BURKE CENTER
PROVIDER NETWORK DEVELOPMENT PLAN 2012

Complete and submit in Word format (do not PDF) to performance.contracts@dshs.state.tx.us no later than October 1, 2012.

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 2010 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	387,078
Square miles	10,393
Population density	37
Number of counties (total)	12
◆ **Number of urban counties**	0
◆ **Number of rural counties**	12
◆ **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
Lufkin	Angelina	32709	85,116	99	22%
Nacogdoches	Nacogdoches	29914	64,297	66	17%

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.

- Public transportation is limited or non-existent.
- 10 of 12 counties exceed state average for number of individuals living below the poverty level; remaining two counties are at state average.
- Federally designated Medically Underserved Area, and not only is there a shortage of behavioral health providers, in most areas there are shortages of other providers, including pediatricians, family practitioners and dentists.
- Technology infrastructure is lacking in many counties in our service area thus rendering communication avenues limited.

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 2010 planning cycle.

- Prescriber recruitment through Burke Center and statewide internet postings.
- Request for bids on crisis hotlines.
- Open enrollment for inpatient hospitalization services.
- Contact with providers who have expressed interest in the past, and those who posted on the DSHS website.

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 crisis hotline	Known to be an accredited hotline provider	Sent RFP, declined to bid because could not meet requirements	
Tarrant County	Known to be	Sent RFP, declined to bid	

MHMR crisis hotline	an accredited hotline provider		
Harris County MHMR crisis hotline	Known to be an accredited hotline provider	Submitted bid	
The Wood Group	DSHS website – this planning cycle	None this cycle; sent RFP in 2010 but they declined to bid.	Interest expressed in providing services packages and discrete services for adults, as well as crisis services. In conversation with Jerry Parker, he indicated they are not interested in responding to the proposed RFP as the volumes to be procured were not feasible at this time.
National Smart Healthcare Inc	DSHS website last planning cycle	None this cycle, submitted bid last planning cycle but it was invalid.	

Local Planning

- ***You are NOT required to solicit additional community input before drafting your 2012 plan update. You are required to solicit community input after your plan update is drafted through the public comment process.***
- *You may solicit additional community input if you believe it will be beneficial in drafting your update. If you do, conduct the provider assessment before engaging stakeholders so the input you receive is relevant to the options you have.*
- *Only include input that is specific to the network development plan.*

3) Status of provider availability assessment for 2012 Update N/A

Complete this section only if you solicited community input before drafting your 2012 update.
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.

4) <u>Community Engagement for the 2012 Plan (If applicable)</u>

If you chose to solicit community input before drafting your 2012 update, provide the following information. 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. If input is received from individuals, identify how many consumers, family members, and other individuals participated.

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**		
			Consumer	**Family**	**Other**

5) PNAC Involvement for the 2012 Update (Required for all plan updates)

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 update and review of the draft plan update. Briefly document the activity and the committee's recommendations.

Date	PNAC Activity and Recommendations
9/24/12	

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 2012 data, provide information from the first six months of the year (September 2119 through February 2012).

SERVICE CATEGORY	Total DSHS funding and Federal Rehab 2009*	External provider contract expenditures 2009		Total DSHS funding and Federal Rehab 2010*	External provider contract expenditures 2010		Total DSHS funding and Federal Rehab 2011*	External provider contract expenditures 2011		Projected DSHS funding and Federal Rehab 2012* (6 months x 2)	Projected external provider contract expenditures 2012 (6 months x 2)	
		Dollars	%		Dollars	%		Dollars	%		Dollars	%
Adult MH Services	$7,201,931	$2,020,886	28%	$6,419,609	$2,174,171	34%	$6,406,875	$2,142,987	33%	$6,525,711	$2,207,127	34%
Child/Adol MH Services	$1,198,598	$999	0%	$895,812	$2,047	0%	$924,776	$1,570	0%	$807,334	$900	0%
TOTAL MH Services	$8,400,529	$2,021,885	24%	$7,315,421	$2,176,218	30%	$7,331,651	$2,144,557	29%	$7,333,045	$2,208,027	30%
Breakout of CONTRACTED SERVICES:												
Medication and Labs		$1,127,327	56%		$1,057,478	49%		$1,133,842	53%		$1,319,270	60%
Physician Services**		$628,892	31%		$908,479	42%		$850,345	40%		$772,932	35%
Counselor Services**		$0	0%		$2,032	0%		$1,570	0%		$785	0%
Crisis Services		$37,760	2%		$41,600	2%		$48,000	2%		$42,240	2%
Residential Services		$0	0%			0%			0%			0%
Inpatient Services		$213,963	11%		$166,000	8%		$110,800	5%		$72,800	3%
Other (list):			0%			0%			0%			0%
nursing Servcies		$13,943	1%		$629	0%			0%			0%
			0%			0%			0%			0%
TOTAL		$2,021,885	100%		$2,176,218	100%		$2,144,557	100%		$2,208,027	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 2012 Contracts in the table below. In the Provider Type column, specify whether the provider is an organization or an individual practitioner. If you have a lengthy list, you may submit it as an attachment using the same format.

Provider	Service(s)	Provider Type	Dollars Allocated
JSA	◆ Emergency Psychiatric Services	Organization	$480,000

James Buckingham MD	◆ Psychiatric Medication Services	Individual	$60,000
Bahadur Sarkari, MD	◆ Psychiatric Medication Services	Individual	$260,000
MHMRA of Harris County	◆ Crisis Hotline	Organization	$46,000
Behavioral Hospital of Longview	◆ Inpatient psychiatric care	Organization	$85,000
Cypress Creek hospital	◆ Inpatient psychiatric care	Organization	$85,000
Kingwood Pines Hospital	◆ Inpatient psychiatric care	Organization	$90,000
Memorial Hermann Hospital	◆ Inpatient psychiatric care	Organization	$85,000
Palestine Regional Medical Center	◆ Inpatient psychiatric care	Organization	$85,000
West Oaks Hospital	◆ Inpatient psychiatric care	Organization	$85,000
Quest Diagnostics	◆ Lab	Organization	$25,000
Christus Jasper Memorial Hospital	◆ Lab	Organization	$10,000
Memorial Health System of East Texas - Lufkin	◆ Lab	Organization	$48,000
ETMC - Crockett	◆ Lab	Organization	$7,000
ETMC - Trinity	◆ Lab	Organization	$6,000
Memorial Health System of East Texas - Livingston	◆ Lab	Organization	$15,000

8) <u>Current and Planned Network Development</u> for FY 2013-2014

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 2011 and FY 2012 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 (tab 3: Service Target County by Component and LOCA). The link is: http://hhsapp08.mhmr.state.tx.us:8080/AnalyticalReporting/WebiView.do?cafWebSesInit=true&appKind=InfoView&service=/InfoViewApp/common/appService.do&loc=en&pvl=en_US&ctx=standalone&actId=224&objIds=7934&containerId=6569&pref=maxOpageU%3D100%3Bmax*

OpageUt%3D200%3BmaxOpageC%3D10%3Btz%3DAmerica%2FChicago%3BmUnit%3Dinch%3BshowFilters%3Dtrue%3BsmtpFrom%3Dtrue%3BpromptForUnsavedData%3Dtrue%3B

- *Column B: State the percent of total capacity contracted to external providers in FY 2011. 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 2011; this is the actual capacity served by contractors.*
- *Column D: State the current percent of total capacity contracted to external providers for FY 2012. 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 2012 (September 2011 through February 2012); 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 2013 and in 2014. This is the cumulative percent you anticipate having under contract in that year, not the percent to be procured in that year.*
- *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**	**Percent total capacity served by contract providers in**	**Percent of total capacity contracted**	**Percent total capacity served by contract providers in**	**Percent of total capacity planned for contract in**	**Percent of total capacity planned for contract in**	**Number of available providers**	**Applicable condition**

		in FY 2011	FY 2011	in FY 2012	FY 2012 (6 mo)	FY 2013	FY 2014		
Adult Service Packages									
Adult RDM SP 1	1960								1
Adult RDM SP 2	35								1
Adult RDM SP 3	125								1
Adult RDM SP 4	14								1
Adult RDM SP 0	39								1
Adult RDM SP 5	80								1
TOTAL Adult Services	2253								
Child Service Packages									
Children's RDM SP 1.1	225								1
Children's RDM SP 1.2	28								1
Children's RDM SP 2.1	0								1
Children's RDM SP 2.2	3								1
Children's RDM SP 2.3	0								1
Children's RDM SP 2.4	1								1
Children's RDM SP 4	87								1
Children's RDM SP 0	0								1
Children's RDM SP 5	0								1
TOTAL Children's Services	344								

1

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 2011 and FY 2012 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 2011	Percent of total capacity contracted in FY 2011	Percent total capacity served by contract providers in FY 2011	Percent of total capacity contracted in FY 2012	Percent total capacity served by contract providers in FY 2012 (6 mo)	Percent of total capacity planned for contract in FY 2013	Percent of total capacity planned for contract in FY 2014	Number of available providers	Applicable Condition
Crisis Hotline	1929	100%	100%	100%	100%	100%	100%	3	
Crisis Residential Unit	638								6
Crisis Extended Observation Unit	624								6
Inpatient Psychiatric Care	37	100%	100%	100%	100%	100%	100%	6	
Lab services	$51,149*	100%	100%	100%	100%	100%	100%	6	
Psychiatric prescriber services	2873	25%	25%	25%	20%	20%	20%	1	1
Emergency psychiatric services	3423	100%	100%	100%	100%	100%	100%	1	

- **We do not track this by number served, this is the expenditure for the service.**

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.

With the exception of the crisis center, for which we have prior arrangements with counties and local hospitals, all services for which interest has been expressed (crisis hotline) will be put up for procurement in this planning cycle. Burke Center will procure 100% of crisis hotline services. No provider has expressed interest in providing children's services in our service area. One provider expressed interest in adult services but withdrew from consideration due to insufficient population density.

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.* N/A

Service	Capacity Needed	External Provider Capacity	Information and Method Used to Determine External Network Capacity

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

Service	Transition Period	Year of Full Procurement

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.

Burke Center's residential crisis programs (an extended observation unit and crisis residential unit) were the result of a carefully wrought collaborative process by the Burke Center and the Regional East Texas Health Network (RETHN). RETHN is a HRSA grant subsidized network, and is made up of consumers, advocates, providers, law enforcement members, county and city governmental officials, and hospital directors. The residential crisis programs were funded not only by DSHS but also by local hospitals and county governments. The crisis units were born of an intensively collaborative process and cannot operate without the partnership with these entities. RETHN does not feel comfortable contracting this out, seeing no advantage to this, but will consider it in future planning cycles.

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.

- All providers must use the Burke Center electronic medical record in a timely manner to facilitate communication and to allow ease of assessment for Quality and Utilization Management activity.
- Providers will be included in oversight including use of the fidelity toolkit and consumer satisfaction surveys.
- Stability of the network, including evidence of a sound organizational structure and strong financial management systems, will be established prior to expanding it to assure continued service provision.
- Burke Center will maintain eligibility determination functions as well as administrative functions to assure appropriate oversight functions.

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
Crisis hotline	Should our contracted hotline terminate unexpectedly (which is not anticipated as we would only contract with a provider with an established history), Burke Center would immediately assume this function as no lapse in this service is tolerable.

Procurement

13) Structure of Procurement(s)

In the table below, describe how the FY 2013-2014 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
5/1/13	RFP	Crisis Hotline	All 12 counties in service area	100%	Service not amenable to choice, external provider must cover entire area
5/1/13	RFA	Inpatient Services	All 12 counties in service area	100%	
5/1/13	RFA	Psychiatric prescriber services for adults	Nacogdoches, Polk, San Jacinto and Tyler Counties	100% Polk, San Jacinto and Tyler counties ; 20% for Nacogdoches counties	External providers for physician services are used in clinics in which capacity necessitates additional service.
5/1/13	RFP	Emergency psychiatric physician services	All 12 counties in service area	100%	Crisis unit requires on demand around the clock access to physician services.
5/1/13	RFP	Laboratory Services	All 12 counties in service area	100%	

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.

Providers of discrete service must provide service in our buildings, provide timely documentation, be available for staffing, and be subject to the same monitoring, training, and quality management and utilization management processes as staff.

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

___X__Yes _____ No

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

- Must comply with requirements of accreditation by The Joint Commission.
- Staff must be computer literate and able to enter data directly into the Center's clinical data system.

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
ACT	Burke Center consumers that are eligible for this service are dispersed throughout the region, and therefore are served by a number of different teams. At the time of this writing, Burke Center has 8 consumers receiving ACT support, and there is no concentration in any one county. To contract out this service effectively to the consumers would not be financially viable

	to any single provider team.
Crisis residential and extended observation programs	The MHEC is funded by cooperative agreements with county hospitals and county governments with the understanding of local control and accountability. Consumer choice is not viable because only one unit is funded, clients under involuntary commitment are not in a position to be offered a choice of services at that time, and to split up services jeopardizes critical infrastructure to maintain this intensive service in accordance with state contract requirements.
Crisis Hotline	In order to minimize any confusions or delay in service provision, which is unacceptable in a crisis situation, only one hotline number is utilized in the 12 county area.

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.

- Providers must provide services with equivalent access times and locations to what they currently receive.
- At intake and with each treatment plan review, consumers will be offered choice of available providers. If a provider is at capacity they will be put on a waiting list for that provider but offered an alternate provider in the meantime.

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.

- All direct care providers, by contractual agreement, must have the ability to provide translation services for hearing impaired and Spanish speaking clients, the 2 communication needs identified in our service area.
- The provider network is required to comply with training required of Burke Center staff including modules on Client Rights and Cultural Diversity at hire and annually.
- Training on General Clinical Cultural Issues in Mental Health Treatment is available to all staff and contractors through Essential Learning on-line training.
- Complaints and Rights Violation Allegations are compiled and trended by the Center's Rights Protection Officer to identify recurring issues and need for additional training among providers.

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 2010 network development plan.

- Use of ETBHN closed door pharmacy to reduce medication costs
- Extensive use of PAP programs to reduce medication costs
- Participation in consolidated process for TRAG authorization with 7 other centers
- Shared Medical Director arrangement with 4 other centers
- Utility Purchasing with 4 other centers
- Purchase of Laserfiche scanning and storage process with 10 other centers

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
1997	East Texas Behavioral Healthcare Network (ETBHN) 11 member centers	Pharmacy and Therapeutics Committee, Utilization Management Committee, Regional Planning and network Advisory Committee, Wide Area Network (WAN), Board of Trustees training, Autism Summit, Business Opportunities Committee, Information Service Workgroup, Veterans Competitive Grant, Peer Provider Training and Support

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

Through ETBHN, the following:

- Televideo screening and intake with open access
- Joint health insurance for employees
- Regionalized crisis hotline
- Cognitive enhancement therapy (CET) summit
- Veterans programs
- Autism programs

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)
SP1 and SP3 adult, 20%, all 12 counties	No willing and able providers
SP2 adult, 50% in all 12 counties	No willing and able providers

List the comments you received after posting the draft procurement documents during the 2010 planning cycle, and how you responded to the comments, including any modifications made to the procurement document. If the comments are extensive, you may provide this information in an attachment.

Comment or Suggestion	LMHA Response
No comments or suggestions	

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.

- Procurement documents, network procedures, and provider contracts have been developed.
- Systems were refined (or in some cases, developed), to monitor external providers.

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 FY 2013-2014 procurement.

Barriers	Plans
Rate not attractive to external providers	Lobby to improve funding
Large geographic area	Identify efficiencies and economy of scale
DSHS contract and TAC requirements for services	Advocate for state provision of regional training opportunities, with

	funding available for participation, and for less prescriptive requirements

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.

- Network development will be expanded as Burke Center develops expertise at managing a provider network.
- Full utilization will be achievable as qualified and willing providers are available in our service area.
- Full utilization will be achievable when increased funding creates more appeal to providers.
- As we test the external provider network and gain confidence in its ability to appropriately serve our communities and in our ability to manage it, and as we act in response to our local stakeholders, we will expand the network.
- The rule does not require a percentage be cited and we are not comfortable to committing to one now.
- A reasonable estimated would be 5-6 years to fully utilize the provider network, and this is contingent on limited turnover in providers.

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.

- Posted on the website for two weeks, beginning 9/13/12
- Notice sent to NAMI, the RPNAC, and the Rural East Texas Healthcare Network
- Notice posted each site where Burke Center mental health services are provided

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
2/1/13	Draft procurement document (RFA/RFP) posted for public comment (at least 14 days)
4/1/13	Publication of final procurement
5/1/13	Due date for procurement responses
6/1/13	Award date
9/1/13	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
	NA

Stakeholder Comments on Draft Plan and LMHA Response

Allow at least14 days 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 received		

COMPLETE AND SUBMIT ENTIRE PLAN TO performance.contracts@dshs.state.tx.us by OCTOBER 1, 2012.

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.