and services directly related to those authority functions, and**
- ❖ **LMHA's strategies for maximizing dollars available to provide direct client services including,**
 - **Efforts to minimize overhead and administrative costs and achieve purchasing efficiencies and**
 - **Efforts to work jointly with other local authorities on planning, administration, purchasing and procurement or other authority functions or on service delivery.**

Administrative Costs and Services directly related to Authority Functions-

MHMRA of Harris County will continue its on-going efforts to provide the needed administrative oversight and management of Agency services, both internal and external while continuing to maximize available service delivery dollars. As the Agency moves towards its implementation of its network development goals, the Agencies administrative services, especially those related to Authority Services will be reviewed and adapted as needed and as feasible within our funding structure. The Agency believes that its past experience in provider network development will assist in

minimizing expenses; however, the increased costs of administrative operations should be expected with such a transition as this. MHMRA projects that at a minimum there will be an increased need for staff with contract development and monitoring experience, as well as an increased need for expanded data management, reporting, auditing, training, and claims processing staff resources. Paired with the ever increasing cost of basic operational needs, MHMRA's concern is the availability of adequate funding to support the projected increased expenses for start-up of the external network. Initially, the internal provider system will need to stay intact as new providers are brought up on training and other competencies. Per our experience, this start-up phase for basic services (not specialized rehab, etc) takes at least 1 year. With no new funds for this initiative, it will be a challenge at best to fund both the internal and external provider network as well as expanded Authority oversight functions for the first 2 years. In years 3 and 4, we should be able to offset some costs as we decrease the internal providers and as the initial start-up of training in the DSHS contract for external providers is completed; however, this is at least 2 years out.

Efforts to minimize overhead and administrative costs-

MHMRA of Harris County maintains distinct separations of Authority and Provider functions which enables the Agency to ensure the separation of such services and to better manage related costs. MHMRA has managed its internal network for years under a fee-for-service model to ensure cost efficiencies, proper utilization management, and consumer outcomes. As such, many efficiencies are already in place and will be expanded to the external network as it develops.

In determining service contracts, MHMRA closely monitors internal costs and ensures that contractual relationships do not exceed these costs per service unit delivered. As such, we are able to provide equal to and in many cases more services under these external contracts. One of our largest challenges is the start-up costs under the Authority for Contracting, training, and credentialing, external providers. This cost is currently incurred under Administration through our Human Resources department and when bringing up external providers this is a large initial cost. In addition, training on the contract requirements, workflows for data exchanges and claim submissions, patient monitoring, etc. as a start-up system is more costly than an internal network which is already developed. Since LPND is not a funded mandate, these costs need to be monitored. Ideally the cost savings of procuring services at a lower cost would cover the additional start-up resources from the Authority; however, this is just speculation and will need to be monitored through roll-out of the Network Plan.

In addition, since Case Management cannot be contracted out from the LMHA, the Authority will have to add this service level (currently covered by the internal provider system)- this cost shift will need to be monitored as it adds Authority costs not previously present and the Agency loses some efficiencies gained by one provider being able to do all services. The Agency will track costs for Case Management under the Authority model as compared to reimbursement/revenue generation. It is anticipated that under the Authority caseloads will be higher and much of the Case Management may be done over the phone due to expanded service locations and Authority staff not being on-site at all of these locations. Since Case Management is not billable over the phone this is of concern. MHMRA will monitor these dollars and revenue streams to determine impact and strategies through roll-out and how to minimize this impact while still meeting the consumer's needs.

MHMRA of Harris County maintains provider notice distribution lists for all provider queries to try and maximize provider responses to Public notices of service procurements and utilizes free distribution lists, free network postings, free newsletter circulation venues, etc. to post notices versus more expensive means of circulation.

The Agency tries to minimize training costs via utilization of on-line trainings where appropriate, electronic competency testing and tracking, and centralized training for both internal and external providers as a means to control costs.

Strategies for maximizing dollars available to provide direct client services-

Achieve purchasing efficiencies- MHMRA has determined the following process for determination of service rates for external contracts as a means to ensure that all external provider contracts are equal to or above internal services in relation to quality of services and outcomes, access, etc. yet at an equal or lesser cost for service provision. This will allow us to stretch limited resources further if economic gains can be incurred while maintaining quality and access to care for our community.

Rate structure options-there are 4 main options as MHMRA looks at each service reimbursement:

- Pay Medicaid Rates minus 5% for administration costs of data up streaming
- Pay Medicaid Rates and Provider completes own data entry direct into the MHMRA system
- If current service costs internally are above Medicaid Rates- consider paying a range above Medicaid to compensate for additional work demands (example: Medicaid +10%-20%) as long as this rate remains below MHMRA current costs (closing the gap while still procuring the service)
- If current service costs internally are below Medicaid Rates- bid the service out under an RFP- listing the highest acceptable rate as 5% below current costs

Efforts to work jointly with other local authorities-

MHMRA of Harris County is currently acting as a subcontractor in providing helpline services to 6 other LMHA's in addition to its own service area. Due to Harris County's large service volume, at this time we have not identified any areas to contract out to other LMHA's as a means to gain efficiencies but we will continue to look for such opportunities as the local planning moves forward.

MHMRA is currently working on a Quad agency initiative between MHMRA of Harris County, Harris County Hospital District, the City Health Department, and Harris County Public and Environmental Services (County Health Department) on a new software system which will allow a no-wrong door approach to eligibility determinations and will ensure benefits are accessed by all consumers who qualify in a streamlined, one stop model which will be more consumer friendly as well as utilizing less eligibility resources due to information sharing and collaborative qualifications.

Whenever possible, MHMRA joins resources with other key local agencies, community providers, and others to identify community priorities, and in a collaborative effort, develop a plan of action to address the issue(s). From these collaborative planning efforts, grant funding requests are often submitted. Through these partnerships and joint efforts, MHMRA and its community partners have been able to expand and/or enhance community-based mental health services. MHMRA currently participates on local task forces and committees related to mental health services for adult and children, jail diversion, crisis redesign, housing and transportation initiatives, and homeless services. We will continue these efforts to remain actively involved in collaborations at the local and state level and ensure prudent use of resources.

What options were considered for collaborating with other LMHA's, including opportunities for joint procurement and network management? Why did the LMHA choose not to pursue them? [See *412.756(f)]

Currently, Harris County is operational with all of its network management functions- though the numbers of positions will need to expand as the network expands, all basic functions are operational (contracting, credentialing, utilization management, claims processing, quality management). As only a few LMHA's have this level of experience, there is no "expert" in this area at this time in order to have a comfort level of contracting with, nor does Harris County feel its limited experience is sufficient for taking on additional business. Due to the newness of this endeavor, the vast size of Harris County, and the significant financial and clinical risks involved, there is not a comfort level currently in a joint venture. Harris County is very open to this concept especially if it is cost effective and can maximize dollars being allocated for service provision. Harris County will continue to watch the development of the LMHA's through this initial roll-out in order to identify any such opportunities down the road.

11) Previous Efforts:

Describe previous efforts to develop an external provider network and the results of these efforts.

Past efforts to develop an External Network-

October 2003-January 2004

■ Open Enrollment for Psychiatrists

Results-

- 25 inquiries/13 applicants
- 4 agreeable to contract terms
- Declined reasons- rates too low, training too extensive, unable to meet contract requirements
- Outcome- Volume too low to be cost effective (patient capacity too low to offset costs)- initiative terminated
- Cost- \$9,568.80 direct costs/\$40,833 administrative costs

March 2004- April 2004

■ DSHS mandated RFI for all MHMRA services (MH and MR)

Results-

- 54 responses
 - ◆ 26 MR providers
 - ◆ 16 MH Adult providers (9 completed app's, 2 agreeable to all SP's)
 - ◆ 12 MH CAS providers (5 completed app's, 0 agreeable to all SP's)
- Declined reasons- unable to meet contract requirements (wanted individual services vs. service pkgs, staff not meeting state minimum requirements.)
- Outcome-This RFI did not include rates, training req, nor contract terms per DSHS guidance, hence little value in information obtained, though numbers still low and not cost effective
- Cost- \$8,780.80 direct costs/\$20,417.00 admin costs

December 2005- January 2006

■ Request for Application – CAS outpatient services

Results-

- 1001 website hits
- 23 applications from 9 different providers/groups
 - ◆ 6-incomplete
 - ◆ 2-withdrew
 - ◆ 1-unable to meet contract req.
- Declined reasons- rates too low, training too timely, documentation requirements too high, unable to meet contract requirements
- Outcome-Initiative cancelled due to lack of credentialable providers
- Cost- \$1,473.96 direct costs/\$32,010.00 admin costs

Current Efforts to develop an External Network-

- Medicaid/Medicare Provider List (initiated April 2007)
 - Soliciting providers interested in seeing our Transitioning Stable Patients (currently 8 Providers responded)
- IOP services (initiated September 2006-)
 - Open Enrollment currently posted
 - 2 contracted providers- (limited referrals, 1 provider still in training phase)
 - 6 providers reviewed/discussed- but declined for low rates
- SP-1 (Stable) Adult Services (initiated April 2007)
 - Open Enrollment currently posted
 - 2 contracted providers- (~250 patients with 1 contractor, other contractor still in training phase)
 - 3 providers reviewed/discussed- declined for low rates, extensive training and documentation requirements
- Current Contract discussions occurring in regards to
 - Jail inreach/outreach contract program- Targeted contract September 2009
 - Inpatient Hospital contract expansion- 6 interested facilities, open enrollment targeted for July 2008
 - Co-Occurring Substance Abuse- residential treatment -4 contracts recently implemented (May 2008)
 - Foster Care contract for Rehab services- Open Enrollment currently underway

What steps has the LMHA taken over the past two years to develop the internal capacity to develop and manage an external provider network? In the next two years, what are your objectives for developing the internal capacity needed for procurement and network management, and what are your plans for achieving them?

Developments over the past two years towards network development capabilities-

- MHMRA of Harris County previously operated a carve-out Behavioral Health Managed Care company (Community Behavioral Health Network – CBHN). As such, it continues to have internal expertise around contracting, credentialing, claims payment, utilization management, quality management, and general network oversight.
- In March of 2007, MHMRA identified a need for contracting Intensive Outpatient Services (IOP) for our community and reinitiated many of these functions on a small scale when releasing an open enrollment package for IOP providers. At that time, we staffed Network Management with 1 individual to complete credentialing, data entry, and claims processing. One external provider has been operational at

this level for 1.5 years and a second external provider group is through credentialing and contracting and in the training phase. This remains open for IOP contracts currently.

- The IOP contracts quickly expanded to include an opportunity to utilize these same providers for step down care as a means for continuity for these patients if coming out of the hospital and not already engaged in our internal provider system. As such, MHMRA of Harris County over the past year and a half has also released open enrollment for SP-1 providers. We currently have over 300 consumers in an external network with 1 large provider and a second external provider group is through credentialing and contracting and in the training phase. This also remains open for interested SP-1 contractors currently.
- The above experience has quickly taught us the challenges to externalizing these contracts as the learning curve for external providers not familiar with DSHS services and requirements has been a tremendous learning curve at cost to both the Agency and the Providers. Our current large provider after 1.5 yrs, continues to learn the basic service requirements and is not yet covering their costs for doing business with us due to this learning curve and more stringent demands than the private sector payers. As a result, we have needed to add two additional staff for this 1 large contractor (~300 patients in services with this provider). MHMRA of Harris County has dedicated 3 full time FTE's to this contract in order to manage training, credentialing/claims processing, business operations advisement, auditing, case management, and clinical/administrative supervision as well as auditing for this population. This does not include utilization management time as that flows through our general operations and is not separate from internal providers. Even with this level of support, the external provider group continues to struggle with contract requirements and paperwork/tracking demands.
- We have put business office workflows together for the external provider network to include (but not limited to) benefits verification procedures, transfers of patients within the network, case management coordination, coordination of lab and pharmacy benefits, eligibility financial recertification's, pharmacy assistance program coordination, electronic data sharing/transfers, record audits, etc.

Developments in the next two years towards network development capabilities-

- As the external network expands- there will need to be a shifting of case management from the internal provider system to that of the Authority to meet the needs of consumers. This is a more costly model as in the current system 1 provider does both services and with an external system due to federal regulations, the Authority must maintain the case management function- hence there is a pass off process, tracking, and resource duplications outside of our control.
- There will also need to be an expansion of training capabilities by MHMRA as the provider base expands to more providers, then training options/opportunities/availability will also potentially have to expand to meet the needs.
- MHMRA internal providers will need to be trained on the external network options and how to offer consumer choice concurrent with treatment planning. Case Management processes to transition consumers and ensure linkage thus will also need to be in place for those choosing to exercise this option.
- MHMRA of Harris County will need to implement Provider fairs for providers to share information and services directly with consumers and to give consumers opportunities to meet Providers, ask questions, and make choices.
- MHMRA of Harris County will need to implement monthly provider meetings as a means to update providers on contractual issues/changes etc. This may be able to be held quarterly down the line but with current DSHS changes occurring frequently and the newness of many contractors to this line of business, it is anticipated that these will initially be more frequent as a means to ensure questions are answered and information understood. A provider newsletter is anticipated for those unable to attend these meetings however this is not as effective per our experience early on as it requires dialogue to ensure providers are understanding concepts during new learning.
- MHMRA of Harris County- has predicted needing to expand staffing by spring of 2009 following the first open enrollment round- expansion areas to include;
 - Credentialing staff,
 - Claims Processors,
 - Trainers,
 - Contracts Mgmt/oversight,

- o Quality Management Auditors, and
- o Authority Case Managers.

Note: These staffing additions are required to control risks and bring up the network per our experience, however, it must be noted that there is no new funding to support these additional costs and in the first 2-4 years it is not expected that there will be an ability to reduce internal costs as these providers will not be fully operational for ~ 2 yrs.

12) Barriers:

Describe any encountered or anticipated barriers to attracting external providers and discuss specific plans to address each identified barrier.

Barriers	Plans
<p><u>Lab services-</u> Most external providers do not have this service on site which results in consumers either choosing internal providers for the convenience of 1-stop shopping and/or poor compliance with labs at external provider sites.</p>	<ol style="list-style-type: none"> 1) If high enough Consumer Choice (patient volume) is present with any of the external providers- the lab contractor has agreed to provide on-site services, however since this is consumer driven it will not be determined until later in the contract implementation whether this is an option or not. 2) Have ensured in the interim that contract stipulations allow for service at any contract lab site throughout the service area. 3) Educate Consumers at time of Provider selection to this issue and contract lab locations so educated decisions are made. 4) Reimburse Provider for lab services if have such available on site IF accepting same or lower rate as contract lab.
<p><u>Pharmacy Services-</u> This is an issue for consumers whose pharmacy benefit is through MHMRA (primarily GR population). Most external providers do not have this service on site which results in consumers either choosing internal providers for the convenience of 1-stop shopping. In addition, MHMRA anticipates increased costs related to getting medications to consumers in an expanded network.</p>	<ol style="list-style-type: none"> 1) Educate Consumers at time of Provider selection to this issue and pharmacy locations so educated decisions are made. 2) We have explored contract pharmacies providing this service but it is cost prohibitive at this time due to the PAP process- will continue to periodically re-evaluate. 3) Exploring fax and fill options of medication delivery to External Provider office and/or home location if cost effective.
<p><u>Payment Rates vs. Contractual Demands-</u> Payment requirement of “no higher than Medicaid rates” yet the Contractual requirements are much more extensive than required for traditional Medicaid services by private providers becomes a contracting issue. Once providers see the training, documentation, and additional paperwork requirements for the Medicaid rate it is often cost prohibitive for them to do business with the MHMRA. This includes unfunded mandates and services which are required but not funded example: TRAG (if no other services is needed at that time), Follow-up</p>	<ol style="list-style-type: none"> 1) Requested in FY '09 contract review that DSHS allow for services to be reimbursed above Medicaid rates if internal costs are higher than Medicaid rates. Would continue to be a cost savings in these cases. 2) Streamline training requirements as much as possible to minimize cost to Providers (ex: on-line trainings were possible to reduce time and cost demands, Test-out options were allowable, etc.). 3) Streamline documentation requirements as much as possible to minimize cost to Providers (ex: sharing internal provider forms, system access if interested in electronic records, etc.).

<p>phone calls for no shows, continuity of care, etc., Engagement services, etc.</p>	
<p><u>Unfunded Mandates-</u> Contracts with MHMRA's become challenging to implement from a fiscal standpoint due to contractual requirements for services which are not reimbursed. Examples include:</p> <ul style="list-style-type: none"> • TRAG (if no other services is needed at that time this is not reimbursed but is required), • Follow-up phone calls for no shows, engagement activities, prior to closure, etc. • Continuity of Care services • Engagement services, etc. 	<p>1) Demonstrate these challenges to DSHS for consideration of contract changes.</p>
<p><u>Training Requirements-</u> Extensive initial and annual training requirements at cost to the Provider for large systems and systems with turn-over becomes costly when not reimbursed for staff time in these activities nor for the tracking of this requirement.</p>	<p>1) Streamline training requirements as much as possible to minimize cost to Providers (ex: on-line trainings were possible to reduce time and cost demands, Test-out options were allowable, etc.). 2) Request train the trainer models where feasible- so internal training can occur within the External Provider groups (cost savings to the MHMRA and the External Provider).</p>
<p><u>High no show rate for this population-</u> External Providers report spending extensive funds on getting programs up and staff trained in contractual requirements but that the high no show rate and the expectation that they complete 3 good faith attempts to contact no shows prior to closure are cost prohibitive as no funding for such services occurs.</p>	<p>1) Complete Engagement training for providers. 2) Provide Business Operations assistance (appointment booking strategies). 3) Provide Case Management supports from the Authority to try and minimize this occurrence.</p>
<p><u>Data Management Issues-</u> Multiple software systems and limitations to allowing acceptance of electronic signatures as a means to expedite communications and documentation reviews/sharing. Reduction of dual data entry and expedition of data and quality reviews.</p>	<p>1) Allow electronic signatures to be captured in secured electronic medical record systems. 2) Ensure streamlining of data interfacing allowed at the State level.</p>

13) Attraction of Providers:

Explain what conditions must be present in order to attract external providers to your local service area.

- ✓ Lessen paperwork demands.
- ✓ Minimize contractual requirements as able (trainings, audits, reporting, paperwork, voter registration, etc).
- ✓ Increase payment rates to compensate for a difficult to treat population and increased contractual requirements. Providers need to be able to cover costs and have at minimum a small profit margin.
- ✓ Improve availability of Psychiatrists in local service area.

14) Long Term Planning:

Discuss plans, including time frames, for at least two years beyond the period covered by this plan, for development or continued development of an external provider network.

Additional two-year planning (years 3-4) -

- Rebalance the MHMRA provider system based on the successes of Network Development in years 1-2
- Repeat the procurement cycle as detailed in years 1-2 (follow same timeframes as years 1-2)
- For all packages successfully contracted out to external providers, increase the procurement another 20-30% based on provider availability.
- Evaluate procurement of services not previously procured (ex: ACT) to see if cost effective now that Provider base is established and operational
- Complete cost analysis to ensure proper shifts have occurred in Administrative functions (complete in year 3 so shifts can be tweaked in year 4 if needed)
- Re-evaluate safety net structure and service capacity necessary for LMHA viability, adjust as needed
- NDAC quarterly meetings to review and tweak the current system

How will the LMHA determine that the external providers are fully operational and have proven clinical and financial stability? How long does the LMHA think that might take?

MHMRA of Harris County will monitor providers in the following areas to best determine when they are operational in a service package-

- “Fully Operational”- is defined as able to independently provide services in the given service package without needed intervention by Authority staff and utilizing the full array of available services within the service package with fidelity to the treatment model.
- Clinical Stability- is defined as an ability to meet fidelity to the service model and will be monitored through various means to include but not limited to:
 - Passing Fidelity audits
 - Compliance with relevant DSHS contract measures- Examples:

- Trag completion rates >95%
 - Minimum hours being met,
 - Outcomes being met,
 - Passing Quality management record audits at or above 95%
 - Absence of active plans of improvement
 - Consumer satisfaction scores within acceptable range
 - Consumer drop- out rate of <5%
- Financial Stability- is defined as an ability to continue to operate in the black under this contract. and will be monitored through various means to include but not limited to:
 - Review of annual financial statements- specific to ensuring income is covering costs by end of year 2.
 - Review of annual financial statements- specific to ensuring reserves demonstrate at least 90 days of operations to ensure can comply with 90 day notification requirement for contract termination and transition of current consumer caseload.
 - Claims payment history reviews with Provider at or above 85% of claim submissions being approved. The operating margin is so tight on the funding under these contracts that providers who cannot manage authorizations and timely claims processing will not be able to cover their costs unless successful in this area early on.

Our current network experience indicates that it will typically take a provider a 2-year time period to be deemed fully operational, as the first year it is difficult to cover costs due to substantial training and learning curves. This may not take as long for providers whom have done DSHS business previously and their timeframes may be closer to the 1 yr- 18 month marks. An additional factor is the ramp up period for consumer caseloads in order to even get a good sampling to measure many of these indicators. With network choice based on consumer preferences, it may take some providers longer to demonstrate this functionality due to higher timeframes to build caseloads.

When an LMHA provides services in order to protect critical infrastructure, the rule requires the LMHA to define a timeframe for transition, during which it procures an increasing proportion of service capacity. The plan does not define a timeframe. How long does the LMHA anticipate it will need to retain a portion of the services in order to protect critical infrastructure

This question is very difficult to answer with any certainty due to the vast number of assumptions that need to be made and of which any one not coming to fruition can throw all others off.

Assumptions:

- Assuming the LPND plan rolls out as described without any difficulties, and
- that capacity is obtained without any difficulties, and
- assuming all providers remain in the network and operational, and
- assuming consumers move to the external network without issue, and
- assuming the authority can creatively fund this initiative without any new funding, and
- assuming MHMRA of Harris County can mitigate risks so that safety net services by the MHMRA are not required (meaning external provider network is vast enough to be its own safety net),

Then the following is our best case scenario:

If contracting in general each package at 20-30% in a 2 year cycle and graduating this by 20-30% every two years thereafter, if all conditions above are met, it would at best take 10 years to transition out all routine services. As this plan does not include Crisis services at this time, those services are not included in this projected timeframe.

Procurement and Transition Timelines

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). The activities and milestones listed are “model” activities and milestones. You may have additional activities. These additional activities and milestones should be inserted at the appropriate location in the following table.

Timing of Procurement-

Since Adult services are currently on Waitlist due to staffing vacancies, it is advisable to start with procurement of Adult care. Secondly, MHMRA will move to procurement of CAS services and lastly, Crisis Care. Crisis Services are placed in the third phase of procurements due to the current crisis system redesign which is occurring at the state/local level and the likelihood of that resulting in significant changes over the next year of roll-out. It would be an additional challenge to procure services for a model which is in flux.

It is also advised that within each Population (Adults, CAS, Crisis Care), MHMRA begin procurement with the lowest level of care first and graduate up to higher levels of care. This in our experience lends itself well to providers grasping the basics of our contracts and minimum requirements first before taking on additional more acute care requirements with higher patient impact. The training is extensive and taking it in graduated pieces would hopefully ease the transition for providers and for patient care, ensuring the success of the programs.

As each service level is procured, MHMRA Network Management will set go-live dates for existing consumers to be eligible to transfer to new providers~ as the PNL becomes available at the EC for new consumers, it will also be rolled out for existing consumers and offered as a choice at each treatment plan update.

Proposed Timeframes- (3-4 month roll-out's)

Adult Procurement- (target dates)

- ❖ Adult SP-1 services~ July 2009
- ❖ SP-2 services~ November 2009
- ❖ SP-3 services~ March 2010

CAS Procurement- (target dates)

- ❖ CAS SP-4 services~ July 2010
- ❖ SP-Brief Internalizing services~ November 2010
- ❖ SP-Brief Externalizing services~ March 2011

This cycle would repeat itself potentially every 2 years. MHMRA will open additional procurements within the two year cycle earlier if needed to meet:

- Shift in consumer needs (ex: service package increases)
- To fill for loss of capacity in a certain package due to loss of provider(s)
- To meet geographic, language, and cultural needs as gaps are identified

Date	Key Activities and Milestones
Ready 30 days prior to Publication target date	Develop draft procurement document – specify RFP or RFA or both
15 days	Publicize draft procurement document (Public comment period – 14 day minimum)
15 days	Timeframe for LMHA to consider all public comment and revise procurement document
See Target Dates listed above by service package	Publication of final procurement
Open Enrollment has no due date If RFP is utilized then 30 day response timeframe	Due date for procurement responses
Within 60 days of receipt of completed Application	Award date

An important part of the development of an external provider network is that it expands choices available to consumers. Please identify the specific steps for consumer’s selection of a provider and the time lines for transitioning consumers to new providers. The steps listed are “model” steps. You may have additional steps in notifying consumers of external provider choice. These additional steps should be inserted at the appropriate location in the following table.

Steps	Time Frames For Completion
Develop a provider list	Updated within 5 business days of any new providers becoming “referral ready.” Referral ready is defined as a provider who has an executed contract, has completed the necessary site audits, trainings, and credentialing and is hence deemed “referral ready” by the network management department. New copies routed to front door Intake staff upon update.
Verify provider information	Quarterly Audit checks to ensure accuracy of information will occur via the Network Management department as a

	part of contract oversight.
Post Provider list to website and distribute to consumer and advocacy groups	Website will be updated at least monthly (at the start of each new month) with current Provider Lists and distributed to Consumer and Advocacy groups as well as to Providers who are offering patient choice at treatment plan update intervals.
Conduct provider forums to allow providers to share information with consumers, LARs, and other stakeholders.	Provider Forums will be held at least annually. In addition- staff will be trained to share this information with consumers, advisory council members will be trained and utilized for consumer information sharing, and will explore a consumer hotline implementation for general information.
Develop internal procedures and forms for consumer selection of providers	Completed- will review and update at least annually.
Develop consumer information materials relating to selection of providers	Target- Early June 2009 prior to first Open Enrollment "go live" date. Will review and update at least annually.
Train internal staff on consumer selection procedures	Target- Aug 2009.
Ensure external providers are trained on consumer selection requirements and procedures	Prior to Providers being deemed "Referral Ready" by the Network Mgmt department- as a part of initial training.
Implement provider selection procedures for new intakes	Upon receipt of first "referral ready" provider- Anticipated Sept 2009.
Implement provider selection procedures for current clients (in conjunction with treatment plan reviews)	1 month following implementation at front door (intake) for training and monitoring purposes- Target Oct 2009.
Develop and implement continuity of care plans for transitioning individual clients to new providers	Sept 2009 prior to first "Referral Ready" provider this process will be in place for activation as needed.
Consumer transition complete	Case specific- target within 90 days of request for new provider.

For each service or service package to be procured, provide an estimate of the amount of time needed to re-establish the service volume lost if a contract must be terminated. (NOTE: The estimated timeframe may be used as the minimum notice to be given prior to terminating an external provider contract for non-compliance.)

Service	Time Needed to Re-establish Service Volume
Adult Sp 1-3	6 months- 90 days for re-hiring process and 90 days for training completion
Adult Sp-4	9 months- 120 days for re-hiring process (longer due to 24 hr coverage needs and intensity of pt population) and 90 days for training completion
CAS –All SP’s	6 months- 90 days for re-hiring process and 90 days for training completion
Crisis Services	9 months- 120 days for re-hiring process (longer due to 24 hr coverage needs and intensity of pt population) and 90 days for training completion

Note: The above timeframes may not be realistic in that currently there is great difficulty in Harris County in recruiting for Psychiatrists, Nursing Staff, and Licensed Professionals of the Healing Arts (LPHA’s). If this provider base is downsized internally, MHMRA’s ability to hire and train appropriate staff may be hindered by such provider availability. Furthermore, it is anticipated that as private providers expand current staffing for this

new business line and/or new providers move services into Harris County, it is likely that higher pay and improved benefits from the private sector will result in a shift of internal MHMRA staff to the external provider market. This has the potential to destabilize the internal provider systems ability to respond to consumer service demand prior to the external provider network being ready to receive the consumer flow. MHMRA will continue its diligent efforts to best manage this impact and to minimize service disruption for consumers as able.

Staff Qualifications

Identify the specific qualifications individual practitioners must meet (only if the LMHA currently exceeds the standards set forth in the DSHS performance contract). These qualifications will serve as minimum standards to be met by the LMHA as well as the external provider.

Practitioner	Qualifications
No additional requirements than those stipulated in the DSHS contract and referenced above	DSHS contract, Licensure qualifications and Criteria listed above as applicable to practitioner levels

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
Does not agree with Harris County plan of delaying SP 4 services to be contracted out; Feels that there are many experienced SP 4 providers. SP 4 services should be contracted out without delay.	Telecare Corporation	MHMRA’s decision was based on our experience with the DSHS contract and our familiarity with the RDM packages. 1. It is critical that providers who provide ACT levels of care are also able to provide the lower step down levels hence our plan to roll-out lower levels of care first and ensure proficiencies are obtained prior to graduating up the RDM service intensity chain. This will allow

		<p>MHMRA to monitor provider’s readiness for more intense services after they demonstrate proficiency with the basic/core contract requirements. This is a way to safeguard patient quality of care utilizing a graduated learning approach.</p> <p>2. It is understand that Telecare has done this level of care and may not need these same smaller steps in familiarizing themselves with contractual requirements, however, under open enrollment, all providers must be treated equally and MHMRA could not initiate higher level of services for one vendor without also opening that to others. We will equally require all providers to demonstrate proficiencies in contract outcomes/compliance, minimum hours, documentation audits, etc prior to opening up the ACT program for bid.</p> <p>3. ACT consumers are the most critical patient population and as such MHMRA is taking a conservative approach to contracting this out as the ramifications to the consumer related to relapse is huge. This is not to say we will not contract it out just that we want to ensure provider readiness first and we can demonstrate that through other levels of care.</p> <p>4. Fiscally, the success of ACT also highly impacts MHMRA’s other crisis service levels and can quickly have high cost impacts to the agency related to acute care demands, coc demands, crisis services demands, etc and needs close monitoring to manage costs.</p> <p>At this time the timeframes for ACT will remain as written.</p>
<p>System will save money by having adequate housing for homeless with possible supervision by MHMRA employees</p>	<p>Pate Pecora, Both Sides Now, Consumer Advocate Group</p>	<p>MHMRA agrees with this statement and would support such programs if funded. Lack of housing resources is currently listed in the plan as a community need for this population. No changes to the plan required.</p>
<p>1. State needs to provide more funds. It is demanding too many contractual requirements for providers at too low of reimbursement. (not enough funding for what is demanded). 2. The LMHA’s hands are tied by not being able to contract out Case Management services 3. Too many mandates and restraints making contracting out services complicated for providers and consumers.</p>	<p>Felix Martinez, Consumer Advisory Council at MHMRA SW Clinic</p>	<p>MHMRA has reflected these concerns in the barriers/challenges section. No changes to the plan required.</p>
<p>Contract out case management to private providers as this will provide clear boundary between provider and authority; also reimbursement increases would encourage providers to f/u with consumers whom they already established good</p>	<p>Juri Lee, LPC, El Camino Counseling, Private Provider</p>	<p>Accepting the comment in full, but cannot make any corresponding modifications to the plan. This requires legislative changes to be able to contract Case Management out. MHMRA has advocated for that in the past to ensure a more cost effective model.</p>

<p>clinical rapport.</p>		
<p>Pay for TRAG assessments or no TRAG. Providers already struggling with meeting state contract requirements. The TRAG training is extensive and too complicated for providers when other private contracts pay higher and does not require so many requirements.</p>	<p>Juri Lee, LPC, El Camino Counseling, Private Provider</p>	<p>Accepting the comment in full,. Added to the Barriers section of the plan below payment rates and contractual demands. MHMRA has passed this on to the State, but they report no plans to change the contract in this regard. Will continue to present this on behalf of private providers.</p>
<p>The 80th Legislature appropriated \$82 million for mental health and substance abuse crisis. We have only six detox beds for people who have no means. What is being done to provide for this array of services</p>	<p>Sandra Young Olsen, D. Ph, Coalition of Behavioral Health Services</p>	<p>Added this to the plan as a gap in services. Currently DSHS does not fund this service level under RDM but will make notation of the need. MHMRA of Harris County will attempt to address these needs in their Crisis Redesign Plan.</p>
<p>An important benefit of a local network should be to rectify the problem of lack of a MHMRA office and services on the Southeast side of Harris County in the Clear Lake Area. Many consumers lack transportation, and have difficulty accessing distant Harris County services. They need the support to prevent relapse and integrate into community life.</p>	<p>Jane Malin, member of Bay Area NAMI support group; Interfaith Mental Health Action Team</p>	<p>The plan states our goal is to ensure services within 30 minutes of consumers home/work environment. Success is dependent on providers interest in the Clear Lake Area, however, we agree that services need to be closer if feasible and will pro-actively recruit in the SE area to better provide coverage as the Network Development Plan rolls out. Added this to the plan as a gap in services.</p>
<p>1. Biggest issue is the low fee for provider services when this population needs much more time and service in each medication visit. 2. Need for therapy. Therapy should be available to those in need, not limited by RDM requirements. 3. Too much paperwork for each client, taking too much (uncompensated) time by providers (ex: disability forms, food stamps, other gov assistance, CPS or legal system letters, etc. 4. PAP forms for MHMRA on top of already too much paperwork increase provider time demands without related reimbursement. 5. Billing requirements are extensive in order to get paid.</p>	<p>Delilah Hampton, Nurse Practitioner, HCPC Outpatient Clinic</p>	<p>1. There is no restriction to the amount of time spent in a service visit. Medication services are paid a flat rate not in 15 min increments. The FY09 DSHS plan draft as it stands currently, prohibits MHMRA's from paying above Medicaid rates even though MHMRA has advocated for higher rates since paperwork and training demands are above general Medicaid requirements. This is listed in our plan as a barrier to attracting external providers. MHMRA will continue to advocate for fee adjustments and/or leniency in setting rates/improved funding per contractual requirements. 2. This is listed in the plan as a gap in-service and under survey responses as a community request currently. 3. This is listed in Barriers to attracting external providers. 4. PAP is critical in maintaining our current service capacity and is not currently funded for our internal providers. 5. Billing requirements are based on DSHS rules and regulations related to clean data. Extensive documentation requirements are listed as a barrier to contracting with external providers in the plan currently. All areas are captured in the current plan so no updates to the plan are required at this time. MHMRA will continue to advocate for changes in the DSHS contract to address these provider issues.</p>

<p>1. Paperwork is very lengthy. 2. Requirements change frequently. 3. Low reimbursement fee. 4. Many patients need therapy but limited to medication management and education only based on RDM rules.</p>	<p>Debra McCrimmons, LPC, Administrator, HCPC Outpatient Clinic</p>	<p>1. Paperwork is noted as a Barrier to attracting external providers currently and is required by DSHS so MHMRA cannot effect changes without DSHS agreement. Comments have been submitted to DSHS. 2. Requirements are driven by DSHS contracts and RDM being a fairly new model has had numerous changes. MHMRA will continue to support providers through these changes. 3. Low fees- The FY09 DSHS plan draft as it stands currently, prohibits MHMRA's from paying above Medicaid rates even though MHMRA has advocated for higher rates since paperwork and training demands are above general Medicaid requirements. This is listed in our plan as a barrier to attracting external providers. MHMRA will continue to advocate for fee adjustments and/or leniency in setting rates/improved funding per contractual requirements. 4. Patients needing therapy not covered by RDM- MHMRA has requested DSHS consider paying for therapy for consumers when medical necessary even if not meeting the DSHS dx guideline, however DSHS has not consented to any changes. MHMRA has listed this in the plan as a service gap. All areas are captured in the current plan so no updates to the plan are required at this time. MHMRA will continue to advocate for changes in the DSHS contract to address these provider issues.</p>
<p>1. Mental health consumers in Harris County have expressed an interest in having choice in their providers yet have also expressed concerns about ensuring that crucial mental health care is available when needed. 2. Developing and training new providers to meet the requirements of DSHS will take time, and it is very important not to leave gaps in service during such a transition. 3. Moving from least critical services to those of more complexity appears to be an important part of the MHMRA plan.</p>	<p>Leslie Gerber, Executive Director, NAMI Metropolitan Houston</p>	<p>1-3 MHMRA has chosen a graduated approach in contracting out services as a means to ensure internal operations continue at a high enough level until the learning curve of external providers is met as a means to ensure service availability and supports are intact for consumers. We will continue to monitor this to ensure safety net services are in place. All areas are captured in the current plan so no updates to the plan are required at this time.</p>
<p>Not so sure what this criteria is. As a home health nurse I know the insurance co.'s have all authority, to keep nursing visits going or put on *hold. Not so sure what part MHMRA plays in the Medicaid realm. What I and my co-nurses see is nursing services are being *held too long.</p>	<p>Diane D. Martinez, LVN,Ph.D.,Rev</p>	<p>Under the DSHS contract- nursing services are incorporated in each service level and will be contracted out as a package (nursing services will not be contracted out as discrete services based on DSHS guidance). Currently MHMRA is contracting out Sp-1 services (which incorporates nursing) and will release each service level as defined in the plan all of which have nursing services included. MHMRA has placed a follow-up call to the provider to better understand what services are perceived as being "held" to ensure better understanding of the concern.</p>

<p>Follow-up care after crisis services due to the long waitlist is a real issue. Also - We have expanded crisis services and are better at identifying the needs; however, there is not sufficient inpatient/ acute care options for indigent care. In addition, our community has received additional crisis funding, without comparable outpatient services.</p> <p>On pages 27 & 30 - it describes Capacity & Projected Capacity --- Is there any way to show actual need so as to emphasize the above?</p> <p>Services Gaps: • Transportation • Housing/Transitional Living</p> <p>Is there any place in this plan to address the inflationary costs of current/increased services?</p> <p>Intensive Case Management services to connect patients to housing and on-going treatment services....helpful to show need vs. capacity to serve.</p> <p>Dual Diagnosis (mental health and substance abuse) services....again big area of need vs. capacity.</p> <p>I saw the ACT Team addressed. Is the FACT team going to be addressed later on in the plan or is it too specialized?</p> <p>Would it be advantageous to show all the county covered provisions on one separate page also?</p>	<p>Belinda Price (Commissioner's Office, Pct 3)</p>	<p>No updates to the plan are required at this time.</p> <p>Follow-up care after crisis is listed as a concern in the plan. Added the impact of the Waitlist and no new outpatient dollars to serve this increased consumer census after crisis resolution. (page 10) Added inpatient acute care option limitations with additional crisis case identification as another concern. (page 10)</p> <p>Since this is a DSHS template, DSHS has requested we not change the charts nor add additional information. DSHS and MHMRA have the numbers reflective of the true need in Harris County and these can be shared with local stakeholders.</p> <p>Added inflationary costs of current/increased services to the concerns since DSHS funding has not increased overtime, though costs and service requirements increase incrementally each year. (page 12)</p> <p>Intensive case mgmt/Dual dx needs are captured at the service level and are a moment in time sampling. These are not numbers that can be easily pulled as they are captured in individual records. Will explore in the future ways to get at this analysis but unable to do so for this plan timeframe.</p> <p>FACT is a local program created to meet the Houston area consumer needs. It is seen at the State level as ACT (no differential between the two)- MHMRA has just taken an ACT team and specialized it in focusing on the needs of the forensic ACT population. As such, there is no separate distinction in this local plan.</p> <p>MHMRA did not include the County covered provisions as this local plan does not include other funding sources. DSHS has requested we not add additional (non requested information to this plan).</p>
<p>Chart on pg 36- Can you add descriptors to the service levels (vs. Sp-1, sp-2) so that it is easier for a layperson to understand? Page 30- Can we add a column which shows the need for each service level not just capacity? Pages 36-43 the rationale for keeping services is all</p>	<p>Peggy Boice, LMSW-AP (Harris County Judge Ed Emmett's office)</p>	<p>MHMRA has added a footnote link to the plan which will take you to the detailed descriptors of what each service package encompasses. Since the service packages contain multiple service options within them, it would be difficult to incorporate this into the chart. The Structure of Procurement Section (page 43+) also elaborates on each service level.</p>

<p>5's or 6's. Makes the recommendations suspect as there are no 1-4 reasons.</p>		<p>Page 30-demosntrate need. Since this is a DSHS template, DSHS has requested we not change the charts nor add additional information. DSHS and MHMRA have the numbers reflective of the true need in Harris County and these can be shared with local stakeholders.</p> <p>Pages 36-43 Rationales for keeping services- There are no 1-4's because those reasons do not apply. Reasons 1-4 all pertain to outcomes of open enrollment (no available providers, minimum choice not met, not same level of access available, not meeting service volume needs). We will not know if any of these conditions are met until after we place services out for bid. Hence, not used currently. Rationales 5 and 6 are preservation of critical infrastructure and loss of revenue which are the reasons first rounds have limited capacity going out for contract which is explained in the plan details. No changes required.</p>
<p>Can you address the need to bridge priority population from crisis to community services (NPC/HCPC/Jail/SMHF) especially continue meds until they can get appts?</p> <p>Significant gaps/concerns- What about addressing the need for transitional residential treatment from crisis services?</p> <p>Can we show not only the #'s that will be served but also the numbers who <u>need</u> each service level to better reflect the demand?</p> <p>What about reflecting the money spent in the jail and on HCPC forensic beds including not only the \$ in the MOU but all of the money (total \$25 million/yr) reflected on page 17 chart?</p> <p>Why is FACT not listed?</p> <p>Page 21 Provider Availability audits- Do you hold the same standards to yourself?</p> <p>Page 33- No notation of the beds MHMRA operates in the Jail (all forensic)</p>	<p>Clarissa Stevens, Harris County Budget Office</p>	<p>Bridge priority pop from crisis to community services-Added this identified need to gaps in services section. (page 10)</p> <p>Transitional Residential Treatment post Crisis services- Added this identified need to gaps in services section. (page 11)</p> <p>Since this is a DSHS template, DSHS has requested we not change the charts nor add additional information. DSHS and MHMRA have the numbers reflective of the true need in Harris County and these can be shared with local stakeholders.</p> <p>MHMRA did not include the County covered provisions as this local plan does not include other funding sources. DSHS has requested we not add additional (non requested information to this plan).</p> <p>FACT is a local program created to meet the Houston area consumer needs. It is seen at the State level as ACT (no differential between the two)- MHMRA has just taken an ACT team and specialized it in focusing on the needs of the forensic ACT population. As such, there is no separate distinction in this local plan.</p> <p>Page 21 Provider Availability Audits- Yes, we hold internal providers and external providers to the same standards and will continue to do so. No changes in the plan required.</p>

		<p>Page 33- The beds within the Harris County Jail are county funded, hence they are not reflected in this plan as it is a DSHS funded services plan only. DSHS has requested we not add additional (non requested information to this plan).No changes in the plan required.</p>
<p>On page 11 Section 4 priorities and gaps with regard to services it discusses lack of housing upon discharge from Local Hospital and Jail. I feel the bigger gap is the fact that because of lack of funding non MHMRA clients are being discharged from local hospitals including HCPC without MHMRA services. Also, the majority of Harris County Jail mental health patient are being released without MHMRA appointments.</p> <p>On page 62 and 63, I believe having public forums annually will not get the word out to the current clients of them having a choice. Because of transportation issues only a very small percentage of clients attend forums. I believe that you should not only train staff on the procedures but also train the consumer council members and maybe other consumer volunteers to assist consumers in making the choices.</p>	<p>Jack W. Callahan, Jr, Advocacy, Inc.</p>	<p>Page 11 section 4- Added this clarification/additional information to the plan.</p> <p>Page 62 and 63- updated plan to reflect staff training, consumer advisory council training, and consumer hotline implementation for assistance in making provider choices.</p>

<p>My thought here is..that someone provide nurses w/ psych training, more specific to what we deal w/ in home visits.</p>	<p>Diane D. Martinez, LVN,Ph.D.,Rev</p>	<p>Nurses will receive training under contract with MHMRA for service provision. Discussed with Provider that under the DSHS contract traditional home health nursing is not a contracted service, however, nursing services are utilized within various service packages and that training of this population is critical as those services roll-out. No changes to the plan required.</p>
<p>Conference Call with DSHS staff regarding draft plan for feedback occurred on 8/20/08. DSHS requested MHMRA of Harris County remove details which were operational in nature if not specifically requested in the plan template. DSHS assisted MHMRA in identifying these items/areas specifically during the call.</p>	<p>Tamara Allen Vicki Belinoski Leslie Milliken Jennifer Swinton</p>	<p>MHMRA of Harris County removed the noted sections and placed them in an <u>Addendum</u> to the plan since they were items specified by stakeholder meetings.</p>

Note: See plan addendum for more detailed information

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

Appendix 25 TAC §412.758 LMHA Provider Status.

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

- a) The LMHA determines that interested qualified providers are not available to provide services in the LMHA's service area or that no providers met procurement specifications.
- b) The network of external providers does not provide the minimum level of consumer choice. A minimal level of consumer choice is present when consumers and their legally authorized representatives can choose from two or more qualified provider organizations in the LMHA's provider network for service packages and from two or more qualified individual practitioners in the LMHA's provider network for specific services within a service package.
- c) The network of external providers does not provide consumers of the LMHA's service area with access to services that is equivalent to or better than the level of access as of a date to be determined by DSHS. Any LMHA relying on this condition shall submit to DSHS information necessary for DSHS to verify level of access. DSHS will use the latest healthcare access technology available to the agency to measure access.
- d) The combined volume of services delivered by external providers is not sufficient to meet 100 percent of the LMHA's service capacity for each RDM service package as identified in the LMHA's local network development plan.
- e) The LMHA documents that it is necessary for the LMHA to provide certain services specified by the LMHA during the two-year period covered by the LMHA's local network development plan in order to preserve critical infrastructure to ensure continuous provision of services. Under this condition, the LMHA will identify a timeframe for transitioning to an external provider network, during which the LMHA procures an increasing proportion of the service capacity of the external provider network in successive procurement cycles. The LMHA shall give up its role as a service provider at the end of the transition period when the network has multiple external providers if the LMHA determines that external providers are willing and able to provide sufficient added service volume within the timeframe specified by the LMHA in its approved local network development plan, as provided in §412.756(g)(8)(F) of this title (relating to Local Network Development Plan), to compensate for service volume lost should any one of the external provider contracts be terminated.
- f) Existing agreements impose restrictions on the LMHA's ability to contract with external providers for specific services during the two-year period covered by the LMHA's local network development plan, or existing circumstances would result in the loss of a substantial source of revenue that supports service delivery during the two-year period covered by the plan. If the LMHA invokes this condition, DSHS may require the LMHA to provide DSHS with a copy of the relevant agreement(s). Examples of such agreements and circumstances include:
 - (1) grants or other sources of funding that require direct service provision by the LMHA and that cannot be amended;
 - (2) buildings or other physical infrastructure that are not reasonably expected to be sold, leased, or otherwise disposed of;
 - (3) tax-exempt government bonds or other long-term financing that place restrictions on the LMHA's ability to meet its financial obligations, either in whole or in part; and
 - (4) leases or contracts that cannot be terminated.