

**COASTAL PLAINS  
COMMUNITY  
MHMR  
CENTER'S**

**LOCAL SERVICE AREA PLAN**

**REVISED FOR FY'S  
2009-2011**

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## I. Vision, Mission, and Philosophy Statements

### Vision

Coastal Plains Community MHMR Center will be a leader in quality human services as defined by the people we serve.

### Mission

Enhancing person growth in our community through support, guidance, education and advocacy.

### Philosophy

#### Values

- \* **Communication** begins with listening and results in mutual understanding.
- \* **Confidence in people:** People, given the opportunity, will fully participate in decisions affecting their lives, gain skills and define their own success.
- \* **Education \* Knowledge \* Experience:** The acquisition of skills and knowledge is a lifelong process.
- \* **Individuality \* Diversity:** We find harmony in diversity by appreciating differences.
- \* **Optimism:** There is power in positive thinking.
- \* **Trust \* Honesty:** Effective partnerships begin with trust and honesty.
- \* **Clarity in what we do:** Reduction of needless complication helps people make informed choices.
- \* **Sense of Purpose:** Happiness comes from having a sense of purpose.

#### Guiding Principles

**Respect** will be demonstrated by consistent application of the following principles:

- We have confidence in people
- We will listen to people's opinions and needs
- We believe that work enhances a person's stature and provides opportunities for meaningful relationships.
- We believe the individual is the driving force in service planning.
- We will address each person's unique preferred lifestyle in productive and meaningful ways.

## II. Planning Process

Coastal Plains MHMR recognizes that planning is a continual process of evaluating needs, identifying internal and external forces, prioritizing needs and services to be provided based on requirements, allocating resources and developing improvements. This ongoing evaluation of progress and revision of needs, goals and objectives is based on the changing environment, State requirements and available resources. The Local Service Area Plan encompasses the agency's other planning initiatives, including the Local Plan and Network Development (formerly two different plans called Network Development Plan and Provider of Last Resort Plan), Quality Management Plan, Diversion Action Plan (previously called the Jail Diversion Plan) and ADA Transition Plan. As the planning process is ongoing, the Director of Quality Management continues to monitor the progress of the agency's plans on either a quarterly, biannual or annual basis. The Quality Improvement Plan (QIP) progress is monitored quarterly. The purpose of this plan is to list the Center's improvement activities for the next year, to include overall goals, objectives and performance indicators.

An important step in the 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. During the planning process, a timeline is developed to seek specific input from the stakeholders. Bi-annual "needs assessment" surveys and "focus groups" are held in each service area. In FY 2008, the needs assessment and focus groups were centered on the requirement to be the "provider of last resort" for mental health services. Though the surveys and focus groups directed towards mental health services, they did include issues and feedback surrounding all service areas, consistent with our Center services. There are also other ways in which input from stakeholders is obtained. They include the following:

- evaluation of the ongoing satisfaction surveys conducted;
- review of complaints/comments made to the rights protection office;
- staff participation in various social coalition groups;
- input from the Board of Trustees;
- input from the Planning and Network Advisory Committee (PNAC); and
- other quality improvement initiatives to solicit input regarding services and service needs.

Coastal Plains MHMR staff collaborates, formally and informally with other state and community service agencies. Some of the agencies which there are ongoing collaborative efforts related to service provision and planning includes staff participation in meetings with:

- Other Community MHMR Center staff to share ideas such as consortium meetings;
- San Antonio State Hospital and Rio Grande State Center staff;

- Community Resource Management Group (CRCG), Community Resource Management Group – Adult (CRCGA) and Community Management Teams (CMT);
- Beeville Social Coalition Group (includes the Texas Departments of Human Services, Family and Protective Services, Pardons and Paroles and other community service agencies including the Vineyard, Bee County Welfare Board, Connections, Coastal Plains MHMR, Beeville ISD, etc.)
- Coalition meetings are held in the majority of service areas with law enforcement, judges, hospital, nursing homes and other agencies to discuss any issues related to mental health
- Chambers of Commerce in main service areas
- Community Action Agency
- Education Service Center
- Head Start
- Social Security Administration
- Texas Department of Family and Protective Services and other State agencies
- Local Independent School Districts

The information shared and gathered at these meetings provides on going feedback to Center management staff. This feedback impacts planning of services both directly and indirectly, by educating the community on services and their limitations available in the community; problems or barriers to services; and decreases the duplication of services.

On an annual basis, the Planning and Network Advisory Committee (PNAC) meets with the senior managers to evaluate the quality improvement plan goals. Every other year they also review the needs of the community (based upon the survey/needs assessment results, focus group feedback and other input received). Whether it is a formal planning year or just an annual review, the Committee helps the Center staff prioritize what the agency should focus on for the next fiscal year or during the two-year planning cycle.

The PNAC is provided information regarding the external and internal factors that affect the agency's ability to provide services. Based upon the committee's review of the community's feedback, recommendations regarding the priorities of the community are made to senior management. Senior Management uses this information to develop goals, objectives, strategies, and performance indicators and forms a Quality Improvement Plan, annually. This plan includes responsible staff and dates for completion, to ensure that the goals are addressed. Throughout this process, Coastal Plains management staff is working with the fiscal management staff to ensure financial allocations are made to meet the goals of the plan.

The Planning and Network Advisory Committee (PNAC) is primarily comprised of consumers and family members from the various service areas. As the majority of the committee membership consists of people who directly or indirectly receive services, the agency receives constructive feedback on a regular basis regarding service provision and local needs. The Board of Trustees receives a report and recommendations from the committee after each meeting if action or recommendations were made. The Board recognizes the importance of the PNAC and this is reflected in the minutes and endorsements to staff.

### **A. Plan Review**

The Director of Quality Management monitors the Quality Improvement Plan quarterly and reports any major concerns to Senior Management which comprises the quality management committee. The committee membership includes members of senior management (the Executive Director, Deputy Director and the directors of Authority functions, Mental Health services and Mental Retardation services, Director of Access and Intake) and the Director of Quality Management.

The QM Committee meets at least twice a year with quarterly reports completed by the QM Director with reports from the Service Directors. From the progress reports, the objectives are evaluated, modified if needed and additional objectives are added, based upon the needs of the Center.

### **B. Local Service Area Plan Goals**

As Coastal Plains Community MHMR Center is in a constant state of change and growth, the Center's goals are broad in scope. On an annual basis, the management staff review the goals and develop outcome measures, strategies and actions to be taken. The Centers goals are as follows:

#### **To meet or exceed**

- **Department of Aging and Disability Services (DADS)**
  - **Department of State Health Services (DSHS)**
  - **Early Childhood Intervention Services**
- outcomes and targets on an annual basis.**

#### **To improve overall services and supports provided in**

- **mental health,**
- **mental retardation and**
- **early childhood intervention services**

### **III. External Assessment**

Coastal Plains Community MHMR Center must evaluate both the internal and external environmental factors that affect the agency's ability to achieve its goals. One of the major external environmental factors influencing services to be provided is general revenue funding. This funding, provided through the State Authority, 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 B) and guidelines for service provision.

The State Authority also defines a "target" number for specific populations to be served. Although evaluation of the target numbers, compared to targets met, is one method of measuring customer demand and public need, these numbers do not provide a complete picture of service needs in the community. Through the Local Service Area Planning process, other methods of information gathering are utilized, in order to assist the Board of Trustees, PNAC and management staff in the understanding local needs.

In addition to the State Authority's requirements, there are other external forces that impact service provision by the agency. 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 either have already affected service provision or could affect service provision in the near future.

#### **A. Resiliency and Disease Management (RDM)**

Over the past four years, the community centers across the state of Texas have converted to the requirement to revise their service provision to the Resiliency and Disease Management model. This is a form of managed care, which provides benefit packages and utilization management guidelines for the centers to utilize. This model of services is based upon "service packages" designed to offer services to eligible individuals based upon their needs. Each individual's needs are assessed through a tool called a Texas Recommended Authorized Guidelines (TRAG). This assessment reviews various areas of a person's life to include support needs, risk of harm, functional impairment, employment, housing, substance abuse issues and criminal justice involvement. The TRAG also reviews a person's current symptoms, as related to their diagnosis. Based upon the assessment, the person will be designated to a service package. This package will be explained to them and they have the choice to accept that package or chose a lesser service package, based on their perceived needs.

#### **B. Legislative Factors**

House Bill 2292 from the 78<sup>th</sup> Legislative Session, combined the eleven state agencies into four state agencies under one umbrella agency, the Texas Department of Health and Human Services. In this split, the Texas Department

of Mental Health and Mental Retardation was abolished. The Department of State Health Services oversees the mental health services functions; mental retardation services functions are under the Department of Aging and Disability Service and the Early Childhood Intervention program went to the new Department of Assistive and Rehabilitative Services. This bill also places responsibility on the mental health authority to use disease management practices when providing services. There were also modifications to the Benefit Design initiative to meet this outcome. There is also a provision in this bill to ensure that there are Jail Diversion strategies through local planning. The goal is to divert people who are at high risk for criminal justice involvement that are also members are the priority population from incarceration. Also, the Mental Retardation Local Authority (MRLA) program was converted to the Home and Community-based Services (HCS) program, effective September 1, 2003.

### **C. Local Planning and Network Development *Texas Health and Safety Code (Section 533.035)***

In this bill, Section 2.74 states that the local MHMR's will be the providers of last resort. This is the result of changes coming out of the 80<sup>th</sup> Legislative Session and was the resolution of the "Provider of Last Resort" language that came out of the 78<sup>th</sup> Legislative Session. Though initially it was thought that the requirements were related to mental retardation services, there was clarification sought from the State Attorney General's office which indicated that the new rule applied to Local Mental Health Authorities (LMHA), such as Coastal Plains Community MHMR Center's mental health services. Upon the determination that the rule applied to mental health authorities, multiple agencies and advocacy groups worked together to develop guidelines which then became law during the 80<sup>th</sup> Legislative Session. This law is called "Local Planning and Network Development (LPND)" which "...charges the LMHAs with the responsibility for ensuring that mental health services are provided in their local area and, further, requires LMHAs to consider public input, ultimate cost-benefit, and client care issues to ensure consumer choice and best use of public money in assembling a network of service providers."

Under the Texas Health and Safety Code (Section 533.035) which was just quoted, this law requires the Local Mental Health Authorities to provide management and oversight to a system of service delivery which offers consumers a choice among multiple service providers. The goal of this process and plan is for Community Centers, like Coastal Plains MHMR, to increasingly expand its network of providers to allow consumers to have choice among multiple service providers; and for the Center to provide management and oversight of the provider network.

### **D. Service Area Demographics and Cultural Diversity**

South Texas consists of a very diverse culture and ethnic population. The beauty of this area is that there are people who are Hispanic, Caucasian, African American, Asian, Native American and a variety of ethnic backgrounds and mixes, among those listed. Though the main language spoken is English, many people are bi-lingual and speak fluent Spanish, though due to the diversity of the area, there are many dialects spoken. As Texas has such a broad cultural diversity, there are many religions, and cultural practices in the area. With that in mind, the people who are involved in our community surveys, coalition groups and receive our services are from a diversified group with a wide variety of opinions and ideas regarding the services provided and needed in the community.

**E. Other Demographic Issues:**

Another concern, in relation to the service area, is the poverty level. The following table represents the poverty level percentages, by county, per the U.S. Census Bureau (most recent statistics for rural area):

<b>County</b>	1999 percentage of total number of people living below poverty level
<b>Aransas</b>	19.9%
<b>Bee</b>	24%
<b>Brooks</b>	40.2%
<b>Duval</b>	27.2%
<b>Jim Wells</b>	24.1%
<b>Kenedy</b>	15.3%
<b>Kleberg</b>	26.7%
<b>Live Oak</b>	16.5%
<b>San Patricio</b>	18%

These statistics are significant, as the poverty rates are high and poverty rates complicate service provision. The following is a list of factors related to our service area, which affect people served:

- No “public transportation” people can take to and from the mental health clinics, grocery stores, work, primary care physicians or other local service providers.
- Medicaid transportation is available, but only on designated days, depending on the city or town that a person lives in.
- Medicaid transportation has restrictions, which many times are barriers for our consumers such as arrangements must be made in advance, last minute cancellations can result in suspension of privileges, etc...
- Some service areas do have low-cost transportation is available, but again, that is only on designated days and with conditions, to include long waits to be picked up, must have driveway to be picked up (many rural homes have dirt roads for driveways), etc...
- Lack of suitable housing options (there are no homeless shelters in any of the counties served);

- Limited health care for people with no insurance, thus the emergency rooms have a higher utilization for everyday health issues;
- Limited health care choices for people who do have insurance, in the rural areas the community mental health center is the only place to receive psychiatric services without driving to a larger city.
- Rising fuel costs, the cost of food and other resources are increasing, limiting the availability of money that consumers have to spend on co-pays and seeking private care.

## **IV. Internal Assessment**

### **A. History and Organizational Overview**

On November 22, 1991, the Texas Department of Mental Health Mental Retardation (TDMHMR) adopted a set of guiding principles, which emphasized a shift in the control of delivery of services from the State Authority to the local communities and consumers. Responding to this mandate, the State began a consolidation of community service operations provided by state hospitals and state schools. As a result of this mandate, on September 1, 1996 Coastal Plain State-Operated Community MHMR Services (CPSOCS) was created.

Coastal Plain SOCS was formed by merging different parts of the community MHMR services divisions of the three existing southern State facilities – Rio Grande State Center, San Antonio State Hospital and the Corpus Christi State School. Coastal Plain SOCS was designated by TDMHMR as the Mental Health and Mental Retardation Authority of Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak and San Patricio Counties. At that time, Coastal Plain was a state-operated component of TDMHMR. It was governed directly by the TDMHMR Community Services Division. Governing Body meetings were held semi-annually with State Authority staff and local senior management team. Open forum sessions were provided during one of these meetings to encourage community comment and input. The agency also received input from its new Planning Advisory Committee that was comprised of consumers, family members and community members interested in mental health and/or mental retardation services.

In accordance with the mandate requiring TDMHMR to shift the control of services to the local level, Coastal Plain SOCS was required to move towards becoming an independent community center. This shift would necessitate the development of a Board of Trustees that represented the nine counties served; a shift in management from state governance to local governance; development of an independent financial team; obtaining of funding at the local government level; a change in benefits packages for staff, including addressing longevity issues

related to state employment; and a multitude of other factors in relation to becoming independent from the state. When exploring options related to becoming an independent community center, the agency considered a possible consolidation with Nueces County MHMR Community Center. In February 1999, the Nueces County Commissioner's Court decided not to pursue the merger. As Nueces County was the only natural geographic and political partner for the nine county area served by Coastal Plain SOCS, the commissioner's courts in each county decided to pursue formation of an independent community center.

On May 18, 1999, Coastal Plain SOCS held its first Board of Trustees meeting with membership comprised of judges and commissioners from the respective nine counties. This new Board voted to change the name of the agency to Coastal Plains Community MHMR Center and to move the administrative offices from Nueces County to San Patricio County. On September 1, 1999 Coastal Plains officially became an independent community center. In September 2000, the administrative offices moved into San Patricio County.

### ***Organizational Overview***

In order to focus on the future, it is necessary to understand the size and composition of the workforce, including the human resources; the organizational structure and process; the composition of the Board of Trustees; and the geographical locations of services. As noted previously, the agency has a Board of Trustees that oversees the overall operation of the Center. The Board is comprised of representatives from the nine (9) county area served. Currently, the nine representatives are either the county judge or a county commissioner, appointed by the county judge to the Board. The Board is charged with the management of the agency and its operations. Business is conducted in open board meetings, which are held on the third Tuesday of the month. The location rotates within the nine counties represented. The public is invited to attend all Board meetings and there is opportunity provided to address the Board at each meeting.

### ***Human Resources Development***

The primary function of the Human Resource Development (HRD) office is to coordinate and present information and training to employees of Coastal Plains Community MHMR Center. Education and training services include orientation, basic skills, pre-service, in-service and continuing education. Training is primarily instructor-led classroom instruction and on-the-job training (OJT). Currently, all staff attends two days of pre-service orientation prior to reporting to their work site. Classes included are: policies and procedures, safety, infection control, sensitivity, abuse/neglect/exploitation, confidentiality, rights, diversity, and verbal intervention skills. One of these days is completed at the work site of the staff person by utilizing e-learning. This is a new form of training in which new employees log into a web site and watch a combined power-point

presentation with a video recorded presentation of the training. They then have the opportunity to take a test. After they have completed the e-training, they link up to the Administrative office for a video teleconference to reinforce the training that they received over the computer.

Staff working directly with consumers also receive training in CPR, First Aid, PMAB (verbal intervention skills), behavior management, seizures, observing and reporting, and pharmacology. An additional day of training is provided to all staff on fleet management, basic computer skills, and assessment of homicidal/suicidal behaviors. Staff working with the mental health (MH) population, also receive training on crisis intervention, treatment planning, billing, etc. Staffs working with people receiving mental retardation (MR) services receive training in treatment plan development, skills training, etc. Case Managers and Service Coordinators receive specialized training based upon the specific service they provide. Each discipline receives on-the-job training once they report to their work site. Staff who are responsible for transportation are provided training on the operation and maintenance of the vans.

### **B. Population**

The following is a summary of the priority populations to be served with general revenue funding (definitions are from the Community Mental Health and Mental Retardation Center Performance Contract Notebook for Fiscal Year 2005):

- Adults who have severe and persistent mental illnesses such as
  - Schizophrenia
  - Major depression
  - Manic depressive disorder, or
  - Other severely disabling mental disorders (with a GAF of 50 or below except for a sole diagnosis of substance abuse or mental retardation) requiring ongoing MH services and were initially eligible for DSHS funded MH services.
- Persons who request and need services and possess one or more of the following conditions:
  - Mental retardation, as defined by Section 591.003 (13), Title 7, Health and Safety Code.
  - Autism as defined in the current edition of the Diagnostic and Statistical Manual (DSM).
  - Pervasive Developmental Disorder (PDD) as defined in the current edition of the DSM.
  - Eligibility for Early Childhood Intervention Services (w/the requirement that DADS memorandum dollars may not be used by the Local Authority (LA) to pay for the same services purchased through the LA's memorandum w/ECI Council).
  - Eligibility for OBRA '87 mandated services for mental retardation or related condition as defined in 42 Code of Federal regulations 453.1009

- Children and adolescents under the age of 18 years with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders who:
  - have serious functional impairment; or
  - 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 serious emotional disturbance.
- Coastal Plains Community MHMR Center also provides services to children, birth to age 3, in Aransas, Bee, Live Oak and San Patricio Counties. Eligibility requirements include children who are birth to three years of age, and
  - Exhibit a developmental delay, or
  - Have a medical diagnosis that places them at high risk for a delay, or
  - Exhibit an atypical development as determined by a qualified professional

The center recognizes that there are many people in the community that do not meet eligibility criteria for services or alternatively choose not to receive services. Some examples of populations of people not receiving services from CPMHMR:

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

### **C. Services and Supports**

#### **Adult Mental Health**

Treatment is provided to help people recover from mental illness and enable them to continue in their jobs, be with their families and remain in the community. Services are provided to people who have serious mental illness and/or have difficulty with daily functioning due to mental illness. The following are examples of services provided:

- 24 Hour Crisis Intervention
- Case Management
- Psychiatric Evaluation and Consultation
- Hospital Screening
- Medication Management
- Psychosocial Rehabilitation
- Supported Housing and Employment
- Assistance with Accessing Benefits

### **Children's Mental Health**

Our goal is to provide treatment that will bring stability to children, adolescents and their families experiencing difficulty due to a mental health disorder.

Services provided include:

- Psychiatric Evaluations and Screenings
- Case Management
- Medication Monitoring
- Skills Training for Children and Adolescents
- Parenting Skills Training
- Cognitive Behavioral Therapy
- Home and School Based Intervention
- Assistance with Accessing Benefits
- 24 hour crisis intervention services

### **Mental Retardation Services**

Our Mental Retardation Centers are offering help and support to hundreds of people with mental retardation. Intake workers and psychologists determine the eligibility for services. Mental retardation services provided include:

- Day Programming
- Service Coordination
- Self-help Skills Training
- Respite
- Residential Support – Supported Home Living
- Employment Assistance
- Assistance with Transitioning from Schools
- Home & Community Based Services
- Texas Home Living Waiver Services

### **Bay to Bay ECI Program**

Bay to Bay is an Affiliate of Texas Early Childhood Intervention and is operated by Coastal Plains Community MHMR Center. Children grow, learn and develop a lot during their first three years. Although each child is special and grows and learns at his or her own pace, some children need extra help. This extra help is called early childhood intervention. Services can include but are not limited to the following

- Early Identification, Screening and Assessment
- Assistive Technology
- Audiology
- Family Counseling
- Family Education
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Service Coordination
- Speech Therapy

### **D. State Facility Utilization**

The Center continues to utilize state facilities, state hospitals and state schools. For state hospital utilization, a trust fund is allocated to the Center for patients not otherwise covered by another pay source. The Center works closely with the state hospitals to ensure that utilization management and continuity of care is provided to the consumer. Utilization management is to ensure that the person receives the appropriate services for the least amount of time necessary, as the goal is to assist the person in getting back into the community as soon as possible. For both local hospitalization and State hospitalization, the intent is to only hospitalize a person for acute crisis stabilization; long-term stays are limited, with the goal of providing outpatient (community) treatment. Current utilization is approximately 62% of allocated bed days.

State school utilization is also limited, with most of the contact with continuity of care staff participation in pre-discharge and discharge planning. Upon intake, and upon request, the Center provides consumers and their families with choices regarding their service options within the community, which includes State School placement. However, the Center also emphasizes the goal of placement in the least restrictive environment, to include independent living with support, when possible. The Center's Rights officer had previously participated on the state school's human rights committee, however, over the past year this participation has not occurred as the school has not requested attendance. There continues to be good working relationships with both the state school and state hospitals that the Center utilizes, through the continuity of care workers.

### **E. Resource Development and Allocation**

As noted previously in this report, the agency's primary funding sources are general revenue money from DADS, DSHS and Medicaid reimbursement. With this limited funding, there is a need to develop strategies to ensure best value for services and to expand revenue. Coastal Plains Community MHMR Center attempts to do this in a variety of ways. The PNAC evaluates contracted services to determine if the service is best provided by the agency or if the consumer would have better **access, choice** and higher **quality** services if the service was contracted. The agency has contracted several services with private providers, as it was determined by the PNAC, management and the Board that this provides best **value**. The Local Plan and Network Development (LPND) addresses specific contracting issues for mental health services which will not be repeated in this plan. For details regarding the various contracted services, refer to the LPND plan which is an attachment to this plan.

## **F. Community Needs and Priorities**

In order to ensure that the planning process was inclusive and representative of the diversity of the local service area, the surveys were translated into Spanish/English versions, with several bi-lingual staff reviewing them to ensure that the translations are congruent with the dialect and slang terms utilized in our service area. The consumer/family survey has explanations for each question. This modification to the standardized survey was made after the first focus group held with consumers, as this was recommended by the consumers and the staff who provided assistance in reading the survey. At every scheduled meeting surveys were provided to each participant and sign-in sheets were obtained. The exception to this rule was when the planning coordinator went to each clinic site and sat in the lobby during medication clinic day to provide education and surveys to consumers; there were no sign in sheets for this as the setting was such that it was not feasible to have a sign-in sheet.

### **Several different approaches were taken to identify participants in the planning process.**

- The first approach was to attend as many coalition meetings as possible within the communities the Center serves. The goal was to ensure that the public and private service providers would be included in the planning process and would have the opportunity to share what they learned, with their co-workers.
- The local advocacy group was included in the planning process. There is only one National Alliance for the Mentally Ill group in the area. However, this group also sponsored a mental health awareness walk in the community in the month of May. The planning coordinator made arrangements to educate the Rockport NAMI group at one of their regularly scheduled meetings. There was also an information table at the mental health awareness walk, where information and surveys were distributed and questions were answered regarding the local planning and network development.
- Another method to solicit input was to set up meetings with consumers and family members. This was a two-step approach. The first being attendance at the peer-support meetings; the second was to solicit input on “doctor” days where there is a constant influx of consumers and their family members in the mental health centers. Education and surveys were provided.
- From previous planning efforts, public meetings scheduled in the evenings and weekends have proven to be unsuccessful. The last planning cycle for FY 2006-2008 meeting attendance, with advertisements and postings in newspapers, in clinics and with flyers sent to community service agencies still resulted in less than favorable turn out (at most, twelve people attended, with the assistance of staff transporting them; and at the majority of the public meetings one or two people attended). This type of public meeting was not scheduled for this planning cycle, as it was not determined to be a good use of staff time or public funds.
- Surveys were sent out with our Center’s quarterly newsletter. Two-hundred (200) surveys that were sent to various stakeholders in the community. These

stakeholders included state representatives, local service providers, contractors and volunteers. Each person who received a survey also received a summary of the local planning efforts in regards to network development and a self-addressed stamped envelope. The newsletter also had a special section which asked each one of the survey recipients to take the time to complete the survey and to contact the planning coordinator, either by telephone (toll-free number provided) or by e-mail if they had any questions.

- The Planning and Network Advisory Committee was involved in multiple phases of this process. They received education, through the use of the state provided power-point presentations, provided surveys and participated in multiple meetings to discuss survey results, the plan and the procurement process.

Description And Date or Timeframe	Participating Organizations (List)	Number of Consumers	Number of Family Members	Number of Interested Individuals
<b>Total Stakeholder Feedback</b>	<b>The majority of the feedback was through the surveys returned at the meetings held. Some participants choose to take surveys with them and return in self-addressed stamped envelopes provided to them.</b>	<b>141</b>	<b>50</b>	<b>93</b>

**1) Summarize the input received from stakeholders regarding...**

***Service needs and priorities for children, adolescents, and adults;***

4/10/08 Coalition Group

- Transportation needs, especially for people with detention warrants, as this ties up law enforcement but places MHMR staff at risk so they cannot transport.
- If services are contracted out, the contractors should have services set up to be provided in a central location (where the clients can see the doctor, nurse, case manager all at the same place).

CRCG Meeting 5/14/08:

- Wouldn't the contracting out of children's mental health services result in a less cohesive system? We need cohesion and consistency for the kids and their parents.
- Services still need to be provided in a central location, where the clients can see the doctor, nurse, case manager all at the same place.

2. NAMI Meeting 5/22/08

- Counseling services needed for most of the consumers (explained service packages and eligibility requirements for CBT)
- State and local hospitals need to communicate discharge planning with family members (explained rights,

- confidentiality, authorizations for disclosures and continuity of care)
- Longer stays in hospitals for people to become stable on medications prior to discharge, not just keep people 2-3 days then discharge them when they are no longer suicidal, as the medications have not had time to take effect.
- Increased housing
- Increased transportation
- Services still need to be provided in a central location, where the clients can see the doctor, nurse, case manager all at the same place.
- ***Crisis response system and services;***
  1. 4/10/08 Coalition Group
    - The system works; law enforcement knows who to go to if issues arise.
    - Services still need to be provided in a central location, where the clients can see the doctor, nurse, case manager all at the same place.
  2. 4/16/08 Coalition Group:
    - There needs to be increased communication between law enforcement, MHMR/crisis staff and hospital staff to ensure medical clearance. This would decrease wait time for transport and ensure efficient use of sheriff's office overtime. Also need to provide notification, in advance, if female officer is needed for transport.
    - Services still need to be provided in a central location, where the clients can see the doctor, nurse, case manager all at the same place.
  3. NAMI Meeting 5/22/08
    - Current crisis system seems to be working. Police department is trained in working with individuals with mental illness and MHMR responds.
    - Services still need to be provided in a central location, where the clients can see the doctor, nurse, case manager all at the same place.
- ***Development of an external provider network;***
  1. 4/10/08 Coalition Group
    - If services are contracted out, this would result in confusion for community service providers (e.g. law enforcement and J.P.'s)
    - Don't want to see MHMR contract out services as this would result in fragmentation of the system.
    - If this happens, the new providers need to make sure that they are providing services like MHMR, where the clients can see different staff at one place.
  2. 4/16/08 Coalition Group
    - Providers would need to be able to provide the same services as MHMR and have a central location
  3. NAMI Meeting 5/22/08
- ***Other significant issues and concerns.***
  1. 4/10/08 Coalition Group

- Law enforcement and Justice of the Peace know MHMR staff and feel that they have a good working relationship and clients need consistency.
  - JP doesn't want some stranger waking him up in the middle of the night to sign a warrant, wants to deal with MHMR staff that he knows and trusts their ability to assess and make recommendations.
  - Centralized location, same type of access (one building with all services at the same site)
2. 4/16/08 Coalition Group:
- This will fragment the system.
  - Will this actually meet the needs of the consumers?
  - Contracting out of mental health services to outside providers will be tragic for the psychiatric population as it would take away the continuity of care.
  - Medical clearance requirements prior to admission into a psychiatric facility sometimes results in long waits, barriers to treatment and transportation issues.
  - All services (case management, nursing, doctors, intake) need to be at the same site
3. Focus Group w/Consumers (5/2/08)
- Will I still be able to come to this clinic? I like things the way they are.
  - I like my doctor and I don't want to change, so I want things the same.
  - Will they have a clinic like this, where I can see different people who do different things for me? Like the doctor and my case manager?
4. NAMI Meeting 5/22/08
- Would this mean that I would have to get a different doctor?
  - What about the staff? I am happy with my case manager and can talk to her.
  - Contractors need to be able to provide all the services at the clinic, like MHMR does.
5. Jim Wells County Community Coalition Meeting 7/16/08
- Do not change things
  - Do not contract out services

**(B) From Surveys**

- ***Service needs and priorities for children, adolescents, and adults;(Services listed in order of importance)***

1. *Doctors/Psychiatric Services (138/202 survey respondents)*
2. *Medications (113/202 survey respondents)*
3. *Counseling (CBT for both adults, adolescents and children) (76/202 survey respondents)*
4. *Case Management (68/202 survey respondents)*
5. *Nursing services (64/202 survey respondents)*

- ***Crisis response system and services;(results from Crisis Redesign Plan)***
  - Transportation
  - Wait time at the hospitals
  - Substance abuse services
  - Education of law enforcement (police & sheriff departments) regarding MH crisis issues
  - Education of emergency room workers regarding crisis services, processes and intervention for people with mental illness (it was expressed that some ER staff are not sensitive to or do not understand mental illnesses or know appropriate intervention)
  - 24 hour crisis line services or supports for consumers when not “suicidal” or “homicidal” e.g. consumer runs out of medication and realizes it after hours; panic attacks, etc...
  - Peer support groups
  - On-going jail diversion activities, such as educating the judges, district attorneys and police regarding options and decreasing incarceration, when the crime is directly related to the person’s mental illness.
  - To continue to have MHMR be the provider of the crisis outreach services, not contract the service out to ensure continuity for the law enforcement and judicial intervention.
- ***Development of an external provider network;***
  1. Contract services should be “convenient location to home” (144/202 survey respondents)
  2. Contract services should have “all services in the same location” (103/202 survey respondents)
  3. Contract services should have “transportation available” (92/202 survey respondents)
  4. “Cost of services” is important (78/202 survey respondents)
  5. “Wait time to see the doctor” is important (77/202 respondents)  
\*special note as the tally was close for this response: 75/202 respondents also wanted a “pharmacy on site”
- ***Other significant issues and concerns (issues brought up consistently in comments or “gaps”).***
  1. Chemical dependency counseling is not available through MHMR
  2. Transportation is a significant barrier to accessing community services
  3. Counseling (psychotherapy/talk therapy/family therapy/group counseling) desired
  4. Lack of housing in the community
  5. “Drop-in” type centers/social clubs for mental health consumers to be during the day to socialize with others
  6. Doctor be available more often or every day at the clinics, in case people “need” to see the doctor and/or decrease wait time to see the doctor

## **G. Impact of Key Forces**

### **SWOT Analysis**

Inclusive of consumer and other stakeholders input, the Center's Management Staff compiled and identified the following strengths, weaknesses, opportunities and threats (SWOT analysis), as well as gaps in services that will affect services over the next biennium.

#### **SWOT Analysis:**

##### **Strengths:**

- Extensive experience in providing mental health services
- Involvement of stakeholders, including consumers and families in planning and contracting of services
- Able to provide services, exceeding targets set by state, with scarce resources
- Provide quality services, based upon data verification and other service reviews
- Responsive to community needs, based upon quality improvement plan and network development plan
- Experience in open enrollment process and contracting of services
- Strong, supportive Board of Trustees with business and governmental experience
- Proven history of partnering with local entities (various community coalition groups, Coastal Bend Rural Health Partnership)
- Provide services "in vivo" to consumers in very rural areas with limited funding
- Able to provide limited transportation for consumers to psychiatric appointments with no funding reimbursement
- Strong Patient Assistance Program application and approval rates
- Good working relationship with contract psychiatrists
- No waiting list

##### **Weaknesses:**

- Large, rural geographical service area with sparse population
- Difficult to find and/or maintain qualified mental health professionals to work in rural areas
- State mandates regarding service provision/service requirements put centers at a disadvantage when competing with service providers (in regards to paperwork/documentation requirements)
- Lack of reimbursement for required service provision for lower service packages (e.g. TRAGS)
- No late evening/weekend hours for routine services.
- Lack of understanding by community/consumers regarding limitations imposed by funding sources (e.g. desire for "reflective counseling" and "extended doctor visits to receive psychotherapy by psychiatrists")
- Exceeding contract targets to prevent waiting lists ("spreading the butter thinner on the bread")
- Lack of choices in communities for private care for insured population
- Lack of private providers interested in the very rural areas

**Opportunities:**

- Continue to educate stakeholders and public regarding changes regarding LPND
- Continue to educate stakeholders and consumers regarding services and their limitations
- Continue to offer late afternoon and early evening psychiatric clinics
- Continue to offer telemedicine services between clinic to provide choice to consumers

**Threats:**

- Funding for social services have not kept pace with inflation
- Rising fuel costs creates barriers to access services for consumers

Gaps in Services (per Stakeholders, Community Members and Consumers)

Adult and Child Services

- Transportation needs –
  - To and from MHMR center services and
  - To and from psychiatric facilities when a mental health detention warrant is issued
- Counselors – community members continually request counseling for consumers and family members, above and beyond Cognitive Behavioral Therapy (e.g. family counseling for parents of children w/emotional disturbances, marriage counseling, drug and alcohol counseling, talk therapy – not CBT, etc...)
- Drop-in Centers or other such facility for adults with mental illness to “hang out” during the day to socialize with others.
- Childcare for children with emotional disturbances who don’t fit in or get kicked out of the afterschool/summer programs
- Free medications – people do not like to pay for/cannot afford co-pays if on Medicare or private insurance
- Residential Care - group homes/housing for adults who have a mental illness, but need some supervision while living in the community
- Community members to be representative payee for social security benefits for consumers are limited
- Non-urgent “crisis” line for after hours, for people who feel that they are in crisis, but feel they need someone to “talk them through things” e.g. don’t have the skills/aren’t retaining skills taught to deal with insomnia, family frustrations, etc...that aren’t appropriate for crisis hotline or crisis face-to-face services
- Limited AA/NA meetings in service areas for linkage for co-occurring disorders, thus 30 meetings in first 30 days impossible for people with goal of recovery
- Limited detox options for people with and without funding
- Medical clearance requirements prior to admission into a psychiatric facility sometimes results in long waits, barriers.
- No funding for education, prevention and outreach

The **opportunities** and challenges projected for the biennium for the Center are:

- Crisis hotline and crisis outreach services to be integrated, with Mobile Crisis Outreach Teams (internal and contracted) communication to clinic case workers for case follow-up
- Continued coordination of services with local law enforcement and hospital emergency rooms to provide efficient and effective services to the people served in a timely manner, with the least amount of barriers possible, for all people involved
- Education of the stakeholders regarding priority population and service limitations, in regards to counseling, drop-in centers, transportation to the Center and group living environments for people with mental illnesses
- Continued initial education and ongoing support to assist people in learning about right to services and responsibility for payment of services and supports, e.g. medication costs; as well as linkage to community services to provide assistance based upon eligibility requirements of patient assistance programs

### **H. Local Authority Service Priorities**

**Priority: Assistance with medication costs**

**What CPMHMR is doing:** Continue with the Medication Algorithm Project, Utilization Management system, education of consumers through TIMA and collaboration with other community service agencies to link consumers with supports. The Center continues to link people to indigent medication programs (Patient Assistance Programs), Medicare Discount Drug Cards and assist people in applying for Social Security benefits. We also continue to collaborate with other medical service providers to assist people in obtaining medications at the lowest cost.

**Priority: Collaboration with other service agencies**

**What CPMHMR is doing:** In the majority of the service areas, the mental health clinic directors meet with the local hospital/emergency service personnel, judges, district attorney(s), probation/parole, police and sheriff departments to address areas of concern that may arise. The Center is especially involved in the Coastal Bend Rural Health Partnership. The goal of this group is to coordinate care and services for consumers of both agencies – to link and refer to the respective agencies in order to help consumer's take care of both primary health care and mental health care needs. Staff members also sit on a variety of community organization committees, such as Rotary, local area social service coalition groups, CRCG's, CRCG-A's, and the United Way. Through these different organizations they share information about services and their limitations.

**Priority: After school/summer programs**

**What CPMHMR is doing:** Continue to collaborate with other service agencies to find and provide after school and summer programs for children. Exploring alternatives for children with serious emotional disturbances through collaboration with the Juvenile Justice System, other providers such as

TCOOMMI and providing case managers with information about available services and resources.

**Priority: Parenting Skills Training**

**What CPMHMR is doing:** When a child is determined to qualify for a service package that includes parenting skills training or if there is a medical necessity to "add on" this service, the parents/Legally Authorized Representative is informed about the service option. As in certain service packages, for a child to receive skills training, the parent must also participate in the skills training modules. CPMHMR staff continue to work to be flexible to meet the needs of the family to enable participation.

**Priority: Substance abuse treatment for individuals with co-occurring psychiatric and substance abuse disorders**

**What CPMHMR is doing:** Continue collaboration efforts with the area substance abuse services providers, including referrals, staff education of symptoms/interventions. Upon employment, staff is trained on the signs and symptoms of substance abuse and referral agencies.