

CENTRAL PLAINS CENTER

LOCAL SERVICE AREA PLAN Fiscal Year 2006-2008

.....improving the quality of lives.....

TABLE OF CONTENTS

I. Mission, Vision, and Values	pg. 3
II. Local Authority Assessment	pg. 4
III. Planning Process	pg. 10
IV. External/Internal Assessments	pg. 13
V. Goals	pg. 27
IV. Provider of Last Resort	pg. 31

I. Mission, Vision, and Values

Mission

Our **mission** is to “improve the quality of life for persons with mental illness, mental retardation and chemical dependence, and their families, by providing accessible services and resources which support individual choices and promotes lives of dignity and independence.”

Our **vision** is to “courteously and professionally provide help, hope, and support to people served, in partnership with their families and communities.”

The focus on our **value** system is on recognizing that people with disabilities have rights, that the individuals served understand those rights, and that they are upheld. We teach people to exercise the highest level of self-determination and personal autonomy. We strive to ensure that they live, work, and play in the least restrictive, non-stigmatizing environments consistent with their strengths, hopes, and desires.

The **general values** that serve as guides for our services include (but are not limited to):

- Referring to individuals served by name when appropriate
- Using “people first” language
- Be sensitive to cultural differences and language barriers
- Provide services in the location most convenient whenever possible
- Support the preservation of family and friendships
- Services must meet or exceed established usual and acceptable standards
- Individual choices and preferences are the driving force behind program decisions

Local Authority Assessment

History and Organizational Overview

In 1963, Hale County Judge C. L. Abernathy was appointed chairman of a committee to develop the Texas Plan for Mental Health Services. This plan, enacted by the 59th Legislature as House Bill 3, was developed from the input of laymen and professionals across Texas.

In 1967 Judge C. L. Abernathy called to the attention of the Plainview Hospital Board that funds were available to construct a mental health facility in conjunction with the new Central Plains General Hospital. An application would need to be submitted to the National Institute of Mental Health (NIMH) and TDMHMR for construction funds.

The Plainview community was already aware of the need for mental health services. High Plains Children's Training Center was already providing services to children with mental retardation through a diagnostic center and day school program. However, NIMH required a catchment area of 100,000 population to qualify for construction or staffing funds. The nine counties of the Central Plains area (Hale, Lamb, Swisher, Briscoe, Castro, Motley, Floyd, Bailey, and Parmer) joined together and appointed one trustee from each county to form the Central Plains Comprehensive Community Mental Health/Mental Retardation Board of Trustees in September 1967. Appointed to serve on that first Board were: W. W. Allen, chairman, Hale; Don Morris, Vice-Chair, Swisher; B.E. Sanderlin, M.D., Bailey; Mrs. Carmen Rhode, Briscoe; Harley McCasland, Floyd; Raymond Lewis, Lamb; Mrs. Freeman Thacker, Motley; Baker Duggins, Parmer; and Noel Gollehon, Castro. These Trustees requested that Mary Bubliss, M.D. and Woody Allen develop a construction application for submission to NIMH and TDMHMR. The Plainview Hospital Authority allocated \$289,000 in local funds for the \$600,000 structure.

Approval was granted by TDMHMR in August 1968 to employ a program planner and the Board employed Mrs. Elizabeth Woodley on November 1, 1968. The plan, submitted to TDMHMR in August 1969, outlined community needs, proposed funding and service delivery systems. In

September 1969, a TDMHMR site visit team met with 45 citizens and Board Members from the nine counties and approved the plan. The Center was funded for partial operation in November 1969. Mrs. Woodley was employed as Executive Director, Faye Steele as secretary, Mary Bubliss, M.D. as consultant, and additional funds were made available to the High Plains Children's Training Center.

Construction on the hospital center was completed and occupied in July 1970, to serve clients on an emergency basis. A three day-a-week hospital program started in February 1971, and full services began in August 1971, with the advent of an eight-year federal staffing grant.

In March of 1991 the name of the Center was changed to reflect the complete array of services provided. The name became Central Plains Center for Mental Health, Mental Retardation, and Substance Abuse. In November of 2000 to Board approved shortening the name to Central Plains Center.

Over the course of 37 years, the Center's scope of responsibility and geographic service area have steadily broadened, even beyond the nine county service area, through its relationship with a variety of state agencies (for example, the Texas Department of Mental Health and Mental Retardation, Texas Commission on Alcohol and Drug Abuse, Texas Department of Criminal Justice, Texas Council on Offenders with Mental Impairments, Texas Department of Protective and Regulatory Services) and its designation as a Local Mental Health and Mental Retardation Authority.

The Center provides mental health, mental retardation and substance abuse services for adults, children and adolescents. As a state designated mental health and mental retardation authority, the Center has the responsibility for:

- Planning
- Policy Development
- Coordination, development and allocation of resources
- Oversight of mental health and mental retardation services

The Center accepts the obligation of public trust and is committed to developing, maintaining, and expending resources in a manner that ensures the greatest benefit to consumers and to the community.

Organizational Overview

The Center is governed by a Board of Trustees comprised of one member from each of the nine counties in the service area. Members are appointed by the representative county's commissioner's court. The Board of Trustees is reflective of the community, includes consumer and/or family member representation whenever possible, and is governmental in nature and accountable to public trust. Business is conducted in open board meetings, which are held on the fourth Thursday of each month. The public is invited to attend all meetings and there is opportunity provided to address the Board at these meetings if desired. Currently, the members of the Board are:

- Pat Moore, Chair, Motley County
- Diane Brunson, Bailey County
- Bob Alldredge, Vice Chair, Floyd County
- David DeBusk, Hale County
- Danny Byers, Secretary, Lamb County
- Josh Arguijo, Castro County
- T.A. Hayhurst, Swisher County
- Fred Strange, Briscoe County
- Robert White, Parmer County

With the introduction of HB 2377, managed care, Resiliency and Disease Management (RDM), and other external forces, the organizational structure of the Center has been forced to reconfigure several times over the last few years. The Center's management team continues to monitor legislative action for its possible impact on center organization and function. Please refer to attachment A for the Centers current organizational chart.

Human Resource Profile

Central Plains Center currently employs approximately 152 staff members as well as about 49 client workers. Staff members represent a variety of cultural and ethnic diversities. The following is a breakdown of employees by sex and ethnicity:

Ethnicity	Male	Female	Total
Black	5	20	25
Asian	0	0	0
Native American	1	2	3
Hispanic	7	42	49
White	16	59	75
Total	29	123	152

The staff turnover rate for FY 05 was 32.79%, which is slightly higher than the FY 04 rate of 28.73. This continued low turnover (in comparison to recent years, i.e. the turnover rate in FY 02 was near 38%) is attributed to several factors, including the introduction of a staff mentoring program (see details below in staff development section) and an increase in salaries.

Staff Development

The primary function of the Staff Development department is to coordinate and present information and training to employees of Central Plains Center. Education and training services include orientation, basic skills, pre-service, in-service and continuing education. Training is primarily instructor-led classroom instruction and computer-based training, along with on the job training. More of the center's required training is available online now than ever before, which makes it much more convenient for staff. Staff Development provides education and training that addresses a variety of subjects and technical skills for staff working with people with mental and physical disabilities.

Several sources determine what training is needed: the Texas Administrative Codes, the DSHS and DADS minimum training requirements, and the MH Community Standards. These requirements and standards primarily cover training mandated by accrediting organizations and legislation; however, there is also emphasis on providing the training staff needs to perform their specific job duties effectively. As specific needs are identified through performance evaluations and employee surveys, training is provided to reduce gaps in the knowledge and skills of staff. A mentoring program for new employees was implemented approximately 4 years ago. In this program, a seasoned employee, who has received specialized training, is assigned to a

newly hired employee to serve as their “mentor” during their orientation period. The mentor provides job specific training to the new employee to assist them in learning their new job duties. This program was added as a direct result of comments made by staff in surveys as well as exit interviews, that they were not getting enough training in their specific job duties.

Population Served

The following is a summary of the priority population to be served with general revenue funding (definitions are from the Department of State Health Services and Department of Aging and Disability Contracts for Fiscal Year 2006):

- 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. With the implementation of RDM in FY 2005, the adult MH population **target** now consists of: those who have a diagnosis of schizophrenia, bipolar disorder, or severe major depression. Eligibility for persons whose diagnosis is Major Depression are required to have a GAF score of 50 or below at intake.
- Persons who need and request services who meet one or more of the following descriptions: persons with mental retardation, as defined by Texas Health and Safety code 591.003; persons with pervasive developmental disorders, as defined in the current edition of the Diagnostic and Statistical Manual, including autism; persons with related conditions who are eligible for services in Medicaid programs operated by DADS, including ICF/MR and waiver programs; nursing facility residents who are eligible for specialized services for mental retardation or a related condition pursuant to Section 1919(e)(7) of the Social Security Act; or, children who are eligible for services from the Early Childhood Intervention Interagency Council.
- Children and adolescents ages 3-17 with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who: have a serious functional impairment; are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or, are enrolled in a school system’s special education program because of a serious emotional disturbance.

In addition to the above, Central Plains Center also provides services to the following populations:

- Male adolescents, ages 13-17, who have a diagnosis of substance abuse.
- Adolescents, ages 10-18, who are involved in the Juvenile Justice System and are at risk of removal.
- Children, ages birth to 3, who: exhibit a developmental delay; have a medical diagnosis that places them at high risk for a delay; or exhibit an atypical development as determined by a qualified professional.
- Adults who meet priority population for mental illness and who also have a substance abuse disorder.

The population that can be served is very limited in scope, as compared to the total number of people who have a mental illness or mental retardation. The Center recognizes that there are many people in the community that do not meet eligibility criteria for services or who choose not to receive services. Some examples of populations not receiving services from Central Plains Center include:

- Adults and children with a primary diagnosis of alcoholism and/or substance abuse (other than those identified above)
- Adults with generalized anxiety, phobias or other disorders that do not have a Global Assessment of Functioning (GAF) of 50 or below
- Adults who do not meet the criteria for Mental Retardation or Pervasive Developmental Disorders
- Homeless people who do not meet eligibility criteria

In response to this need, the Center is currently providing the following services:

- Through a contract with DFPS, counseling services for non-priority population individuals and families with abuse issues.
- Through a contract with the South Plains Health Provider Organization, counseling services for non-priority population individuals who receive services from that organization.
- One of the Center's LPC's is offering individual and marriage/family counseling to members of the non-priority population. This is a valuable service to the community as resources are limited in our rural area.

II. Planning Process

The primary purpose of establishing a planning process for CPC is to enable our community advocates, consumers, family members and staff to gather information about community problems and developing trends, identify critical issues for resolution and/or advocacy, and develop strategies to achieve a desired outcome in each area. By achieving these goals, CPC will be able to successfully achieve its mission and vision as established by the Board of Trustees.

The Planning and Network Advisory Committee (PNAC) has an active role in the Centers planning process and provides feedback through informal and formal recommendations throughout the planning cycle. The PNAC currently consists of 9 members and 3 alternates appointed and charged by the Board. At this time 6 of the members are current or former consumers or family members of consumers (with equal representation from MH, MR, and children's services) and 3 are community leaders. The PNAC meets quarterly and reviews assessments, UM reports, QM reports, and data from CARE and the Center's internal MIS system. A service provider is present at each meeting to provide information regarding their particular program. Recommendations are then presented to the Management Team and to the Board for their consideration and, if approved, implementation of these recommendations.

Local input and advisement is of utmost importance in establishing goals and objectives for the Center to assure we are meeting the individual needs in each of our communities. Although CPC covers a 9 county catchment area, we are making efforts in obtaining input and satisfaction data in each community. This is an activity that will continue to evolve in the future.

An important step in the strategic planning process is to identify and recognize the needs of the stakeholders. Stakeholders include consumers, family members, staff, local advocacy groups, community service providers, local businesses, governmental service agencies, school personnel, and community members. Historically, we have had low turnout at public forums and low return rates on needs assessments sent to stakeholders. However, there are other ways input from stakeholders can be obtained. They include the following:

- Evaluation of the ongoing satisfaction surveys conducted
- Review of complaints/comments made to the rights protection officer
- Staff participation in various social coalition groups
- Input from the Board of Trustees
- Input from the PNAC committee

Central Plains Center staff collaborates, formally and informally, with other state and community service agencies. Some of the agencies with which there are ongoing collaborative efforts related to service provision and planning are:

- Meetings with other community MHMR center staff to share ideas
- Lubbock State School
- Big Springs State Hospital
- North Texas State Hospital
- Regence Health Network (formerly South Plains Health Provider Organization)
- Community Resource Management Group (CRMG)
- Hale County Resource Network
- Local law enforcement officials
- County officials
- Social Security Administration
- Texas Department of Family and Protective Services and other state agencies
- Caprock Community Action
- Local school districts
- Education Service Center
- Hale County Crisis Center
- South Plains Association of Governments
- City of Plainview

The Chief Executive Officer, as well as various other staff of CPC, meets regularly with the local and county judges to discuss items of mutual interest including numbers served from their local communities, Mental Health Deputy programs, jail diversion activities, and the various issues and needs of their respective areas.

The information shared and gathered during interaction with these entities provides ongoing feedback to Center management staff. This impacts planning

of services both directly and indirectly, by educating staff on services and their limitation available in the community; identifying problems or barriers to services; decreases duplication of services, and impacts planning of services in the future.

While long term strategic planning has historically proven to be of value to business, in today's ever changing environment the approach to planning seems more relevant if scaled down to one to two years at a time. To assist the Board and staff in clearly focusing on those factors of great importance to the long-range future of the Center, several goals, objectives, and strategies have been identified. These are outlined elsewhere in this document.

The continuously changing environment forces reassessment periodically. Monthly, the Board receives reports from Management Team members on issues of concern to the Center, as well as recommendations for improvements. As a result of these discussions, the Center's goals will be reviewed and revised, if appropriate.

As noted above, the Center has an ongoing process for monitoring and evaluating the strategic plan. The Director of Contracts Management, through the Quality Council (QC), monitors the plan quarterly. QC membership includes member of senior management (the Chief Executive Officer, Chief Operations Officer, Chief Services Officer, and the Chief Financial Officer), all Program Directors, and the Director of Human Resources. The QC meets at least quarterly to review the progress on all of the quality improvement initiatives. A semi-annual report will be presented to the Board for review. Any recommendations or concerns of the Board will be addressed immediately.

External/Internal Assessments

External Assessment

It is critical to identify and adjust to the external environment surrounding Center operations. The external environment includes factors such as economics, public perception, legislation, political climate, changing demographics, technological advances, research findings, and treatment innovations. One of the major external environmental factors influencing services to be provided is general revenue funding. This funding, provided through the State Authorities (i.e. DSHS, DADS, etc.), has stringent guidelines of what populations of people we can serve with this funding. The limitations include who can be served, priority population (definitions found in Section IV) and guidelines for service provision. While it is impossible to anticipate and plan for all external factors, dynamic leadership and flexibility allows for prompt reactions to the demands of the environment.

The State Authorities also defines a “target” number for specific populations to be served. Although evaluation of the target numbers, compared to actual number of people served, is one method of measuring customer demand and public need, these numbers do not provide a complete picture of service needs in the community. In addition, with the implementation of RDM, the state has also set “minimum hours”, performance outcome measures, and other service requirements for consumers with mental illness, dependant on what service package they are assigned to. Through the strategic planning process, other methods of information gathering are utilized in order to assist the Board, PNAC and management staff in understanding local needs.

In addition to the State Authority’s requirements, there are other external forces that impact service provision by the Center. As there are too many external forces to list all of them and their current or potential impact on the agency, the following are some of the major factors that could affect service provision.

Political Environment

Through the enactment in 2003 of House Bill 2292 and its numerous companion bills, the Governor and the 78th Legislature directed Texas health

and human services agencies to consolidate organizational structures and functions, eliminate duplicative administrative systems, and streamline processes and procedures that guide the delivery of health and human services to Texans. The Texas Department of MHMR was consolidated into two new agencies. Mental health and substance abuse services (formerly TCADA) now fall under the umbrella of the Department of State Health Services, and mental retardation services are now under the Department of Aging and Disability Services. This bill has also significantly impacted service delivery at the local level, the effects of which will be felt for years to come.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program was developed to address the insurance needs of an estimated 1.4 millions uninsured children in the State of Texas. This program has undergone recent changes, but as of the date of this writing had been reinstated to its previous level of coverage.

Medicaid/Private Insurance

Medicaid and private insurance continue to re-define what services are "medically necessary" services, who is eligible for those services, and at what rate providers will be reimbursed. In the early 1990's, the public trend was for counseling, group therapy, and group training of skills (including intensive inpatient and outpatient hospitalizations) all of which were billable services. By the end of the 90's, utilization management and managed care curbed the intensity of services by not providing "blanket" services to everyone with certain diagnoses thus decreasing the number of people receiving multiple, intensive, and frequent services. Services became more individualized, based on need. With that, financial compensation decreased, as it was determined that not everyone needed or would benefit from group therapy or intensive services, as previously believed.

The age of managed care became a reality as private insurance developed utilization management systems, which required justification for service provision and placed stricter limits on the maximum services allotted to an individual. Medicaid also changed the reimbursement rate for case management/service coordination. In the past, the reimbursement rate was "fee for service" in which the providers could bill each time a service contact was made with a consumer. Now that has changed to a "case rate" where the

provider can only bill one time a month for case management/service coordination services, no matter how many times the provider saw the consumer. Another major impact to community services was the decrease in reimbursement rates for rehabilitative services that became effective September 2001, along with the possibility of future rate decreases.

Population of Service Area

Central Plains Center covers a nine (9) county service area that is primarily rural. Those counties and their respective populations are: Hale, 36,233; Floyd, 7,174; Lamb, 14,467; Swisher, 7,828; Motley, 1,299; Parmer, 9,754; Bailey, 6,726; and Briscoe, 1,644; and Castro, 7,640. The population has decreased slightly since the 2005 plan was written. Approximately 46% of the population served by our nine county catchment area is hispanic. Although a recent mental health report released by the U.S. Surgeon General states that minorities are less likely than whites to use services and they receive poorer quality mental health care, this is not the case in our catchment area, as approximately 53% of the individuals served by CPC are hispanic. The diversity of the West Texas/South Plains area calls for the assurance of services that are culturally appropriate. It is always critical to address the disparities in the percentage of minorities receiving services as compared to the general population. Furthermore, it is necessary to ensure that consumer and public input is obtained from a diverse representation of the population.

Another special population group are those persons who are over the age of 65. In the Center's nine county service area, 16.2% of the population are over the age of 65, compared with 9.9% statewide. As people become older they tend to require increased support services and medical care. It is important for the system to meet the needs of consumers as they age. It is also necessary to take into account the aging of the primary caregivers of people with mental illness and mental retardation. Some elderly develop major depression, other major mental illness, Alzheimer's, and other forms of dementia later in life. Suicide rates among people over the age of 85 are nearly twice the overall average.

Although the population in the nine counties served is fairly low (approximately 93,000), the total number of square miles covered is 8,409, which equals approximately 11 persons per square mile. The rural nature of the CPC service area requires that innovative approaches to service delivery be developed. In order to provide quality services the Center has service sites in 5

of our 9 counties. Even with this level of accessibility, surveys indicate that it is still difficult for people to get to these service sites. The majority of individuals served live below poverty level and many do not have their own means of transportation. Even though there is some public transportation and Medicaid transportation available in the communities, there are limitations to these services (i.e., limited to transporting to and from medical appointments, only run on certain days, hours are limited, and/or transportation must be scheduled at least 24 hours in advance). This presents a unique problem for both the consumers and the Center alike. In an effort to alleviate this barrier for consumers living in our outlying counties, the Center is conducting clinics via telemedicine in our Lamb County and Bailey County clinics. However, the Center does not receive reimbursement for these services due to the fact that third party payors currently will not pay for telemedicine services. Also, approximately 63% of the Center's services are provided "in vivo", which refers to the clients home or natural environment. Due to the costs associated with travel (staff time, mileage expenses, vehicle expenses, etc) the Center's cost per service is, in most cases, higher than the same service provided in a more urban area

The service area has other unique attributes. The unemployment rate for the nine county service area ranges from 1.9% (Motley) to 6.4% (Lamb) with the overall average being 4.35% (6.7% statewide average). Another significant element in the composition of the Center's service area is the average number of people living at or below poverty level. The state average for people living at or below poverty level is 15.4%, while the local service area average is approximately 18 % of the population. All of the counties served have significantly higher ratios of people to direct care physicians with the average being approximately 1400 people per direct care physician (state average is 701 people per physician). Seven of the nine counties served have been designated as a "health professional shortage area" with Hale and Floyd counties being the only ones without this designation. All nine counties were designated as being a "health professional shortage area" in the field of mental health. Briscoe, Castro, Floyd, Lamb, Motley, Parmer, as well as part of Hale, counties have also been designated as "medically underserved areas". To our north and south we have Lubbock and Amarillo, of which both have an abundance of medical professionals and specialists. However as mentioned earlier, locating the necessary transportation to and from these areas is a big issue.

As indicated in this brief review, there are multiple external forces that influence the success of Central Plains Center in achieving its mission and goals. The major financial sources impacting local service delivery is the allocation and designation of general revenue funding from the Texas Health and Human Services Commission (HHSC) and the Medicaid reimbursement rate. Though there are other funding sources that impact service delivery, these two are the most significant. Designated priority populations that must be served, clearly defined services to be provided and limitations placed on reimbursable services to be provided are also major factors. Additionally, the changes in the healthcare industry, especially in the area of behavioral health care, both in funding and service provision, affects what is defined as priority services and what services can be provided. As there are constant changes in agencies and legislative initiatives, the direction of services to be provided also shifts. Changes can be especially challenging for a population of people who want (and sometimes need) consistency in their lives.

Internal Assessment

In addition to the external factors discussed above, the Center must also be in tune to internal factors that drive Center operations. These internal factors are assessed in a number of different ways. During the spring of 2003 the Center conducted an organizational self-assessment using the “How to Respond to Managed Behavioral Health Care” self-assessment tools. Nine individual committees were formed to look at the nine different domains in the assessment tool. The committees were asked to review the questions, list strengths and opportunities, and to brainstorm on ways that we could improve performance in each area. The total points and area preparedness scores for each of the domains were as follows:

- Area 1: Leadership and Vision – total points 195 (well along)
- Area 2: Human Resources – total points 370 (prepared)
- Area 3: Service Delivery – total points 460 (well along)
- Area 4: Quality Management – total points 170 (moderate)
- Area 5: Service Utilization – total points 170 (moderate)
- Area 6: Financial Planning & Mgmt – 170 (prepared)
- Area 7: Consumer and Financial Acctg – 540 (well along)
- Area 8: Management Information – 1470 (prepared)
- Area 9: Marketing & Public Relations – 510 (prepared)

Several areas of concern seem to be shared by all committees. Those areas are:

Staff satisfaction/appreciation/motivation/incentives

Credentialing of staff

Nothing done with the available data (computer reports, exit interviews, audits, etc.)

No team spirit (“us vs. them” mentality)

Not utilizing available technology

CMHC system not being used to capacity

Poor communication between departments and within departments

Lack of transportation

Analysis of this information shows that these areas of concern could be grouped into three main categories: communication/information sharing, staff related issues, and transportation. This data was presented to the Board and to the Management Team for review. A plan of improvement was then developed based on the recommendations made by the individual committees.

In the spring of 2006 the Center conducted an employee satisfaction survey. The majority of staff who completed the survey responded favorably in all areas. The area with the most positive results was in the area of questions that asked about the employees’ relationship with their direct supervisor. Negative comments tended to be in the areas of staff recognition (or lack of) and communication between departments. Results were compiled into a report that was distributed to all staff via the program coordinators. This information has also been presented to the Board and to the PNAC committee for review.

The Center also evaluates itself through review of satisfaction surveys that are completed periodically. There are multiple survey methods and tools utilized, and though some are more statistically valid than others, the Center values all feedback. Each program conducts client satisfaction surveys periodically and reports these results quarterly through the Center’s quality management process. Other tools used to measure satisfaction with services are the Adult Mental Health Consumer Survey and Child and Adolescent Surveys sent out annually by DSHS, and an MR programs assessment conducted regularly by the Center. The various satisfaction surveys indicate that, overall, people are satisfied with their services.

Compliance with performance contract requirements is monitored through the Center's Quality Management process. CARE and data warehouse reports are reviewed at least monthly and quarterly to ensure that targets are being met. Any area that falls below the established target will have a specific plan of improvement implemented to correct the deficiency.

Services and Supports

The following summarizes the services provided by Central Plains Center. These summaries do not reflect the whole of services and their limitations; however, they do provide basic information about the services. The Center must provide services within the scope of those deemed appropriate by the State and based upon need.

Mental Health Services

Case Management is provided to all people who receive services. The Case Manager assists individuals in accessing and receiving all resources and services necessary to reach and maintain an optimal level of functioning in their community. This is done through referrals, monitoring and advocacy.

Medication Services includes psychiatric and nursing services. These services include prescribing of medications and periodic monitoring of their effectiveness. Staff work to ensure that undesirable side effects are minimized and that medication is, in fact, being taken as prescribed. Monitoring may take place in the various outpatient clinics (in person or via telemedicine) or in the clients' home.

Inpatient Hospital Services are provided to the Central Plains area through the state hospital system, primarily Big Springs State Hospital. We also have MOU's with several private psychiatric hospitals in the area.

Psychosocial Rehabilitation Services provides skills training and supports designed to assist people with severe psychiatric disorders in learning how to identify and build upon strengths and abilities. Services also help people develop coping skills to better deal with symptom as well as recognizing factors that may contribute to mental illness.

Supported Employment provides customized training, placement, and on-going employment consultation services for people who are motivated and able to perform in a working environment.

Supported Housing provides assistance to enable individuals to succeed in chosen housing situations. These supports are based on the specific needs of each person, including locating affordable housing, negotiating leases, acquiring household items, obtaining subsidies, moving into residences and training on how to successfully maintain their homes.

24-hour crisis hotline is a staffed telephone service providing information, support, intervention, and referrals to individuals in crisis.

Intensive Case Management (ACT alternative services) consists of a multidisciplinary mobile outreach team with the capacity to provide intensive, frequent mental health treatment, rehabilitation, case management, general support, and vocational services for people who have a history of intensive needs, as reflected by their use of the system. These services are used to reduce crisis and hospitalizations. Services are provided in the person's natural environment.

Co-Occurring Psychiatric and Substance Disorders provides wrap-around services to individuals who have both a mental health and a substance abuse disorder and who have used a substance within the last 30 days. This program serves both adolescents and adults and is 6 months in duration.

Substance Abuse Services

The Center operates an intensive residential treatment program for adolescent males ages 13-17 that have a diagnosis of substance abuse. In addition, an adolescent outpatient program is available for both males and females in the same age group.

For adults, the Center offers outpatient substance abuse services for both male and female consumers. These services are funded through either DSHS, through GR dollars (COPSD program), or through other third party payors.

The Center also provides life skills groups for both male and female prisoners at the county jail. This program is 6 weeks long.

Child and Adolescent

Assessment: a face to face interview to obtain from the child and family seeking services the social, functional, psychiatric, academic and other information needed to determine priority population eligibility and treatment needs.

Skills Training and Development: a structured intervention to provide and improve skills needed for the child to function appropriately in the community, and to enhance child behavior management and increase the skills necessary to manage/decrease the child's level of functional impairment.

Family Training: training provided to the primary caregivers to assist the child in learning skills to manage daily responsibilities, communication skills and any skills identified as medically necessary in the treatment plan in order to assist in managing the child's behaviors more effectively.

Routine Case Management: facilitation of child/family's access to community resources and continuity of care between services.

Intensive Case Management: activities that assist the child/family including service planning and coordination, monitoring service effectiveness, and proactive crisis planning and management. The family service plan is developed using a wraparound planning approach.

Mental Health Information Training: information provided to the child and family on the mental health disorder, medications and monitoring of symptoms and side effects.

Family Support Group: support and informational meetings for parents of children receiving services that are facilitated and routinely scheduled.

Counseling: provided in order to resolve a concrete problem in daily functioning or symptoms resulting from maladaptive thoughts, feelings, interpersonal disturbances, consistent with DSM-IV diagnoses (CBT).

Family Partner: peer mentoring, education and support provided by an experienced parent to the caregivers of a child who has been or is being served in the mental health system.

Respite: services provided for short-term relief of primary caregiver(s) from the responsibilities of providing care for their children with serious emotional disturbances.

Treatment Foster Care: a voluntary treatment placement in which the child lives with a specially trained foster parent who provides supervision and management of the child and peer training to the custodial parent to assist in the successful reunification of the family.

Psychiatric Evaluation: a psychiatric clinical diagnostic interview as well as prescribing of medications if deemed necessary by the physician.

Medication Management: a service provided by a licensed medical professional to a child or family to determine symptom remission and the medication regimen needed to initiate and/or maintain the child's plan of care.

Inpatient Hospital Services: usually short-term residential services provided in a psychiatric hospital to a child who is demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting.

24 Hour Crisis Hotline: services provided to a child/family through either a face to face contact or telephone interview to determine the need for possible crisis intervention. The intervention could consist of but is not limited to: rehabilitation training, case management or admission to a psychiatric facility. The intervention should be the least restrictive environment until the crisis is resolved or the child is placed in a clinically appropriate environment.

Mental Retardation Services

Service Coordination is provided to all people who receive services. The Service Coordinator assists individuals in accessing and receiving all resources and services necessary to reach and maintain an optimal level of functioning in their community. This is done through referrals, monitoring and advocacy.

Psychological Services includes diagnostics, psychological assessments and consultation to facilitate adaptive behaviors, counseling, as well as consultation with a psychiatrist if needed.

Supported Employment assists individuals to acquire and maintain community-based employment. Vocational assessments are completed followed by job placement, which fits individual choice and needs. Job training is provided at the job site for a period of time, followed by support to help individuals maintain their job.

Site-based Habilitation Program provides comprehensive individualized training in self-help skills and academics with an emphasis on independence while encouraging family and community involvement and support. The array of services provided includes: adult basic education classes, day programming, and habilitation with emphasis on the reinforcement of independent life skills.

Support Services provides training in the individual's home based on the persons need (i.e., cooking, laundry, money management, shopping, socialization, community inclusion, transportation, translation, etc.)

Residential Services provides an opportunity for individuals to live in the community rather than being institutionalized. Services include both ICF/MR and HCS facilities. Nursing is part of the array of services offered in both programs, including monitoring, coordinating medical appointments, consultation, and staff/consumer training on consumers' special medical needs.

Mental Retardation- Continuity of Care provides assistance to individuals who are seeking residential placement in an ICFMR or HCS home or facility, or in the State School.

State School Liaison monitors individuals from our counties that reside in a state school facility, and coordinates placement from the State School into a group home in the community.

Early Childhood Intervention Program

Service Coordination helps the child and family get services in the community. The Service Coordinator works with the family to support the child's development and to arrange for services in and outside of ECI.

Assessment Services including screening and evaluation to assess cognitive, speech/language, fine and gross motor, self-help, hearing, vision, nutrition and social/emotional development.

Specialized Services includes occupational, physical and speech therapy as well as nutritional, audiological, and visual consults, social work services, and educational activities, based on need. These services are provided in the home or other community settings (such as day care centers). Instruction in the community setting enables the parents and caregivers to receive instruction and guidance to foster the development of the child.

Resource Development and Allocation

As previously noted in this report, the agency's primary funding sources are general revenue money from HHSC and Medicaid reimbursement. With this limited funding, there is a need to develop strategies to ensure best value for services and to expand revenue.

One of the services contracted out is our pharmaceutical services. This results in a multitude of savings, as the Center does not have to hire pharmacists and take on the other related costs of operating a pharmacy. Assistance is provided in finding other alternatives to cover the costs of medications, including linkage to the pharmaceutical companies that have patient assistance programs and/or sample programs. This provides savings to both the Center and the consumers. In fact, the Center's drug bills have been reduced by over 50% since the beginning of FY 2006 by being able to pursue these other funding options.

The Center continually invests staff time in seeking additional resources. We currently have an individual on contract whose main duty is to research and seek out grant opportunities. Recently the Center was awarded a grant to help fund our jail diversion program. We will continue fund raising activities to increase support for services limited by a lack of available funds. Cost savings,

efficiencies, use of physical resources such as Center-owned vehicles, utilities and physical plants are continually being monitored.

The Center is currently collaborating with local schools, juvenile justice departments, and service providers from several counties preparing to apply for a “systems of care” federal grant. Funding for this may not be available for a couple of years, but planning is already being done in anticipation of this. The Center is also in the process of applying for grants to help fund jail diversion activities and a Juvenile Drug Court.

Community Needs and Priorities

Mental Health

Central Plains Center provides all the core services as described in the Performance Contract for adults and children/adolescents. Public input indicates the community has needs beyond the departments’ description of priority population and core services. Some additional services needed are:

- Counseling
- Expanded respite services for children and adults, especially in the rural counties
- Support systems outside the Center
- Resources for uninsured people
- Enhanced services for individuals in the criminal justice system
- More efficient services for people in crisis
- Services for people not in the target population
- Crisis stabilization services closer to home
- More funds for medication and transportation
- Dependable and stable clinic and doctor services
- Search for cheaper medication and distribution system

The Center is seeking alternative funding and resources to diversify and fulfill the needs of more people in our service area. We are also aggressively working with other agencies (i.e. Regence Health Network) in exploring avenues in which we can work together to meet the communities’ needs. We will continue to ask for feedback from the community and our consumers to

establish an order of priority of services to be expanded in the future, as funding becomes available to do so.

Mental Retardation Services

Persons of all ages with a diagnosis of mental retardation are eligible to participate in employment, residential, education, leisure, and habilitative services offered by the Center. Input from the community indicates a need for:

- More services for persons with mental retardation who also have a diagnosis of mental illness
- Expanded opportunities for community education and training – especially in the more rural areas
- More funds and/or staff to reduce time spent on waiting lists
- Expanded respite services, especially in the rural counties
- Transportation
- Training in bilingual/bicultural differences
- Day habilitation program in outlying counties
- Reduction in waiting lists for some MR services

Additionally, the Center offers Early Childhood Intervention services in all nine (9) counties of its service area. Selected planning priorities based on needs identified by state and local stakeholders include:

- Expansion of Child Find activities to ensure eligible families are aware of available services
- Increased utilization management efforts through performance monitoring and productivity studies

Substance Abuse

The Center continues to operate a residential program for boys 13-17 years of age and an outpatient program for both males and females in the same age group. There are no adult residential services available north of Lubbock. A prevention and intervention program for at risk youth is offered by three of the five Juvenile Justice districts in our catchment area.

We continue to explore ways to obtain funds for the following identified needs:

- Adult residential services
- Detoxification services
- Adult outpatient services
- Residential treatment services for adolescent females

Impact of Key Forces

Ironically, the major opportunities in the future of this business lie in the major threats to the long-term security of Central Plains Center. The major forces include managed care, RDM, changes in Medicaid reimbursement and billing requirements, continued increases in medication expense, increased competition from private providers reduction in available public sector funds, and fee-for-service.

The current and future expansions of the Medicaid waiver programs will have a significant impact on how we do business. We will be required to look at how we do business and whether it might be more cost efficient and effective to outsource some services to more competitive providers.

The role of authority vs. provider for community mental health centers continues to be uncertain. We will be developing more authority functions and planning processes to determine which services may be better contracted to external providers. The ‘provider of last resort’ issue has the potential to dramatically alter our organizational structure and future planning.

Goals and Objectives

The key concerns of the Center are based on feedback received from stakeholders as well as service providers and staff. Data from center departments, as well as input from both internal and external stakeholders serve as the driving force for all improvement efforts, thus ensuring that staff, funding, and information resources are allocated to these priorities.

The following broad based goals have been developed:

1. CPC will continue to seek out the most efficient and economical means of operating the outpatient clinics.

Objective: Increase efficiency and quality of services

Strategies:

- a. Investigate the possibility of hiring a physician jointly with another facility/agency.
 - b. Investigate the feasibility of hiring a Physician's Assistant or a Family Nurse Practitioner.
 - c. Possibility for RFP's on pharmacy and medication contracts to ensure best value.
 - d. Utilize telemedicine system to its fullest
 - e. Physician directed performance contract requirements (i.e. TIMA, UM, etc.)
2. To provide quality services to consumers, family members, and the community.

Objective A: Provide prompt and easy access to services

Strategies:

- a. Reduce time spent on waiting lists in MR programs
- b. Reduce time between intake and first doctor visit for MH clients
- c. Crisis response will be available within one hour
- d. Ensure all facilities are physically accessible for persons with a handicapping condition
- e. Bi-lingual staff will be available as needed to assist Spanish-speaking consumers

Objective B: Provision of services according to consumer and community needs

Strategies:

- a. Continue to enhance the Center's jail diversion program through collaboration with local law enforcement agencies
- b. MH consumers receive on average at least 80% of the services authorized for their RDM service package
- c. Continue to use Person Directed Planning in MR services
- d. MR clients receive at least 80% of the services indicated in their PDP

- e. Maintain HCS waiting list with 100% accuracy
- f. Perform more outreach and education with the various organizations and schools districts in our local communities
- g. Continue to solicit input from stakeholders

3. Improve and expand available technology

Objective: Increase efficiency, outcomes of services, and billing accuracy

Strategies:

- a. Purchase additional laptops for staff use
- b. Increase wireless connectivity
- c. Update current wireless system
- d. Expand use of telemedicine equipment

4. To maintain and enhance an effective infrastructure and to develop resources that supports the Center in fulfillment of its mission.

Objective A: Improve communication between Center departments

Strategies:

- a. More direct involvement of mid-management staff with Management Team
- b. More specific Center information in the Center newsletter
- c. Continue to develop the Center's internet website

Objective B: Reduce staff turnover

Strategies:

- a. Develop a career ladder for direct care staff
- b. Increase direct care staff salaries
- c. Create specific program incentives
- d. Develop credentialing for professional staff

5. Prepare Center systems for Fee-For-Service (FFS) environment

Objective: Minimize financial impact when FFS is implemented

Strategies:

- a. Develop system of financial monitoring with a proposed “practice” rate
- b. Communicate FFS status frequently with Directors and other staff
- c. Continue to improve performance outcomes to gain efficiencies in FSS environment
- d. Budget to replenish reserve fund balance

As with all such goals, the continuously changing environment forces reassessment periodically. Monthly, the Board receives reports from Management Team members on issues of concern to the Center, as well as recommendations for improvements. These regular discussions are directly related to the above, continually forcing review of the Center’s progress towards these major goals.

Provider of Last Resort Plan

The FY 05 Performance Contract between Central Plains 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” in November 2004. This plan stated that the Center anticipated 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 the

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 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 our local service area.