

# THE CENTER FOR LIFE RESOURCES

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## FY 2008 – FY 2010 LOCAL PLAN

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## **I. VISION, MISSION AND VALUES**

The Center for Life Resources, located at 408 Mulberry Street, Brownwood, Texas provides health care for individuals demonstrating mental health disabilities, and individuals with intellectual and developmental disabilities. Services are provided to residents in Brown, Coleman, Comanche, San Saba, Eastland, Mills and McCulloch counties.

Service delivery is driven by input from consumers, family members, stakeholders, the Risk Management Committee, the Utilization Management Committee, Planning and Network Advisory Committee, community collaborative, the organizational self-assessment, consumer surveys, and Quality Management. The Local Plan captures, to a larger degree, the scope of State-wide initiatives to enhance services to the populations served.

Due diligence has been given Crisis Redesign, and Local Planning and Network Development to provide consumer choice through an array of service providers. Both greatly improved the quality of care and clinical expertise available to consumers. The Co-Occurring Psychiatric and Substance Use Disorders (COPSD), Adult and Youth Substance Abuse Outpatient, and Prevention programs compliment psychiatric care. Resiliency and Disease Management (RDM) outcomes affirm the value of the intensified approach to mental health care. Co-operation with local law enforcement in addressing the mental health needs of offenders and Jail Diversion continues to provide appropriate intervention and support.

A commitment to QAIS principles and the attention given to the dignity and respect of consumers by assessing descriptive verbiage elevates the level of care for Individuals with Intellectual and Developmental Disabilities. The pursuit of options to integrate individuals into their respective communities to ensure quality of life is pertinent to consumer care. The attention being given to alternative living options will elevate living standards, and fulfillment in their life experience.

The Center has a 501(c) (3) non-profit status to pursue alternative funding opportunities that would accomplish two purposes. It allows the Center to expand services and create a more consumer friendly community infrastructure. The Center pursued grants that would either provide direct services or develop programs in the community that would provide additional resources to consumers. Grant funding generally targets as large a population as possible. To make the dollar investment more prudent, the Center focused on using some grant fund resources to develop infrastructure. Individuals served by our programs usually benefit from most community programs that meet the criteria to be funded by grants. This reality and the need for data to drive local planning prompted us to lead initiatives that would provide relevant data. In addition to the efforts to obtain grant money the Center made volunteerism an integral part of its operation. The need of a visionary, entrepreneurial, cost effective, outcome oriented service delivery system reaffirms the Center's commitment to provide services and opportunities that will enhance the quality of life for the people of Central Texas.

- **Vision**

“The Center is the leader for quality behavioral health care designed to meet the needs of people in Central Texas.”

- **Mission**

“Providing services and opportunities for enhancing the quality of life for the people of Central Texas.”

- **Values**

The Center, philosophically, is committed to building community, the scope of which encompasses staff, consumers, family members and all stakeholders. This commitment to staff growth and community spirit requires that, administratively, the following values be embraced and practiced:

Dignity

We believe in the inherent worth of every individual.

Integrity

We believe that our personal and professional integrity is the basis of public trust.

Choice

We encourage the freedom to make choices.

Empowerment

We encourage personal decision-making.

Personal Growth

We believe in every individual’s ability to continuously develop and achieve.

Relationships

We strive to build upon natural supports, developing each individual’s connectedness to the community.

Innovations

We embrace an environment that encourages and rewards creativity and promotes leadership.

The emphasis on community extends to consumers and their families. The environment that invites inclusiveness develops trust and provides opportunities to implement preventive measures.

## **II. LOCAL PLANNING PROCESS**

Proactive planning for Resiliency and Disease Management predicated on Medicaid Managed Care concepts has required rapid organizational and operational change. The priority status given the Center’s commitment to best practices and Authority/Provider of Last Resort roles required a reassessment of planned community outreach initiatives. The focus upon organizational development, financial credibility, and staff development was a prerequisite to the process. It facilitated the Center’s concentration on best practices and personalized care. The successes of previous plans are the foundational precepts upon which this plan is developed. Outreach initiatives are threefold: 1) Solicit meaningful data to provide direction for local planning, 2) Sustain meaningful collaborative partnerships and 3) Develop a regional network of credentialed providers.

The reality of drastic reductions from Medicaid and General Revenue is inconsistent with the staggering needs of the most vulnerable citizens residing in our rural communities. Compelling considerations

provided focus. 1) Rural communities do not have the infrastructure to support the scope of needs experienced by the population we serve, 2) Prohibitions are inherent to a rural setting in developing a comprehensive array for consumer choice, and 3) Funding through grants is so specific it is often not compatible with the priority population criteria. The identification of these realities directs our local planning objectives:

**Objective 1:** Build, systemically, a process to collect comprehensive data on community needs. Data collection on relevant needs in our rural counties is, at best, piece meal. The local structure to identify community needs and formalize data does not exist.

**Objective 2:** Participate in the building of a community infrastructure that will expand service opportunities and services to the individuals served. The Center is aggressively pursuing grant funding and volunteerism to provide revenue for community projects to expand consumer resources.

**Objective 3:** Participate in building a local collaborative network to expand resources for referral and adjunct services. Center staff members actively participate in the local Community Collaborative and continue to coordinate efforts to generate local community networks throughout the service area. The Center is affiliated with national and regional community resource databases. The Center has joined the national Association for Information and Referral System. This national affiliation lists the Center with the Regional Help in Texas (211.)

**Objective 4:** Review administrative areas and programmatic expenses that are susceptible to excessive costs and develop strategies to reduce cost while maintaining the quality of services. The Center engages regularly in a comprehensive review of all expenditures to assess areas of risk.

**Objective 5:** Sustain the spirit of community that exists between consumers, family members and staff.

**Objective 6:** Sustain and expand the Center's sphere of influence in the communities served while strengthening advisory committees and encouraging stakeholder input.

The Center seeks opportunities to participate in community survey processes. Past surveys consisted of regional, comprehensive, general community concerns, and those specific to the needs of mental health consumers and individuals with Intellectual and Developmental Disabilities residing in our service area:

The Center has partnered with the city of Brownwood, Brownwood Chamber of Commerce, the Brownwood Regional Hospital, and the Family Service Center to conduct regional surveys. The participants formed the Community Partnership of Central Texas to establish a credible identity. The domains were comprehensive. The categories of issues included in the survey are Education, Health, Nutrition, Employment, Housing, Transportation, Social Support Services, Quality of Life and Substance Abuse/ Mental Health. Chambers of commerce, human service agencies, juvenile justice entities, civic clubs, school districts, county judges, law enforcement, hospitals, and governmental agencies were targeted in the survey.

The Center has periodically solicited the help of research classes at Howard Payne University to conduct an assessment to identify specific behavioral health care needs in the community. The intent of this exhaustive survey initiative was to create a database to identify needs and to request funding predicated on

validated needs.

- **Local Planning and Advisory Committee Development**

Rural Impact: The Center is one of four in the state that serves an exclusively frontier/rural area. Identified barriers are inherent and evident. Access and choice issues prevail due to large geographic areas, population dispersion, and a limited numbers of providers, a large under-insured population, cultural barriers, and limited resources. Multiple community “planning committees”, if effective, require available, committed members invested in the welfare of the consumers being served in their respective community. Individuals in smaller communities that demonstrate a benevolent spirit generally serve on multiple boards. This reality inhibits, or in some cases, prohibits participation. Three issues plague the process: committee membership, participation, and prevailing doubt as to the efficacy of Committee input.

- **Local Plan Review, Monitoring, and Evaluation**

The objectives outlined in the plan will be incorporated into the budgeting process for FY 2008 and FY 2009. – Annually

Solutions to assess community needs through the collaborative efforts of all participating agencies to meet those needs that are beyond the scope of the service delivery system will be assessed. –Annually

The aggregate funding of grant initiatives will be assessed to determine the impact of the revenue and a meaningful infrastructure to best utilize funding will be developed. - Annually

Constructive measures to address identified consumer needs will be evaluated by the Risk Management and Utilization Management Committees. – Annually

Sensitivity to community needs that are relevant to the Center’s capacity to perform the service will be stimulated through the Planning Network and Advisory committee. – Quarterly

To ensure service quality and to reduce costs, internal program managers will submit their planning processes and identify specified goals routinely. Each program manager interacts with the CEO. – Annually

The Risk Management will assess the progress and status of identifiable corrective measures related to organizational or operational planning. – Weekly

The QM Department will evaluate the effectiveness of the Center’s public outreach and community involvement. – Annually

Reports will be distributed to the Risk Management and Utilization Management committees, the Governance Board, the PNAC Committee, consumers, parents, and stakeholders. – Annually

### **III. EXTERNAL/INTERNAL ASSESSMENT**

- **Organizational Self-Assessment**

The Center has accessed and used differing models to assess organizational strength. The Malcolm Baldrige model focused on leadership, planning, customer and market focus, information and analysis, human resources and development, process management, and business results. The process has been replicated over consecutive years to provide insight and direction in the determination of pertinent domains. The continuity of the process permitted the Center to compare trends over an extended period. In addition to this process, the Center implemented the Balanced Scorecard to assist with the strategic planning initiatives. The four domains are Financial Perspective, Internal Business Perspective, Customer Perspective, and Innovation and Learning Perspective. Budget restraints with stringent guidelines for administrative staff allocations necessitated the need to build internal systems based on the expertise gained in the use of the formal assessment processes. The Risk Management Committee, using the techniques of these processes, accepted the task of weekly analyzing, operational procedures, alerts, internal data systems and the risk indicators identified in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) to assess and strengthen organizational processes.

Purpose

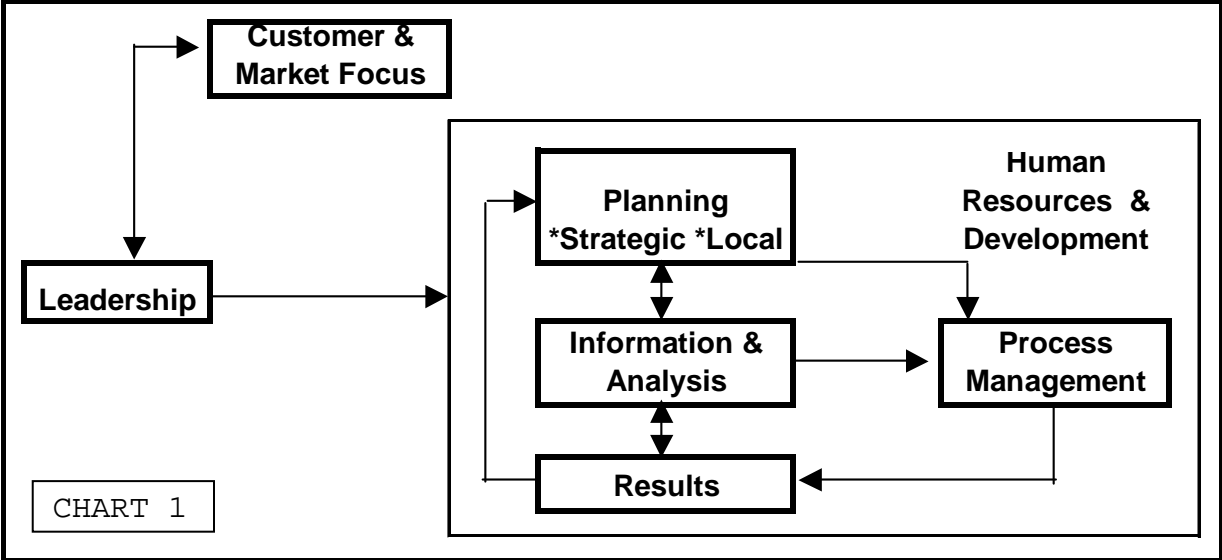
The purpose is to identify and to increase the Center’s ability to meet customers’ needs. The ability to do this depends on continuously improving all of the processes that contribute to providing services and producing results that satisfy the customers — consumers, their family members, community, staff, funding sources, and other stakeholders.

Planning

Center-wide information is gleaned from program managers, internal providers, and network staff. Information is assessed to determine trends, identify strengths or weaknesses and compliment planning strategies.

▪ **Self-Assessment Process**

Management of key processes is paramount in our management system. Process management, as indicated on chart 1, is an integral component. The Center now has the capability to make data based organizational and operational decisions.



Process management was crucial to implement strategies leading to the separation of the Authority function with the Provider of Last Resort role.

○ **Leadership**

Leadership development is, as in the past, at the heart of organizational restructuring. The Center, historically, has focused on the development of management through our internal leadership development initiative. The program managers are empowered to lead their programs and expect programmatic accountability. In response to constructive input, identified needs were targeted resulting in the following leadership directives.

Leadership focuses on community building, effective communication and conflict resolution. Five Principles for community building have been introduced and implemented: 1) Relate with love and respect, 2) Communicate with authenticity, 3) Deal with difficult issues, 4) Bridge differences with integrity, and 5) Celebrate individual differences. Leadership building includes a six-week mentoring program for all new staff and staff members desiring professional growth.

○ **Strategic Planning**

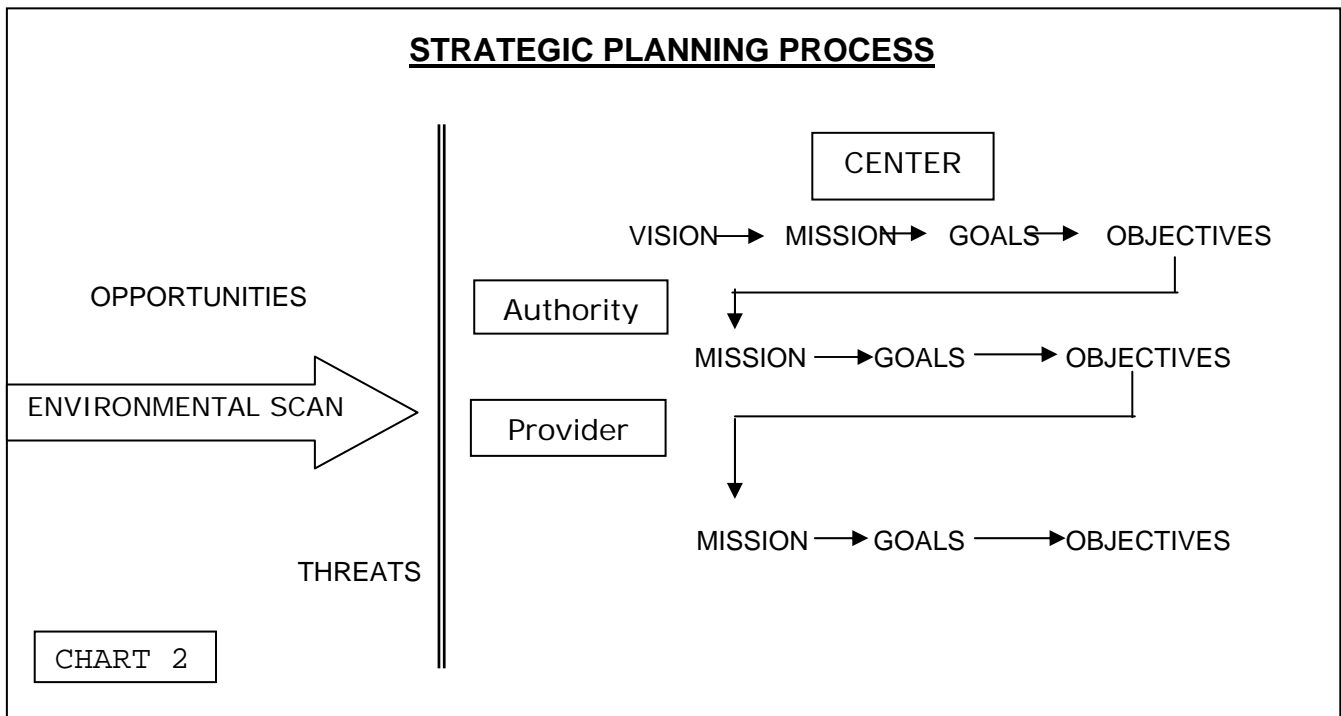


Chart 2 depicts a process that necessitates a thorough understanding of the Center’s Authority role and service environment. Subsequent action requires the accomplishment of desired outcomes. Strengths and weaknesses are identified in the process. Methods include assessments, consumer feedback, community input, performance contract outcomes, and legislative directives. The Center’s vision, predicated on consumer, community and stakeholder involvement, develops the Center’s Mission. Specific goals are developed to support the Mission and contract performance objectives. The objectives are measurable and quantifiable; outcome oriented, and assigned a completion date.

Strategic planning is continually reviewed because it is a “living plan” and must adapt to changes and discovered gaps, or needs. The formal strategic planning process will be a recurring process. The previous plan establishes the framework for subsequent plans. In addition, input is obtained from the state, local agencies, and the community. Goals and objectives are updated using all the available information. These are consistent with the vision and mission of the Center. It will be imperative to maintain clarity of purpose and open communication at all levels, and between all levels. Feedback, as appropriate, is given to all participants in the strategic planning process. Planning is formulated with the vision of developing a rural behavioral health care system for the region. The centerpiece of strategic planning is a cost effective internal management system. The Center believes the service base will broaden, consumer satisfaction will be enhanced, and quality behavioral health care will be provided.

- **Customer and Market Focus**

Center staff members are involved in the community and many serve on various boards to include organizations such as ARK Domestic Violence Shelter, Brown County United Way, Brownwood Chamber of Commerce, and Brown County Association for Retarded Citizens, the American Red Cross and private healthcare providers. Participation allows staff frequent opportunities to share information and solicit input regarding services.

The Center’s participation in the local Community Collaborative, Children’s Community Resource Collaborative Group, Adult’s Community Resource Collaborative Group –Adults, and Community Children’s Advisory Committee provides additional insight to assist in identifying consumers and providers.

The Center participates in the annual Community Health Fair with adequate representation to capitalize on the exposure afforded by the event...

The Center, as a community based public entity, has provided leadership training to communities desirous of the training. Past response from community businesses and organizations provided another resource for local planning initiatives.

- **Human Resource Development and Management**

A Human Resources Director, an HR Specialist/ HR Benefits Coordinator, HR Clerk, and Volunteer Coordinator currently staff the Human Resource Department. Payroll is a Business Office function. The HR Clerk processes applications, employee files, conducts pre-service, new employee orientation and exit interviews. The HR Specialist/Benefits Coordinator processes new employees for Benefit Packages, monitors COBRA enrollments, communicates updates, changes and information relevant to retirement and health insurance plans. The Volunteer Coordinator recruits and coordinates volunteer activity.

- **Training and Safety Officer**

The Training Specialist serves in a dual role by coordinating all training activities and serving as Safety Officer. The Safety Officer monitors compliance with ADA, Federal and State safety requirements, and Departmental requirements. On-site inspections are conducted and required provider life and safety drills

are monitored.

- **Process Management**

Processes are assessed based on legislative, departmental, and the evolving authority roles. The diversity of network development and management for services to the mentally ill and individuals with intellectual and developmental disabilities require periodic reviews of the Center's progress and present status. Recommendations for improvement are made predicated on these findings:

- **Business Results**

Historically, local community centers have operated from an entitlement mindset providing, primarily, indigent care. General Revenue funds and Medicaid Revenue financed service delivery. Funding sources were generous and little accountability was required. The system was encumbered with prescriptive guidelines predicated on funding resources. Service delivery systems were designed and individuals were placed in these programs. Consumer and family input was minimal and prescriptive delivery systems took precedence over consumer satisfaction and consumer driven outcomes. This resulted in the state funded pilot projects designed to establish the roles of the local community centers. An evolution of events led to legislative action that placed service delivery under the Texas Department of State Health Services and the Texas Department of Aging and Disability Services. This action retained, constitutionally, the Authority role for MR services but relegated Centers to a Provider role for MH services. The continuing evolution of the process has once again established the role of an MH Authority, responsible for the development, oversight, and maintenance of a Provider network. It is obvious legislative expectations regarding the State Budget deficit will require entrepreneurial initiatives to replace bureaucratic stagnation. "Business as usual" will jeopardize a social service organization that fails to acknowledge the need for change and the courage to implement it. The pace and magnitude of changes within the state system will overwhelm local service delivery systems that remain organizationally stagnant.

#### **IV. ASSESSMENT COMPONENTS**

- **History and Organizational Overview**

The Center for Life Resources is located at 408 Mulberry Street, Brownwood, Texas. The counties included in the service delivery area consist of Brown, Coleman, Comanche, Eastland, McCulloch, Mills and San Saba. A nine-member board governs the Center, eight are appointed by the County Commissioners in the respective counties served and the Brownwood City Council appoints one. These members represent the respective counties served.

The Center is a publicly funded agency of the State of Texas and presently governed by the rules and regulations of the Texas Department of Health and Human Services. The agency is a result of the Community Mental Health and Mental Retardation Facilities Act (Public Law 88-164). This act provided for the creation of local governing boards. These boards were to develop and implement community based mental health and services for individuals with Intellectual and Developmental Disabilities. Such service systems are designed for those persons who can be effectively treated in their own community and who do not require long term institutional care.

In 1970, the Center was established, after long range planning by several community advocates, for the

mentally challenged, i.e. Janie Clements, Reverend Darden and W. Lee Watson. Reverend Darden assumed the duties as Chairman of the Board, and Jackson King, an Abilene College professor was appointed Executive Director. The staff, which consisted of a psychiatrist, social worker, and business manager, secured an office at 100 Melwood Avenue in Brownwood. During the next few years, the staff grew and services improved. In early 1972, a training facility for vocational training was dedicated. The workshop was named after Janie Clements in appreciation of her efforts on behalf of individuals with mental retardation.

In 1974, a new era was initiated for the Center. The Center had outgrown its old facilities and moved to its present location at 408 Mulberry Street in Brownwood. The community mental health concept evolved. The following years brought a change in Executive Directors as Jackson King resigned and Roy Cronenberg was hired to replace him. In 1976, it was decided that the Center would open regional offices so caseworkers could be in each of the six out-counties. This plan was implemented in 1977. Later that same year, sheltered workshops were located in Eastland, Comanche, McCulloch, and Coleman counties. A workshop was opened later in Mills County. The Center is now an integral part of the communities it serves.

In August of 1997, Ghasem Nahvipour assumed leadership of the Center as the Chief Executive Officer. His administration began an organizational restructuring based on nine principles of organizational growth. Those principles were Business Management, Open Book Management, Organizational Management, Employee Empowerment, Learning Organization, Organizational Humanization, Leadership Development, Cross Management Training, and Community Development.

In 2002, the Governing Board took action to provide the Center a new identity. It was determined Central Texas Mental Health and Mental Retardation Center would do business as The Center for Life Resources. The need to be entrepreneurial prompted the need for a different image. In addition to a new identification, the Center applied for and received a 501(c) (3) status. The non-profit status allowed the Center to pursue alternative grant funding. The Center pursues diligently its affiliation and identification with the communities served. Grant funded programs that provide services to meet needs that are commonly experienced by consumers are beneficial while preventing consumer relapse due to unmet resources.

#### ▪ **Internal Operations Guidelines**

- Business Management Function: The agency has to work as a business if it is to compete in today's behavioral health care arena.
- Open Book Management: Disclosure of operational costs and the need for cooperative efforts to generate revenue is a focus for staff, program managers, and the administrative staff.
- Organizational Flattening: All program managers and administrative staff members are under the direct supervision of the Chief Executive Officer.
- Employee Empowerment: Staff members are empowered to perform tasks and encouraged to submit suggestions for improvement.
- Learning Organization: A special emphasis is placed on the need to learn principles and techniques that are proven to be successful in business operations.
- Organizational Humanization: Individual concerns are recognized and personalized attention is given staff.

- Leadership Development: Leadership training was formally offered to the community, program managers, and staff with special emphasis placed on identifying individuals within the organization that demonstrate leadership potential. Over 70% of management evolved from existing staff.
- Community Building: The community building initiative to create an environment for personal and professional growth facilitated committee building teams, exercises and an employee mentoring program.
- Cross Functional Management: The enrichment process enables and empowers multiple staff to diversify and perform work roles beyond the scope of their present work assignments. It enhances professional growth while it strengthens our organization and enhances our service potential.

▪ **QM Structure**

**Mental Health and Services for Individuals with Intellectual and Developmental Disabilities**

The advent of the Business Objects Report, the need to take a more global approach to risk factors, and Resiliency and Disease Management Guidelines necessitated two distinct committees. The Total Quality Management Committee became two committees. The Risk Management Committee addresses all risk factors while the Utilization Management Committee component was expanded and specialized to better focus on the clinical needs of consumers. The quality management process was disseminated and QM responsibilities were assumed by respective supervisors. Individuals with specific or credentialed expertise were also assigned QM responsibilities. The process made quality management an agency wide initiative, not a police action taken by a single department. Respective staff members became responsible for Data Verification, Fidelity Reviews, RDM, and Clinical issues. The Quality Management Office focuses on planning, coordination, and the facilitation of quality management activities, including risk management and utilization management. This process allowed our limited resources to be more effectively used. It, too, sensitized credentialed staff and made quality everyone’s business.

**1. The Risk Management Committee-Operational QM Component**

The Risk Management Committee meets weekly on Thursday morning to review the activity for the past seven days with regards to the following areas of responsibility. On an as needed basis pertinent reports from the Business Object Reports are shared with the Committee. Areas of concern, identified trends and outliers are discussed.

- Medicaid Inquiry
- Workers’ Compensation
- Incident Reports
- Safety Issues
- Rights/Abuse
- Consumer Complaints
- Infection Control
- Systems Alert
- Chart Form Approval
- MR Data Elements
- Behavioral Plans
- Productivity Reports
- Timeliness Reports
- MBOW Reports
- Data Verification
- Billing

- CARE data
- Encounter Data
- State Performance Contract Monitoring
- Provider Contracts Monitoring
- Management Risk Assessment
- Bed Days
- QM Monitoring Reports
- Policy and Procedure Action
- Credentialing
- Service Barriers

The Center has designated staff members of the Risk Management Committee who are responsible for the submission of the following critical incident data per the performance contract:

- Medication Errors
- Serious Physical Injuries
- Deaths
- Behavior Intervention Plans Authorizing Restraints
- Emergency Personal Restraints
- Emergency Mechanical Restraints
- Emergency Chemical Restraints
- Individuals Requiring Emergency Restraints

A verbal report is given in the Risk Management Committee meeting with the hard copy filed in the Risk Management minutes.

## **2. Utilization Management (UM) Committee-Clinical QM Component**

The UM Committee meets each Thursday to conduct clinical reviews, review admissions, monitor and review hospital, crisis and Respite recidivism, TRAG questions, service targets, and waiting lists. The agenda includes, but is not limited to:

- Gate keeping – facility admissions
- Hospitalizations/Bed Days/Continuity
- Intakes
- Screenings
- Access/Waiting lists
- Discharge Reports
- Financial Report: Productivity – Number of clients being served
- Financial report: Capacity – Monthly Care Report – Current Case Loads
- Financial issues
- Encounter Data
- Client Benefit Report
- Clinical Overrides – Consumers who are being overridden (up or down) that are at-risk, or have resource limitations.
- High Risk Alerts
- Client Deaths
- Suicide Attempts
- Case Reviews

- Appeals
- Crisis Outliers
- Crisis Authorization Review
- Rural ACT
- Substance Abuse Program Report
- Respite (CFLR Stabilization and Treatment)
- Medication Errors
- Medication Request for weekly/monthly refills
- Behavior Plan Development
- UM Training

▪ **Populations**

The priority population for Mental Health services consists of:

- Children and adolescents under the age of eighteen who have a diagnosis of mental illness who exhibit severe emotional or social disabilities that are life-threatening or require prolonged intervention.
- Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders which require crisis resolution or on-going and long-term support and treatment.

The priority population services for Individuals with Intellectual and Developmental Disabilities include those persons who request and need services and possess one or more of the following conditions: Individuals with Intellectual and Developmental Disabilities, as defined by Section 591.0003 (13), Title 7, Health and Safety Code.

- Autism as defined in the current edition of the Diagnostic and Statistical Manual (DSM-IV).
- Pervasive Developmental Disorder (PDD) as defined in the current edition of the DSM-IV.
- Eligibility for Early Childhood Intervention Services (with the requirement that contract dollars may not be used by the Center to pay for the same services purchased through the Center’s contract with the Early Childhood Intervention Council).
- Eligibility for OBRA ’87 mandated services for individuals with intellectual and developmental disabilities or a related condition as defined in 42 Code of Federal Regulations 453.1009.
- In targeting services to the priority populations, the choice of admission to services is determined jointly by the person seeking service and the Authority. Criteria used to make these determinations are the level of functioning of the individual, the need of the individual, and the availability of resources.

Behavioral health care is provided to two targeted populations predicated on an identified priority population criteria. In a typical month, the Center provides assistance to an average of six hundred and fifty adults in mental health services, two hundred adults in services for individuals with intellectual and developmental disabilities, and one hundred and seventy individuals in children’s services. These figures reflect an average of one thousand and twenty individuals who receive services each month

Seven rural counties consisting of Brown, Coleman, Comanche, Eastland, Mills, McCulloch and San Saba constitute the Center’s service area. This service area has a total population of 98,946 and covers 6,574 miles. The cultural ethnic breakdown of the area is: Hispanic – 17%; African American – 3%; Caucasian –

80% and other – less than 1%.

The Center employs one hundred and fifty full time and twenty three part time staff members. Fifty-six have undergraduate degrees and twenty three have graduate degrees. Of the seventy nine degreed staff, two are psychiatrists, six are licensed professional counselors, two are LPC interns, six are licensed social workers, four are licensed vocational nurses, two are registered nurses, and one is a nurse practitioner, Thirty-six are qualified mental health professionals (QMHP), and nine are qualified mental retardation professionals (QMRP).

The Center contracts with a panel of service providers, including mental health and services for individuals with intellectual and developmental disabilities.

**Mental Health:**

- 2 general hospitals
- 3 psychiatric hospitals
- 1 crisis hotline provider
- 1 Licensed Professional Counselor
- 1 pharmaceutical supplier
- 1 crisis respite
- 2 laboratory service providers

**Individuals with Intellectual and Developmental Disabilities:**

- 2 general hospitals
- 17 foster care providers
- 1 dietician
- 3 day habilitation providers
- 8 physicians for emergency services
- 14 dentists
- 1 psychologist
- 3 respite providers

The Center’s Volunteer Services Program consists of community volunteers.

▪ **Service Population Demographics**

	Mills	McCulloch	San Saba	Eastland	Coleman	Comanche	Brown
Total Population	4726	8802	5812	17,489	9443	13,584	36,847
Male Population	2314	4231	2845	8481	4528	6739	18,116
Percent under 18 years	24.2%	28.3%	30.3%	23.7%	24.5%	24.5%	26.8%
Percent over 65 years	23.1%	18.5%	20.2%	20.9%	23.3%	19.7%	15.7%
Caucasian	85.5%	64.5%	74.1%	87.3%	81.0%	78.2%	79.3%
African American	0.3%	2.2%	2.2%	2.2%	3.0%	0.4%	5.4%
American Indian, Eskimo	0.2%	0.2%	0.1%	0.3%	0.4%	0.5%	0.5%
Asian/Pacific Islander	0.1%	0.1%	0.1%	0.3%	0.1%	0.1%	0.4%

	Mills	McCulloch	San Saba	Eastland	Coleman	Comanche	Brown
Hispanic	14.1%	33.4%	23.6%	10.1%	15.6%	21.2%	14.8%
High School Graduates	1984	3613	2258	7817	4012	5310	14,620
College Graduates	411	797	435	1360	652	842	2976
Homeownership	79.3%	71.8%	73.0%	74.3%	73.1%	77.3%	71.8%
Median Income	\$24,013	\$23,532	\$21,722	\$22,645	\$21,718	\$23,687	\$26,963
Persons below poverty level	19.4%	22.7%	24.4%	21.5%	23.9%	21.8%	19.5%
Children below poverty level	28.1%	30.6%	35.5%	29.5%	34.7%	33.6%	27.0%
Minority-owned firms	NA	109	NA	NA	NA	NA	139
Women owned firms	123	217	133	460	272	348	836
Land Area (square miles)	748	1069	1135	926	1273	938	944

### ▪ Services and Supports

Service delivery is predicated on best value and related economics, as well as, compliance with sole source or service provider of last resort directives. Conformity to respective performance contract guidelines requires discretionary use of funds while ensuring accessibility to individuals requiring services.

The Center offers a full array of services for every age group. Availability, accessibility, and a “user friendly” environment enhance the quality of services provided. Services provided include children’s services, adult mental health services, and adult services for individuals with Intellectual and Developmental Disabilities.

### **Agency: Texas Department of Assistive and Rehabilitative Services**

#### **Early Childhood Intervention (ECI) Contract**

ECI makes developmental screenings and assessments available to infants and young children (ages 0 through 2). Children with medical diagnoses that typically result in developmental delay qualify automatically. Qualifying children receive developmental services in their natural environment.

#### Services:

- Developmental Screenings
- Educational Services
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Parent/Infant Training
- Service Coordination/Case Management
- Speech Therapy

### **Agency: Texas Department of State Health Services**

#### **Children’s Services**

The Center's Child and Adolescent Services Program provides quality family-focused, community-based mental health services and supports to children ages 3 through 17 and their families. Services and supports are individualized based on family-identified strengths, needs, preferred services and supports, and outcomes.

Services:

- Crisis Hotline: A telephone service available 24 hours per day, 7 days per week for information, support and referrals when a child is experiencing a psychiatric crisis.
- Screenings: A Qualified Mental Health Professional (QMHP) from the Center talks to a parent or a legally authorized representative and their child, either face-to-face or over the phone, to gather information to find out if there is a need for a detailed assessment.
- Crisis Services: A QMHP provides crisis services to a child who is determined through an initial screening to be in need of emergent or urgent mental health community services until the crisis is resolved or until the child is placed in a clinically appropriate environment. A diagnosis is not required.
- Pre-Admission Assessment: Diagnostic Eligibility Assessment: This face-to-face pre-admission assessment determines whether or not the child is eligible for services based on the definition of priority population and treatment needs. There is no waiting list for this service. A licensed professional practicing within the scope of their license must perform this service. QMHP Assessment: This assessment is a face-to-face interview by a QMHP designed to obtain information from the child and family seeking services. This service must be provided to all children and their families who have been screened and who appear to have a need for services through the Center.
- Case Coordination: The Center's case coordinator provides services for children with less intensive needs. The case coordinator coordinates the individual's treatment and provides continuity of services, including discharge-planning activities.
- Service Coordination: The service coordinator helps the child access medical, social, educational, and other appropriate services that will help the child achieve quality of life and community participation acceptable to the child and family. The service coordinator also coordinates the child's treatment, provides continuity of care, and develops a plan for the services needed by the child when he/she completes his/her treatment.
- Treatment Planning: The Center recognizes that developing the child's individualized treatment plan is a collaborative process involving the family, child, and staff person. It includes measurable goals and objectives. The treatment and supports reflect the needs and preferences of the family and child, focusing on his or her strengths.
- Counseling: Individual, group and/or family counseling is provided by the Center's LPHA to resolve problems that result from the consumer's mental, emotional or behavioral disorder.
- Skills Training: The Center staff offers the child opportunities to learn and improve skills needed to function as appropriately and independently as possible in the community. Skill training is designed to maintain the child's quality of life and occurs, as much as possible, within a natural setting, such as home or school, rather than in the Center's offices.
- School-based Services: The Center offers counseling, skills training, and day treatment on school campuses in the service delivery area.
- Respite Services: Respite is provided as a temporary, short-term periodic relief of primary caregivers. The Center can provide either program-based or community-based respite for children.

- Respite services can be planned ahead of time or provided in a crisis.
- Flexible Community Supports: The Center's Flexible Community Supports are non-clinical in nature and are provided as a wraparound approach. These face-to-face services assist in community integration, reduce symptomatology, and maintain quality of life and family integration for children.
  - Medication-Related Services (non-NGM): The Center provides medication-related services by a licensed nurse or other qualified and properly trained persons working under the supervision of a physician or registered nurse, as proved by state law, for any child prescribed psychiatric medication other than New Generation Medication. These services include medication administration, monitoring, training, provision, and pharmacological management.
  - Medication-Related Services (NGM): The Center provides medication-related services by a licensed nurse or other qualified and properly trained persons working under the supervision of a physician or registered nurse, as proved by state law, for any child prescribed New Generation Medication. These services include medication administration, monitoring, training, provision, and pharmacological management.
  - Inpatient Services: Hospital services provide 24-hour care to children who cannot be stabilized in a less restrictive environment. Services are designed to provide safety and security during an acute psychiatric crisis. The staff provides intensive interventions designed to relieve the child's acute symptoms so that the child can return to his/her community.
  - Child & Family Education Services: Molly Lopez, Ph.D., trained seven of the Center's staff who work with children on February 23, 2005. Also in attendance for the training were Pecan Valley MHMR and Central Plains MHMR. When a consumer has a doctor's appointment at the Center, he/she also has an appointment with a designated Case Manager for medication training and support. Other Case Managers fill in the gaps between doctor visits as needed.
  - Consumers Referred by TYC: The Center provides services to consumers referred by the Texas Youth Commission, pursuant to Title 37, TAC, Chapter 87, Subchapter B, Special Needs Offender Programs, §87.79, Discharge of Mentally Ill and Mentally Retarded Youth.

### **Adult Mental Health Services**

The priority population for adult mental health services consists of adults who have severe and persistent mental illnesses such as schizophrenia, major depression, and bipolar disorder. Service determination is based on the level of functioning of the individual, the need of the individual, and the availability of resources.

Services:

- Crisis Hotline: A telephone service available 24 hours per day, 7 days per week for information, support and referrals.
- Screenings: A Qualified Mental Health Professional (QMHP) from the Center talks to an individual or a legally authorized Representative, either face-to-face or over the phone, to gather information to find out if there is a need for a detailed assessment.
- Crisis Services: A QMHP provides crisis services to an individual who is determined through an initial screening to be in need of emergent or urgent mental health community services until the crisis is resolved or until the individual is placed in a clinically appropriate environment. A diagnosis is not required.
- Pre-Admission Assessment: Diagnostic Eligibility Assessment: This face-to-face pre-admission assessment determines whether or not the individual is eligible for services based on the definition

of priority population and treatment needs. There is no waiting list for this service. A licensed professional practicing within the scope of their license must perform this service. QMHP Assessment: This assessment is a face-to-face interview by a QMHP designed to obtain information from the individual and family seeking services. This service must be provided to all children and their families who have been screened and who appear to have a need for services through the Center.

- Case Management: The case manager assists the consumer in accessing medical, social, educational, and other appropriate services that will help the consumer achieve quality of life and community participation acceptable to him or her. The case manager also coordinates the individual's treatment and provides continuity of services, including discharge-planning activities.
- Treatment Planning: The Center recognizes that developing the individual's individualized treatment plan is a collaborative process. It includes measurable goals and objectives. The treatment and supports reflect the needs and preferences of the consumer and builds on his or her strengths.
- Counseling: Individual, group and/or family counseling is provided by the Center's LPHA to resolve problems that result from the consumer's mental, emotional or behavioral disorder.
- Respite Services: Respite is provided as a temporary, short-term periodic relief of primary caregivers. The Center provides program-based respite. Respite services can be planned ahead of time or provided in a crisis.
- Medication Services: The Center provides medication-related services by a licensed nurse or other qualified and properly trained persons working under the supervision of a physician or registered nurse, as proved by state law, for any consumer prescribed medication. These services include medication administration, monitoring, training, provision, pharmacological management, and a patient assistance program.
- Skills Training: The Center staff trains consumers in skills that will help further his or her independent functioning in the community. Skill training promotes community integration, increases community tenure, and maintains the consumer's quality of life.
- Supported Employment (Best Practices): The Center's Supported Employment program provides individualized services to assist consumers in choosing, obtaining, and maintaining employment. Supported Employment includes intensive and maintenance levels of services.
- Supported Housing (Best Practices): Supported Housing provides individualized services to assist people in choosing, getting and maintaining regular, integrated housing. Support services such as accessing transportation, meal preparation, and budgeting may also be provided through this program at the Center for Life Resources.
- Assertive Community Treatment Alternative (Best Practices): The ACT Alternative program at the Center provides Intensive Case Management (ICM) services with a team approach. The ICM team maintains 24-hour responsibility and availability for covering and managing crisis and emergencies for ACT Alternative consumers.
- Inpatient Services: Hospital services provide 24-hour care to children who cannot be stabilized in a less restrictive environment. Services are designed to provide safety and security during an acute psychiatric crisis. The staff provides intensive interventions designed to relieve the child's acute symptoms so that the child can return to his/her community.
- Substance Abuse Services: Through funding by the Texas Commission on Alcohol and Drug Abuse (TCADA), the Center added an outpatient treatment program for youth and adults in Brown, Coleman, Comanche, and Eastland counties. The funding expanded the Center's Co-Occurring

Psychiatric and Substance Use Disorders (COPSD) program. New funding initiated a Drug Prevention Program. Program goals state that:

- The COPSD program will ensure that both psychiatric and substance use disorders are addressed with intensive services designed to stabilize and engage the client in active treatment.
- Outpatient treatment services will be offered to youths and adults in the respective counties. Clients will be provided weekly individual counseling and group therapy over a three to four month period to support them in breaking the bonds of alcoholism and drug addiction.

## **Agency: Texas Department of Aging and Disability Services**

### **General Revenue Funded Services**

Admission to services for Individuals with Intellectual and Developmental Disabilities are based on an individual's need and eligibility for a particular service, in accordance with rules and policy of the department. These services receive funding from the State of Texas' general revenue account in an appropriation to DADS. While these services receive state funding, many are supplemented by local funds that may include county or city funding, various charitable organizations or other non-general revenue funds.

### **Services Provided:**

- Eligibility Determination: This service determines if an individual with intellectual and developmental disabilities meets the criteria for definition of priority population.
- Service Coordination: The Center's service coordinator coordinates and monitors services to ensure the individual's needs is addressed across time and programs. In addition, the service coordinator assists with consultation and coordination when changes in services are needed. Service Coordination includes: 1) Basic Service Coordination; 2) Continuity of Services-State Facilities; 3) Continuity of Services-Medicaid Programs; and 4) Service Authorization and Monitoring.
- Support Services: Community Support: Individualized activities provided by the Center to a consumer in the individual's home or community. Respite Services: Respite is provided as a temporary, short-term periodic relief of primary caregivers. This support service is provided in the home or at another location. Supported Employment: The Center's Supported Employment program provides temporary employment assistance to consumers who are seeking community employment and who are not receiving Vocational Training. This program also provides support services to enable an individual to maintain employment with an employer.
- Day Training: Vocational Training: Janie Clements Industries, a Center program, provides day training and support to consumers to help them obtain and retain employment. Specific services are tailored to fit each individual's needs and abilities. Day Habilitation: The Center's Alternative Day Program (ADP) accommodates the needs of those who are not ready to participate in vocational training. These services provide the training needed to help the individual participate in the community.
- In Home & Family Support Services: Program funds are used to purchase items or services that would not be required if the person did not have a disability; are disbursed upon fund availability; and are not an entitlement or income supplement. There is a limit of \$2,500 per year, with the amount granted depending on the individual's needs, income, and application of a sliding fee scale. This is a resource of last resort.

- Determining Designated MRA & Less Restrictive Setting: Information is provided, with adequate explanation, to all potential and incoming consumers of their rights and choice.
- Permanency Planning for Children Requesting ICF-MR or HCS: The Center’s MR Intake Director oversees and documents Permanency Planning for children requesting ICF-MR or HCS services using the appropriate instrument based on age.

**Medicaid ICF/MR Services**

An individual must be eligible for ICF/MR services. The Center for Life Resources owns and operates 3 Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities. These facilities provide residential and habilitative services, skills training, and adjunctive therapies with 24-hour supervision and coordination of the individual program plan.

Services Provided:

- Adaptive Aids
- Service Coordination
- Counseling And Other Therapies
- Minor Home Modifications
- Dental Treatment
- Nursing
- Residential Assistance
- Respite
- Day Habilitation
- Supported Employment

**Medicaid Waiver Services**

Medicaid home and community-based waiver programs provide services and supports to individuals with intellectual and developmental disabilities in their own or their family’s home or in other home-like settings in the community. A distinguishing feature of these programs is the funding ability to move with the individual to any part of the state. DADS certifies all waiver providers initially and then reviews each provider at least annually to ensure the provider continues to meet the program certification principles.

Services Provided:

- Home and Community-based Services: The Center’s HCS Program provides services to individuals with intellectual and developmental disabilities who either live with their family, in their own home, in a foster/companion care setting or in a residence with no more than four individuals who receive services. The program provides services to meet the individual’s needs so that he/she can maintain him/herself in the community and have opportunities to participate as a citizen to the maximum extent possible. In the HCS Program, individuals pay for their room and board either with their SSI check or other personal resources.
- Texas Home Living Program: The TxHmL program provides essential services and supports so that individuals with intellectual and developmental disabilities can continue to live with their families or in their own homes in the community. TxHmL services are intended to supplement instead of replace the services and supports an individual may receive from other programs. Program services are limited to a yearly cost of \$11,000 per participant.

## **Client Support Services**

- The Center provides a Patient Assistance Program (PAP) to help consumers obtain psychiatric medications to include New Generation Medications that are relevant to their care.
- The Center has a trained Benefits Specialist to screen and assist individuals with Social Security Benefits applications.

## **VI. RESOURCE DEVELOPMENT AND ALLOCATION**

### **• Resource Development and Allocation**

In general, funding for The Center for Life Resources comes from two primary sources: Medicaid earned revenue and general revenue and block grant funds from the Texas Department of State Health Services, the Texas Department of Aging and Disability, and the Texas Department of Assistive and Rehabilitative Services. Very little, if any, funding is available for “discretionary” spending, i.e., providing different services for programs or enhancing the number of persons receiving services. The Center is also faced with fluctuating general revenue dollars and reduced Medicaid reimbursement rates. Given this state of funding, The Center engages consistently in activities to increase the number of resources and funding sources to maintain the current level of services being provided, and when possible, provide additional services and supports. Resource development activities to maximize opportunities for existing and new dollars and resources include:

- Implementation of strategies to increase the number of Medicaid eligible service recipients and implementation of activities to increase direct service time by service providers to maximize Medicaid earned revenue;
  - Implementation of a Patient Assistance Program and an aggressive initiative to obtain medication samples to reduce pharmacy costs;
  - Implementation of a competitive salary structure and pay incentives linked to productivity are designed to increase revenue, boost morale, and reduce staff turnover.
  - A 501(c)(3) status with the Internal Revenue Service to increase eligibility and opportunities for foundation grants;
  - Aggressive pursuit of grants funding to build community infrastructure.
  - Performance of analysis of the financial impact of the Children’s Health Insurance Program (CHIP) and determining strategies to maximize the revenue from the program;
  - Aggressive development of an active volunteer program in all seven counties served by the Center.
  - Constant initiatives are conducted to evaluate existing direct service practices for all consumer services, identify and eliminate inefficiencies, clarify staff roles, redesign programs and address systemic updates.
- 
- Fiscal Planning  
Reductions in Case Management and Rehab Medicaid revenue dictated a need for the Center to enhance the UM process to assume a more stringent role with reduced resources. Deficits in the State Budget added another crucial dimension to the need for frugality. The prevailing issues of decreased funds and increased needs call for creativity. Cost cutting measures are being pursued

and administrative costs are being reduced.

Periodically, cost saving measures are taken to address the inevitabilities of reduced revenues and the requirement of the Mental Health, Mental Retardation Local Authority readiness initiatives. Positive steps have been taken in past reviews to expedite the process. The intent was twofold: 1) the quality of care would not diminish, and 2) layoffs were not an acceptable option. These recommendations resulted in initiatives to:

1. Sustain administrative costs at 10%;
2. Assign licensed staff serving in administrative roles to clinical roles where possible;
3. Utilize the 501(c)(3) status to generate alternative funding;
4. Continue to aggressively pursue grant funding;
5. Build community infrastructure through collaborative efforts and grant funded community projects;
6. Expand the volunteer program;
7. Reduce travel to representative attendance at all meetings;
8. Provide EAP services to local corporations; and
9. Expand entrepreneurial projects through the Janie Clements Foundation.

- **Community Needs and Priorities**

The conclusions for relevant plan development are, and will be, based on input from the following sources:

1. An analysis of self-assessments, the continued progress through plans of correction, and the applicability of each plan to the rapidly changing environment of community based behavioral health services.
2. Consumer and family member input through interviews and surveys.
3. Appropriate follow-up with program managers on their respective plans of corrective action.
4. Surveys to evaluate staff perception of organizational strength will be conducted on an as-needed basis.
5. Regional or area specific planning processes that will provide data on the needs of the communities served by the Center.
6. Solicitation of local university students to participate in projects to identify priority needs
7. County community forums, when possible and as needs dictate, with community law enforcement, public officials, and community leader participation at service delivery sites.
8. Center staff involvement in a combination of one-on-one and group meetings, solicited input from community leaders, politicians, stakeholders, forums and the Brownwood Chamber of Commerce.
9. Special presentations to civic groups, organizations, local schools and public forums to solicit public input. Presenters are asked to submit reports reflecting the perceived needs of participants in these meetings. Participants are asked to respond to the following inquiries:
  - a. What is the Center doing that is working?
  - b. How can the Center improve services to the community?
  - c. What else would you like to know about MHMR services?Participants are also asked to respond to an inquiry regarding their availability, or desire, to participate in the Center's Volunteer Services Program.
10. Staff interviews are conducted for constructive input.
11. Administrative program committees assess areas for improvement and develop plans of action.

12. The MH/MR Advisory Committee (now PNAC) are asked to provide input and solicit information from the community to provide directives and recommendations for improvement.

Areas for Improvement and Corrective Action

**1. Key Processes**

Need: Sustain compliance with HIPAA guidelines

Date of Implementation: Ongoing

Need: Enhance the validity of documentation

Date of Implementation: Ongoing

Need: Sustain an effective data base and billing capability to capture billable services based on credible data accuracy.

Date of Implementation: Ongoing

Need: Build capacity to implement the Clinical Management for Behavioral health Services (CMBHS) for electronic Medical Record system.

Date of Implementation: FY10

Need: Develop the capacity to sustain an efficient Center infrastructure to support the transition to a Provider of Last Resort.

Date of Implementation: FY10

Need: Develop, systemically, a prudent, efficacious Provider of Last Resort process to obtain and sustain choice, access, and quality for consumers of Center services.

Date of Implementation: Has been initiated and is on-going with complete transition by FY10.

**2. Key Customers**

Need: Expansion of Co-occurring Psychiatric and Substance Use Disorders (COPSD) program to include Prevention programs.

Date of Implementation: FY08 in development

Need: Pursue transitional housing for individuals with severe psychiatric disorders through RFP process.

Date of Implementation: FY09

Need: Begin transition, based on client input to Provider of Last Resort. Respire Program

Date: FY09

Need: Sustain TCCOMMI funding for service delivery

Date of Implementation: Routine RFP process

Need: Sustain Tenant-based rental assistance

Date of Implementation: Routine RFP process

Need: Continuity for 18-year-old individuals with intellectual and developmental disabilities leaving public schools

Date of implementation: FY10 Initiated through the PNAC Committee, and is an on-going initiative.

Need: Pursue resources and/or programs through RFP process for Autism Spectrum Disorders services.

Dates of Implementation: FY10

Need: Full implementation of the Local Planning and Network Development Plan.

Dates of Implementation: FY10

### **3. Methods to Describe Key Processes**

Need: Revise, publish, and develop intranet access of Center policy and procedures.

Date of Implementation: FY09

Need: Systematic reporting of meaningful data

Date of Implementation: Initiated through MBOW reports to UM and Risk Management Committee and process is ongoing.

Need: Continued HIPAA orientation of all staff

Date of implementation: Ongoing

Need: Educate families, consumers, and providers regarding the transition of service delivery to private providers.

Date of Implementation: FY10

### **4. Development of Key Indicators**

Need: Develop process to profile high priority audits, Medicaid billing, and performance profiling.

Date of Implementation: 2009

Need: Develop process to profile private providers

Date of Implementation: FY10.

Need: Develop the infrastructure to ensure and monitor required training for all clinical staff, internal and private providers

Date: FY10

Need: Develop measures to assess capacity, based on personnel and budget needs, during incremental transitions to Provider of Last Resort service delivery.

Date of Implementation: FY10

### **5. Appropriate Staff Participation**

Need: Leadership Development and Management Training

Date of Implementation: FY08 – FY09

Need: Develop initiatives to engage new employees

Date of Implementation: Ongoing

Need: Sustain a community building environment to promote participation

Date of Implementation: Ongoing

Need: Develop a system to involve out-county staff members in planning processes.

Date of Implementation: FY09

Need: Develop a system to engage program managers in out-county staff orientation

Date of Implementation: FY09

## **6. Deployment to All Relevant Staff**

Need: In-service training with signature forms for training items to be forwarded to Training Coordinator.

Date of Implementation: Ongoing

Need: Management Training

Date: FY08 – FY09

## **7. Management Strategy**

Need: Risk Management and Utilization Management Teams weekly review processes

Date of Implementation: Ongoing

Need: Accountability of flat-lined management process

Date of Implementation: Ongoing

Need: Enhance processes to stress staff accountability

Date of Implementation: FY09

Need: Review and revise process to disseminate information from Risk Management and Utilization Management Teams to general staff having a need-to-know.

Date of Implementation: FY09

Need: Develop a system to inspire staff retention to facilitate career path advancement in the Center...

Date of implementation: FY09-FY10

## **8. Feedback Systems**

Need: Develop tracking mechanisms to chart effectiveness and efficiency of private providers.

Date of Implementation: FY10

Need: Review and revise an effective reporting system to disseminate feedback

Date of Implementation: FY09

Need: Review and revise the process to track accountability for timely action plans and submissions for Performance Contract requirements.

Date of Implementation: FY09

### Managed Care Service Delivery

The millennium ushers in a new era for all social service agencies, especially those providing care for the mentally ill and individuals with intellectual and developmental disabilities. Conceptually, fee-for-service

reimbursement and cost accounting methodologies that position community centers to compete in the private arena is designed to enhance services in a cost efficient manner. This requires fiscal responsibility, service quality, consumer choice, identifiable outcomes, and verified satisfaction from those receiving services. These outcomes can best be served when driven by active community input and local ownership of the service delivery system. Medicaid Managed Care is a reality in the state of Texas and is an integral component in the planning process.

Local communities must prepare rapidly for this reality. Anxiety over managed care delivery systems focuses on the fact these systems are perceived to be impersonal. Frequently even the quality of care has been questioned. Creative local community centers now have an unprecedented opportunity to demonstrate that managed care mandates can be mobilized without sacrificing community focus. This can be accomplished through aggressive community input, consensus, involvement, and a strong provider network. These will provide credible safe guards and a sense of security for the vulnerable populations served by public local community centers.

Local participation is crucial to local ownership. Local ownership dictates that services are specific to the needs of the communities served. An ownership relationship requires accountability to specific local community directives and personalizes what could be perceived to be an impersonal system. It also controls the quality that is desired and deserved by the taxpayers of the local community. Local community centers provide the convenience of available, accessible, stable, cost efficient services. Local service delivery systems can more economically provide services to rural communities due to their existing infrastructure and the luxury of an active, local community support system. This discretionary use of public funding allows the savings to be re-invested in the communities served. National data suggests that the operation of a private managed care company will take 25% to 30% local revenue from the community it serves. Local participation is critical to the preservation of a proven process.

To provide a continuum-integrated system of services, The Center currently provides and manages services, and/or provides services, and/or manages services for those agencies currently orchestrating collective efforts as facilitators and/or providers. By providing these services, the Center currently acts as a safety net for many of the agencies of the service delivery area. The ultimate goal is the completion of a transition process that will enable the Center to be the Provider of Last Resort. The Center will sustain an infrastructure to allow it to manage a network without undue interruptions in contracted care. The Center recognizes the need to pursue greater community involvement to lead in a unification process. The process will be a collaborative effort to identify service needs, coordinate those services currently being offered and initiate efforts to facilitate services not being offered, or funded. The Center pioneered a network management initiative to facilitate a shift in organizational design. Responsibilities include protecting the public interest, oversight and monitoring to ensure that organizations serving public consumers of services are held accountable. The Authority role oversees the quality of services delivered to a targeted population. In its present provider role the agency oversees the quality of care provided to each eligible individual who requests it. The initiative will ensure objectivity in the selection of providers, evaluation of services, referral of consumers, and treatment of providers to ensure consumer and family member participation.

#### Data Collection Method

Consumer/Family input is predicated on surveyed and/or interviewed consumers and parents. This reflects formal structures to solicit input as well as informal encounters.

Agencies/Network input is solicited in the collaborative meetings. The conclusions below reflect input gleaned from program presentations, civic groups, open house activities and Destination Dignity activities. The community collaborative includes public and private providers or agencies and network providers. The periodic assemblage of the Community Partnership of Central Texas to conduct comprehensive regional surveys and the research conducted by classes through Howard Payne University provide sometimes exhaustive insights into community needs

**Percentage of Participation by Collection Methods:**

- Community Network/Agencies/Network Input 25%
- Community Partnership of Central Texas Survey 20%
- Research work through HPU 10%
- Consumers/Family Survey 15%
- Programmatic Presentations Input 20%
- Open House Input 05%
- Destination Dignity Activities Input 05%

Results of Data Collection from Community  
Community Participation

**MENTAL HEALTH SERVICES**

<b>Community Participants</b>	<b>Information Gathering Methods</b>			
	<b>Focus Group</b>	<b>Public Hearing</b>	<b>Survey</b>	<b>Other</b>
• Consumers	0	0	185	40
• Family members	0	0	40	0
• Advocacy organizations	1	0	1	0
• Interested citizens	9	0	63	20
• Other State Agencies	0	0	4	21
• Local Governance	2	0	35	0
• Other	0	0	20	0

**SERVICES FOR:**

**INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES**

<b>Community Participants</b>	<b>Information Gathering Methods</b>			
	<b>Focus Group</b>	<b>Public Hearing</b>	<b>Survey</b>	<b>Other</b>
• Consumers	0	0	52	21
• Family members	0	0	35	10
• Advocacy organizations	1	0	1	0
• Interested citizens	5	0	30	9
• Other State Agencies	0	0	0	0

• Local Governance	0	0	10	0
• Other	0	0	26	0

### Additional Planning Activities

#### Planning and Network Advisory Committee (PNAC)

Because the resource pool of individuals are limited in rural communities, the Center had to recruit and engage community individuals in multiple committees (Adult MH Advisory, MR Advisory, Network Advisory, Children’s Advisory, Home and Community Based Services, etc.). Usually individuals willing to serve are committed to several committee positions at once. Necessity dictated an alternative approach to committee structure. The approval to have a single Planning and Network Advisory Committee (PNAC) provided the infrastructure to create a single committee that could collectively focus on the needs of our communities from differing perspectives. The Center recruited individuals from varied disciplines that had either vital interests or personal knowledge of community needs regarding mental health and services to individuals with intellectual developmental disabilities. The committee acts as a community liaison, meets quarterly for input, and formulates recommendations to the Center’s Governance Board. The Governance Board entertains the review as a routine agenda item. A member of the Governance Board represents the Board in the PNAC meetings

- The Process: The Committee meets quarterly and provides specific insights regarding needs. Family members, consumers, law enforcement, public school representatives, medical and community leaders will be asked to share their thoughts regarding needs or trends they are observing. Recommendations that fall within the perimeters of service capacity are solicited. Advocacy issues are entertained. This information will be compiled monthly and submitted to the Center’s Governance Board.
- Membership:
  - Chair Person
  - Community Members - 6
  - Consumers of MH Services – 5
  - Parents of MH Consumers – 2
  - Juvenile Probation Officer – MH
  - Consumers of Developmental Disability Services – 4
  - Parents of individuals with developmental disabilities – 3
  - Foster Parents of individuals with developmental disabilities – 4
  - Non-member Center Staff -5
- Perspectives, issues and outcomes include, but are not limited to the following :
  - The impact of private providers on service delivery
  - Knowledge of unfulfilled needs related to client care in the communities
  - Implications of persistent change in the state system
  - Noticeable trends that may impact client care
  - Identification of barriers to services or access issues
  - Suggestions related to quality of care
  - Knowledge of any client care deficiencies, client rights or abuse

<b>PNAC Information Items</b>	<b>Yes</b>	<b>No</b>
The Local Authority (LA) has a PNAC.	*	

LA participates in a regional PNAC.		*
50% or more of the PNAC membership are consumers or family members of consumers.	*	
The PNAC membership includes family members of children or adolescents.	*	
The PNAC members receive initial and on-going training.	*	
The LA ensures conflicts of interest are avoided in performing the responsibilities of the PNAC.	*	
LA has established outcomes.	*	
PNAC receives information necessary to achieve expected outcomes.	*	

### Recognized Gaps in Services

#### Gaps in Mental Health Services for Adults

Title	Description/Purpose	Identified Barrier
1. Multiple Providers	Limited options for choice	Rural area
2. Spanish Speaking staff	Availability of Clinicians	Credentialing for service
3. Homelessness	Stabilize Housing	Local Resources/Finances
4. Detoxification	Crisis (Mental Health & Substance Abuse)	Physician/Facility Resources
5. Transportation	Adequate Transportation	Limited Resources

#### Gaps in Mental Health Services for Children and Adolescents

Title	Description/Purpose	Identified Barrier
1. Respite	Adequate Accommodations	Limited Resources
2. Child Psychiatrist	Support Clinical Transition	Not available
3. Flexible Funding	Support Wrap-Around Services	Limited Resources
4. After School Program	Stabilization in Community	Limited Resources
5. Monitoring	Provide Family Support	Funding

#### Gaps in Services for Adults with Intellectual and Developmental Disabilities

Title	Description/Purpose	Identified Barrier
1. Transportation	Adequate Transportation	Limited Resources
2. Vocational	Jobs in the Community	Limited Employers
3. HCS Slots	Community Housing	Limited Slots
4. Counseling	Sustain Quality of Life	Funding
5. Psychologist	Local availability	Rural area

#### Gaps in Services for Children and Adolescents with Intellectual and Developmental Disabilities

Title	Description/Purpose	Identified Barrier
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1. > 18 years in age	After Graduation Care	Funding
2. Respite	Adequate Respite Accommodations	Limited Resources
3. Counseling	Meet Intervention Needs	Funding
4. Advocates	School Advocates	Limited Resources
5. After School Program	Stabilization in Community	Limited Resources

▪ **Impact of Key Forces Using a SWOT ANALYSIS**

Strengths

- Financial strength due to proactive budgeting, revenues produced, and alternative funding.
- Administrative flexibility and the willingness to be innovative to meet the demands of constant change within a governmental system.
- A strong and viable community support network with a proven history of participation in successful collaborative networks.
- Assumption of an aggressive role in pursuing alternate funding that includes a designated staff person to focus on special projects.
- The liberty permitted by the Governing Board to be creative in exploring alternate resources.
- The development of the Community Partnership of Central Texas to collect regional data.
- The enlistment of the local university in research and publicity initiatives.

Weaknesses

- The availability of Spanish speaking credentialed staff.
- The availability of a local psychologist
- A 10% Administration budget allocation with increased Departmental and Performance Contract requirements requiring an inordinate amount of administrative duties.
- The costliness of persistent Departmental changes and uncertainties.
- The inability to get concise directives for technical assistance due to transition uncertainties and departmental reorganizations.
- Limited rural and frontier resources to develop effective provider networks.
- State budget deficit reductions

Opportunities

- The challenge to develop an efficient rural provider network of providers.
- Offer meaningful choices to individuals seeking services.
- Opportunity to enhance the expertise of clinical staff providing services.
- Facilitate opportunities to provide more consumer choices in service delivery.
- Local planning processes can, and have, created local collaborative groups to meet the challenges of increased demand and reduced revenues.
- Build a “user friendly” infrastructure for consumers.
- Partner with local communities in meeting individual’s needs.
- Develop community within the organization to enhance staff satisfaction and retention.

Threats

- The State budget deficit and subsequent mandatory reductions
- The challenges related to recruiting qualified service providers who have the capacity to serve rural counties.

- A continuing trend of reductions in general revenue and diminishing Medicaid rates for services delivered.
- A 10% budget allocation for administration expenses while meeting Departmental expectations that will require more administrative responsibilities to develop and maintain the provider of Last Resort system.
- Reductions in bed day funding for state hospitalizations and a hospital UM process that is not sensitive to Center budgets.
- The ability to competitively compensate staff. Staff recruitment and retention are crucial to ensure credible service delivery.

▪ **Service Priorities**

- **Crisis Redesign:** A prevailing priority for the seven county service delivery areas is the availability and accessibility of emergency care, detoxification resources, and crisis intervention services. The focal point of interaction with law enforcement, local judges and the general public appears to be singular in nature. The process to expedite service delivery to the most vulnerable citizens of the communities served is crucial to our role as a community center, responsible for local service delivery. Three initiatives are now in place to support crisis services. The hotline is under contract to AVAIL, Inc., The MCOT concept is functional and effective, and negotiations with an RFP respondent are expected to be finalized in the operation of a Respite Crisis program.
- **Medication Services:** The escalating costs for medications and more specifically the costs of New Generation Medication are directly related to the effectiveness and quality of care available through the Center. Stabilization of the chronically ill, hospital recidivism and community integration are all contingent on available funding for medication services.
- **Case Management:** The transition to a provider network necessitates an assessment of the dynamics of the CM role and how they can most effectively help consumers through the transition. The objectives of required hours, productivity, client care, and employee satisfaction were decisive considerations. All Case Managers are expected to obtain an average of 75 client hours every quarter. New employees will be given 3 months to obtain this standard. If target is not achieved employees will be taken through a five step coaching process. This process will help the Case Manager become successful or it will lead to the demotion of the Case Manager to either part time employment or termination.
- **Local planning and Network Development:** The development and maintenance of a Local Service Area Plan in compliance with The Department of State Health Services (DSHS) Performance Contract. The Plan is written to reflect the Center's compliance with the following newly adopted rules; §§412.751-412.754, §412.756, §412.758, §412.760, §412.762, §412.764, and §412.766, concerning local mental health authorities (LMHAs) and the development of a network of service providers within each LMHA's local service area. March 16, 2007 edition of the *Texas Register* (32 TexReg 1458) These new rules establish the requirements of an LMHA in assembling and maintaining a network of service providers and set forth the conditions under which an LMHA may serve as a provider of services. Therefore, the Plan is designed to develop a Network of Providers that will meet local needs and priorities, allow for more consumer choice, improve access to services, make best use of available funds, and promote consumer, provider, and caregiver partnerships.
- **Rehabilitation:** Medicaid rehabilitation redesign is imperative as service domains are identified and benefit packages are designed to facilitate the Center's UM initiatives. Internal rehab program

service providers are focused on defining service delivery criteria to prevent service duplication and ensure compliance with the Center’s Medicaid Compliance Plan.

- **Flexible Community Supports:** Children requiring access to multiple agencies often are at-risk. The Wraparound process develops individual services and supports that are crucial for children and families experiencing con-going emotional problems. The integration of services and systems eliminates service duplication, reduces costs and prevents unconnected treatment plans.
- **ACT Alternative:** The Center received a waiver from the Texas Department of State Health Services to provide ACT Alternative services. The introduction of the TRAG resulted in the integration of appropriate ACT consumers into an Intensive Case Management (ICM) model, but it was discovered the integrity of the team approach could not be adequately maintained. The program is presently being reconstructed to incorporate essential components of the ACT concept for success.
- **Residential Services:** Individuals in crisis frequently are confronted with transitional housing needs. The Center’s Respite program has attempted to accommodate, as much as possible, some of these needs. A foster care program has provided housing options for some, but the prevailing need continues to be problematic for some consumers. The Center has initiated a program to transition this unique population of consumers from the hospital to Respite and then to the Supportive Independence Program (SIP). Expansion will be predicated on the effectiveness of program design and outcomes.
- **Counseling/Psychotherapy:** The Center has a fully credentialed staff to provide counseling to consumers requiring these services. Salary costs for licensed professionals negatively impacts budgetary considerations requiring an innovative approach to subsidize this expense. The Center has obtained a 501(c) (3) status to pursue alternative possibilities for counseling services.
- **Jail Diversion:** Consistent with House Bill 2292, The Center for Life Resources will identify individuals who are at high risk for criminal justice involvement or who are already involved with the criminal justice system and who have a diagnosis of Schizophrenia or Bi-Polar Disorder and develop jail diversion strategies for these persons.
- **Substance Abuse:** Through funding by TCADA, the Center identifies individuals with co-occurring psychiatric and substance use disorders (COPSD), ascertains available resources, provides referrals for ongoing services as necessary to address the individual’s unmet substance use treatment needs, and aggressively provides Drug Prevention programs to local school districts..

Community Priorities Input

1=High Priority; 2=Medium Priority; 3=Low Priority

NON-PRIORITY POPULATION ADULTS	Community Priorities	Authority Priorities
Public Awareness	1	1
Employment Opportunities	2	2
Jail Diversion	1	2
Substance Abuse	2	1
Housing	2	1
Peer Support	3	3
Family Training	3	2

Transportation	1	2
Respite	3	3

**V. SERVICE PRIORITY GOALS**

**Administrative Efficiency**

Following are just a few examples that demonstrate how services are increased and enhanced through self-organized collaborations, pooled initiatives, in-kind contributions and other local and statewide efforts. These examples describe in real terms what happens when communities share responsibility and become part of the solution.

**To increase access to housing**, the Center, annually, sustains and perpetuates a grant to provide housing for persons with mental impairments. The new HOME Grant in March 08 was \$275,000.00 for a 32 month time frame.

**To increase access to treatment instead of incarceration and improve the interface between the Center and the criminal justice system**, the Center received \$163,840.00 in TCOOMMI funding. Jail diversion and treatment agreements with local jails and other criminal justice entities exist, in conjunction with collaborative arrangements with local law enforcement agencies for alternative care options

**To increase access to medications**, the Center has aggressively used the Patient Assistance Program and established other purchasing mechanisms to reduce the costs of pharmaceuticals. Our Patient Assistance Program in 2007 was \$93,000 and, as of July 2008, \$86,000 for 2008. The active and aggressive utilization of Medication Samples has resulted in a savings of \$360,000.00 in 2008 in the same time period. The Center initiatives generated a total of \$446,000 to meet the increasing client demands of our client base. Because of these efforts, the Center is able to further extend the purchasing power of state general revenue dollars and serve well beyond the target numbers set by the Legislative Budget Board for access to new generation medications.

**To improve access to substance abuse services**, our Center contracts with the Texas Department of State Health Services for treatment and prevention services. The Texas Commission on Drug and Alcohol Abuse has awarded The Center for Life Resources \$330,640.80 to provide treatment services to Adults, Youth, Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) These services have been provided, and expanded since September 1<sup>st</sup>, 2006. The Center received new funding in the amount of \$58,195.00 for Youth Prevention Services in 2008.

**To improve integration of primary health with mental health care**, the Center was instrumental in the relocation of a Federally Qualified Health Center to the city of Brownwood to facilitate the healthcare needs of the population we serve.

**To increase access to services in general**, The Center aggressively pursued Pooled Initiatives and Collaborations:

1. Center-based volunteerism reflects a cost efficiency saving of \$131,186 in FY06-07; \$63,135 in FY07-08; and \$11,189 in FY08-09.

2. Law Enforcement Coalition – a Law Enforcement Coalition was created to generate city and county funding for crisis triage.
3. Medication samples and rebates are pursued and obtained from pharmaceutical suppliers.
4. Continue to resource the local CRCG (Adult Community Resource Coordination Group) to provide networking for unmet needs.
5. A collaborative agreement has been negotiated with the Division for Rehabilitation Services (TRC) for job placement and supported employment services.

**To cut administrative cost and utilize more dollars for client services**, systemic reorganization occurred to create a cost efficient infrastructure.

1. Organization has been flattened and multiple roles for staff members reduced overhead.
  - a. No top/middle management (Single layer management)
  - b. Organizational structure is not tiered
  - c. CEO provides direct supervision to managers
2. Programs and managers operate without support staff. No secretarial positions in the organization.
3. Revised staff training procedures to more quickly place new staff into work roles.
4. All managers are “working managers” and participate in the workload.
5. Ability to pay and subsequent collection process to encourage client responsibility.
6. Clerical staff positions in the out-counties were eliminated to further reduce overhead expenses.
7. Attrition and assumption of multiple work roles reduced costs.
8. Travel and meetings were reduced through representative staff attending.

**To improve alignment of community, State, and Federal resources**, the Center actively participates in a variety of community planning initiatives and submits a comprehensive local plan to the state for the purpose of informing the legislative appropriation request.

These initiatives are all about making it happen in our local community. They demonstrate the realization of a common vision and shared responsibility for addressing the needs of people who require support for significant life challenges. They demonstrate the realization that there is a significant return on the state’s invested dollar and it is generated from the grassroots of our state: local communities.

▪ **Benefit Design Disease Management**

Goal: The Texas Department of State Health Services Benefit Design Assessment Workgroup’s initiative to design a benefit package and financing methodology for public mental health services in the State of Texas provides a model to manage services and ensure continuity in care.

Objective: The Center subscribes to the Benefit Design Disease Management initiative to:

1. Develop a systemic assessment process for measuring mental health service needs based on their principal diagnosis and nine dimensions.
  - a. Risk of Harm
  - b. Support Needs
  - c. Psychiatric-Related Hospitalizations
  - d. Functional Impairment
  - e. Employment Problems
  - f. Housing Instability
  - g. Co-Occurring Substance Use
  - h. Criminal Justice Involvement

- i. Response to Medication Treatment (MDD Only)
2. Continually improve methodologies for quantifying the assessment of service needs to allow reliable recommendations for authorization into the various levels of care or service packages with specified type and amounts of services.

Status: Fully Operational

▪ **Balanced Scorecard**

Goal: The Center subscribes to the Balanced Scorecard Initiative to assess four interacting domains: Financial Perspective, Internal Business Perspective, Customer Perspective and Innovation and Learning Perspective.

Objective:

1. Financial Perspective: How should we look to stakeholders?  
Focus: measures historical financial performance and, when used in context of the other three domains, offers foundation for organizational decision –making critical to continued existence.
2. Internal Business Perspective: What business processes must we excel at?  
Focus: efficient business processes, high productivity, and reasonable costs of service.
3. Customer Perspective: How should we appear to our customers?  
Focus: measures customer satisfaction and the organization’s ability to support the achievement of personal outcomes.
4. Innovation and Learning Perspective: How will we sustain our ability to change and improve?  
Focus: measures diversification of revenue sources, products, and market share and evaluates provider expertise and the organization’s ability to promote and manager change.

Status: Objectives serve as directives and are sustained.

▪ **Regional Infrastructure**

Goal: Build a community infrastructure to create consumer friendly communities. Drastic reductions in revenue will result in a reduction of service opportunities and longer waiting lists. Individuals with chronic mental health implications are especially susceptible to reductions in service opportunities. Optional service opportunities can serve as a preventive measure for those waiting for services.

Objective: The Center is partnering with city and county governments and community collaboratives to obtain grant money that will enhance the quality of life in the community. Grant money will be pursued through cooperative relationships to build a “user friendly” infrastructure. While these projects will serve the community-at-large, consumers will benefit from expanded opportunities.

▪ **Provider of Last Resort - Rural Behavioral Healthcare Model**

Goal: A behavioral healthcare system, if effective, requires a seamless delivery system that is community specific to each community served. The heartbeat of every community must drive the system and a service provider must have the capability to feel the pulse of the communities served.

Objective: This effort requires community discernment and/or input and a discerning sensitivity to all constructive directives. The Center is an integral component of a statewide system that is designed to be driven by local needs and local control. Our role is to motivate, listen, create and initiate a total behavioral system of care for every resident of every age residing in each of the seven counties we serve.

Status: The Center continues efforts to develop in every county a collaborative network of private and public providers to assume a leadership role that will enhance the Center's service objectives.

Implementation/Resource Strategy:

- Continue to facilitate countywide meetings that are inclusive of private and public providers.
- Solicit, compile and cooperate with other agencies to develop a comprehensive service delivery directory in every county.
- Develop a full array of service providers affording options for consumer choice

#### ▪ **Cost Accounting Methodology**

A unique blend of cost accountability, innovative management strategies and administrative reorganization will be implemented to eliminate the costly overhead of unproductive patterns that could inhibit organizational growth.

Goal: To establish a standardized cost accounting methodology, which is consistent with industry norms for the determination of cost, and then it will be possible for The Center to determine the cost of services, which are currently being provided directly, and to then compare that against the marketplace.

Objective: Utilize these budgetary guidelines to purchase cost efficient contracted services from available and interested providers. Decisions will be made based on several factors, cost considerations, quality, best value, and performance history. In order to demonstrate objectivity, it will be imperative that cost finding for services provided by the Center be predicated on the "Provider of Last Resort" criteria. Funding to sustain a needed infrastructure must figure into this equation. The standardized cost methodology will not only provide a means of demonstrating objectivity, but will also provide the Center with a powerful local management tool.

Status: Components of the Cost Methodology

- a. Standard Chart of Expenditure Accounts – The Center has established a standard chart in conjunction with information supplied by the HB 2377 pilot programs.
- b. Standard definitions for MH services – The Center's MIS department has completed the "Mapping" between the Center's software and the standard MH services grid.
- c. Consistent distribution of indirect and program administration costs – The Center has invested in a "pooled" strategy with certain other Centers to develop software "Anasazi". This strategy should result in a consistent distribution of costs.
- d. Consistent/standardized worksheet formats – Respective Departments (DADS/DSHS) have developed worksheet formats for all Centers to report on, thereby maintaining consistency and standardization for all reporting Centers.
- e. Summary reporting to the State Authority – DADS/DSHS requires all reporting Centers to report using the same summaries.

#### **Alternative Funding Resources**

The inevitability of the need for alternative funding resources will be given a priority status. Future planning must include the reality diminishing resources. Recent trends reflect a pattern, not an exception. The Recent State Budget shortfall emphasizes the importance of this initiative. Revenue reductions in service coordination, rehabilitation services and general revenue contributes to the need.

Goal: Continue the Center's focus on grant funding.

Objective:

- a. Continue to obtain grant funding to augment consumer services.
- b. Cooperate with city, county and collaborative groups to obtain grant funding for the community.

Status: The Center actively pursues grant funding. .

▪ **Medicaid Compliance Initiative**

Goal: To further its commitment to compliance and to protect its employees and contract providers, internal or external, The Center places emphasis on its Compliance Plan to address regulatory issues likely to be of most consequence to Center operations.

Objective:

- a. Designation of a Compliance Officer and responsible persons charged with directing the effort to enhance compliance and implement the Compliance Plan.
- b. Incorporation of standards, policies and administrative guidelines directing Center personnel and others involved with operational practices.
- c. Identification of legal issues that may apply to business relationships and methods of conducting business.
- d. Development and implementation of an education program for the Governing Board, clinical staff, administrative staff, advisory committees and contract providers, internal or external, addressing obligations for adherence to applicable compliance requirements.
- e. Implementation of a mechanism for employees and contract providers, internal and external, to raise questions and receive appropriate guidance concerning operational compliance issues.
- f. Development and implementation of an on-going monitoring and assessment process identifying potential risk areas and operational issues requiring further education.
- g. Development and implementation of a process for employees and internal or external contract providers to report possible compliance issues including a process for such reports to be fully and independently reviewed.
- h. Enforcement of standards through documented disciplinary guidelines and policies and training addressing expectations, sanctions and consequences.
- i. Formulation of plans for corrective action to address identified areas of noncompliance.
- j. Coordination with contract providers, internal and external to ensure effective compliance in areas where activities of the Center and internal and external contract providers overlap.
- k. Implementation of regular reviews of the overall compliance requirements efforts of the Center to ensure that operational practices reflect current compliance requirements and address strategic goals for improving Center operations.
- l. An annual exclusion review of every staff member will be conducted at the time of hire and every year thereafter.

Status: Fully operational

**Health Information Portability and Accountability Act**

Goal: The goal is to maintain full and timely compliance with the Health Insurance Portability and Accountability Act of 1996.

Objective: Computer software has been modified to comply with electronic data interchange (EDI) standards. Policies and procedures have been adopted to protect the privacy and security of health information. Policies and Procedures give individuals certain rights with regard to their health information. A written notice (notice of privacy practices) is given to each consumer/consumer describing

how we use and disclose confidential information. Privacy official has been designated to handle complaints and questions regarding our notice of privacy practices. Contracts with business associates will be amended to protect the privacy and security of health information. Job-specific privacy training and security awareness training is provided to all employees. A reporting and response system for privacy and security violations has been established. A sanctions policy for the discipline of privacy and security violations has been adopted for employees, agents, and contractors. A security officer has been designated.

Status: Fully operational

**Cultural Competence**

Needs were identified based on the comprehensive regional assessment and an internal assessment. Service population demographics reflect the scope of need.

Goal: Create a culturally competent services system.

Objective:

- a. Training for staff and Governing Board to enhance cultural sensitivity.
- b. Diverse ethnic representation on the Governing Board.
- c. Consumers will be served in their preferred language.
- d. Culturally competent staffing to meet cultural diversity needs.
- e. Solicit information from individuals in the four minority groups.
- f. Public education and outreach will be targeted to the four minority groups.
- g. Culturally competent practices will be pursued based on solicited input from the four minority groups.
- h. Cultural norms, values, and critical life events will be considered in recovery and rehabilitation concepts. A racial/ethnic will be involved in evaluation and treatment either directly or via supervision or consultation.
- i. Develop a needs assessment template for distribution to diverse populations to identify cultural specific needs.
- j. Conduct a cultural competency assessment of existing providers.
- k. A requirement of all future service providers will be the required Cultural and Linguistic Competency Assessment.
- l. Make cultural sensitivity integral to the RFP process and pursue financial incentives for Spanish speaking staff.

Status: Staff ratio is satisfactory; a responsible Spanish-speaking staff is available to consumers that speak only Spanish. The Center has a Spanish-speaking resource pool consisting of staff recruited from their respective programs on an as needed basis. This arrangement has worked well because the interpreters are knowledgeable of service needs. Future hiring will target this need. The Governing Board does not reflect ethnic diversity. The Board Chairperson is familiar with the need and is committed to a resolution with future appointments.

For Underserved/Underrepresented Racial/Ethnic Groups

Mental Health Services

How many persons of each group	Hispanics	African	Asian / Pacific	Native	White
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		American	Islander	American	
• Live in your service area	16,937	2,640	347	347	78,675
• Live in poverty	3,535	475	62	62	14,162
• Are uninsured	3,387	528	69	69	15,735
• Sought treatment from Community Services	NOT AVAILABLE				
• Received treatment from Community Services	212	73	1	1	1419
• Dropped out of Community Services before treatment is Completed	15	7	0	0	109
- An average of the number of time in treatment (per person)	NOT AVAILABLE				
• Received treatment from restrictive settings (inpatient, residential, and/or involuntary placements)	16	6	0	0	145
- An average of the number of placements in a restrictive care setting (per person)	1	1	0	0	1
- An average of the length of stay for each placement in a restrictive care setting (per person)	71	32	0	0	32
• Received favorable treatment outcomes	198	68	1	1	473

Racial/Ethic Composition of Staff	Hispanics	African American	Asian / Pacific Islander	Native American	White
• Percent of clinical/treatment staff who are:	13	4	0	0	82
• Percent of all staff who are:	6	2	0	0	92

Services for Individuals with Intellectual and Developmental Disabilities

How many persons of each group...	Hispanic	African American	Asian / Pacific Islander	Native American	White
• Live in your service area	16,937	2,640	347	347	78,675
• Live in poverty	3,535	475	62	62	14,162
• Are uninsured	3,387	528	69	69	15,735
• Sought treatment from Community Services	NOT AVAILABLE				
• Received treatment from Community					

Services	76	34	0	1	330
• Dropped out of Community Services before treatment is completed	0	0	0	0	7
- An average of the amount of time in treatment (per person)	NOT AVAILABLE				
• Received treatment from restrictive settings (inpatient, residential, and/or involuntary placements)	0	0	0	0	4
- An average of the number of placements in a restrictive care setting (per person)	0	0	0	0	0
- An average of the length of stay for each placement in a restrictive care setting (per person)	0	0	0	0	30
• Received favorable treatment outcomes	25	17	0	1	110

Racial/Ethnic Composition of staff	Hispanic	African American	Asian / Pacific Islander	Native American	White
• Percent of clinical/treatment staff who are:	6	7	0	0	87
• Percentage of all staff who are	3	4	0	0	93

Cultural Competence of Local Mental Health Service System

*Level of involvement Scale: 0 = Never; 1 = Sometimes; 2 = Routinely; 3 = Every time*

<b>ORGANIZATION</b>	
0	• The composition of the local authority governing board and advisory groups is proportionate to consumers in ethnicity and language.
2	• Culturally competent staff serves consumers who are in one of the four minority groups.
2	• Consumers are served in their preferred language.
3	• Ongoing training and staff development in cultural competence is provided.
2	• Public inputs gathered from individuals in one of the four minority groups.
1	• Public education and outreach is targeted to one of the four minority groups.
0	• Rewards/incentives are provided for utilizing culturally competent practices.
<b>TREATMENT</b>	
3	• Consumer rights and treatment plans are explained in a language and communication style understandable to the consumer
2	• Cultural and demographic factors are addressed in assessment process.
1	• Racial/ethnic Mental Health Specialist are involved in evaluation and treatment either directly or via supervision or consultation.
3	• Services are consumer driven with a strong collaboration between consumers, family members and providers in determining the course of treatment.
2	• Family / cultural strengths such as natural support systems, community organizations

	and religious/spiritual organizations are incorporated into treatment plans.
3	<ul style="list-style-type: none"> <li>• Cultural norms, values, and critical life events are considered in recovery and rehabilitation concepts.</li> </ul>
0	<ul style="list-style-type: none"> <li>• Feedback opportunities in own language to a culturally representative/competent ombudsman are easily accessible.</li> </ul>
<b><u>OUTCOMES</u></b>	
3	<ul style="list-style-type: none"> <li>• Comparable rates of access across overall service population.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Comparable rates of consumer satisfaction across overall service population.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Comparable rates of clinical results/treatment outcomes (including rates of symptom relapse and recidivism into restrictive placements) across overall service population.</li> </ul>

Cultural Competence of Local Service System for:

Individuals with Intellectual and Developmental Disabilities

*Level of involvement Scale: 0 = Never; 1 = Sometimes; 2 = Routinely; 3 = Every time*

<b><u>ORGANIZATION</u></b>	
0	<ul style="list-style-type: none"> <li>• The composition of the local authority governing board and advisory groups is proportionate to consumers in ethnicity and language.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Culturally competent staff serves consumers who are in one of the four minority groups.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Consumers are served in their preferred language.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Ongoing training and staff development in cultural competence is provided.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Public inputs gathered from individuals in one of the four minority groups.</li> </ul>
1	<ul style="list-style-type: none"> <li>• Public education and outreach is targeted to one of the four minority groups.</li> </ul>
0	<ul style="list-style-type: none"> <li>• Rewards/incentives are provided for utilizing culturally competent practices.</li> </ul>
<b><u>TRAINING SERVICES AND SUPPORTS</u></b>	
2	<ul style="list-style-type: none"> <li>• Consumer rights and treatment plans are explained in a language and communication style understandable to the consumer</li> </ul>
2	<ul style="list-style-type: none"> <li>• Cultural and demographic factors are addressed in assessment process.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Racial/ethnic Mental Health Specialist are involved in evaluation and treatment either directly or via supervision or consultation.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Services are consumer driven with a strong collaboration between consumers, family members and providers in determining the course of treatment.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Family / cultural strengths such as natural support systems, community organizations and religious/spiritual organizations are incorporated into treatment plans.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Cultural norms, values, and critical life events are considered in recovery and rehabilitation concepts.</li> </ul>
0	<ul style="list-style-type: none"> <li>• Feedback opportunities in own language to a culturally representative/competent ombudsman are easily accessible.</li> </ul>
<b><u>OUTCOMES</u></b>	
3	<ul style="list-style-type: none"> <li>• Comparable rates of access across overall service population.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Comparable rates of consumer satisfaction across overall service population.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Comparable rates of clinical results/treatment outcomes (including rates of symptom relapse and recidivism into restrictive placements) across overall service population.</li> </ul>

**Psychiatric Inpatient Hospitalization**

### **State Mental Health Facilities**

**Goal:** Utilize the State Hospital as a safety net for individuals experiencing life threatening behavioral episodes.

**Objective:** An MOU with the State Hospital exists to provide intensive inpatient care.

- a. Individuals in life threatening crisis will be admitted to a State Hospital for Stabilization.
- b. At least twice a month, the liaison will make face-to-face contact with hospitalized consumers. The effort will be supported by frequent telephone calls and personal interaction with the hospital social worker to coordinate and plan for the movement and discharge of each hospitalized consumer.
- b. The Center frequently monitors consumers' progress and has active communication with hospital staff and community based service delivery systems.
- c. Frequent telephone contacts are conducted to facilitate monitoring, coordination, and implementation of the consumer's discharge plan.
- d. The Center's mental health facility utilization of state bed days for FY08-FY09 is problematic. The Center received an allocation of \$975,185. Successive years of reduced funding, the equity initiative, the hospitals' policy to use the acute rate for billing, and the increased numbers of individuals requiring hospitalizations are conflicting dynamics. The Center's response has focused attention on utilization management, a clinical concept for respite, staff encouragement to make frequent consumer contacts and use of private hospitals.

### **Local Hospitals**

**Goal:** Continue to contract with available private psychiatric hospitals in the region.

**Objective:** The Center will continue to resource ACADIA Hospital in Abilene, River Crest Hospital, Shannon Medical Center, and San Angelo Medical Center in San Angelo to augment state hospital beds.

**Status:**

- a. The Center has subscribed to best practices to place these providers on our provider panel.
- b. Private hospitals are used to support our inpatient care needs.
- c. The Center frequently monitors consumers' progress and has active communication with hospital staff and community based service delivery systems.
- d. Frequent utilization management contacts are conducted to facilitate monitoring, coordination, and implementation of the consumer's discharge plan.
- e. Projected need for FY08 – FY09 will require that the Center develop local community-based alternatives. Resources are very limited in the rural areas served by the Center. The Center must continue to develop its own community-based resources:
- f. The procurement of contracted services for the Crisis Respite Program will provide appropriate services in an operational 23-hour observation room for consumers in crisis.
- g. A supportive independence program will operate in conjunction with the contracted service.
- h. Continue to pursue grant funding to expand alternative care.
- I. Crisis Redesign Follow-up will be used to monitor, assist, and support the needs of consumers following hospitalization.

### **Medications**

**Goal:** Reduce the Center's pharmaceutical purchasing costs.

**Objective:** Post annually a Request for Proposal for pharmaceutical services to procure best value and to maximize medication efficiencies.

**Status:** Ongoing

Goal: Reduce waste by creating tighter inventory system.

Objective: Link all consumers to the Center's Patient Assistance Program (PAP).

Status: Fully operational

### **MR Outcomes**

Goal: Ensure that quality services are provided to individuals with intellectual and developmental disabilities through personal outcomes.

Objectives:

Maintain a routine internal program chart review by the Service Coordinators to assess quality of care, consumer input, consumer outcomes, and adherence to QAIS principles.

Status: Outcomes are routinely monitored.

### **Crisis Services**

The introduction of MCOT to crisis response assures timely and clinically sound responses to crisis events. The restructuring is more user-friendly, and responsive to all seven rural counties served. Intense routine training and required training of staff are key components in the reconfiguration. Certifications by the American Association of Suicidology strengthened clinical skills, and brought a higher level of competency to staff members in the program.

### **Impact Statement:**

Question: What would be the impact of hospital funds being moved into the community to purchase additional community services?

Response: The Center's response is predicated on the premise that adequate funding is prudent and realistic. Drastic reductions for this fragile population would jeopardize consumer safety and make the Center vulnerable to costly liabilities. With adequate funding, the Center can judiciously develop and purchase community services that will ensure stabilization and community integration. This conclusion is experientially substantiated:

1. Historically, the Center has demonstrated the ability to control bed day usage through alternative programming.
2. The Center has discovered the importance of frequent and timely contacts with individuals that are experiencing behavioral symptoms.
3. The Center has verified the effectiveness of a "23 hour observation" concept.
4. The Center has learned that unlicensed individuals respond well to clinical training from licensed professional staff.
5. The Center has effectively developed a Respite program that focuses on clinical care and community retention.
6. The Center's Supportive Independence Program documented verifiable outcomes with alternative programming. Outcomes following discharge from the SIP program:

Consumer 1: This individual left the SIP program and returned to her parent's home for several months. Her parents then requested assistance to locate a group home facility where the consumer would have a lot of contact with her peers as the parents live out in the country and the consumer felt isolated. A group home was located in Graham Texas. She participates in numerous activities with peers in the community and is doing well. Severe behaviors that impeded her ability to live in community are in remission.

Consumer 2: This gentleman is living independently in an apartment. He is working part-time with the Texas Work Force and managing his finances well. He has had no exacerbation of

symptoms of his illness or crisis incidents since moving into the community. He continues to receive support services approximately two times a month.

Consumer 3: This individual has been living independently in an apartment in the community. She previously had been a consumer who was one of the highest utilizes of rehab and crisis services. She is receiving services approximately four times per month. Additionally she is now working competitively at a manufacturing company in this community.

Consumer 4: This individual was discharged from the SIP program. She is living in an apartment independently and is receiving community rehab services approximately three times a week to assist her through the transition of living on her own. She is now receiving disability benefits and is being assisted with budgeting and paying household expenses for her apartment. She has had no incidents of crisis or exacerbation of symptoms and serious impairments in occupational, psychological and social functioning continue to improve.