



Helen Farabee Regional MHMR Centers

**LOCAL/QUALITY MANAGEMENT PLAN**

**2006-2007**

**September 1, 2005 through August 31, 2007**

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Submitted by: Ken Andrews  
Chair – Board of Trustees  
Helen Farabee Regional MHMR Centers  
Board of Trustee Review and Approved  
September 7, 2006

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# **VISION – MISSION – PHILOSOPHY**

## **VISION**

The vision of the Helen Farabee Regional MHMR Centers (Center) is to provide a mental health and mental retardation system which will be a partnership of consumers, family members, service providers, and policy makers, working as a team to create options that are responsive to each person's needs and preferences.

## **MISSION**

The mission of the Helen Farabee Regional MHMR Centers is to provide resources, opportunities and supports to enable people with mental illness, mental retardation, or developmental disabilities to live satisfying, responsible and productive lives to the fullest extent of their abilities.

## **PHILOSOPHY**

The Helen Farabee Regional MHMR Centers takes pride in its commitment to the public service and to the support of the people we are privileged to serve; and, value individual worth, quality, integrity, innovation and teamwork throughout our system.

## **PLANNING PROCESS**

Central to assessing current services and planning future services is the Center's ability to receive input related to service needs from consumers, family members, and community stakeholders. Opportunities for such input include:

- Public comment periods during monthly Board of Trustee meetings;
- Formal surveys conducted by the Planning Advisory Committees;
- Regular participation in targeted community focus groups;
- Involvement with local support and advocacy organizations;
- Ongoing input from members of the Planning and Network Advisory Committees; and
- Utilize web-based survey to access public input.

The senior staff (Improvement and Oversight Committee IOC) oversees implementation of system responses, with updates given as necessary during twice-monthly meetings. The Center's local plan is updated using information gathered through various efforts, with primary focus and coordination responsibility being assigned to the Center's Community and Consumer Support and Quality Management Departments.

# LOCAL AUTHORITY GOALS AND OBJECTIVES

## FY 2006 – 2007

In reviewing the goals from the previous Local Plan, the Planning and Network Advisory Committee along with Senior Management Staff determined to keep the goals developed previously with changes being made to some objectives.

**Goal 1: Continue to expand, enhance and more appropriately utilize traditional and non-traditional revenue sources.**

**Status:**

During the first three quarters of this planning period:

- The Montague County Mental Health Mental Retardation Center has moved into a new building.
- The Helen Farabee Regional MHMR Centers (HFRMHMRC) have received \$220,000 in new funding from Texas Department of State Health Services for Adult and Adolescent Outpatient Substance Abuse Services (January, 2006).
- HFRMHMRC has established an Inter-Local Agreement with Pecan Valley MHMR Center to provide Management Information System Support and Billing services (this will help offset administrative costs and potentially bring in \$40,000 to \$60,000 annually in additional revenue).
- HFRMHMRC is involved with the Local Homeless Coalition and are seeking Housing and Urban Development Funds for the homeless;
- As of November, 2005, HFRMHMRC is part of the Magellan's Provider Network; in 2007, we will begin pursuing the provision of Case Management services.

**Original Objectives:**

- 1.1 Continue to advocate for, and maximize usage of traditional funding sources such as state general revenue, Medicaid (to include Mental Retardation Waiver Programs), and local community funding.
- 1.2 Continue to develop greater competencies in pursuing emerging and/or non-traditional funding sources such as Children's Health Insurance Plan, third-party insurance, corporate

employee assistance programs, contract opportunities for other state sources for services closely related to our core focus.

- 1.3 Establish collaborative relationships and/or partnerships with local mental health service providers and related health care entities, such as the Wichita Falls Community HealthCare Center, to enhance services for the mentally ill and mentally retarded population it serves.

**Goal 2: Expand and refine utilization management and outcome measurement process.**

**Status:**

- As a result of the David Lloyd consultation, HFRMHMRC will continue to focus on assessment, treatment-planning, and documentation of medical necessity and refining provider profiling.
- HFRMHMRC will continue to utilize family and consumer satisfaction surveys with follow-ups with individuals/families that have expressed a need or are dissatisfied.

**Original Objectives:**

- 2.1 Continue to develop utilization review and provider profiling processes that focus on both internal and external mental health, and mental retardation service providers.
- 2.2 Continue to develop a system of identifying and tracking unmet or inadequately addressed consumer and family needs.
- 2.3 Consider and implement only those service models that have integrated outcomes into the treatment planning process. Entrée into and discharge from services will be based on outcome measures.

**Changes in Objectives as result of Review:**

- 2.1 Continue to develop utilization review and provider profiling processes that ensure both internal and external mental health, substance abuse and mental retardation service providers comply with fidelity and documentation standards.
- 2.2 Continue to refine a system of identifying and tracking center-wide consumer and family outcomes and experiences with care.

Service delivery systems will be modified as indicated by these outcome measures.

- 2.3 Continue to measure outcomes to service delivery based on each consumer's assessed need and changes in functioning will modify the course of treatment based on these outcomes.

**Goal 3: Expand service options for Child and Adolescent population and families.**

**Status:**

- Fully implemented Family Partnering (September, 2005).
- Actively pursuing a full-time child and adolescent physician
- Adolescent Outpatient Substance Abuse Services (January, 2006)

**Original Objectives:**

- 3.1 Identify and seek opportunities to incorporate respite and crisis resolution models for the mental health population under the age of 18.
- 3.2 Pursue working relationships with community entities to establish children's flexible community supports to address unmet needs of children and the families of children we-serve.

**Changes in Objectives as result of Review:**

- 3.2 Further develop access to substance abuse services for children and adolescents.
- 3.3 Increase the availability and access of competent child and adolescent service providers.
- 3.4 Increase our service array to include psychological testing and assessment based on the individual's need and/or request.
- 3.5 Continue to look at ways to work more collaboratively with the Juvenile Justice system.

**Goal 4: Improve accessibility to existing services and supports.**

**Status:**

- Developed Peer Provider Services (February, 2006).
- Mental Retardation Respite budget was increased in FY 2006.
- HFRMHMRC video conferencing capabilities will be upgraded.

**Original Objectives**

- 4.1 Continue to employ existing and emerging technologies to improve timely accessibility and provision of services, supports and referral information to persons throughout our service region.
- 4.2 Continue to seek new and innovative ways to retain, recruit and build professional competencies of staff, contract providers and volunteers throughout the service region.
- 4.3 Increase funding of Core Respite to MR consumers and their families.

**Changes in Objectives as result of Review:**

- 4.1 Renewed commitment to customer service as evidenced by compliance with payer standards for acute, urgent and routine access to care.
- 4.2 Continue to employ existing and emerging technologies to improve timely accessibility and provision of services, supports and referral information to persons throughout our service region.
- 4.3 Maintain current funding of Core Respite to MR consumers and their families.

**Goal 5: Strengthen the Center’s resource management capabilities and continue to develop collaborative community partnerships.**

**Status:**

- Re-organized by placing Mental Health-Mental Retardation Utilization Management-Quality Management, Mental Health Crisis Services, Jail Diversion, and Continuity of Care under one division (September, 2005).
- Tools were developed to measure compliance with Resiliency and Disease Management
- As a result of the David Lloyd consultation, HFRMHMRC is refining clinical processes, utilization management and performance measures for both Mental Health and Mental Retardation Services.

**Original Objectives:**

- 5.1 Continue to strengthen the planning and evaluation process for the full array of Mental Health and Mental Retardation Services.

- 5.2 Continue to update provider information to ensure consumers and their families have a wide array of service providers and options.
- 5.3 Develop and enhance objective, data driven provider network management tools.
- 5.4 Balance cost efficient business practices with clinically effective service delivery models.
- 5.5 Collaborate with the local Association for Retarded Citizens (ARC) to enhance availability of community support services to the non-waiver persons with mental retardation through the reallocation of available Mental Retardation General Revenue.

**Changes in Objectives as result of Review:**

- 5.1 Continue to strengthen the planning and evaluation process for the full array of Mental Health, Substance Abuse, and Mental Retardation Services.

**Goal 6: Integration of Behavioral Health and Primary Health Care**

- 6.1 Seek permission from the Department of State Health Services to provide basic primary health care as part of the Center's medical service array for priority population adults, adolescents and children who have Medicaid, Medicare and/or other third-party coverage

**Changes in Objectives as result of Review:**

- 6.1 Continue to work with local health care providers on integration opportunities.

## **Future Plan Review**

Recognizing the need for on-going monitoring, the local plan for FY 2006-2007 will be reviewed, with formal revisions made as necessary but not fewer than two times during the two-year plan period.

The reviews will include summary reports of plan requirements and milestones, proposals for new goals or objectives based on community needs, as well as assessments of external regulatory, administrative and fiscal factors impacting the plan and its execution.

Plan reviews will fall under the general auspices of the Improvement Oversight Committee which includes all department directors as well as the first level of program management staff. Goal reviews, data collection and summary reporting will be coordinated by the Community and Consumer Support Department and the Quality Management Department.

# **EXTERNAL - INTERNAL ASSESSMENT**

## **Assessment of External Forces and Internal Process and Outcomes**

Our system of behavioral health care continues to be impacted by major changes occurring on the federal, state and local levels. The on-going restructuring of funding sources such as Medicaid, CHIP (Children's Health Insurance Program), and state general revenue continues to present challenges to ensuring stability of basic services and supports.

The ever changing vision of how public MHMR services are to be structured guides us toward a process that should be more inclusive of, and responsive to, local community needs. However, as resources diminish and demand for services increases, it will become more and more of a challenge to meet local service needs.

Regional demographic and political trends outlined below promise to play major roles in service development and delivery:

### **Growth and Distribution**

2000 Census Bureau data indicates a modest growth rate for the Center's 19 county service-area. Wichita County remains the most urban and densely populated of the counties, representing nearly 43% of our total population base. Wise County has experienced the most dramatic increase in population, representing 16% of the Center's total population base. Given its proximity to the Dallas – Fort Worth metroplex, this population trend is expected to continue in the future and will have a major impact on plans for rural service development

### **Ethnicity**

With one exception, the mix of ethnicities served by the Center matched the overall ethnicity rates reported by the 2000 Census Bureau data for our service territory.

### **Local Funding**

As a result of declining population in many of the counties served by the Center, the tax base is smaller. This, along with agricultural problems (crop quarantines, drought, and higher fuel prices) is likely to have a negative impact on tax revenues. These economic factors, as well as the need to assure that all service sites, regardless of size, meet local, state and federal requirements for safety,

accessibility and privacy (HIPPA), and the reduction in funding levels have forced local sponsors to rethink their ability to sustain the local match necessary to maintain the current array of service sites in their areas. We have consolidated several rural sites and will continue to view this as a possible need in the course of this planning cycle. For those counties with oil reserves, \$70 per barrel has significantly increased their tax base.

**Restructuring of State General Revenue Funding**

Transition from a grant-in-aid funding to a fee-for-service/managed care environment will require a major shift in focus for clinical and administrative functions. As benefits packages are implemented in the fee-for-service environment, the resulting restricted service options will impact advocates, consumers/families and community stakeholders who have been accustomed to greater access to care.

**SWOT (Strengths, Weaknesses, Opportunities and Threats)**

**Analysis**

The SWOT Analysis was utilized to gain insight into the community’s perception of the Center. The survey was sent electronically or via conventional mail to all Center employees, the Board of Trustees, the three advisory committees and was included on the Center’s website. Responses were very encouraging and the results are below:

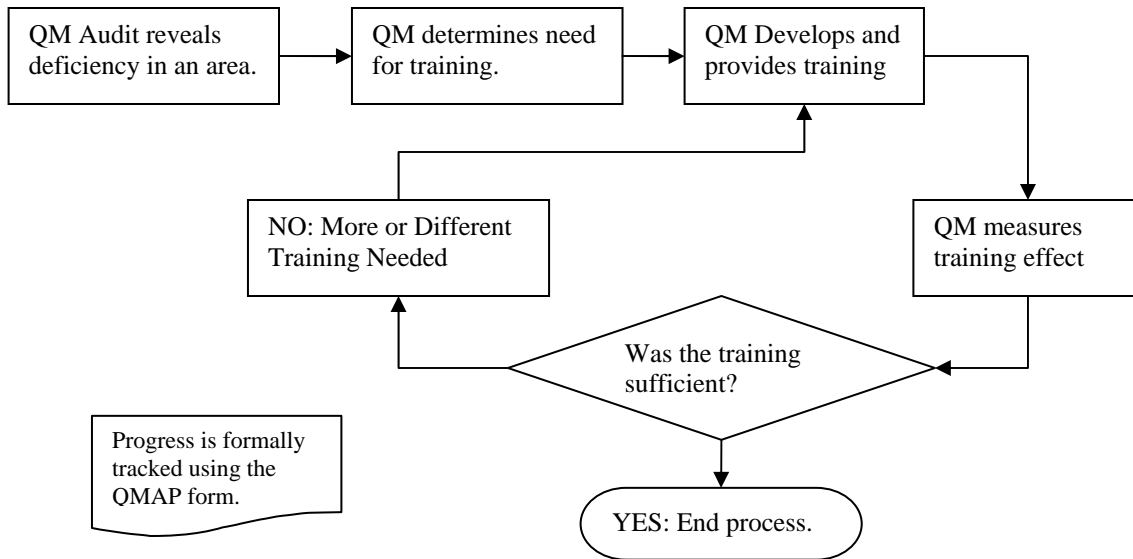
**SWOT ANALYSIS**

<b>Index</b>	<b>Response</b>
Strengths:	With almost unanimous response, the main strength lies in the dedicated and knowledgeable staff
Weaknesses:	Responses indicated the lack of funding to be the greatest weakness.
Opportunities:	Partnering with community entities was felt to be the leading opportunity being presented to the Center at this time.
Threats:	Like the weaknesses, the majority of responses were lack of funding along with government and legislation.

## **Monitoring of External and Internal Processes and Assessments**

It is the responsibility of the Quality Management Department (QM) to measure, assess and improve the accuracy of data from across all Center departments. Continual analysis of internal processes, outcomes, and external forces provides the Center with valuable information that guides the development and redevelopment of Quality Management, service delivery systems, and business practices.

An integral component in improving service delivery and Center practice requires QM oversight in training staff in deficient areas, measuring the effectiveness of that training, and providing objective feedback to the Improvement and Oversight Committee (IOC) as well as to the Board of Trustees (BOT). The QM Department is responsible for developing and/or coordinating training curricula when it has determined there is sufficient need for staff training. The training is designed to improve the following areas defined in more detail below: Local Authority (LA) functions, services provided by the LA, service capacity and access, as well as the accuracy of data reported internally and externally. The extent to which this training has made an impact on staff behavior or business practice is evaluated through additional QM measurement/assessment after training has been provided. QM will initiate a Quality Management Action Plan (QMAP), outlining deficiencies and providing recommendations for improvement and will submit to Program Directors to follow up and complete recommendations within 2 weeks of the noted deficiency. Program Directors will complete the QMAP indicating recommendations have been completed and will submit to QM. QM will reevaluate within 2 weeks to ensure that recommendations resulted in improvement in quality and/or contractual standards. This process continues until the deficiency is corrected and should flow in the following way:



Aggregate results and progress are provided regularly to the IOC and/or BOT for oversight or further recommendations. Each of the following areas is subject to this level of review to ensure that data gathered by QM results in quality improvement and is subject to departmental oversight.

## I. Measuring, Assessing, and Improving Local Authority Functions

- a. Improvement and Oversight Committee: The Improvement Oversight Committee (IOC) consists of all Program Directors and has the ongoing function during twice monthly meetings to review outcomes across the following Center provider and authority functions:
  - i. Adult Mental Health
  - ii. Child Mental Health
  - iii. Utilization Management
  - iv. Quality Management
  - v. Mental Retardation
  - vi. Medical Records
  - vii. Finance
  - viii. Information Systems
  - ix. Clients Rights/Protection
  - x. Human Resources
  - xi. Medical Services

- b. This ongoing IOC review provides the planning environment to monitor progress and identify barriers and to develop strategies for improving organizational and service processes and outcomes. Monthly, quarterly, and annually, items related to QM duties, Center and services processes, and outcomes are summarized and compiled for presentation to the Board of Trustees.
- c. Improving Authority Functions: Deficiencies in any area will indicate QM follow up through the QMAP process detailed on page 15, paragraph 2.

## **II. Measuring, Assessing, and Improving Services Provided by the LA**

- a. Measurement of Symptoms/Functioning:
  - i. QM Staff will monitor MR outcomes/training objectives in the Person Directed Plan as well as functioning scores on Daily Living Assessments (DLA) as a measurement of outcomes. QM tracks whether there is reduction of symptoms/improved functioning and makes recommendations to Program Directors.
  - ii. QM staff will monitor MH outcomes as tracked through functional scores on the TRAG and as recorded in MBOW as well as through the DLA. MH outcome expectations are defined in the performance contract and QM staff may have recommendations on how programs can meet contractual requirements. MH outcome results may indicate the need for a Fidelity Review as requested by DSHS (see “Fidelity Review” IV, b.).
- b. Monitoring Assessed Needs and Treatment Planning
  - i. Monitoring the Mental Retardation Person Directed Plan (PDP): QM will monitor consumer needs as indicated by scores on the Daily Living Assessment (DLA), the ICAP, and the Service Coordination Assessment. The DLA should be completed on all consumers yearly and when updating required plans that are based on assessed functional needs. QM will monitor the completion of these assessments. QM will track how the needs are addressed in the Initial and annually updated PDP’s and how the interventions used correspond to the

recommended service amounts recorded on the Individual Plan of Care (IPC).

1. 10% of PDP's per program (Texas Home Living Waiver Program, Intermediate Care Facility –Mental Retardation, Home and Community-based Services, General Revenue) are sampled each quarter and compared with DLA and IPC data.
- ii. **Monitoring the Mental Health Treatment Plan:** QM will monitor client needs as indicated by scores on the Daily Living Assessment (DLA), the Uniform Assessment and the TRAG LOC-R/LOC-A. The DLA should be completed on all clients quarterly and when updating required treatment plans that are based on assessed functional needs. QM will monitor the completion of these assessments through CMHC reporting. QM will track how identified needs are addressed in the Initial and quarterly treatment plans and how interventions used correspond to the recommended service amounts identified on the individual's Treatment Plan.
- c. **Provider Profiling:** The amount of service provision (quantity) is monitored by QM staff using the productivity standards defined in the job description per service type. Service provision quality will be monitored by QM staff by selecting 25% of MH and MR providers across all programs quarterly. Providers are only selected once a year to ensure all providers are selected and monitored each year by QM staff.
- d. **Consumer Surveys:** QM will develop Helen Farabee Regional Mental Health Mental Retardation Centers internal consumer satisfaction surveys. Surveys will be mailed to a random sample of 10% of active consumers. QM will monitor and evaluate survey responses to identify improvement needs in any area.
- e. **Client Rights Complaints, Consumer Abuse, Neglect, and Exploitation:** The Departments of Risk Management, Consumer Affairs, and Quality Management will conduct a monthly review of all documentation/data related to Client Right's complaints, allegations, and critical incidents. Quality Management will analyze, assess and trend data to identify needs for improvement in

processes/procedure/training. The department of Consumer Affairs will provide a monthly report to the Improvement and Oversight Committee and Executive Director summarizing the review and any need for improvement in processes/procedure/training.

- f. Internal Reviews for Mental Retardation Residential Services: QM Staff review service sites yearly and complete a residential review/checklist to identify deficiencies. Correction plans are provided to service sites to remedy any deficiencies prior to an external review.
- g. Improving Services: Deficiencies in any area will indicate QM follow up through the QMAP process detailed on page 15, paragraph 2.

### **III. Measuring, Analyzing, and Improving Service Capacity and Access**

- a. Mental Health Service Package Capacity: QM staff track service package population through Utilization Management oversight. Package capacity is a function of client count per package, minimum services required for each client in that package, and number of qualified staff available to serve clients in a given package. Other variables may affect this ratio such as geographic location and travel requirements. QM personnel will monitor the objective measures noted above and make capacity decisions based on this data.
- b. Mental Health Waiting List: Waiting list assignment is a Utilization Management function and is ultimately monitored through the QM department. By reviewing waiting list assignments (LOC8) in MBOW monthly, QM staff will ensure that waiting list development and assignments are made according to the criteria set forth in the Utilization Management Program Manual, UM Guidelines, and local Policy and Procedures.
- c. Screening Encounters: QM Staff will monitor the number of monthly MR screenings that occur as well as the time interval from the initial screening (when sufficient paperwork/records have been reviewed) to the next service provision to ensure that access times are within contractually required limits.

- i. Mental Retardation time intervals are monitored by referencing Service Activity Code 49 in CMHC.
  - ii. Mental Health time intervals are monitored via MBOW which tracks the date of assessment compared to the actual provision of service.
- d. Mental Retardation Interest List: QM staff will review the Explanation of Services and Support Form and the Identification of Preferences form and associated screening progress notes to verify screening quality (that consumers were provided options verified by signature). QM will verify through the screening progress notes that consumers who chose the HCS program were then added to the Interest List. CARE reports show clients on the Interest List. QM staff will confirm list status monthly through monitoring Service Activity Codes associated with Interest List activity through CMHC. The CMHC report will show who needs to be contacted yearly in order to confirm interest and identify any issues/needs.
- e. Mental Retardation Waiver Enrollments: QM staff will monitor enrollments into the HCS and TxHmL programs, ensuring that consumers are placed at the frequencies designated in the MR Performance Contract Attachment K (page K-1). Placement is monitored weekly by referencing CARE reports that are submitted to the MRA monthly through Department of Aging and Disabilities Services (DADS) as well as through official notification letters sent from state facilities when an individual is discharged.
- f. Permanency Planning: Service codes associated with Permanency Planning are monitored by QM staff to ensure individuals are contacted initially and at least every 6 months. CARE reports that indicate this contact are also referenced to confirm that required contacts are being made.
- g. MR Caseload/Provider Ratio with Expected Direct Service Hours: Caseload assignments are reviewed monthly through CMHC by QM staff. Assignments are made and maintained according to Service Capacity, a figure which reflects the maximum number of consumers that can be served by one staff assuming the consumer receives the minimum prescribed amount of services per program. Travel

requirements are also considered in determining this figure per service region.

- h. Improving Service Capacity and Access: Deficiencies in any area will indicate QM follow up through the QMAP process detailed on page 15, paragraph 2.

#### **IV. Measuring, Assessing, and Improving Accuracy of Reported Data**

- a. Data Verification: QM Staff participate in required DVC activities scheduled in the Performance Contract including self audits, submitting self audit results and supporting documentation for desk reviews, and participating in DADS or Department of State Health Services (DSHS) on-sight reviews. Based on review findings, QM personnel initiates the QMAP process internally and also develop Plans of Correction addressing any issues. Plans of Correction are submitted to DADS and DSHS for approval according to the Performance Contract.
- b. Resiliency and Disease Management (RDM) Fidelity Review: QM staff will oversee the fidelity self-assessment process with the provider staff (Program Supervisors or Managers) and will utilize data results to guide future program development in order to ensure adherence to evidence-based practices. Fidelity reviews are completed at the frequency indicated by DSHS and completed by the established deadline.
- c. TIMA Auditing: QM personnel, in conjunction with the Center Medical Director, evaluate the use of Texas Implementation of Medication Algorithms (TIMA) through conducting quarterly audits as requested by DSHS. Audit results indicate whether medical staff use mandated forms and if TIMA prescribing practices are in place.
- d. Internal Chart Auditing: Service Coordination contacts are monitored quarterly by QM staff to ensure that contacts occur at the required frequency, that services are justified, and that the appropriate RO codes are opened.
- e. Medical Records: As QM participates in DVC audits, a review of the medical record may indicate changes are needed in document processing, exclusion, or inclusion. QM will make recommendations

to the Medical Record Director in order to meet contractual standards and audit requirements.

- f. Improving Data Accuracy: Deficiencies in any area will indicate QM follow up through the QMAP process detailed on page 15, paragraph two.

# **LOCAL AUTHORITY ASSESSMENT COMPONENTS**

## **History and Organizational Overview**

The Mental Health Mental Retardation Center of Wichita County (MHMRC-WC) was established in September, 1969 through an agreement between Wichita County, the City of Wichita Falls, and the Wichita Falls Independent School District. The school district withdrew their sponsorship in 1974 and the Center was restructured, becoming the Wichita Falls Community Mental Health Mental Retardation Center (WFCMHMRC); the city and county remained as local sponsors. In 1992, the Board of Trustees voted to change the operational name of the agency to “The Helen Farabee Center.”

In September 1996, the Texas Department of Mental Health and Mental Retardation (TDMHMR) created Rolling Plains State-Operated Community Services (RPSOCS) by consolidating existing mental health and mental retardation outreach services in the following North Texas counties: Archer, Baylor, Childress, Clay, Cottle, Dickens, Foard, Hardeman, Haskell, Jack, King, Knox, Montague, Shakelford, Stephens, Stonewall, Throckmorton, Wilbarger, Wise and Young. RPSOCS established their administrative headquarters in Graham, Texas in Young County in 1997.

Through a series of meetings held between July and September 1997, representatives from the City of Wichita Falls, Wichita County and the 19 counties served by RPSOCS reached agreement to consolidate services into a single, regional Center. (Shakelford County sought and gained consolidation with Abilene Regional MHMR Center.) In December 1997, the Board of TDMHMR approved this plan for consolidation, to become effective September 1, 1998, thus paving the way for the 20-county center known as Helen Farabee Regional MHMR Centers (Center). In March 2002, Stephens County also made the decision to move their services to Abilene Regional MHMR Center – Betty Hardwick Center thus reducing the Center to a 19 county service area.

The Center is governed by a nine member volunteer Board of Trustees who is appointed for two year terms by the Center’s sponsors as defined above. Representation comes from across the Center’s service region, and local sponsors make every attempt to maintain a Board that represents a wide ethnic, age and socio-economic base. Board meetings are conducted in different communities,

allowing residents throughout our 19 county service area the opportunity to meet and address the Board with their concerns and suggestions for improved services.

**Current Board Membership**

<b>MEMBER</b>	<b>APPOINTED BY</b>
Bill Coombs, Vice Chair	Archer, Clay and Montague Counties
Shelly Owens	Jack and Wise Counties
Ken Andrews, Chair	Throckmorton and Young Counties
Bobby Smith	Baylor, Haskell and Knox Counties
Judge Bobby McGough	Cottle, Dickens, King and Stonewall Counties
JoAnn Marquart	Childress, Foard, Hardeman and Wilbarger Counties
Sue Nunn, Secretary	Wichita County
Robert Clement	City of Wichita Falls
Michael J. Ezell, Jr.	City of Wichita Falls

The Helen Farabee Regional MHMR Centers continue to provide access to community based treatment and support to persons with severe, persistent forms of mental illness and/or mental retardation or related developmental disabilities that live within a 16,000+ square miles, 19 county service area located in North Central Texas.

**Population Served**

The Center has provided access to services and supports to 2,770 individuals within the priority population defined below:

Adult Mental Health	2,189
Child/Adolescent Mental Health	348
All Ages with Mental Retardation	233

**Priority Population Definitions**

**Mental Health Priority Population**

- Adults who have severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

- Children and adolescents under the age of 18 who have a diagnosis of mental illness or who exhibit severe emotional or social disabilities which are life-threatening or require prolonged intervention.

### **Mental Retardation Priority Population**

Those individuals who meet one or more of the following criteria:

- Have mental retardation as described in THSC §591.003. Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
- Have a pervasive developmental disorder. A severe and pervasive impairment in the developmental areas of reciprocal social interaction skills or communication skills, or the presence of stereotyped behaviors, interests and activities manifested during the developmental period.
- Have a related condition and be eligible for services in a Medicaid program operated by the Center.
- A nursing facility resident, who is eligible for specialized services for mental retardation or a related condition.
- A child who is eligible for early childhood intervention services.

### **Secondary Population Served**

- Persons with behavioral health issues not in the TDMHMR priority population may receive services through the Employee Assistance Program contract with Grassland National Park in Wise County or through full fee payment arrangements, including third party payers.

## **Services and Supports**

### **Mental Health**

Mental Health services are available through nine mental health centers in the 19 county area. Administrative headquarters for mental health services is located within the clinical service location in Wichita Falls at 500 Broad Street.

Director of Mental Health Services: Lynn D. Hartje M.S., LPC

Administrative Assistant: (940) 397-3313  
Tanya Lee  
(940) 397-3312

There are nine mental health centers throughout the entire 19 counties:

Childress County Mental Health Center, 8150 US Hwy. 287, Childress,  
Texas 79201

Hardeman/Foard County Mental Health Center, 510 King St., Quanah,  
Texas 79252

Headstream Memorial Mental Health Center, 1201 N. 1<sup>st</sup> St., Haskell,  
Texas 79521

Montague County Mental Health Center, 605 Decatur, Bowie, Texas  
76230

Seymour-Baylor-Throckmorton Mental Health Center, 301 N.  
Washington, Seymour, Texas 76380

Wichita-Archer-Clay Mental Health Center, 500 Broad St., Wichita Falls,  
Texas 76301

Wilbarger Mental Health Center, 2500 Wilbarger, Vernon, Texas 76384

Wise County Mental Health Center, 407 Park West Court, Decatur,  
Texas 76234

Young County Mental Health Center, 1702 4<sup>th</sup> St., Graham, Texas 76450

The following services are accessible at each of the sites listed above unless otherwise indicated:

- 24-Hour Emergency (Crisis) Services (Staffed by on-call professionals and available through 1-800-621-8504)
- Non-Crisis Assessment Services (Centralized intake, linked to outlying areas via telecommunication equipment.)
- Crisis Resolution Unit (Contracted through the Woods Living Center. Although this unit is located in Wichita Falls, it is accessible to the entire 19-county service area.)
- Medication Related Services (provided either face-to-face or via telemedicine)
- Community Support Services
- Service Coordination
- Psychiatric Rehabilitation Services (Internal and External Contracted through the Woods Living Center.)
- Hospital Liaison Services
- Court Liaison Services
- Respite Services



- NAMI
- North Texas State Hospital
- United Way
- Wichita Falls Community Healthcare Center

## **Resource Development and Allocation**

Funding for the Center comes from three primary sources: Medicaid earned revenue, general revenue funds from TDMHMR, and funds from local sponsoring agencies. With the budget shortfall in the state this biennium, the Center is faced with providing services to the same number of individuals with less money than in the past. We do remain committed to ongoing refinement of all business and clinical practices to ensure maximum utilization of existing funds and engage in activities to increase the number and diversity of resources and funding sources. First priority for allocation of dollars is maintaining the scope and quality of essential and core services for priority population service recipients of the Center service area.

<b>DIVISION</b>	<b>CENTER BUDGET</b>	<b>PROPOSED FY 07</b>	<b>CONTRACT TARGETS</b>
<b>Adult Mental Health</b>	<b>\$ 6,514,600</b>	<b>\$6,700,00</b>	<b>1926</b>
<b>Children's Mental Health</b>	<b>\$ 1,550,000</b>	<b>\$1,600,00</b>	<b>278</b>
<b>Mental Retardation</b>	<b>\$ 3,700,000</b>	<b>\$3,700,00</b>	<b>248</b>

*Indicates revision to Contracted Budget amounts*

The Center has a total budget for FY 07 of \$14,100,000.

## **Community Needs and Priorities**

Based on a survey of consumers, consumer families, service providers and stakeholders that was conducted in 2003, the following was indicated:

- Adult Mental Health Priorities:

- Additional Counseling
- Rehabilitation Services
- Expanded Crisis Services
- Children's Mental Health Priorities:
  - Respite
  - In-Home and Family Support
  - Testing
- Mental Retardation Priorities:
  - Expanded employment opportunities
  - Respite
  - Expanded in-home training.

These surveys were administered through the use of direct mail, person to person, internet, and focus groups.

### **Identified Collaboration with State Facilities**

- Joint Center and North Texas State Hospital (NTSH) Medical Director
- Continuity of Care staff works with state facilities for community placement
- Ongoing discussion and work around the NTSH MOU and utilization management activities
- Shared Training Opportunities with NTSH
- Joint recruiting initiative for physician replacements with NTSH
- Job share with physicians at NTSH
- Joint community education efforts with NTSH

### **Identified Needs from State Facilities**

- Acute stabilization for children and adolescents in the state hospital
- Acute stabilization for adults in the state hospital
- Long-term state school placement for individuals who are too severe or behaviorally inappropriate for successful community placement
- Access to specialized practitioners at state facilities

## **NETWORK DEVELOPMENT**

Helen Farabee Regional MHMR Centers (the Center), as the local authority, will continue the development and maintenance of a network of service providers that allows consumers to have increased options for service providers, increased accessibility of services and continuous quality monitoring.

The FY 2005 Performance Contract between the Center and Texas Department of State Health Services (DSHS) and Texas Department of Aging and Disability Services (DADS) required the Center to submit a “Provider Of Last Resort Plan” that contained a summary of all responses to the Center’s March 2004 RFI as well as a listing of all the services for which the Center planned to contract and timelines for implementation. The Center submitted its “Provider of Last Resort Plan” on December 1, 2004. This Plan stated that the Center anticipated submitting its Local Plan inclusive of the Baseline Provider Network Analysis and the procurement plans. In addition, it stated that the determination of which services will be procured for FY 2006 and the implementation timeline would be contingent upon a variety of factors including: (a) analysis of baseline level of current provider network; (b) incorporating the procurement plans with public input process, including the Local Plan; and (c) obtaining clarification and guidance for the concerns enumerated in the Plan.

However, because of the uncertainty of the “Provider of Last Resort” laws, as well as other pending legislation, the Center submits for consideration in this Local Service Area Plan that any plans or timeline for procurement of client services for FY 2006 be temporarily delayed. This postponement is not sought for merely for delay but instead so that adequate information will be available to both the Center and the relative State Departments as to the responsibilities of Local Authorities in FY 2006 and beyond. As in the past, the Center will continue to respond to the requests of DSHS and DADS and will comply with all legislative, regulatory and contractual requirements—plans and timelines for procurement of client services for FY 2006 are no exception. Additional time, however, will grant the Center the ability to use the important resources of staff and advisory committees to its highest extent and ensure compliance with any and all requirements necessary to fulfill its mission of ensuring that mental health, mental retardation and substance abuse services are provided to the residents of its Local Service Area.

# Attachment I

## Jail and Detention Diversion Action Plan Helen Farabee Regional MHMR Centers FY 2006

Helen Farabee Regional MHMR Center's (HFRMHMRC) jail diversion strategies are in accordance with the Texas Health Safety Code (THSC) §533.0354(d) as added by SB 1182, 78<sup>th</sup> Leg., R.S., and in accordance with THSC §533.108. The plan focuses on jail and detention diversion strategies for both adults and juveniles with serious mental illnesses with serious emotional disturbances served by HFRMHMRC.

### **Goal:**

The goals of the Jail and Detention Diversion Action Plan (JDDAP) are to identify and define the following:

- Identification of “high risk” consumers
- Formalization of the Jail and Detention Diversion Task Force (JDDTF)
- Process for early and ongoing identification of consumers with serious mental illness and serious emotional disturbances in the criminal and juvenile justice systems
- Pre and Post Booking strategies
- Matching of jail and detention records with CARE
- Procedures for referrals from Criminal Justice (CJ) entities
- Protocol for providing crisis screening/assessment adults and juveniles
- Training of staff and Criminal Justice (CJ) entities
- Integration of community resources and state appropriate funds
- Actions, timelines, responsible parties and resources to support the Jail and Detention Diversion Action Plan JDDAP

### **I. Identification of “high risk” consumers:**

HFRMHMRC needs assessment has identified a number of persons at high risk for Criminal Justice (CJ) involvement. Currently, HFRMHMRC is serving approximately 2100 -2200 adults. Of those, approximately 250 currently have or have had criminal justice involvement (probation or parole). Data reveals that HFRMHMRC averages 3 to 7 active patients in the Wichita County jails at any point in time. The actual number of inactive consumers incarcerated at any one

time is likely two to three times that amount, with the majority having a diagnosis of co-occurring substance abuse and targeted psychiatric disorder. In Wichita County, 100+ patients per month have been identified as having had significant interaction with the CJ system. This MIS-derived data is captured from the Uniform Assessment (TRAG). These consumers are considered to be at risk for further involvement with the CJ system. As we move forward with plan implementation, we are collecting data to guide changes and/or enhancements.

The centers' staff has received training in recognizing and providing intervention services to consumers with co-occurring mental illness and drug/alcohol abuse and/or involvement in the Criminal Justice System (CJS). This type of training assists in the identifying the behaviors and symptoms that typically result in interaction with law enforcement entities.

HFRMHMRC participates in another strategy for identification of "high risk" consumers and diversion with Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). HFRMHMRC currently holds one adult probation grant from TCOOMMI in two locations, Wichita County and Jack/Wise Counties. Staff members from both HFRMHMRC and the Community Supervision and Corrections Department (CSCD) share a specialized caseload of offenders with mental illness. The probation office refers an offender to HFRMHMRC, an intake assessment is conducted and the individual is placed into the program for which he/she is eligible and deemed appropriate. The supervision level is determined by CSCD. TCOOMMI caseworkers are required to make four (4) face to face contacts with each consumer every month, unless staffed appropriately with the determination that fewer face-to-face encounters is appropriate. The probation officer and his/her supervisor, the TCOOMMI caseworker and supervisor, the primary psychiatrist, along with HFRMHMRC Mental Health Director meet on a monthly basis to review consumers progress, compliance and treatment plan. The additional contact with the caseworker and probation officer helps prevent any re-offense and/or re-arrest.

## **II. Formalization of the Jail and Detention Diversion Task Force (JDDTF)**

Stakeholder collaboration, coordination and input is pivotal for the success of the Jail and Detention Diversion Action Plan (JDDAP). The Jail and Detention Diversion Task Force (JDDTF) has been formed and are meeting on a regular basis until the diversion process is fully operational and functions appropriately. Upon

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~~† QMHP – Qualified Mental Health Provider – trained at a bachelors degree level with 2 years mental health experience.~~

reaching this goal, the JDDTF meet on a monthly basis. The task force includes persons from the community who meet the following categories: MH service providers, consumers, family members, child and adult advocates, law enforcement, probation and parole departments and the local judiciary. The task force will review the diversion process, barriers, concerns and/or problems. The goal will be to enhance access to services and supports. Enhancements include quick reference tools for police officers to use in managing persons who present with mental illness.

A concentrated 10-member Workgroup originating from the Task Force has been identified to further research the needs and resources in the community. The Workgroup is a culmination of community participation and resources dedicated to developing a jail diversion model that fits the needs of this unique catchment area. The Workgroup currently meets on a monthly basis and is a concentrated, task-oriented, guided effort to identify the needs of the community. The Workgroup focus is as follows:

- Assuring that the peace officer training is occurring and adequate
- Diversion is occurring when the peace officer comes in contact with a mentally ill individual
- Treatment is occurring and in the jail
- Continuity of Care is occurring for individuals once adjudicated
- Identifying community resources to further develop the jail diversion program

### **III. Process for ongoing and early identification of consumers**

HFRMHMRC will use the following pre-booking and post-booking engagement strategies: The Center staff will work with detention authorities to ensure a minimum time frame of 24 business hours for clinical (and CARE) screening and assessment when a consumer is identified by the detention entity. Once the detaining entity has determined that the individual demonstrates symptoms of mental illness or emotional disturbance, a memorandum of understanding will guide service access.

### **IV. Pre and Post Booking Processes**

Diversion and treatment options are dependent on the severity of the offense and psychiatric diagnosis i.e. felony vs. misdemeanor; non-violent vs. violent offenses;

victimless vs. victimization type offenses; number of prior offenses and major mood-disorder vs. major thought disorder.

#### 1. Pre-Booking Process:

Center staff, law enforcement, Adult Probation, juvenile justice staff, and other first responders will be trained in the essential elements of this diversion plan. Case managers are required to evidence competency regarding identification and treatment options for individuals who have co-occurring psychiatric and substance abuse disorders. Additionally, the Center provides all case managers with initial and annual training that ensures competency in all of the areas related to their job requirements, including crisis assessments and interventions.

#### 2. Post Booking Process - County Jails:

Helen Farabee Regional MHMR Centers has Memoranda of Understanding (MOU) with the county jails, for both adults and juvenile detainees. In accordance with jail standards and the Texas Juvenile Probation Commission, all detainees are screened for mental illness, suicidal ideation or mental retardation, regardless of any known or unknown history. These MOUs require the jail and juvenile detention center staff to complete a standardized screening form on all detainees who exhibit any signs or symptoms related to mental illness. The local MOUs are updated to include any new requirements. Adult and juvenile offenders taken into custody are assessed at admission by trained staff. The instrument used is called the Mental Disability/Suicide Intake Screening Form for adults, and/or the MAYSI (Massachusetts Assessment Youth Screening Instrument) for children. Both assessment tools consist of structured interviews. The Mental Disability/Suicide Intake Screening Form is divided into three categories:

- Questions that address mental status
- Questions that pertain to the observations of medical staff or mental health officers
- Questions that are related to suicide (i.e. depression, thoughts, attempts or any other recent event that may lead to suicide)

Based on the screening results a determination is made regarding the level of risk that the detainee presents. If the detainee is determined to be a high risk, the jail or detention center staff will contact the Center for additional evaluation. The Center will respond in one of two ways, depending on the circumstances

- HFRMHMRC provides a face-to-face evaluation to determine if the detainee meets the requirements for psychiatric services
- If the detainee is found to be in need of services, HFRMHMRC is able to provide a psychiatric assessment via telemedicine or the individual may be brought into the Center for evaluation by the jail or detention facility staff. Note: Transportation is the responsibility of the facility in which the person is in custody.

Once identified, immediate intervention by the Center is provided to ensure placement in the most appropriate, therapeutic treatment setting. The available treatment alternatives include hospitalization for those individuals who are presenting an imminent danger to themselves or others due to their psychiatric symptoms and who cannot be safely maintained in a custodial setting. If they are not presenting an imminent danger to themselves or others, they will either receive an:

- intake appointment (if they are not currently a consumer)
- appointment with their service coordinator (if currently a consumer) or
- appointment with the psychiatrist for an evaluation.

The Center continues to provide psychiatric and medication related services to incarcerated consumers who have a case assignment open with the Center. In addition, initial psychiatric evaluations, including the prescribing of psychiatric medication, are provided to incarcerated non-consumers.

## **V. Care Database Screening:**

HFRMHMRC has developed a process for identification of persons previously treated for a mental illness who are booked into local detention facilities. These individuals are screened for priority population criteria and/or for prior treatment as evidenced by prior inclusion in the Department of State Health Services CARE database.

### **Access During and After Business Hours:**

On a daily basis, during regular business hours, the detaining entity contacts (by phone or electronic transmission) HFRMHMRC Jail Diversion Staff member with demographic information sufficient to identify current or prior treatment. After hours, holidays and weekends, CARE access will be accessed through the Crisis-on-call paging system. Back-up supervisors will have laptop connectivity to

CARE system 24-7. The level of clinical acuity or opportunity to divert an individual prior to booking process will determine whether a batch process is conducted or an immediate individual query response is provided.

### Technical Screening Process:

Web-based interface process requires the following data elements:

- Field entries:
  - Legal Name
  - Date of birth
  - Social Security Number if known
  - Gender
  - Race
  
- Database construction
  - Field entry by CJ entity
  - Store data for batch process
  - Batch processed
  - CARE screening conducted
  - Match indicated
  - Report generated
  - Report submitted to CJ entity
  
- Batch Option
  - CJ entity submits an electronic file to HFRMHMRC
  - At designated time of day, data is “batched” to CARE for overnight processing
  - Next morning, HFRMHMRC staff receive report from CARE process and submits matches to CJ entity

Currently, two county jails in the catchment area are not actively participating in the identification of persons previously treated for a mental illness who are booked into local detention facilities. A concentrated effort by HFRMHMRC is being undertaken to gain participation.

## **VI. Procedures for Receiving Referrals from Criminal Justice Entities**

HFRMHMRC has developed a centralized process for receiving CJ referrals. The local police, sheriff and jail staff members are provided contact information for Helen Farabee Regional MHMR Centers. Included in the process are memoranda

of understanding between the center and each county in our catchment area that guide the referral protocol. During regular business hours, the referral is received by any operator or receptionist at HFRMHMRC. That staff member notifies the Crisis Services director or designee. After regular business hours the calls are received by our after hours contractor who refers the caller to an on-call caseworker for screening and determination of service access. Video conferencing is also available during business hours and allows mental health professionals to evaluate the mental health needs of detained individuals.

**Texas Youth Commission (TYC) Referrals:** If a child/youth incarcerated by the Texas Youth Commission has a mental illness or emotional disturbance and is pending discharge, the parent(s)/Legally Authorized Representative(s) (LAR) are provided the option of accessing services at Helen Farabee Regional MHMR Centers or obtaining their own private psychiatrist. If the LAR wishes for their child to receive Center services, TYC staff will contact Helen Farabee Regional MHMR with prescreening information and the release date via phone facsimile. Staff will review the information and contact TYC and/or the LAR to arrange the intake appointment.

## **VII. Protocol for Providing Crisis Screening/Assessment Adults and Juveniles**

HFRMHMRC is responsible for the provision of appropriate care for our communities' most severely and persistently mentally ill. A primary objective is to provide care in the least restrictive and most clinically appropriate environment. Decisions, including out- and in-patient options, are made using best practices-based clinical guidelines and consideration for our fiscal responsibility to efficiently manage state taxpayer dollars.

**Organization of CIS:** The Crisis Intervention Services (CIS) Unit is staffed by three full-time QMHPs, supported by a full-time secretary. The unit is under the supervision by a Qualified Mental Health Professional Program Manager. During business hours, two QMHP's are available to make assessments in the community when requested by community stakeholders. After hours Crisis Intervention Services are coordinated by this office.

**After Hours Staffing:** A primary on-call clinician is available after business hours for intervention and jail diversion services and assessments. A back-up clinician is available when the primary clinician is involved with another crisis intervention. Administrator back-up is available, as well as access to an on-call psychiatrist. A

licensed professional provides direct supervision for these clinicians. Each of these clinicians has received intensive intervention training.

How to contact the center for services: The CIS unit may be contacted by calling (940) 397-3395 during business hours or calling the crisis hotline number 1-800-621-8504, which is answered 24 hours a day. The answering staff member will then page the crisis-on-call clinician. Note: In the event the 800 number is down, services may be accessed by calling (940) 766-3877.

### **VIII. Training of Staff and Criminal Justice (CJ) entities**

Upon request, HFRMHMRC program managers provide training on jail diversion and mental health-related topics to area law enforcement officers. A one-day in-service has been established to address all aspects of the interface between the criminal justice system and individuals with mental illness or symptoms of mental illness. This has been expanded to MHA presence to the Police Training Academies.

The Director of Crisis Services participates with the local police department in the police academy mental health training curriculum. The Center continues to work with local detention systems to further develop enhancements to the diversion process as opportunities emerge. For example, center staff is present and participate in new officer training and annual update training for the local police department academy. It includes the following elements:

- early identification
- how to handle crisis calls/situation to include de-escalation of the individual
- linking the caller with HFRMHMRC on-call crisis staff.
- access the mental health system
- diagnostic presentation of individuals with mental illness or mental retardation

### **IX. Integration of community resources and state appropriate funds**

A combination of General Revenue and TCOOMMI funds are utilized to plan and implement our jail diversion strategies and plan. Community resources are provided by criminal justice stakeholders in the form of collaborative memoranda of understanding and task force participation.

**X. Jail and Detention Diversion Action Plan (JDDAP) Actions, Timelines, Responsible Parties**

What	Due Date	Status	Responsible Party(s)
CARE system 24-7	August 2005	Operational	Director of MIS and Center Staff
Law Enforcement Training	January, 2006	Operational	Director of MH Services Director of Crisis Services
Management of Jail and Detention Diversion Action Plan (JDDAP).	July, 2005	Operational	Director of MH Services and Director of Crisis Services

**Attachment 2**  
**Helen Farabee Regional MHMR Centers**  
**Provider of Last Resort**  
**Procurement Plan FY'05**

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VII. Attachment B

A. RFI Summary

**I. Background**

The 78th Legislative Regular Session had profound effects on the mental health, mental retardation and chemical dependency service delivery system throughout Texas. Specifically, the amendment of Texas Health & Safety Code §533.035(e)<sup>2</sup> required a Local MHMR Authority (LA) to assemble a network of service providers in which the LA may only serve as a provider of last resort. The LA is considered the provider of last resort if it can demonstrate that it has made every attempt to solicit an available and appropriate provider base and there is no willing provider available in the local service area or county of need.

However, the new requirements of Sec. 533.035(e) must be followed in conjunction with the requirements contained in Sec. 533.035(c). This means that the “potential providers” would ultimately be assembled into a network by the LA through consideration of public input, ultimate cost-benefit, and client care issues to ensure consumer choice and the best use of public money.

To that end, in March 2004, a Request for Information (RFI) process was developed and initiated as a means of determining interest in a comprehensive treatment network for people with mental illness and mental retardation. Respondents were asked to provide information on various service packages and include any topics or questions the respondent or any other interested parties believes important to address in any future Request For Proposal (RFP). The RFI document included a geographic description of the local service areas, thus giving the respondents an

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<sup>2</sup> a.k.a. HB2292, Sec. 2.74 (2003)

opportunity to indicate the preference to serve the entire local service area or a portion thereof. The RFI document also included the verbatim service descriptions from LA's FY 2004 TDMHMR Performance Contract, Attachment IX-Exhibits A, B, and C. Respondents were given an opportunity to express interest in providing the entire service package or individual services within the package. See Attachment A., below, which includes a list of services presently being contracted by Helen Farabee Regional MHMR Centers, and Attachment B., below, which is the RFI Summary.

After reviewing the RFI responses, comments and questions, Helen Farabee Regional MHMR Centers, the designated Local MHMR Authority for the Local Service Area specified in its FY 2005 Performance Contract, now submits its FY 2005 Procurement Plan.

## **II. Notification: Local Authority Designation and Provider Status**

This Provider of Last Resort Procurement Plan is submitted as required in Attachment VIII.; section VI.I of the FY 2005 Performance Contract between Helen Farabee Regional MHMR Centers and the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS). Submission of this Provider of Last Resort Procurement Plan is conditioned upon the express understanding that nothing contained in this Plan shall be construed to limit Helen Farabee Regional MHMR Centers' ability to act as a provider of the services described in Attachment A, now or at any time in the future, nor shall it be construed to limit Helen Farabee Regional MHMR Centers' ability to act as Local Mental Health Authority and/or Local Mental Retardation Authority for its Local Service Area, now or at any time in the future.

## **III. Goals of Procurement Process**

1. Provide the basis for negotiation of timelines between Helen Farabee Regional MHMR Centers and TDMHMR in accordance the December 9, 2003 memo from TDMHMR Commissioner, Karen Hale and the FY 2005 Performance Contract;
2. Coordinate the Procurement Plan with the FY 2005 Performance Contract required Local Plan due June 1, 2005;
3. Comply with *Guidelines for Local Service Area Planning*;
4. Optimize the availability of providers in Helen Farabee Regional MHMR Centers' Local Service Area;
5. Ensure compliance to the relevant statutory, regulatory, and contractual requirements including Texas Health and Safety Code Chapters 533 and 534, 25 TAC Chapter 412 Subchapter B, 40 TAC Chapter 2 Subchapter B, Medicaid rules, and TDMHMR Performance Contract requirements; and
6. Seek participation of Helen Farabee Regional MHMR Centers' Board of Trustees, advisory committee members and other stakeholders to consider public input, ultimate cost-benefit, and client care issues thus ensuring consumer choice and the best use of public money.

## **IV. Current and Future Areas of Concerns**

1. Ambiguity/Uncertainty of Texas' new service delivery system;
2. Uncertainty of the role of Local Authorities in the future;
3. Medicaid concerns, including applicability of rehabilitation requirements (including under-arrangement agreements), administrative claiming, and service coordination /case management mandates;
4. Funding instability and uncertainty, including consideration that rates of service have not been adequately determined for all services which have the potential for procurement;
5. Potential Department of Labor / IRS concerns caused by the degree of control required to be exercised by the LA over the potential contract providers; and
6. Inconsistent requirements of present and future relevant statutory, regulatory, and contractual requirements enumerated in Health and Safety Code Chapters 533 and 534, 25 TAC Chapter 412 Subchapter B, Medicaid rules, and Performance Contract requirements.

**V. Determination of Services to be Procured and Implementation Timeline**

The determination of which services will be procured for FY06 and the implementation timeline will be contingent upon a variety of factors including:

- Analysis of Baseline level of current provider network;
- Analysis of availability and capability of RFI respondents to provide services in our local areas;
- Incorporating the Procurement Plan with Public input process including the LA's Local Plan; and
- Obtaining clarification and guidance for the concerns enumerated in Section IV., above.

Helen Farabee Regional MHMR Centers will submit its Local Plan inclusive of the Baseline Provider Network Analysis and the FY 2005 Procurement Plan.

**I. Attachment A**

- A. List of Services Provided and Contracted by Helen Farabee Regional MHMR Centers

<b>Helen Farabee Regional MHMR Centers-Provider Services and Helen Farabee Regional MHMR Centers-Contracted Services</b>		
<b>MENTAL RETARDATION SERVICES</b>		
<b>Service</b>	<b>Provider</b>	<b>Procurement Information</b>
Community Support	Supported Home Living: Sandra Sue Boyd Tomye Christian Shirley S. Pate	Procured via Open Enrollment
Respite	Seven Oaks Nursing Home Damian Deon Jackson Tomye Christian	Procured via Open Enrollment
Employment Assistance and Supported Employment	HFRMHMRC	Open Enrollment may be Utilized for FY'06

		Pending Local Planning process
Vocational Training	HFRMHMRC	Open Enrollment may be Utilized for FY'06 Pending Local Planning process
Day Habilitation	American Habilitation Services Alternate Business Services Daybreak Community Services HFRMHMRC	Procured via Open Enrollment
Nursing	Gwendolyn K. Rogers	Procured via Open Enrollment
Behavioral Support	Counselor: Denise Ann Matysek	Procured via Open Enrollment
Specialized Therapies	<i>Audiology:</i> Clinics of North Texas Head & Neck Surgical Hearing Health Care <i>Dietician:</i> Pannalu R. Reddy Sherrel J. Mulvaney <i>Podiatry:</i> Ben W. Lam <i>OT/PT/ST:</i> North Texas Rehabilitation <i>Sign Language Interpreter:</i> Goodrich Center for the Deaf Big Country Services for the Deaf & Hard of Hearing Susan Cornell	Procured via Open Enrollment
GR Residential Services	N/A	
Other MR Services	Foster Care: Charlene Hawkins Dorothy Honea Shirley Pate Dorothy Morgan Margueritte Gray Darlene Wise Mineola Schenk Cherry Dunkel Sandra McGary Stephanie Marsh Carrie Andree Gardner Dianna M. Morris John & Sandra Leonce Willie Bernice Baker	Procured via Open Enrollment

<b>MENTAL HEALTH SERVICES</b>		
<b>Service</b>	<b>Provider</b>	<b>Procurement Information</b>
Crisis Services—crisis counseling, psychiatric consultation, crisis respite	HFRMHMRC  TWG Investments, LTD	Open Enrollment may be Utilized for FY06 Pending Local Planning Process Sole Source
MH Crisis Services—Inpatient Hospitalization	North Texas State Hospital	Sole Source
Pharmacological Management Services	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Routine Case Management	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Rehabilitative Services	HFRMHMRC  TWG Investments, LTD	Open Enrollment may be Utilized for FY06 Pending Local Planning Process Sole Source – Quanah
Supported Employment	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Rehabilitative Counseling and Therapy	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Medical Support	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Skills Training—Child and Parent	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Multisystemic Therapy	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Family Psychoeducation	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning

		process
Case Coordination	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Counseling	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Family Partner	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Intensive Case Management	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Medication Management	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Psychiatric Evaluation	HFRMHMRC	Open Enrollment may be Utilized for FY06 Pending Local Planning process
Treatment Foster Care	N/A	
Other MH Services—	Pharmacy Services: Pharmacy Health Care Network  Laboratory Services: Laboratory Corporation of America	Request for Proposal  Sole Source

## **B. Baseline Level of Network Development Activities**

### **1. Legal and Contractual Requirements for Network Development**

Texas Health & Safety Code §533.035(c) requires that Helen Farabee Regional MHMR Centers consider public input, ultimate cost-benefit, and client care issues to ensure consumer choice and the best use of public money in: (1) assembling a network of service providers; and (2) making recommendations relating to the most appropriate and available treatment alternatives for individuals in need of mental health or mental retardation services. In addition, the Performance Contract has required that each Local Authority have a process for objectively evaluating services on a routine basis. These requirements represent only a few of the various measures that Helen Farabee Regional MHMR Centers' Senior Management Team and Board of Trustees that

any problems identified are properly understood and addressed and that Helen Farabee Regional MHMR Centers' provider network has sufficient capacity and quality of services to serve the communities of its Local Service Area.

## **2. Ensuring Public Input, Cost Benefit, and Client Care in Network Development**

The challenge for Helen Farabee Regional MHMR Centers has been to successfully engage its local community in planning for, assembling, and managing the performance of a network of providers which offers the greatest value in the provision of services and supports for people with mental illness or mental retardation in a manner which reflects the highest integrity and stewardship over public resources. Helen Farabee Regional MHMR Centers must analyze its provider network to ensure that it has the capacity to provide its consumers with access to a full range of services. This capacity can best be understood by using various Network Development Analysis Tools, described below, to examine the strengths and weaknesses of the current provider system. The objective is to identify gaps in services and to solicit input from consumers, family members, and other stakeholders, in compliance with the statutory and contractual requirements stated above. This approach has provided the information necessary to analyze Helen Farabee Regional MHMR Centers' provider network while building a provider base that supports the goals of the Helen Farabee Regional MHMR Centers in many ways.

## **3. Network Development Analysis Tools**

Examples of Network Development Analysis Tools that Helen Farabee Regional MHMR Centers has utilized to ensure consideration of public input, cost benefit and client care include:

1. Planning and Network Advisory Committee;
2. Consumer Satisfaction & Outcome Surveys;
3. Analysis of Cost and Provider Service Data; and
4. Service Needs Surveys

## **4. FY 05 Provider Network Development Assessment and Implementation Timeline**

In the past, the tools and processes described above have assisted Helen Farabee Regional MHMR Centers in determining whether to provide a particular service or to contract that service out. More importantly now, however, in light of the changes brought by the "Provider of Last Resort" amendment of THSC §533.035(e), these processes will continue to assist Helen Farabee Regional MHMR Centers by ensuring the ongoing requirement of considering public input, ultimate cost benefit, and client care issues in assembling its network of providers. It is anticipated that Helen Farabee Regional MHMR Centers will incorporate these tools and processes into its Local Plan, which will be completed by June 1, 2005, as per FY 2005 Contract, Attachment XVIII, Page XVIII-3. After June 1, 2005, the determination of which services will be procured for FY 2006, if any, and the timelines for implementation of procurement, will be contingent upon a variety of factors. These factors include (1) consideration of the information received through Helen Farabee Regional MHMR Centers' public input process; (2) analysis of provider interest, such as responses to the RFI process; and (3) examination of provider capacity, as may be evidenced by RFI Respondents' existing services and activities in Helen Farabee Regional MHMR Centers' Local Service Area. By recognizing these factors, Helen Farabee Regional MHMR Centers will ensure that the goal of the Local Planning process—to aggregate the requirements of all of customers, internal, external and ultimate, into a set of initiatives which guide Helen Farabee Regional MHMR Centers' resource allocation and priorities, taking into

account fiduciary responsibility as well as excellence of care—is met while ensuring compliance with all relevant statutory and regulatory requirements as well.

## **II. Attachment B**

### A. RFI Summary

Attached is the **RFI Summary** Helen Farabee Regional MHMR Centers submitted to TDMHMR, that lists all respondents to the RFI Document.

**Attachment 3**  
**Helen Farabee Regional MHMR Centers**

**Plan to Reducing Confirmed Incidents of Client Abuse, Neglect and Exploitation**

1. All new employees, full-time, part-time, and PRN, who are hired to provide direct consumer care will not provide services until they have received new employee orientation, and tested on human rights, abuse, neglect, and exploitation.
2. All employees of the HFRMHMRC are mandated to attend annual refresher training through our Staff Development Department. Records are maintained electronically and manually in the Staff Development Department.
3. The Human Resources/Staff Development will follow policies and procedures to assure that new employees receive new employee orientation prior to beginning work assignments.
4. The Staff Development Department will continue notifying new employees and his/her supervisor of the date of new employee orientation training.
5. The Staff Development Department will continue to notify employees and their supervisors of annual refresher training dates and other scheduled/required training through memos and postings on the public folders in our automated system.
6. The Center will continue to provide verbal review (in the appropriate language) of consumer rights for persons with mental illness and/or mental retardation to ensure that those individuals receiving Center services understand their rights as a consumer of Center services. There is a form that staff and consumer sign annually that they have gone over the rights handbook. This form is placed in the consumers chart.
7. The Center has two Human Rights Committees which meet monthly. The Committees are located in Graham and Wichita Falls. The committees consist of community individuals, consumers, family members, staff, and the Director of Client Rights & Protection chairs both committees. Minutes are recorded and kept in the Client Rights & Protection Department.
8. The Human Resource Department will continue to implement criminal background checks on all candidates for employment via the Texas Department of Public Safety. The Human Resource Department will search the employee misconduct registry and nurses aid registry maintained by the Texas Department of Human Services. **The Client Rights & Protection Department will continue to implement employee history checks for abuse/neglect using the statewide CANRS reporting system.**
9. Risk Management and Client Rights & Protection will continue to work together to identify critical indicators as incident reports are received. Risk Management receives incident reports and refers them to the Client Rights & Protection Department for review and possible follow-up.
10. Following receipt of investigative reports provided by the local TDPRS Office, the Director of Client Rights & Protection reviews the case and then refers it to the Executive Director for final approval. This allows the Director of Client Rights & Protection to review the case for determining if the case needs to be sent back to TDPRS for review of finding.

11. All staff and consumers are directed to phone the Department of Protective and Regulatory Services Hotline even when unsure if abuse, neglect or exploitation has occurred. Even when cases have been unconfirmed or unfounded, the Center is taking the recommendations that are provided by the TDPRS and taking corrective action when needed (training, in-service, etc.).
12. The Director of Client Rights & Protection or Executive Director is available to TDPRS 24 hours per day, to respond to the immediate needs of the investigator. Any allegation made against staff results in said staff being reassigned until the investigation has been completed. If the finding is confirmed a meeting is set up with the employee, HR Director and Executive Director to give the employee a chance to tell their side of the story. If the ED sides with the employee the report is sent back to TDPRS with a review of findings attached along with an explanation of why we as an agency want the review.
13. The Client rights & Protection Department conducts training at sites with staff and consumers. The Client Rights Officers picture is posted along with the rights handbooks in English and Spanish. How and who to contact for abuse and neglect is also posted at each site.
14. The Texas Department of Protective and Regulatory Services investigate allegations between consumer and staff. The Client Rights & Protection Department in the Center investigates consumer to consumer.
15. In addition to these proactive procedures used to reduce the potential for abuse, neglect, and exploitation, our Quality Management department reviews monthly, the total number of allegations and confirmed cases, for trending of increases/decreases per site/program/staff. If there are any concerns they are taken to the Executive Director.

## Attachment 4 TIMA Report & Results 2004

### I. Overview

As required by the TDMHMR FY 2004 Performance Contract the Quality Management Department of Helen Farabee Regional MHMR Centers completed a TIMA study to monitor for implementation and trends with the mandated system.

### II. Procedures

The sample drawn for review was not a completely random selection. It was determined that the sample needed to have one required element of equity across the three diagnostic categories. A sample of 59 cases was reviewed across all 9 Mental Health Clinic sites. The following tables offer a breakdown per diagnostic category and the resulting physician caseload distribution of the drawn sample. The process utilized a review of the Medical Progress Note section and the most recent doctor's session documentation.

Diagnostic Categories	# Cases Reviewed
Bipolar	19
Schizophrenia/Schizoaffective	20
Major Depressive Disorder	20
<b>Total Cases Reviewed</b>	<b>59</b>

Doctor I.D.	# Cases Reviewed
1617	4
3001	15
3202	18
3547 (Relief)	1
3617	11
3630 (ANP)	10
<b>Total Cases Reviewed</b>	<b>59</b>

### III. Data Reviewed

The following 7 items were reviewed:

- Correct TIMA form utilized
- Patient Global Self Report
- Clinical Rating Scales
- Bi-Polar Disorder Symptoms
- Overall Side Effect Severity

## Overall Functioning Staging

If the most recent Doctor's visit was not documented on a TIMA form this resulted in all items receiving a negative response.

### IV. Results

In comparison to the study completed in FY 2003 there were more items reviewed and a new scoring system was implemented. There were two items indicated in the last review that can be compared:

- 1) In 2003 only 61% of the doctor's sessions were documented with the TIMA required form/elements, in this study 96.6% of the sessions were documented on the required TIMA form.
- 2) In 2003 only 29% of the TIMA documentation included the required staging, in this study 94.7% of the TIMA documentation indicated staging information.

An average of 80% compliance was achieved across the sample when utilizing a scoring system of expected positive responses required and actual positive responses achieved. The "Clinical Rating Scales" consistently received a negative response as this section of the TIMA documentation was left blank. If this item were removed from the scored criteria a 92% compliance would have been achieved.

### V. Current Plan of Improvement

- 1) Summary, caseload, and line item scoring will be reviewed with the Mental Health Director and Medical Director to identify system problems and staff training needs to address the areas of negative trending.
- 2) Follow up review will be completed at least annually.

## Attachment 5 Local Service Area Plan - Information Supplement

### I Community Participation

For each table below, state the number of people who have participated since the last planning cycle in each of the information gathering methods.

#### MENTAL HEALTH SERVICES

Community Participants	<u>Information Gathering Methods</u>			
	Focus Group	Public Hearing	Survey	Other
• Consumers		5		
• Family members		7		
• Advocacy organizations	26	3		
• Interested citizens	74	3		
• Other State Agencies	57	10		
• Local Governance	78	3		
• Other <u>PNAC</u>	5	10		

#### MENTAL RETARDATION SERVICES

Community Participants	<u>Information Gathering Methods</u>			
	Focus Group	Public Hearing	Survey	Other
• Consumers				
• Family members		2		
• Advocacy organizations		2		
• Interested citizens	48			
• Other State Agencies	24			21
• Local Governance	36			
• Other <u>Community Centers</u>				77

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

Provide a “Yes” or “No” response for each item below.

<b>PNAC Information Items</b>	<b>Yes</b>	<b>No</b>
Local Authority (LA) has a PNAC	X	
The LA participates in a regional PNAC		X
50% or more of the PNAC membership are consumers or family members of consumers	X	
The PNAC membership includes family members of children or adolescents.		X
All PNAC members receive initial and on-going training	X	
The LA ensures conflicts of interest are avoided in performing the responsibilities of the PNAC	X	
The PNAC has established outcomes	X	
The PNAC receives information necessary to achieve expected outcomes	X	
The PNAC meets the reporting requirement	X	

## III. Planning Considerations

Provide a “Yes” or “No” response for each item below.

<b>In developing the Local Service Area Plan, the LA gave consideration to:</b>	<b>Yes</b>	<b>No</b>
Criteria for assuring accountability for, cost-effectiveness of, and relative value of service delivery options	X	
Goals to minimize the need for state hospital and community hospital care.	X	
Goals to ensure a consumer with mental retardation is placed in the least restrictive environment appropriate to the person’s care.	X	
Opportunities for innovation to ensure that the Local Authority is communicating to all potential and incoming consumers about the availability of services of state schools for persons with mental retardation in the local service area of the Local Authority.	X	
Goals to divert consumers of services from the criminal justice system	X	

Goals to ensure that a child with mental illness remains with the child's parent or guardian as appropriate to the child's care.	X	
Opportunities for innovation in services and service deliver.	X	