CENTRAL PLAINS CENTER

LOCAL SERVICE AREA PLAN
Fiscal Year 2026-2027

………improving the quality of lives………

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PREFACE

The purpose of the Central Plains Center (Center) Intellectual and Developmental Disabilities (IDD) Local Plan (Plan) is to define a plan that communicates the mission, vision, values, goals, and objectives throughout the organization; it furthers the Center's development by providing a framework to accomplish those goals and objectives. The Plan describes the Center's IDD programs and services while providing a systematic, organization-wide approach to designing, measuring, assessing, and improving consumer treatment, outcomes, and support services. The Plan is designed to be responsive to community and consumer needs and improve consumer outcomes

The Plan represents a collaborative effort, all parts of the organization contributed to its development. The Center's goals and objectives to include IDD were developed by the Management Team (MT) from reviewing the following: Fiscal Year (FY) 2020 Performance Contracts; input from the Planning and Network Advisory Committee (PNAC), consumers and community representatives, staff through department/unit meetings, and the various center committees.

The Plan is the framework for performance improvement initiatives. IDD Services identify the Center's goals and key functions that most affect the consumer's personal outcomes. Leadership, management, and quality improvement bodies analyze and focus initiatives in order to improve processes and/or correct identified problems

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."

Vision

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

Values

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

Guiding Principles

The Center developed a set of guiding principles in to provide a basis for decision-making and prioritization of the Center's activities and use of resources. The use of the guiding principles by Center staff in their daily activities and decision-making should strengthen the Center's performance as a consumer-focused service delivery organization bringing best value return on the public funds invested in our mission. The guiding principles are as follows:

1. To provide personal outcome-based services in partnership with the individual, the family, and the community.

2. To empower the individual and family by respecting their right to make choices about their lives.

3. To provide innovative solutions that shapes the current operations and future direction of the organization.

4. To work together with others across all Center systems.

5. To address issues proactively and in a timely manner.

6. To seek best value for the individual, the community, and the organization.

7. To continue building community support for the Center's mission and services.

Local Authority Assessment

History

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 Bublis, 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 Bublis, 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 in 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:

- Marilyn Hicks, Motley County
- Basil Nash, Bailey County
- Marty Lucke, Floyd County
- David Mull, Hale County
- Mike DeLoach, Lamb County
- Mandy Gfeller, Vice-Chair, Castro County
- Doyle Ozment, Swisher County
- Garrett Davis, Briscoe County
- Robert White, Chair, 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 FY25 was 28%. This has risen from 20% pre-covid in FY 20 to the 28% in FY 25.

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 several 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.

Description of Services

The Center is one of 39 Community Mental Health and Intellectual and Developmental Disabilities Centers within The Texas MH and IDD system. The Center's programs are responsible for the delivery of a broad array of services within our 9-county area. These counties include Hale, Lamb, Bailey, Parmer, Castro, Swisher, Floyd, Motley, and Briscoe.

Intellectual and Developmental Disabilities Populations Served

Because demand for services and support exceeds available resources, delivery of services are prioritized in accordance with published directives and needs. The DADS priority population for IDD services consists of individuals who meet one or more of the following descriptions:

- Persons with IDD, as defined by the Texas Health and Safety Code 591.003;
- Persons with pervasive developmental disorders (PDD) 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 the ICF/IDD and waiver programs;
- Children who are eligible for services from the Early Childhood Intervention program; or
- Nursing facility residents who are eligible for specialized services for IDD or a related condition pursuant to Section 1919 (e) (7) of the Social Security Act

IDD Services

A full range of IDD services are available to the consumers of the communities served by the Center. Professional diagnostic, therapeutic and rehabilitation services are provided. Consumer services may include:

Service Coordination: Assistance in accessing medical, social, educational, and other appropriate services and supports that will help a consumer achieve a quality of life and community participation acceptable to the consumer as described in the Plan of Services and Supports.

Crisis Services: Services provided to an individual who is determined through an initial screening to be in need of crisis services. This service includes crisis intervention and/or monitoring of the individual until the crisis is resolved or the consumer is placed in a clinically appropriate environment. The crisis hotline and the mobile crisis intervention team are used during times of emergencies. The crisis hotline is a continuously available staffed telephone service providing information, support, and referrals to callers, 24 hours per day, seven days per week. The mobile crisis intervention team offers face-to-face, out of the office, crisis intervention/support services to assist individuals and families in managing an identified crisis. Crisis Services will be expanded with the implementation of new funds.

Crisis Intevention Services – Crisis counseling and respite services for IDD consumers experiencing a crisis event. This also includes crisis prevention services.

Respite Services: Services provided for temporary, short-term, periodic relief of primary caregivers.

Skills Training: Training consumers in skills that will help further his or her independent functioning in the community. This training promotes community integration, increases community tenure, and maintains the consumer's quality of life.

Supported Employment: Supported employment is provided to a consumer who has paid, individualized, competitive employment in the community to help the consumer sustain that employment.

Community Support: Individualized activities that are consistent with the consumer's person-directed plan and provided in the consumer's home and at community locations.

Vocational Training: Day Training Services provided to a consumer in an industrial enclave, a work crew, a sheltered workshop, or an affirmative industry, to enable the consumer to obtain employment.

Day Habilitation: Assistance with acquiring, retaining or improving self help, socialization, and adaptive skills necessary to live successfully in the community and to participate in home and community life. This service is available to non-waiver clients as well as our PASRR clients who choose to attend.

Individualized Skills and Socialization: Medicaid-funded services (HCS/TxHmL waivers) for people with intellectual or developmental disabilities. These services focus on personalized skill training, community integration, and social interaction, replacing traditional day habilitation.

Service Delivery System

Entry to Services: Individuals seeking Intellectual and Developmental Disabilities Service go through an assessment or endorsement conducted in accordance with THSC §593.005 and 25 TAC Chapter 415, Subchapter D to determine if an individual has IDD or is a member of the DADS IDD priority population. Once eligible, a consumer is assigned a service coordinator in IDD.

Other Assessments: The Service Coordinator determines the individual's need for IDD Service Coordination by completing a Service Coordination Assessment – IDD Services form.

Person Directed Plan: A personal directed plan for Intellectual and Developmental Disabilities consumers is developed. The plan identifies training and support services that address the needs and preferences of the consumer and builds on the strengths of the consumer. The personal directed plans are reviewed as prescribed by Texas Administrative Codes and new plans are developed.

Referrals: Referrals are made to internal or external providers and other community resources for services identified within the plan.

Continuity of Care: The Center strives to provide care in a systematic, continuous, and seamless manner that meets the needs of the consumer. The quality of consumer care is assessed on a continual basis through progress reviews of treatment/personal outcome plan and actions are taken to improve consumer care.

Discharge Plan: A discharge plan is developed when a consumer leaves Center services; it ensures the consumer will be assisted in the community through other resources or providers. The Center provides authority and provider services to consumers.

Service Priorities

There are services required by legislation to be provided by all local authorities for Intellectual and Developmental Disabilities Service. These services are noted with an "R" in the respective service description section.

Intellectual and Developmental Disabilities Service

Authority Services:

- Screening (R)
- Eligibility Determination (R)
- Service Coordination, Medicaid Waiver (R)
- Basic Service Coordination (R)
- Continuity of Services
- Service Authorization and Monitoring (R)
- PASRR/Habilitation Coordination (R)
- Crisis Intervention Services (R)

Provider Services:

- Respite (R)
- Community Support Services
- Day Habilitation
- Behavioral Support
- Nursing
- Family Living
- Residential Living
- Contracted Specialized Residences
- HCS Waiver
- Employment Assistance

Supported Employment
Vocational Training
Specialized Therapies

Administrative Services

The Center's administrative services consist of financial/accounting/audit control, budgeting, contract management, purchasing and supply, billing/reimbursement, property and building management, transportation, maintenance and environmental services, communication systems, information management, human resources, risk management, quality management, utilization management, consumer rights, and staff development

Client Rights

The goal of client rights is to ensure that the rights of all persons are respected and that the Center's practices are in keeping with the highest ethical standards. Consumers are informed of their rights and how to contact the Rights Protection Office upon entry into services and annually thereafter. Consumers receive a Clients Rights Handbook based upon their service program (e.g., Mental Retardation, Home and Community-based Services). Specific services provided include mediation of disputes, assistance in resolving complaints, and consultation and referral on matters of ethical concern. The Human Rights Protection Officer ensures due process for consumers with Intellectual and Developmental Disabilities when a limitation of their rights is being considered. A Human Rights Committee could convene if a behavior management plan is developed to ensure the required processes are followed and informed consent to participate is documented. Other functions include curriculum development and training in the area of rights, ensuring clients are informed on how to make a complaint, and liaison with the Texas Department of Family and Protective Services to ensure an adequate system is in place to resolve abuse and neglect issues. The Center Rights unit collects consumer rights/complaint issues conducts trend analysis on the data collected. Trends are shared with appropriate supervisors and the Integrity and Compliance Committee to develop improvement strategies.

Resource Development and Allocation

As previously noted in this report, the agency's primary funding sources are general revenue money from HHSC in addition to block grant funds, local match funds, and Medicaid earned revenue. With this limited funding, the timely and effective development of resources in support of Center programs and operations is paramount. Additional support and revenue must be generated beyond existing resources in order to sustain current services and, if possible, grow the level of services and supports to an improved level.

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 well over 50% 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. We also have projects connected to the 1115 waiver program.

The Center is currently collaborating with local schools, juvenile justice departments, and service providers from several counties after we were awarded a "systems of care" SAMHSA grant.

Other resource development initiatives include:

Utilization review and management
Third party billing
Collaboration with other service providers

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 Supported Living Center
- Big Springs State Hospital
- North Texas State Hospital
- Regence Health Network (formerly South Plains Health Provider Organization)
- Community Resource Management Group (CRCG)
- 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, 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, 34,263; Floyd, 7,174; Lamb, 13,275; Swisher, 7,828; Motley, 1,299; Parmer, 9,754; Bailey, 6,726; and Briscoe, 1,644; and Castro, 7,640. The population has been decreasing slowly over the last few years. 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 89,000), 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, Bailey, Floyd, and Castro county clinics. 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 2013 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 2013 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.

Community Needs and Priorities

The purpose of local planning is to identify community needs and priorities. Community needs are identified through public forms, focus groups, Board of Trustee meetings, Center's performance data, Center's quality improvement efforts and the PNAC.

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.

IDD Services

Persons of all ages with a diagnosis of IDD 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 IDD 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 IDD 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 IDD 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. IDD 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.