



PROVIDER NETWORK DEVELOPMENT PLAN

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

- ◆ Cohort II: July 31, 2010

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

Responses should be concise, concrete, and specific.

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

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

When completing a table, insert additional rows as needed.

Local Service Area

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

Population	796,074
Square miles	6,977
Population density	114
Number of counties (total)	8
◆ Number of urban counties	0
◆ Number of rural counties	8
◆ Number of frontier counties	0

Major populations centers (add additional rows as needed):

Name of City	Name of County	City Population	County Population	County Population Density	County Population Percent of Total
Round Rock	Williamson	104,000	435,355	383	24%
Seguin	Guadalupe	26,394	128,975	181	20%
Bastrop	Bastrop	8,378	81,717	91	10%

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

- ♦ Williamson County (north of Austin Texas) is experiencing a huge population growth and is therefore placing stress and demand on existing public services. Round Rock has no public transportation...and in addition the county continues to have a rural disposition with Hutto, Taylor, Jarrell and Georgetown also within the county city limits.

Provider Availability

1) Provider Recruitment

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

- Issued an RFP for Crisis Respite Services (residential) in 2008 and received two bids. The Wood Group was accepted and on November 2008 BBT opened the San Gabriel Crisis Respite Residential program under contract.
- BBT issued an RFP on July 15, 2009 in an effort to recruit external providers for SP-1 and SP-2 services (entire package including doctor services were requested). Under this Proposal the number of General Revenue clients to be referred for services in Williamson County was 450 for Service Package 1 (21%) and 50 (100%) for Service Package 2. No Bids were received.
- Sent out alert letters on February 11, 2010 to all previously interested providers regarding our current efforts (2010 – 2011) to recruit providers. Interested providers were directed to complete provider inquiry form at the DSHS website (<http://www.dshs.state.tx.us/mhcommunity/LPND/providers.shtm>).
- BBT continues to recruit for discrete services including psychiatric (doctor) services, counseling, and crisis services, on ongoing bases.

2) Provider Availability

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

Provider	Source of Identification	Summary of Follow-up Meeting or Teleconference	Assessment of Provider Availability, Services, and Capacity
Avail Solutions Inc.	DSHS	Met with Janie Harwood in Round Rock Texas for a face to face conversation with the LPND team on June 9, 2010. Avail is currently providing Hotline Services for BBT, they wanted to ensure these services were continued in the future. They also provide MOT services for Andrews Center and Coastal Plains. She has a crisis hotline service in those areas and uses staff associated with the hotline to also provide face to face emergency screening under contract. She is not able to just have dedicated staff waiting for a crisis call, they have to be associated with another after hour service to make this work for her. She would like to consider a hotline service in this area which would enable her to provide face to face emergency screenings for BBT.	Avail will consider MCOT services but only if the service providers could be assigned to other, after hours services, in our area. She is not able to have just dedicated MCOT service providers for our areas, it could not be cost effective without having probably a Hotline System in addition to the MCOT services. She would have to come into our area(s) and hire staff (not contract staff). Avail currently provides our Crisis Hotline services and would like to continue to provide this service.
Excell ...Rise Above the Rest	DSHS Website	Telephone call on June 29 th and June 30 th , 2010. Left messages.	No return calls.
Methodist Health Care Systems of San Antonio	DSHS Website	Telephone Discussion with Liza Jensen on June 30, 2010. Interested in contracting for inpatient beds since SASH / ASH beds are regularly on diversion.	Methodist Hospital would like a contract to provide inpatient psychiatric services for persons from our service areas (Guadalupe and Gonzales Counties). They sometimes have clients from our service area and would like to have a funding source for these beds.

<p>Providence Service Corporation of Texas</p>	<p>DSHS</p>	<p>Telephone conversation with Richard Wallace on April 13, 2010. Providence provides in home counseling for mostly children (60% kids and 40% adults) but also adults. Medicaid rate is very low at \$58 per session but they are able to pay providers \$38,000 to \$40,000 salaries....with low overhead. It has a lot to do with the rate, case rate is interesting. Volume is another issue; it would have to be a good business model for them to be interested. If referrals are not guaranteed it would be tough to put time and effort into an RFP. Has a family preservation services contract with Juvenile Probation in Travis County...family therapy and individual services and can use LPC-I to provide the services.</p>	<p>Providence provides licensed counseling services (in home services). Richard indicated he has no MHMR contracts and was interested in Intensive services if the rate was acceptable. He indicated he would like to bill for services directly than have to take a cut for our billing services...especially if they are CARD services (Counseling is CARD services). Interest in discrete Rehabilitative services for Adults and Children, but would like to review the rate and determine if it would be feasible to provide care in our service areas. Discussed the DSHS training requirements and his concern that this is not reimbursed. No indication of how many clients he could consider for this initiative.</p>
<p>Retrospective Solutions</p>	<p>DSHS Website</p>	<p>Telephone conversation with Victoria Jones on June 14, 2010. She is interested in counseling services. Would like to consider a contract for services.</p>	<p>Provides counseling services to children in the Austin Area and is interesting in contracting for CBT services for both Adult and Children. Referred her to contracts (Kathy Kuehner at BBT) since we are already contracting most of our counseling services.</p>
<p>Telecare Corporation</p>	<p>DSHS Website</p>	<p>Telephone conversation with David Pan on June 30, 2010. He has an extensive history providing intensive MH services in the San Antonio Area. They have current contracts with Molina (HMO) and the Center for Health Care Services along with Harris County. Intensive CM services are their expertise. Prefers caseloads of 1:8 but at times it may be 1:10. He follows the ACT model and is certified by CARF – Rehabilitative Services.</p>	<p>David Pan is interested in contracting for intensive services which may include the medication services as well (bundle all services for SP-3 and SP-4 clients). He would need a service area with at least 100 persons enrolled in Intensive services. He would need</p>

			two or three months to establish his agency in our area.
The Wood Group	DSHS Website	Telephone conversation with Jerry Parker on April 8, 2010. He reviewed his interest in providing Rehabilitative services and his current contracts with multiple MHMR agencies. He has mostly residential services under contract with numerous agencies but does provide rehabilitative services in the valley. He manages a small clinic for Camino Real MHMR but does not provide the doctor services. Not interested in Children or DD services. Starting a new contract / services with Tarrant County which includes the full service package for both GR client and Medicaid clients.	Jerry is interested in Rehabilitative Services...is not interested in the doctor services but rather discrete SP-3 services. He would need at least 50 cases to ensure he is able to be cost effective. Currently Wood Group provide our Crisis Respite Residential Services and would like to continue providing this service for BBT.

Local Planning

Guidelines for Gathering Community Input

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

3) Status of provider availability assessment

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

Yes No

If no, briefly describe the difference. N/A.

4) Community Engagement

In the chart below, show the process used to provide information and solicit input about provider network development from stakeholders. Include specific events as well as activities that take place over a period of time, such as surveys. Note that a variety of communication formats may be used, including telephonic, electronic, and paper. List surveys and similar activities first, including timeframes during which the activities took place, followed by events in date order. Insert additional rows as needed.

Description, Location/Format, and Date or Timeframe	Participating Organizations (List)	Summary of Input Briefly summarize input relating to the network development plan. If the LMHA has identified interested providers, include recommendations for how the LMHA should implement the mandate to develop the provider network.	Number of Individuals		
			Consumers	Families	Other
Mental Health Task Force Committee 4/29/10 @2-4 pm at the BBT conference room in Round Rock, TX	WM County Sheriff's, WM County Jail, WM County Commissioners, WM County Veteran's Services Officer, Austin State Hospital Superintendent, Local Hospital Administrators, FQHC, WM County MOT Unit, WM County Health District and BBT Administrators	The Mental Health Task Force is an ongoing Monthly Meeting where we gather valuable information on the services offered by Bluebonnet Trails and other community providers. The agenda always includes Crisis Respite Unit data and issues, as well as Crisis Intervention Team (CIT) and Mobile Outreach Team (MOT) services and issues. Local hospital administrators provide feedback on how well we respond to crisis issues in the hospital and review related issues to the treatment of persons with MI. Most recently the task force has reviewed the county's Veteran Programs and the Vet Peer Specialist initiatives. The County Veteran's Services Officer attends on a monthly basis. In addition, Valerie Covey has provided insight as a member of the LANAC committee. She has educated the MH Task Force members on the importance of the development of our provider network and the State process to ensure protocols are followed.	0	0	21
Mental Health Task Force Committee 5/27/10 @2-4 pm	WM County Sheriff's, WM County Jail, WM County	The Mental Health Task Force is an ongoing Monthly Meeting where we gather valuable information on the services offered by Bluebonnet Trails and other community providers. The agenda always includes Crisis Respite Unit data and issues, as well as Crisis Intervention Team (CIT) and Mobile Outreach Team (MOT) services and issues. Local	0	0	22

<p>at the BBT conference room in Round Rock, TX</p>	<p>Commissioners, WM County Veteran's Services Officer, Austin State Hospital Superintendent, Local Hospital Administrators, FQHC, WM County MOT Unit, WM County Health District and BBT Administrators</p>	<p>hospital administrators provide feedback on how well we respond to crisis issues in the hospital and review related issues to the treatment of persons with MI. Most recently the task force has reviewed the county's Veteran Programs and the Vet Peer Specialist initiatives. The County Veteran's Services Officer attends on a monthly basis. In addition, Valerie Covey has provided insight as a member of the LANAC committee. She has educated the MH Task Force members on the importance of the development of our provider network and the State process to ensure protocols are followed.</p>			
<p>Mental Health Task Force Committee 6/24/10 @2-4 pm at the BBT conference room in Round Rock, TX</p>	<p>WM County Sheriff's, WM County Jail, WM County Commissioners, WM County Veteran's Services Officer, Austin State Hospital Superintendent, Local Hospital Administrators, FQHC, WM County MOT Unit, WM County Health District and BBT Administrators</p>	<p>The Mental Health Task Force is an ongoing Monthly Meeting where we gather valuable information on the services offered by Bluebonnet Trails and other community providers. The agenda always includes Crisis Respite Unit data and issues, as well as Crisis Intervention Team (CIT) and Mobile Outreach Team (MOT) services and issues. Local hospital administrators provide feedback on how well we respond to crisis issues in the hospital and review related issues to the treatment of persons with MI. Most recently the task force has reviewed the county's Veteran Programs and the Vet Peer Specialist initiatives. The County Veteran's Services Officer attends on a monthly basis. In addition, Valerie Covey has provided insight as a member of the LANAC committee. She has educated the MH Task Force members on the importance of the development of our provider network and the State process to ensure protocols are followed.</p>	<p>0</p>	<p>0</p>	<p>20</p>
<p>Consumer Survey was solicited at all MH Clinics</p>	<p>All consumers who presented at each MH clinic</p>	<p>Surveys distributed to all consumers who entered the MH Clinics during this two week period.</p>	<p>31</p>		

during 7/5/10 thru 7/16/10	during the time frame listed.	<ul style="list-style-type: none"> • The survey results showed of all respondents 45.3% are very satisfied with services, 25% satisfied, 12.5% somewhat satisfied, 7.8% unsatisfied and 9.4% very unsatisfied. • Respondents indicated the important factors Bluebonnet should consider as: 41% experience in providing mental health services was most important, 32.8% the ability of the provider to provide all services in one location, 13.1% cost of services, 8.2% hours of operation and 4.9% cultural/language competence. • The three services that respondents felt should be expanded are counseling for adults, independent housing for persons with mental illness and drug and alcohol treatment. • 60.7% of respondents felt that Crisis Intervention Services provided by Bluebonnet are responsive to community emergencies, 8.2% indicated “no” and 31.1% said the question was “not applicable”. • 59.3% felt that crisis evaluations after the initial call for assistance is timely, 15.3% indicated “no” and 25.4% stated “not applicable”. • 44.3% support diverting persons with mental illness from criminal justice agencies and programs. • In answer to whether they had to wait longer than they thought necessary to receive mental health services, 49.2% indicated “no”, 31.7% indicated “yes” and 19% indicated “not applicable”. <p>Comments included:</p> <ul style="list-style-type: none"> • They have help me come along way I would have to see them be able to grow more so they may help others like they have help me. • Very Good ServicesComforting talking to a Christian Clinician. • I believe that the choosing or hiring of the psychiatric doctor at each clinic is perhaps one of, if not the most important decision that will be made. Sometimes it doesn't seem much thought is put into this decision at all. • Maybe eye exams and dental care. -----No ---- go to canada. • I hate being on time everytime and always having to wait. Babysitters are expensive. • They are doing such good things here! I can't say enough about how wonderful the staff, and doctors have been. They need whatever financial support to help them help more people, and continue what they are doing. • Transportation and Housing. • would like to see more help with to support and stronger guidance. It is not always possible to get this from family. 			
Survey distributed	Family members	Surveys distributed to families during clinic visits and advertised in the local newspapers		6	

<p>to families at MH Clinic and through the local newspaper.</p>	<p>who were present during clinic appointments and those who were reached through the local newspapers.</p>	<p>for feedback.</p> <p>Comments from family members included:</p> <ul style="list-style-type: none"> • help get individuals out of institutions reduce cost of same, last person I took into my home cost over \$7000.00. just in lawyer fees. • I did not know the website was available. 			
<p>Community Stakeholder Survey was distributed by email request. In addition we advertised in local newspapers the survey http link and request for comments.</p>	<p>Private Providers Government Official Interested Citizen Judicial System Law Enforcement</p>	<p>Survey http link (surveymonkey) advertised in all local newspapers and by email to community stakeholders.</p> <p>Comments from Community Stakeholders included:</p> <ul style="list-style-type: none"> • A great job is being done. • Too long between appointments. • Stronger enforcement of OSAR treatment interventions and ongoing follow up with mothers whom have involvement with CPS in Bastrop. Possible to many repeat offenders. Going through the programs but slipping through the crack thus endangering those vulnerbale children again and again. • They should have petty cash assistance for those who have co-payments on medication. • I feel MHMR should have seminars with police, sheriffs. I feel that I would like to help with awareness to these individuals on handling mental ill people. After all we know the do's and don't s we need. I have experienced time and time again our needs are not met, but always overlooked because they don't know what to look for. The police dept and sheriffs are not properly trained. Not all but a significant amount. It's easier to say the person fine, when in reality the person is crying out for help. Lack of not really looking at the facts at hand. Especially a repeated person that's constantly ill and not taking meds. To me what more could you need. Red Flag? Suicide? Then no one knows what happened! It's no one's fault they didn't see the signs. When truly its just protocol they follow. (Unawareness and uneducated.) Help us help them. • Todo esta bein. Todo me qusta como attienden muy buenos doctores muy ambles. • Crisis Service - They helped me. • Keep Going Thank you • The wait time can be improved. I usually spend 2 hrs waiting from seeing doctor to case manager to seeing the lady who hands the meds & appt. • No- No more comment's Thank you. • more doctor time to serve those individuals waiting to see the doctor; more Intake LPHA to see more patients; the Waiting List needs to be removed, those patients are given a false hope of receiving services. • Actual assistance time between crisis call - Law....CIT arriving is too long. 			<p>27</p>

5) PNAC Involvement

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

Date	PNAC Activity and Recommendations
01/05/10	Reviewed update to the LPND Plan requested by DSHS, after the RFP submitted in 2009 did not achieve its intended goal. Update plan indicates no external providers were interested in services offered and alert posted on our website. The PNAC members were not surprised by the lack of response from the private sector. Planning will begin soon for the FY 2010-2011 Plan.
4/13/2010	Reviewed objective of LPND and the process being considered for community input / consumer input. The committee thought it was necessary to follow protocol ensure providers are really available to participate in our network. A lot of variables exist that may deter a provider from joining...such as Medicaid rate and providing for the entire service package (doctor services). Members were optimistic in the expansion of our network and providing Choice to our customers.
7/6/2010	Provider information and provider interviews reviewed with PNAC members. Discussed Choice (entire package choice versus discrete service choice) and whether to proceed with plan to recruit external providers in a single county versus multiple counties (rural and urban-like counties). Recommendations made to consider choice in all counties although our largest county may be more inviting to external providers. We should not limit ourselves to just discrete services on the RFP.

Provider Network Development

6) Contract Expenditures

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

<i>Service Category</i>	<i>Total DSHS Funding and Federal Rehab</i>	<i>External provider contract expenditures 2007</i>	<i>Total DSHS funding and Federal Rehab</i>	<i>External provider contract expenditures 2008</i>	<i>Total DSHS funding and Federal Rehab</i>	<i>External Provider contract expenditures 2009</i>	<i>Total DSHS funding and Federal Rehab 2010*</i>	<i>External provider contract expenditures 2010</i>

	2001*			2008*			2009*			(6 months)		(6 months)	
Adult MH Services	\$8,646,350	\$2,479,588	29%	\$8,406,530	\$2,737,781	33%	\$8,793,470	\$2,528,123	29%	\$3,859,839	\$1,086,238	28%	
Child/Adol MH Services	\$944,399	\$458,671	49%	\$952,649	\$544,208	57%	\$1,085,941	\$538,493	50%	\$678,311	\$193,762	29%	
TOTAL MH Services	\$9,590,749	\$2,938,259	31%	\$9,359,179	\$3,281,989	35%	\$9,879,411	\$3,066,616	31%	\$4,538,150	\$1,280,000	28%	
Breakout of CONTRACTED SERVICES:													
Medication and Labs		\$1,838,560	62.6%		\$2,005,214	61.1%		\$1,558,460	50.8%		\$608,441	47.5%	
Physician Services**		\$572,706	19.5%		\$638,785	19.5%		\$592,913	19.3%		\$282,275	22.1%	
Counselor Services**		\$17,815	0.6%		\$53,476	1.6%		\$83,928	2.7%		\$36,060	2.8%	
Crisis Services		\$239,687	8.2%		\$368,838	11.2%		\$371,933	12.1%		\$178,060	13.9%	
Residential Services		\$188,437	6.4%		\$162,085	4.9%		\$175,641	5.7%		\$0	0.0%	
Other (list):			0.0%			0.0%			0.0%			0.0%	
Intake Services		\$26,900	0.9%		\$5,714	0.2%			0.0%		\$1,050	0.1%	
Respite Services		\$20,649	0.7%		\$15,822	0.5%		\$259,941	8.5%		\$160,790	12.6%	
Family Partner		\$24,000	0.8%		\$16,955	0.5%			0.0%			0.0%	
Nursing Services		\$9,505	0.3%		\$15,100	0.5%		\$23,800	0.8%		\$13,324	1.0%	
TOTAL		\$2,938,259	100%		\$3,281,989	100%		\$3,066,616	100%		\$1,280,000	100%	

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

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

7) FY 2010 Provider Contracts

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

Provider	Service(s)	Provider Type	Dollars Allocated
Darla Absher	♦ Crisis On-call	Individual	\$25,00.00/fiscal year

Darla Absher	◆ CBT	Individual	\$25,000/fiscal year
Maria Alvarez	◆ Crisis On-call	Individual	\$41,790.00/fiscal year
Avail Solutions, Inc.	◆ Crisis On-call	Organization	\$102,000.00/fiscal year
Kathryn Bean	◆ CBT	Individual	\$25,000/fiscal year
Mark E. Bowles	◆ CBT	Individual	\$25,000/fiscal year
Sandra Brady	◆ CBT	Individual	\$25,000/fiscal year
Jon Briery	◆ Counselor (Juvenile Justice population)	Individual	\$25,000.00/fiscal year
Henry Cabrera	◆ CBT	Individual	\$25,000/fiscal year
Keith Caramelli, MD	◆ Psychiatric Services	Individual	\$28,000.00/FY10
Tiffany Collie	◆ Crisis On-call	Individual	\$25,000/fiscal year
Gregory Couger	◆ Crisis On-call	Individual	\$25,000/fiscal year
Sara Cunningham	◆ Crisis On-call	Individual	\$25,0000/fiscal year
Thelma Davis	◆ Nursing	Individual	\$25,000.00/fiscal year
Marissa Engel	◆ CBT	Individual	\$25,000/fiscal year
Patricia Huber	◆ CBT	Individual	\$25,000/fiscal year
Cecilia Jackson-Moore	◆ Crisis On-call	Individual	\$25,00.00/fiscal year
Debra Lawson	◆ CBT	Individual	\$25,000/fiscal year
National Extended Care	◆ Pharmacy Benefits Management	Organization	\$1,010,000/fiscal year
Gregory Paul, MD	◆ Psychiatric Services	Individual	\$191,000/fiscal year
Denise Reynolds	◆ CBT	Individual	\$25,000/fiscal year
Kim Richter	◆ Crisis On-call	Individual	\$25,00.00/fiscal year
Kathryn Van Dusen	◆ CBT	Individual	\$25,000/fiscal year
Barbara Webb	◆ Crisis On-call	Individual	\$25,000/fiscal year
Williamson County MCOT	◆ Mobile Crisis Outreach Team	Organization	\$100,000/fiscal year
The Wood Group	◆ Crisis Respite Unit	Organization	\$334,850.00/fiscal year

Arlene Zwald, APN	◆ Advanced Practice Nurse	Individual	\$136,448.00/fiscal year
East Tx Behav. Health	◆ Pharmaceuticals	Organization	\$165,000/ fiscal year
JSA Health	◆ Telemedicine	Organization	\$75,000 / fiscal year
Vanessa Moore	◆ Psychiatric Services by telemedicine	Individual	\$18,000.00/fiscal year '10
Jose Aguilera	◆ Foster Care	Individual	\$14,600.00/fiscal year
Ricardo Aguirre	Foster Care	Individual	\$14,600.00/fiscal year
Kyle Ahart	Foster Care	Individual	\$14,600.00/fiscal year
Diana Albach	Foster Care	Individual	\$14,600.00/fiscal year
Doris Allen	Foster Care	Individual	\$14,600.00/fiscal year
Kay Baca	Foster Care	Individual	\$14,600.00/fiscal year
Shirley Beaudoin	Foster Care	Individual	\$14,600.00/fiscal year
Sandra Bennett	Foster Care	Individual	\$14,600.00/fiscal year
Monti Brunson	Foster Care	Individual	\$14,600.00/fiscal year
Sandra Carrillo	Foster Care	Individual	\$14,600.00/fiscal year
Ramona Cedillo	Foster Care	Individual	\$14,600.00/fiscal year
Robert Cornett	Foster Care	Individual	\$14,600.00/fiscal year
Helen Delancey	Foster Care	Individual	\$14,600.00/fiscal year
Alberta DeShay	Foster Care	Individual	\$14,600.00/fiscal year
Manuel Escalante	Foster Care	Individual	\$14,600.00/fiscal year
James Estes	Foster Care	Individual	\$14,600.00/fiscal year
Anna Flores	Foster Care	Individual	\$14,600.00/fiscal year
Nancy Flores	Foster Care	Individual	\$14,600.00/fiscal year
Donna Garcie	Foster Care	Individual	\$14,600.00/fiscal year
Lee George	Foster Care	Individual	\$14,600.00/fiscal year
Martha Hernandez	Foster Care	Individual	\$14,600.00/fiscal year

Ronald Hodge	Foster Care	Individual	\$14,600.00/fiscal year
Linda Hollis	Foster Care	Individual	\$14,600.00/fiscal year
Karla Holloway	Foster Care	Individual	\$14,600.00/fiscal year
Catherine Ingalls	Foster Care	Individual	\$14,600.00/fiscal year
Cathey Jackson	Foster Care	Individual	\$14,600.00/fiscal year
Marie Jackson	Foster Care	Individual	\$14,600.00/fiscal year
Stella Ladd	Foster Care	Individual	\$14,600.00/fiscal year
Reba Leming	Foster Care	Individual	\$14,600.00/fiscal year
Amy Limas	Foster Care	Individual	\$14,600.00/fiscal year
Mary Stella Limas	Foster Care	Individual	\$14,600.00/fiscal year
Wanda Littleton	Foster Care	Individual	\$14,600.00/fiscal year
Marco Lopez	Foster Care	Individual	\$14,600.00/fiscal year
Maria Macias	Foster Care	Individual	\$14,600.00/fiscal year
Paul Martinez	Foster Care	Individual	\$14,600.00/fiscal year
Deborah McNiff	Foster Care	Individual	\$14,600.00/fiscal year
Kathy Mika	Foster Care	Individual	\$14,600.00/fiscal year
Rene Minjarez	Foster Care	Individual	\$14,600.00/fiscal year
Betty Jean Mlasko	Foster Care	Individual	\$14,600.00/fiscal year
Patricia Parson	Foster Care	Individual	\$14,600.00/fiscal year
Alice Pavia	Foster Care	Individual	\$14,600.00/fiscal year
Rosa Pickens	Foster Care	Individual	\$14,600.00/fiscal year
Angelica Pruneda	Foster Care	Individual	\$14,600.00/fiscal year
Stephanie Rodriguez	Foster Care	Individual	\$14,600.00/fiscal year
RoseMary Sanchez	Foster Care	Individual	\$14,600.00/fiscal year
Tommy Schurig	Foster Care	Individual	\$14,600.00/fiscal year

Dorothy Scurto	Foster Care	Individual	\$14,600.00/fiscal year
Susan Southard	Foster Care	Individual	\$14,600.00/fiscal year
Shelley Steed	Foster Care	Individual	\$14,600.00/fiscal year
Linda Taft	Foster Care	Individual	\$14,600.00/fiscal year
Susan Taylor	Foster Care	Individual	\$14,600.00/fiscal year
Violanda Villasana	Foster Care	Individual	\$14,600.00/fiscal year
Evetra Williams	Foster Care	Individual	\$14,600.00/fiscal year
Johnny Williams	Foster Care	Individual	\$14,600.00/fiscal year
Elva Zuniga	Foster Care	Individual	\$14,600.00/fiscal year
Simmoni Roper	Care Coordination	Individual	\$13,000.00/fiscal year
Autism Center for Educ.	Certified Behavior Analyst	Organization	\$90.00/hour
Patricia Scott	Certified Behavior Analyst	Individual	\$90.00/hour
Shaping Behavior, LLC	Certified Behavior Analyst	Organization	\$90.00/hour
Amazin Grace Day Hab.	Day Habilitation	Organization	\$15/\$18/\$25/\$38/hour
FE Care	Day Habilitation	Organization	\$15/\$18/\$25/\$38/hour
R.O.A.D. Foundation, Inc	Day Habilitation	Organization	\$15/\$18/\$25/\$38/hour
Carus Dental	Dental Services	Organization	\$1000.00/consumer
Dennis Goehring, DDS	Dental Services	Organization	\$1000.00/consumer
Cindy Manning	Dietician	Individual	\$5,000.00/fiscal year
Reavis Rehab Center	OT/PT/Speech	Organization	\$5,000.00/fiscal year
Tiffany Collins	Pharmacist	Individual	\$5,000.00/fiscal year
Davidson House	Respite Facility	Organization	\$10.00/hour
Kyle Ahart	Respite Services	Individual	\$10.00/hour
Arc of the Capital Area	Respite Services	Organization	\$10.00/hour
Kay Baca	Respite Services	Individual	\$10.00/hour

Shirley Beaudoin	Respite Services	Individual	\$10.00/hour
Monti Brunson	Respite Services	Individual	\$10.00/hour
Bobby Cornett	Respite Services	Individual	\$10.00/hour
Janelle Dolphin	Respite Services	Individual	\$10.00/hour
Beate Donnelly	Respite Services	Individual	\$10.00/hour
Joseph Espinosa	Respite Services	Individual	\$10.00/hour
James Estes	Respite Services	Individual	\$10.00/hour
Vaughn Dell Eubank	Respite Services	Individual	\$10.00/hour
Nancy Flores	Respite Services	Individual	\$10.00/hour
Donna Garcie	Respite Services	Individual	\$10.00/hour
Linda Hollis	Respite Services	Individual	\$10.00/hour
Karla Holloway	Respite Services	Individual	\$10.00/hour
Brenda Hubert	Respite Services	Individual	\$10.00/hour
Catherine Ingalls	Respite Services	Individual	\$10.00/hour
Cathy Jackson	Respite Services	Individual	\$10.00/hour
Reba Leming	Respite Services	Individual	\$10.00/hour
Rebecca Lemons	Respite Services	Individual	\$10.00/hour
Paul Martinez	Respite Services	Individual	\$10.00/hour
Nikka Miller	Respite Services	Individual	\$10.00/hour
Betty Jean Mlasko	Respite Services	Individual	\$10.00/hour
Angelica Pruneda	Respite Services	Individual	\$10.00/hour
Lynn Purcell	Respite Services	Individual	\$10.00/hour
Quality Home Care	Respite Services	Individual	\$10.00/hour
Nissa Ramirez	Respite Services	Individual	\$10.00/hour
Stephanie Rodriguez	Respite Services	Individual	\$10.00/hour

Sharing the Love Health Care, Inc.	Respite Services	Organization	\$10.00/hour
Shelley Steed	Respite Services	Individual	\$10.00/hour
Kimberlee Stephens	Respite Services	Individual	\$10.00/hour
Linda Taft	Respite Services	Individual	\$10.00/hour
Jean Tanksley	Respite Services	Individual	\$10.00/hour
Ashley Travis	Respite Services	Individual	\$10.00/hour
Evettra Williams	Respite Services	Individual	\$10.00/hour
Theresa Williams	Respite Services	Individual	\$10.00/hour
Linda Wilson	Respite Services	Individual	\$10.00/hour
Lisa Coleman	Supported Home Living/Community Support	Individual	\$16.00/hour
Janelle Dolphin	Supported Home Living/Community Support	Individual	\$16.00/hour
Beate Donnelly	Supported Home Living/Community Support	Individual	\$16.00/hour
Barbara Foran	Supported Home Living/Community Support	Individual	\$16.00/hour
Brenda Hubert	Supported Home Living/Community Support	Individual	\$16.00/hour
Cathey Jackson	Supported Home Living/Community Support	Individual	\$16.00/hour
Rebecca Lemons	Supported Home Living/Community Support	Individual	\$16.00/hour
Richard Luna	Supported Home Living/Community Support	Individual	\$16.00/hour
Carolyn Nicholson	Supported Home Living/Community Support	Individual	\$16.00/hour
Mary Jane Perez	Supported Home Living/Community Support	Individual	\$16.00/hour
Perez Diversity	Supported Home Living/Community Support	Organization	\$16.00/hour
Lynn Purcell	Supported Home Living/Community Support	Individual	\$16.00/hour
Sharing the Love Health Care, Inc.	Supported Home Living/Community Support	Organization	\$16.00/hour
Victor Shaw	Supported Home Living/Community Support	Individual	\$16.00/hour
Barbara Smith	Supported Home Living/Community Support	Individual	\$16.00/hour

Shelly Steed	Supported Home Living/Community Support	Individual	\$16.00/hour
Kimberlee Stephens	Supported Home Living/Community Support	Individual	\$16.00/hour
Cynthia Suarez	Supported Home Living/Community Support	Individual	\$16.00/hour
Sullivan Consulting Group	Supported Home Living/Community Support	Organization	\$16.00/hour
Susan Taylor	Supported Home Living/Community Support	Individual	\$16.00/hour
Diana Vara	Supported Home Living/Community Support	Individual	\$16.00/hour
Lisa Villegas	Supported Home Living/Community Support	Individual	\$16.00/hour
Theresa Williams	Supported Home Living/Community Support	Individual	\$16.00/hour
Bruce Wilson	Supported Home Living/Community Support	Individual	\$16.00/hour
Smithville Regional Hospital	Speech Therapy	Organization	\$5,000.00/fiscal year
Richard Luna	Supported Employment	Individual	\$20.00/hour
Sullivan Consulting Group	Supported Employment	Organization	\$25.00/hour
Janelle Dolphin	Supported Employment	Individual	\$20.00/hour
Brenda Hubert	Supported Employment	Individual	\$20.00/hour
Carolyn Nicholson	Supported Employment	Individual	\$20.00/hour
Mary Jane Perez	Supported Employment	Individual	\$20.00/hour
Perez Diversity Social Services	Supported Employment	Organization	\$20.00/hour
Victor Shaw	Supported Employment	Individual	\$20.00/hour
Barbara Smith	Supported Employment	Individual	\$20.00/hour
Susan Taylor	Supported Employment	Individual	\$20.00/hour
Lisa Villegas	Supported Employment	Individual	\$20.00/hour
Bruce Wilson	Supported Employment	Individual	\$20.00/hour
Airport Flash	Transportation	Organization	\$12.00/round trip
CARTS	Transportation	Organization	\$40,000.00/fiscal year

Bilingualistics	Speech Therapy	Organization	\$78.00/session
Meredith Brand	Speech Therapy	Individual	\$65.00/session
Theresa Franzke	Speech Therapy	Individual	\$65.00/session
Lynn Raska	Speech Therapy	Individual	\$75.00/session
Tara Cecil	Occupational Therapy	Individual	\$65.00/session
Annalyn Espiritu	Physical Therapy	Individual	\$65.00/session
Teresa Hanak	Physical Therapy	Individual	\$70.00/session
Kimberly Richardson	Physical Therapy	Individual	\$70.00/session
Dana Zander	Physical Therapy	Individual	\$75.00/session
Sara Rangel	Spanish Translator	Individual	\$35.00/hour
Karen Wang	Chinese Translator	Individual	\$75.00/hour

8) **Current and Planned Network Development**

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

- *Column A: Document current capacity for all service packages, regardless of past or planned contracting. Current service capacity is the average monthly capacity based on service data from FY 2009 and FY 2010 through the most recent closed quarter for services controlled by the DSHS contract. Capacity for service packages is expressed as the number of clients served; use the following DSHS data warehouse report to determine current service capacity: PM Service Target LPND (Enterprise: CA Utilization Mgt: UM Service Delivery: PM Service Target LPND). If projected capacity is significantly different than current capacity, insert a footnote noting the projected capacity.*
- *Column B: State the percent of total capacity contracted to external providers in FY 2009. This is the maximum capacity to be served by external provides according to the terms of the contract.*
- *Column C: Document the percent of capacity served by contractors in FY 2009; this is the actual capacity served by contractors.*
- *Column D: State the current percent of total capacity contracted to external providers for FY 2010. This is the maximum capacity to be served by external provides according to the terms of the contract. .*
- *Column E: Document the percent of capacity served by contractors in the first six months of FY 2010 (September 2009 through February 2010); this is the actual amount paid to external providers during this period. When calculating percentages, use six month figures in both the numerator and denominator.*
- *Columns F and G: If you will be procuring complete service packages in the next biennium, state the percent of current capacity planned for contract in 2011 and in 2012.*
- *Column H: Note the number of available providers based on your provider assessment documented in the previous section.*
- *Column I: Use the following list to identify the number of the applicable condition that justifies the level of service the LMHA will continue to provide internally. Include all conditions that apply. Refer to the Appendix B for complete language as specified in 25 TAC §412.758.*

1. *Willing and qualified providers are not available.*
2. *The external network does not provide minimum levels of consumer choice. Use this condition if only one external provider is interested in contracting with the LMHA, and the LMHA will therefore provide up to 50% of the service. This condition does not justify the LMHA providing more than 50% of services.*
3. *The external network does not provide equivalent access to services. Use this condition if access is the only reason the LMHA will not use all of the available external capacity. Applicability of this condition will probably be made after procurement.*
4. *The external network does not provide sufficient capacity. Use this condition if the LMHA will use all of the available external provider capacity and directly provide only the balance of current capacity.*
5. *Critical infrastructure must be preserved during a period of transition. Use this condition if the LMHA will not use all of the available external provider capacity. Instead, the LMHA plans a phased transition to full utilization of external provider capacity, increasing the volume of contracted services over two or more planning cycles.*
6. *Existing agreements restrict procurement or existing circumstances would result in substantial revenue loss. Use this condition if an external restraint is the controlling factor limiting full use of external provider capacity.*

PAST and CURRENT						PLANNED			
	A	B	C	D	E	F	G	H	I
Service	Current service capacity	Percent of total capacity contracted in FY 2009	Percent total capacity served by contract providers in FY 2009	Percent of total capacity contracted in FY 2010	Percent total capacity served by contract providers in FY 2010 (6 mo)	Percent of total capacity planned for contract in FY 2011	Percent of total capacity planned for contract in FY 2012	Number of available providers	Applicable condition
Adult Service Packages									
Adult RDM SP 1	2,297	0	0	0	0	20%	20%	0	1
Adult RDM SP 2	112	0	0	0	0	100%	100%	0	1
Adult RDM SP 3	478	0	0	0	0	20%	20%	2	1,4
Adult RDM SP 4	31	0	0	0	0	100%	100%	2	1,4
Adult RDM SP 0	101	0	0	0	0	0	0	0	1
Adult RDM SP 5	29	0	0	0	0	0	0	0	1
TOTAL Adult Services	3,049								
Child Service Packages									
Children's RDM SP 1.1	302	0	0	0	0	0	0	0	1
Children's RDM SP 1.2	88	0	0	0	0	0	0	0	1

Children's RDM SP 2.1	0	0	0	0	0	0	0	0	1
Children's RDM SP 2.2	23	0	0	0	0	0	0	0	1
Children's RDM SP 2.3	5	0	0	0	0	0	0	0	1
Children's RDM SP 2.4	2	0	0	0	0	0	0	0	1
Children's RDM SP 4	296	0	0	0	0	100%	100%	0	1
Children's RDM SP 0	11	0	0	0	0	0	0	0	1
Children's RDM SP 5	4	0	0	0	0	0	0	0	1
TOTAL Children's Services	728								

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

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

	PAST and CURRENT					PLANNED			
	A	B	C	D	E	F	G	H	I
DISCRETE ROUTINE SERVICES And CRISIS SERVICES	Units of service delivered in 2009	Percent of total capacity contracted in FY 2009	Percent total capacity served by contract providers in FY 2009	Percent of total capacity contracted in FY 2010	Percent total capacity served by contract providers in FY 2010	Percent of total capacity planned for contract in FY 2011	Percent of total capacity planned for contract in FY 2012	Number of available providers	Applicable Condition
Crisis Hotline (Avail Solutions)	4,159	100%	100%	100%	100%	100%	100%	1	N/A
Crisis Respite Residential Bed days	2,278 (bed days)	100%	100%	100%	100%	100%	100%	1	N/A
Psychiatric/Diagnostic Evaluations	2,594	38.55%	38.55%	34.34%	34.34%	36%	36%	4	N/A
Pharmacological Mgmt	23,257	26.77%	26.77%	25.80%	25.80%	26%	26%	4	N/A
Venipuncture	279	46.95%	46.95%	52.76%	52.76%	50%	50%	1	N/A
CBT Counseling	2,057	87.21%	87.21%	83.42%	83.42%	85%	85%	11	N/A
Crisis Intervention Svc	3,294	47.29%	47.29%	47.65%	47.65%	47%	47%	10	N/A

9) Rationale for LMHA Service Delivery

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

Assuming achievement of the stipulations of: (1) availability of qualified external providers interested in contracting with the center and (2) willingness of external providers able to provide sufficient service volume in a timely manner, the Center intends to achieve full utilization of available external provider capacity by gradually increasing the percentage of service capacity procured over the next three years. If these stipulations hold true, the potential for procurement of 100% of service capacity by external providers may be accomplished by January 1, 2013. As the Center gains experience with our providers, the Center will assess, discuss and consider increasing the percentage of the service capacity to be contracted out based on: (1) demonstrated stable service delivery and (2) willingness and ability of the external provider to accept additional capacity.

Adult Services

- As enrolled adults in need of mental health services make up 80% of the total capacity of mental health services provided through the eight counties served by the Center, the primary goal of the previous planning cycle had been establishing a procurement target for adult services. As the capacity procurement target had not been achieved during the previous planning cycle, the Center will maintain the target for AMH SP1 and SP2 for the FY 2011 planning cycle.
- During the FY 2011 planning cycle, we will broaden our base seeking external providers for AMH SP3 and SP4.
- We will continue to recruit external providers for all adult service packages who are able to demonstrate they may be able to effectively provide the services in each of our eight (8) counties.
- The Center has chosen not to prioritize crisis services for this planning period as the Center currently has 47% of the services provided by external providers.
- As the Center received no notice of interest from external providers for Adult Services during the previous planning cycle—and, therefore, as the Center has no experience resulting from contracting during the initial LPND planning cycle—the Center will continue to ensure the internal provider system in each county remains operational as a safety net while the external network is developed.

Child and Adolescent Services

- This planning cycle will be the first attempt for the Center to recruit external providers for Child and Adolescent services.
- The Center will begin with seeking external providers for CMH SP4 services. At this time, children and adolescents in SP4 make up 40% of the entire CMH capacity for the Center.
- The Center will seek external providers demonstrating capacity to serve persons in SP4 in each of our eight (8) counties.
- If the Center is successful in recruiting external providers for SP4, the next step will be to offer CMH SP1.1, as the Center has a high concentration of persons served (41%) in this package.
- Currently, the Center has external providers responsible for 100% of the discrete counseling services associated with SP1.2 and SP2.3 and is not placing this as a procurement priority for this planning cycle.

- As the Center has no experience resulting from contracting during the initial LPND planning cycle, the Center will not be considering contracting crisis services at this time. In addition, the Center will continue to ensure the internal provider system in each county remains operational as a safety net while the external network is developed.

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

- *N/A*

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

- *At this point BBT has limited information in which to support a conclusion, we will receive additional information on whether the external providers will be willing to provide services in all of our eight (8) county service area. Some providers have indicated they would not be interested in outlying counties but we are not sure until we approach the providers with the RFP. The follow up visits with external providers listed did not ensure capacity was available for all of the counties in our service area. More information will be collected within the next 6 months or after the RFP is published.*

Service	Capacity Needed	External Provider Capacity	Information and Method Used to Determine External Network Capacity
<i>See note above.</i>			

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

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

- N/A

Service	Transition Period	Year of Full Procurement
N/A		

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

- N/A

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

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

- N/A

11) Strategies to Protect Critical Infrastructure

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

- The external provider initiative in the past two years did not lead to a deterioration of our infrastructure. We will continue to monitor this issue and advise DSHS accordingly.

12) Time to Re-establish Lost Service Capacity

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

Service(s)	Time Needed to Re-establish Service Volume
Pharmacological Mgmt and Psychiatric Evaluations	120 days
Skills Training	60 days
MCOT Services	90 days

CBT Counseling	90 days
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Procurement

13) Structure of Procurement(s)

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

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

Date(s)	Method (RFA or RFP)	Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Percent of Clients	Rationale
3/14/2011	RFP	SP-1, 2, 3, 4 (bundled services include doctor, counseling, and skills training services.)	Entire Service Area: Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson Counties	20% to 100% of the service package listed	PNAC members would like persons to have Choice of Providers in all eight (8) counties. BBT will therefore support an RFP which will cover the entire service area in an effort to develop more choice options for persons enrolled in BBT services.

14) Fidelity and Continuity of Care (complete only if discrete services will be procured).

If you plan to procure discrete services (rather than full service packages), describe how you will maintain fidelity and continuity of care in the provider network. The content of this section describes what changes or additions will be made to your standard process to address the additional

fragmentation that can occur when services for a single consumer are provided by multiple contractors, often in multiple locations. Enter NA if you have no interested providers or plan to procure service packages only.

- *Note: BBT has discrete services on contract for psychiatric (doctor) services, counseling and crisis services. We will continue to support these initiatives and COC strategies to ensure continued client care and communication of any concerns.*

15) Enhanced Staff Qualifications

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

Yes No

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

Consumer Choice

16) Single Provider

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

Service to be Provided by a Single Provider	Reason(s) for Limiting Client Choice
Intake (Screening, Pre-admission Assessment)	The Center believes that this is an essential LMHA role to retain these services in order to establish eligibility for services. The Center is also responsible for ensuring that authorized services do not exceed dollars allocated
Case Management Services	CM services will continue to be an essential role for the LMHA to assess the right level of service and monitor recovery of the person receiving services.

17) Choice and Access

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

- Consumer access and choice are critical aspects of expanding the provider network. Consumers expressed their desire for improvements in terms of relationship, access and service quality.
- Minimally, it is expected that individuals who receive services can expect high quality of services and improved access. Through the survey process, public input, meetings, and other opportunities to gather consumer concerns, individuals have expressed a desire to have services closer to home or able to access transportation services (Carts).
- Consumers desire pleasant wait areas with timely appointments and shorter wait for services. If appointments are cancelled for any variety of reasons, consumers want to be assured that they will be rescheduled promptly.
- They would appreciate timely return of telephone calls and assistance in negotiating conflicts with providers and an opportunity to choose a provider, particularly doctors and counselors.
- Consumers expressed the desire to be engaged with providers who are professional, friendly, sensitive and who clearly communicate expectations of care.
- Consumers want someone who believes in their recovery.

18) Diversity

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

- The Center is committed to ensuring that all individuals who receive services have the opportunity to effectively communicate with their service providers. It encourages and works to facilitate the involvement of families and consumers regardless of the language which the consumers speak or their cultural background. The Center recognizes that culture impacts how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and utilize and respond to mental health treatment. While there is an ongoing goal of bringing quality services to consumers and to continuously improving those services through the use of treatment approaches such as evidence-based practices, it is recognized that cultural adaptation must also be utilized to keep the services consistent with the consumer's culture.
- The Center will maintain its position that cultural competency takes place in the mental health service delivery system when cultural issues are acknowledged and addressed at all organizational levels (administration, service delivery and clinician). Requirements that all individuals receiving services will have the opportunity to effectively communicate with their service providers will be included in provider contracts. Bi-lingual staff are recruited and hired for those positions needing that skill whenever possible.

Capacity Development

19) Cost Efficiency

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

- Partnership with ETBHN Network is anticipated to ensure cost savings in Pharmacy Services, Authority Functions and UM functions;
- FQHC partnership in Gonzales, Caldwell and Guadalupe Counties. MH Services / offices will be co-located with the FQHC program in Gonzales, Texas by the end of FY 10. .

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

Start Date	Partner(s)	Functions
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional Utilization Management
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional file sharing
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional medical records conversion
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional pharmacy
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional audio/video teleconferencing
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional Services Authorization (TRAG by LPHA)
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional Credentialing Services for Licensed Professionals
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional Coordination and Partnership in Grant Submissions
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional Public Relations
9/01/2009	ETBHN Network: Eleven MHMR Centers	Regional (shared) Medical Director
3/25/2010	East Texas South Collaborative – Veterans Grant: Eight MHMR Centers	Resource Coordination, Training and Finances
3/25/2010	Center Texas Collaborative – Veterans Grant : Four MHMR Center	Resource Coordination, Training and Finances

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

- BBT is working with Camino Real, CHCS, Gulf Bend, and Tropical Texas MHMR Centers in establishing options for Crisis / Residential and Respite Services including a Unit on the grounds of the San Antonio State Hospital. Planning is continuing at the submission of this Plan. It is expected that this partnership will provide support for persons transitioning out of the State Hospital setting or will ensure persons in the community can receive crisis related services when State Hospital beds are not available.

20) Previous Network Development Efforts

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

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

Procurement (Service, Capacity, Geographic Area)	Results (Providers and Capacity)
Adult Service Package 1 (21%) and Adult Service Package 2 (100%) for Williamson County	No External Providers submitted response to RFP
Benefits Coordination Services from External Provider	Reviewed proposal from Cardon Healthcare Network, Inc. for provision of Benefits Coordination (3 FTEs). Proposal submitted December 2009. It was not financially viable for us to accept this initiative.

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

Comment or Suggestion	LMHA Response
None (2008)	N/A

In bullet format, list specific steps taken over the past two years to develop the LMHA’s internal capacity to develop and manage the external provider network. The scope of activity should be appropriate to the level of interest from external providers.

- BBT attempts to develop our network in 2008 – 2009 did not attract any external providers. Although we were unsuccessful in the recruitment process we will continue to promote our efforts to ensure the best possible network for our service area.
- Discrete services such as crisis, counseling and psychiatric (doctor) services are ongoing recruitment efforts that will continue through-out the planning period and between fiscal years.

- UM processes have been established to manage the increase in our external provider network. As our provider network grows we will ensure that our UM Department is able to handle the increase responsibility.

21) Barriers

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

Barriers	Plans
Shortage of external providers willing to provide the full array of services in our entire service area (8 counties).	Maximize the efficiency of the external network by focusing on procuring providers willing to provide the full array of mental health-related services
Rates not attractive to external providers	Continue supporting legislation and lobbying efforts to improve funding
Transportation restrictions, including increased gas prices and limited public transportation options	Work with public transportation in the community and possibly implement telemedicine services were feasible to reduce provider travel expense
Providers reluctant to meet DSHS contract requirements	Continue to work with DSHS regarding contract requirements and potential to streamline regulations
RDM requirements in training (CBT for example) can be prohibited for external providers to support financially	Accept the expertise of community providers without requirements to receive DSHS CBT training. Support acceptance of other forms of training.

22) Long Term Planning

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

If the LMHA is continuing to provide services in order to protect critical infrastructure, briefly describe your plan for transitioning to full utilization of the service capacity being offered by external providers. Assume that proposed procurement plans are successful and the contractors prove to be

stable providers and meet established performance standards. The plan must include a target date for the transition and measurable objectives for each procurement period.

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

- If BBT is successful in recruiting external providers to our network, we intend on expanding capacity as necessary to ensure Choice of Providers for all counties in our service areas. Success to BBT is defined as first recruiting external providers but also achieving and promoting recovery based thinking, to reduce the symptoms of MI but also to increase independence for the persons enrolled in MH services. Compliance with contract requirements, customer satisfaction, and access to services will also promote success for this initiative. BBT welcomes this relationship and will nurture these providers to ensure our network is competitive and successful in the provision of mental health care.
- BBT believes that the primary focus of behavioral health care planning and organization should lie in the community. The staff of the Center working with the stakeholders, advisory committee members, consumers and families and its board of trustees, has established business practices based on the planning considerations we have identified to prepare for this service model shift. This has allowed the Center to be able to prepare the community, consumers and their families as well as Center staff to the realities of this new environment. The Center must continue to refine our service delivery outcomes and prepare standard measures for service delivery that are consistent, timely and provide quality outcomes for people that meet our community's expectations so that this Center can position itself as having a network of Behavioral Health Care Providers that enhances services and quality of life for consumers within our service areas. Long term strategic planning has historically proven to be of value to this Center. Some of the principles we are keeping in the forefront of our future planning include:
 - Consumers and families are best at determining "what's working." Using consumer input and listening to and taking direction from consumers to determine the measure of our success is part of the foundation of the quality schema.
 - Viewing the wellness of the whole person and connecting physical and behavioral health will contribute to determining the appropriate course of services for individuals in treatment.
 - Viewing the whole person and his or her connection to family and community will build alliances to sustain individuals in treatment and services. When providers are aware of a consumer's housing, employment, social connections, spirituality and educational desires and work in partnership with consumers, providers and the authority, to fulfill those desires, consumers and their families can be better positioned to becoming self sufficient and live productive lives.
 - Center infrastructure (Information technology, UM/QM, Case Management, and Contracts, will be developed during the next phase of the LPND process but will continue to be emphasized as we move closer to a comprehensive external provider network that will ensure quality services to the local MH service system. The financial implication to this Center will be better defined during the 2011 – 2012 planning phase.

The Center will continue to work on access to services and public education of mental health services. We are all aware that stigma plays a large role in preventing individuals from seeking the treatment they need. Stigma is pervasive and, as mentioned in the report of the President’s New Freedom Commission, must be eliminated. The President’s New Freedom Commission on Mental Health sets as Goal 1: “Americans Understand that Mental Health is essential to Overall Health.” In the description that follows this goal, it is stated that, “Improving service for individuals with mental illness will require paying close attention to how mental health care and general medicine care systems work together. While mental health and physical health are clearly connected, the transformed system will provide collaborative care to bridge the gap that now exists.” Our communities must understand that mental health is essential to overall health. To address stigma, we need to carry out a community-based message that is tailored to match cultural, ethnic, gender, age, linguistic, and spiritual practices. These efforts require continually developing partnerships at the community level that will reach sustainability over time. We, as a unified community, want to make recovery a possibility for everyone in need of care.

In addition, Veteran Services will be prioritized during the following planning phase as we develop better ways to reach out to our veterans and encourage evaluation and treatment of PTSD issues. We are in the beginning stages of setting up Veteran Peer to Peer groups to encourage local support networks that can reach out and support those veterans who are experiencing difficulty in their transition back into society. The Operation Resiliency Family (ORF) program will also reach out to family members who are separated from their love ones during deployment or who are experiencing the day to day difficulties of their love ones attempting to transition back into the community. The efforts of BBT will be to ensure gaps in services for Veterans will be addressed and services such as outreach, screening, assessment and referrals (OSAR), along with counseling and crisis services are available to the Veterans living in our service area.

23) Public Comment

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

- Draft LPND Plan was published on the BBT website on July 12, 2010 in support of public comments.
- Copy of LPND Plan submitted to Board of Trustees on July 26, 2010 in support of public comments and approval.
- Distribute notice of draft plan at our local MH Centers directing persons to comment on the LPND plan available on the website.
- Distribute notice of draft plan to Local MH Task Force members.

Implementation

24) Procurement Timeline

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

Date	Key Activities and Milestones
January 14, 2011	Draft procurement document (RFP) posted for public comment (at least 14 days)
March 14, 2011	Publication of final procurement
April 15, 2011	Due date for procurement responses
May 25, 2011	Award date
September 1, 2011	Contract start date

25) Consumer Transition

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

Date or Timeframe	Key Activities and Milestones
June 15, 2011	Date provider list will be posted to website and distributed to consumer and advocacy groups
July – Aug. 2011	Timeframe for hosting provider forums to allow providers to share information with consumers
Sept. 1, 2011	Date to begin offering consumers choice of providers in the new network
Ongoing	Period of time given to consumers to select provider
Sept. – Dec. 2011	Timeframe for transitioning current clients to new providers

Stakeholder Comments on Draft Plan and LMHA Response

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

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

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

Comment	Stakeholder Group(s)	LMHA Response and Rationale
No comments were received.		

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

Appendix A

LPND Potential Interested Provider Contact Steps

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

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

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

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

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

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

Appendix B

25 TAC §412.758 LMHA Provider Status.

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

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