COMMUNITY CENTER READINESS GUIDE

Healthcare Opportunities Workgroup
August 2011

Texas Council
of Community Centers

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Dear Members of the Texas Council of Community Centers,

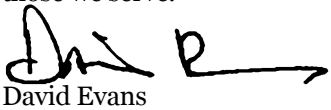
Established by the Executive Directors' Consortium, the Healthcare Opportunities Workgroup (HOW) convened to bring focused attention to changes arising from national healthcare reform and their potential impact on the system of Community Centers in Texas. The tasks were to determine steps Centers could take now to prepare for the future and to look at collective actions to make the transition successful for those we serve.

The Community Center Readiness Guide is the first product of the workgroup. Based on research, discussion, and recommendations gathered by the HOW, the Guide provides a framework Centers can use to prepare for the future. Texas is a large and diverse state: Centers will have to adapt this process based on their unique local conditions. There are, however, common elements to consider and these are included in the Guide.

We are in uncharted territory. In this Readiness Guide, the Healthcare Opportunities Workgroup has outlined steps that Centers can undertake now to prepare themselves for the changes underway in the healthcare landscape. Center leaders—Board members and administrators—must address these changes and develop local responses to meet the challenges to come. Together, we will work to shape our system of care into something that better meets the needs of those we serve.

We are not alone in this endeavor. The Texas Council is a significant resource to help us prepare. As decisions are made at the state and national level, the Texas Council will continue to be a valued voice in the discussions. The Texas Council can respond to requests from the Board and various staff consortia to facilitate learning collaboratives, training opportunities, and further statewide initiatives to help Centers adapt to the changes ahead. Each of the imperatives explored in this readiness guide contains subjects that can be further addressed at the consortia level and through additional training.

The Healthcare Opportunities Workgroup recommends that the Texas Council, through the Board and staff consortia, continue to look for ways to share learning and gain the expertise needed to succeed in the days to come. Centers need to commit to participate and contribute financially to support this work. This Readiness Guide is only the first step. Combining our efforts can make each Center stronger and better able to meet the needs of those we serve.



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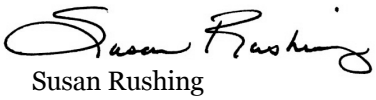

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SECTION I – INTRODUCTION

The healthcare landscape is changing in significant ways at the federal, state and local level. Across a span of more than forty-five (45) years, the Community Center system has experienced and shaped numerous cycles of change and demonstrated its strength in the face of many changes. The next several years may bring the most significant change yet – offering great opportunities for Centers and the people we serve with specialized healthcare needs.

Understanding the Changing Landscape

There are multiple changes occurring between now and 2015 that will significantly alter how people receive healthcare services and how providers are paid for the services delivered. These changes may very well disrupt institutions, habits, beliefs and revenue streams for healthcare providers across the country.

Affordable Care Act

The Affordable Care Act (ACA) combines insurance regulation reform, coverage expansion, delivery system redesign and payment reform. The most direct impact to the Community Center system is coverage expansion for Medicaid. The ACA expands Medicaid eligibility to persons up to 138% of the Federal Poverty Level (FPL), or about $15,000 a year for an individual. The Texas Health and Human Services Commission (HHSC) estimates that in 2014, the rate of the uninsured in Texas will drop from 26% or 6.5 million people to 9% or 2.3 million people. Of the 4.2 million newly insured Texans, 1.2 million will be Medicaid adults and 574,000 will be children that are currently eligible but not enrolled in Medicaid or CHIP.

In Texas, Community Centers can expect a large portion of uninsured customers who are currently covered by General Revenue to become Medicaid eligible. This has significant implications for billing, revenue streams, productivity and reserve requirements. Depending on the benefit design, the availability of certain services could be impacted. Contractual requirements and relationships with state agencies will also be affected.

In addition to the Medicaid expansion, another significant coverage expansion will be for individuals with incomes above 138% of the federal poverty level. Individuals and families with higher incomes will be eligible to purchase insurance through a health insurance exchange. To assist in purchasing insurance, federal subsidies will be available for families above 138% and up to 400% of the federal poverty level.

Studies suggest that within a one year period, more than half of all adults with family incomes below 200% of FPL will

Healthcare Changes – A Timeline

August 2011	**Readiness Guide Published**
September 2011	**Contiguous County Managed Care Expansion**
March 2012	**Statewide Managed Care Expansion**
January 2013	**Legislative Session** Refinancing of GR services to be covered with Medicaid expansion Discussion of the benchmark benefit package Identification of the Managed Care Program infrastructure to be used for expansion population
July 2013	**Exchange Qualified Health Plans Selected**
November 2013	Exchange begins selling insurance
January 2014	**Medicaid Coverage Expansion** Coverage for all individuals up to 138% FPL Defined benchmark benefit package
January 2014	**Exchange Coverage Available**

Within one year, 50% of adults with family incomes below 200% will move between Medicaid and the Exchange.

experience a shift between the Exchange and Medicaid or the reverse. For continuity of care, Centers will need to contract with insurers participating in Medicaid and the Exchange. Contracting with insurers in both programs will allow Centers to serve a person throughout the course of treatment regardless of changes in insurance coverage. And for all newly insured individuals, medical and behavioral health providers will be in high demand.

A New Vision at SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created a new, more integrated vision of the Substance Abuse and Mental Health Block Grants with a focus on supplementing treatment and support services not covered by other insurers. Under this new approach states will have the opportunity to use block grant dollars for prevention, treatment, recovery supports and other services that supplement services covered by Medicaid, Medicare and private insurance. The Block Grant funds will be directed to four purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- Fund primary prevention – universal, selective and indicated prevention activities and services for persons not yet identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan the implementation of new services on a nationwide basis.

The two (2) SAMHSA block grant programs have historically been administered by separate SAMHSA centers. In an effort to streamline application and funding procedures, SAMHSA is now issuing guidance promoting consistent application and reporting dates across both block grants and offering states the option to submit one coordinated plan for Substance Abuse and Mental Health.

Texas Medicaid Managed Care

At the same time Texas is preparing for significant changes in the insurance market, the Texas Health and Human Services Commission (HHSC) is moving forward with a major statewide expansion of Medicaid Managed Care. According to HHSC, all counties in Texas will have HMOs with responsibility for the Medicaid population starting in March 2012. As opposed to billing TMHP for Medicaid services, Community Centers will be required to contract and bill HMOs for payment for Medicaid services, with the exception of Mental Health Rehabilitation, Case Management, and services for persons in Intellectual and Developmental Disability waivers.

Although many Centers have contracted with HMOs for a wide range of services for many years, for some Centers this is a new way of doing business. It requires learning a new state agency, a new language and a new, more complicated billing system. This will require Centers to be vigilant in understanding cost of services, credentialing requirements, billing systems, appeals and covered services.

Texas Fiscal Outlook

Even with strong economic growth, the next Legislature will face a very difficult fiscal environment in 2013. The Texas population will continue to grow. Costs for goods and services will continue to go up and state revenues necessary to maintain current services will likely continue to fall short. The steps taken to balance this biennium's budget will make balancing the next budget even harder, particularly in Health and Human Services where Medicaid was underfunded by a projected $4.4 billion for the 2012-2013 biennium.

"All of us might wish at times that we lived in a more tranquil world, but we don't. And if our times are difficult and perplexing, so are they challenging and filled with opportunity."
— Robert F. Kennedy

Getting Ready for the Future

How do Centers get ready? How do we work to improve the quality of care and health outcomes while controlling costs and improving customer satisfaction? Meeting this "triple aim" in healthcare is a great challenge and the ability of Centers to find innovative, locally driven solutions represents an opportunity over the next few years.

What are our learning, stakeholder, operational and financial imperatives for 2011-2015? And, how do we know we are ready to meet them? Members of the Texas Council are actively participating in the National Council's Learning Community, examining how the Affordable Care Act impacts behavioral health providers throughout the country. This work, along with the work being done through the Healthcare Opportunities Workgroup and other Council Consortia, will assist Centers in preparing for changes in the healthcare system while coping with funding reductions. The Healthcare Opportunities Workgroup proposes that the Texas Council and Staff Consortia align their work to help Centers succeed at the following imperatives.

Learning Imperatives

- Understand the larger healthcare context in Texas and nationally
- Enhance clinical capacities to maximize outcomes for customers
- Adopt effective new technologies

Stakeholder Imperatives

- Provide a customer experience that leads to clinical success and business retention
- Uphold role as a valued partner in the healthcare community

Operational Imperatives

- Design and implement programs that can operate within the rates being paid
- Build workforce capacities
- Define and deliver expected outcomes

Financial Imperatives

- Define true costs of services, productivity requirements and required reserves
- Negotiate contracts with payers at reasonable rates and terms
- Successfully collect all claims

Project Guiding Principles

As the Workgroup began to create this document, we were challenged by the breadth of uncertainty surrounding the endeavor. Rather than dwell on the unknowns, we agreed to focus on developing actionable steps in four core areas to prepare for the future. The work was informed by a set of guiding principles intended to preserve the values of the Community Center system in Texas and inspire us for the work ahead. Following are our Guiding Principles:

We serve a greater cause: Our primary responsibility is to ensure that specialized mental health/intellectual disability services and supports are available to those who need them. This is more important than any institution, tradition, or legacy role.

We welcome change: The changes underway provide an unprecedented opportunity to expand and improve care. We can play a key role in this transformation.

We build on success: If Community Centers are to be viable, we must deliver results within the resources available. We have a proven record of delivering results in ways that meet local needs.

We enter a new arena: We must understand the larger healthcare environment and become valued partners within it.

SECTION II – LEARNING IMPERATIVES

Advocates for persons with behavioral health issues have worked for decades to bring about equitable treatment for physical and behavioral healthcare. With the passage of parity legislation and the Affordable Care Act, federal policies are promoting prevention and wellness, parity between behavioral and physical health issues, increased access to insurance for all persons and coordination between primary and specialty care. Prevention, early intervention and when necessary, treatment of mental and substance use disorders are clearly understood as an integral part of improving and maintaining overall health.

Some might say, dog catches car.

With behavioral health as a more integrated part of a larger healthcare system, Centers must be more aware of and participate in the larger healthcare system while maintaining focus on the specialized needs of customers accessing Center services. For example, coordination, communication, and linkage with primary care can no longer be optional given the prevalence of co-morbid health, mental health and substance use disorders.

With the new and increasingly more challenging environment, Centers must increase their knowledge beyond traditional DSHS, DADS and DARS services and consumers. The learning environment includes a larger healthcare context, workforce development issues and opportunities, along with ever-changing and rapidly developing information technology solutions.

Understand the Larger Healthcare Context in Texas and Nationally

Over the past 45 years, Community Centers have become experts in meeting the contractual requirements of the Department of State Health Services and the Department of Aging and Disabilities Services. With the changing landscape, Centers must look more broadly at the opportunities and challenges facing our Centers and our customers. Changes to our contractual relationships and business structures may be necessary in order to preserve our mission.

Medicaid Managed Care

The Texas Medicaid program, under the direction of the Texas Health and Human Services Commission, has laid out a plan for statewide expansion of Medicaid Managed Care. Through contract amendments and a large-scale competitive procurement, HHSC intends to have health plans managing Medicaid and CHIP services in every county in the state effective March 2012. Although mental health rehabilitation and case management are carved out of the expansion, every Center in the state will need to have the skills to operate under a health plan contract for certain Medicaid services for most Medicaid beneficiaries.

For more information about Medicaid Managed Care, see Additional Resource #1 on page 37.

Centers have a wide range of contractual relationships with health plans and in some cases do not contract with particular health plans when mutually agreeable terms cannot be reached or past experience indicates a reason to discontinue the contract. In most cases, Centers agree to see Members of the plan, even those members who do not meet DSHS priority population criteria. In some contracts, Centers provide services beyond Medicaid and CHIP including other health plan products such as Medicare or commercial insurance. These are important distinctions from the traditional relationship with DSHS and Centers should be clear about the obligations and agreements in the Center-HMO contract.

As a system of care, Community Centers employ a large percentage of the behavioral health providers participating in Medicaid. Centers and HMOs need to understand each other and form partnerships that maximize the strengths of each system to the benefit of the member.

2010 Texas Council of Community Centers Position Survey

Title	FTE	Title	FTE
Adult Psychiatrist	137	Occupational Therapist	88
Child Psychiatrist	64	Speech Therapist	90
Ph.D. Psychologist	30	Registered Nurse	247
Licensed Clinical Social Worker	43	Licensed Vocational Nurse	283
Licensed Professional Counselor	365	I/DD Service Coordinator	501
Licensed Masters Level Social Worker	99	Qualified I/DD Professional	159
Psychological Associate	28	Qualified MH Professional	1,832
LCDC-level Substance Abuse Counselor	127	Mobile Crisis Outreach QMHP	174
Physical Therapist	41	Mobile Crisis Outreach LPHA	42

Corporate Healthcare Structures

Community Centers in Texas have taken several approaches to developing corporate healthcare structures in order to engage with HMOs and BHOs and/or to gain efficiencies through volume and/or sharing administrative responsibilities.

Providing Administrative Services for a Health Maintenance Organization

In Tarrant County, an HMO and four (4) Community Centers created a unique partnership building on the strengths of the Community Center system and the resources of an HMO. This partnership provides a unique and innovative approach in providing behavioral health services between a public community-based organization and a managed care company.

The innovative and unique partnership around service care management provides an opportunity to integrate primary care and behavioral health service coordination through the co-location of HMO and Community Center staff. Further, four Community Centers partner with the HMO as behavioral health providers for priority and non-priority populations.

In this partnership, the Community Center provides:

- A Behavioral Health Hotline;
- Mobile Crisis Outreach including coordination of such services with the other Centers within the Tarrant Service Area; and
- Co-location of two Community Center Master's level licensed staff with the HMO to provide behavioral health service care management to all enrolled STAR+PLUS members in the network within the Tarrant Service Area.

Behavioral Health Hotline. One Community Center provides a 24/7 Behavioral Services Hotline for the HMO's STAR+PLUS Members of the Tarrant Service Area to include Tarrant, Wise, Denton, Johnson, Hood and Parker Counties. Members can access this line for evaluation of need and referral to appropriate services. Members accessing the line are assessed for risk and level of care required. Follow-up is coordinated. Members presenting an Emergency Behavioral Health Condition or Urgent Behavioral Health Situation are assessed and referred to 911 or referred to the Crisis Outreach Team "MCOT" for face-to-face evaluation. Routine calls or calls where an Emergency Behavioral Health Condition or Urgent Behavioral Health Situation is not detected are referred for routine and/or community follow-up. Calls can also be warm transferred to the HMO's Nurse Hotline.

Mobile Crisis Outreach Team. The Community Center, directly in Tarrant County and through subcontracts with other Centers in the surrounding counties, provides face-to-face assessment and intervention, coordination of referral(s), and post intervention follow-up to children and adults HMO Members of the STAR+PLUS Program needing crisis intervention in the community setting.

Behavioral Health Service Care Management. The Community Center, through the co-location of two staff, provides Behavioral Health Service Care Management via telephone contact with the Member or significant other. This service is co-located with the HMO Case Management Service to provide support with mental health conditions that are

impacting the medical stability of the Member in the community. The co-located Community Center staff provides:

- Follow-up to identified Members accessing the crisis line after hours and requiring routine outpatient and/or community services coordination;
- Assessment of the mental health needs of Members referred by the HMO case management staff;
- Coordination on the level of BH services required based on lethality and risk assessments;
- Follow-up to identify Members discharged from any level of in-Member services on the day of discharge or within seventy-two (72) hours post discharge;
- Coordinated follow-up by mental health professional within seven (7) days post discharge from any level of in-Member services;
- Telephonic follow-up on cases identified as high utilizers of service, noncompliant with treatment who are accessing outpatient service via the HMO network of providers; and
- Telephonic motivational counseling to Members.

This partnership allows for the development of an innovative and unique partnership opportunity in which a managed care company recognizes the importance of a public community-based organization and the key role they play in providing behavioral health services in the target service area.

This partnership allows the HMO to leverage and utilize existing expertise of community-based organizations to better develop and implement a program that addresses the needs of the STAR+PLUS population in the Tarrant Service Area. It also integrates behavioral health and medical services through the co-location of Community Center behavioral health staff with HMO staff to eliminate barriers that are present when entities work in silos.

5.01(a) Non-profit Healthcare Corporation

A "5.01(a)" is a physician group authorized by the State Board of Medical Examiners under the Texas Occupations Code 162.001(b), formerly 5.01(a) in the Medical Practice Act. Through this corporation, a Center is allowed to accept capitation payments from a health plan, which may increase the likelihood that a health plan will be interested in contracting for behavioral health administrative services.

Typical functions of a 5.01(a) include network management, utilization management, credentialing, claims and billing and quality management. These administrative services are contracted to a health plan for the health plan's entire service area, not the Center's designated counties. The administrative side of the corporation may be handled by non-physician officers, but all medical decisions and the overall medical policies of the organization must be made by physicians.

The nature of this certification increases legal, fiscal and performance requirements for a Center more than a typical provider role. The Corporation must inform the Texas Medical Board of changes in by-laws and boards of directors, and must file detailed reports every two years to maintain certification. One example of this type of a 5.01(a) is Tejas Behavioral Health Services, a corporation of Austin Travis County Integral Care.

Regional Behavioral Health Network

A regional approach to planning and service delivery has been used by multiple Centers throughout Texas. One example is the East Texas Behavioral Health Network. Starting as a Workgroup in the 1980's by five (5) Centers focused on reducing State Hospital census, ETBHN has gone through many changes. Today, eleven (11) Centers, covering seventy (70) Texas counties, partner through an Interlocal Agreement and bylaws that govern the organization. ETBHN has been extremely successful in creating new programs, maximizing operational efficiencies and reducing costs to member Centers.

Through an Interlocal Agreement, ETBHN is owned and governed by the Centers it serves. The Regional Oversight Committee serves as a Board of Trustees to the ETBHN Executive Director. This Board is made up of the CEO of each member Center plus one consumer/ family member. The Board meets monthly to review financials, discuss and authorize new projects and programs, and review committee and workgroup activity.

A small staff working for ETBHN are managed by the Executive Director. Full-time staff include several pharmacy staff, an Executive Assistant and a Business Director. In addition, ETBHN contracts with member Centers for staff time related to a Medical Director, a Utilization Management Specialist/Authorization Director, an Information Services consultant, grant writers, a Developmental Disability consultant, and an attorney that attends all Board meetings. As the organization continues to grow, some staff will be hired directly and some contracted with through member Centers. A wealth of knowledge and information exists at each Center and ETBHN is committed to maximizing the utilization of that expertise.

The Burke Center, a local Mental Health and Intellectual Disability Authority, operates as the fiscal agent for ETBHN. Utilizing a partner Center as a fiscal agent has several benefits including a structure for fiscal accountability and procedures, limited start-up costs, and appropriate insurance coverage. As ETBHN continues to grow, the structure of the organization will be examined to determine the most advantageous design in the changing healthcare landscape.

The ETBHN provides a number of functions to its member Centers:

Maximizing Staff Resources. Instead of individual Centers hiring a Medical Director, and a Human Resource Director, those services are offered on a regional level. Member Centers pay only for the time they utilize. The combined estimated savings for MD and HR services is approximately $573,714 annually.

Streamlining Administrative Processes. ETBHN Centers have streamlined multiple administrative processes to achieve greater efficiency at lower overall cost. For example, ETBHN provides state mandated authorization services on a regional level. This service provides a combined estimated savings of $423,334 annually. Patient Assistant Programs (PAP) services are also offered to member Centers through the ETBHN pharmacy. The combined estimated savings for both Pharmacy and PAP services is $29 million annually. Member Centers are connected to a Wide Area Network and have been able to conduct meetings via video conference. This saves money on travel to and from meetings, along with promoting a culture that embraces technology.

Quality Improvement. Over time, trust has been built between the Community Center CEO's, staff at each member Center and between Centers in the Network. What works and does not work at each Center is shared. Through programs such as the Utilization Management Committee, data across the network is reviewed to identify benchmark performance and identify best practices. When one member struggles, a high performing Center is identified and used as a model.

Shared Learning Community. The ETBHN structure provides member Centers with the opportunity to have national speakers present on topics such as: Autism, Housing, Veterans' Services, Generational Issues in the Workplace, Peer to Peer training, and Fund Development. These efforts would not be financially viable without the combined cost sharing between member Centers and investment by ETBHN. Also, the speakers and Committees have inspired projects such as the joint purchasing of Re-Think Autism, Sharepoint software, Laserfiche, and individual Center efforts on housing and fund development.

For more information about ETBHN, see Additional Resource #2 on page 37.

One advantage of this type of regional model is that it is not a "consolidation model". ETBHN allows Centers to remain independent, while sharing administrative functions to create greater efficiency. ETBHN prides itself on letting each member Center choose what service is right for them at the time that is right for them. This is referred to as a "Menu Option Plan". Each Center moves on what they need to assist them when they need it.

ETBHN learned through experience that if complete agreement is required among all Centers before moving forward on a project, the most likely result is difficulty moving forward. If two (2) or more member Centers decide to implement a particular program or service provided by ETBHN, cost savings are expected. Experience over time has shown if more Centers join in,ETBHN programs and services become even more cost efficient. Member Centers are not forced to participate in ETBHN programs or services, which has strengthened collaboration within the organization.

Having a very clear Strategic Plan each year is also critical to maximize efficiencies and to maintain a manageable workload for regional staff. CEOs at the Centers have a wide range of interests, ideas and priorities for both their Centers and ETBHN. The strategic plan prioritizes those interests and ideas into a workable plan for the year. It spells out practical steps of moving forward, while maintaining flexibility.

Federally Qualified Health Centers

Throughout the Community Center system of care, there are a variety of relationships between Centers and local Federally Qualified Health Centers (FQHC). These relationships are based on unique alliances that have been created over time with FQHCs focusing on primary care services and Community Centers focusing on behavioral health services. As healthcare providers continue to work towards the integration of physical and behavioral health, opportunities for expanding access and increasing quality of care should be closely examined.

There are three (3) models of integration that Community Centers can consider when examining the FQHC system of care:

- Contractual Agreement;
- Collaborative Model; or
- Community Center as FQHC model.

Decisions related to these options depend on the local healthcare landscape and the best fit for meeting the needs of the local community.

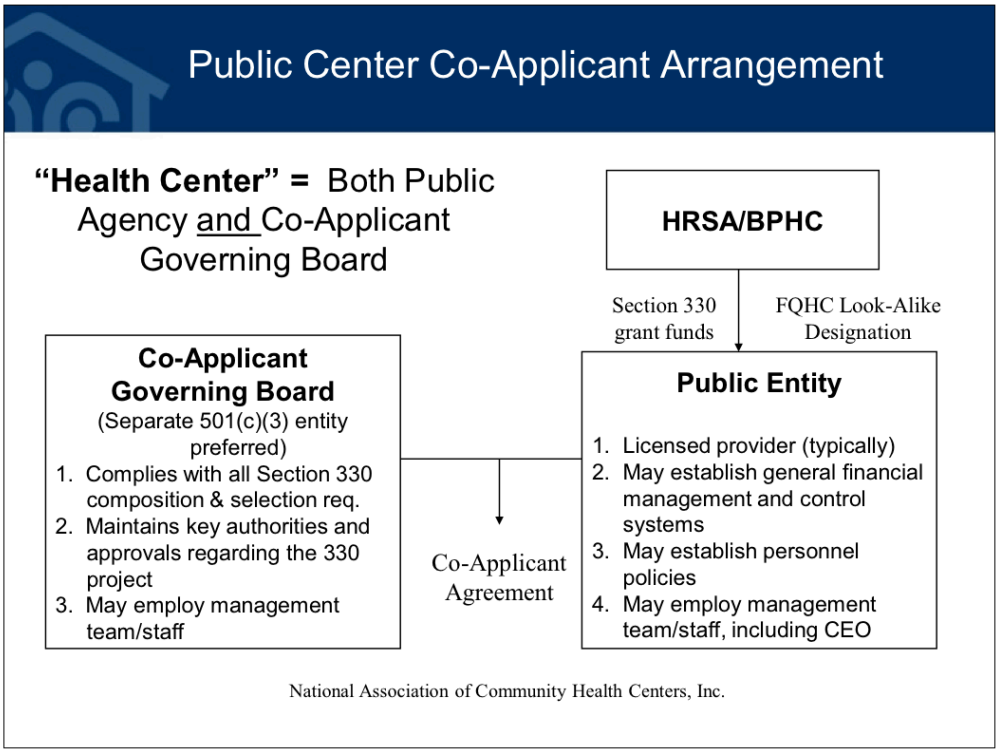
Contractual Model. In a Fee for Service contractual model, the Community Center provides some required services to patients on behalf of the FQHC and is paid either on an hourly or negotiated fee basis. Under this arrangement, the Community Center provides clinical, administrative and/or managerial expertise and experience that the FQHC cannot obtain directly but wants to include in-scope. The FQHC is financially, clinically and legally responsible for the services purchased. The patients receiving services remain FQHC patients and the FQHC owns the medical records, does all billing and handles collections.

In a Referral Arrangement contractual model, the Community Center is a partner provider of services. Under this arrangement, the Community Center provides defined services to health center patients who are referred to the Center by the FQHC regardless of ability to pay. The Community Center is financially and legally responsible for the patients, including billing and collecting payment for services.

Collaborative Model. In an Umbrella Affiliation with an FQHC, a Community Center provides some services for FQHC patients to develop a broad continuum of activities that the FQHC and the Center partners provide for each other. Under this arrangement, the FQHC's grant requirements drive the relationship and the Center defers to the autonomy of the FQHC.

Another option in the collaborative model is an Integrated Services Model, where a Center provides services within the FQHC's scope of services. Integrated services and programs are operated under the FQHC umbrella and the FQHC assumes operational and financial authority for the services and programs. The Community Center's practitioners are either integrated into the FQHC's workforce or purchased by the FQHC through a "Lease of Clinical Capacity".

Community Center as an FQHC. Community Centers also have the option to seek FQHC status by applying to HRSA as a public entity. This model requires substantial commitment because it requires a Center to either become an FQHC or establish a co-applicant board to create the FQHC. Either of these two options requires a comprehensive model of physical health, behavioral health and dental services provided under the requirements established by the HRSA Bureau of Primary Healthcare.



Enhance Clinical Capacities to Maximize Outcomes for Customers

As a system of care, Community Centers have a responsibility to continually enhance the clinical capacities of staff and to maximize positive health outcomes for individuals accessing our services. For the purposes of this readiness guide, the HOW has identified four (4) areas as critical clinical capacities where Centers should be leading the way for others in the healthcare arena: Trauma Informed Care, Cultural Competency/Inclusion, Peer Support, and Integration.

Need for Adopting Trauma-Informed Care Practices

For more information about Trauma-Informed Care Practices, see Additional Resource #3-5 on page 37.

Research has shown that trauma is a leading factor in the onset of mental illness and substance use disorders. Traumatic experiences can create significant barriers to recovery and in fact, often hinder people from getting the services they need. Being trauma-informed means realizing that the vast majority of people accessing services have trauma histories. Trauma informed services must be seen as the expectation, not the exception, in behavioral health treatment service delivery.

Make Trauma Recovery Consumer-Driven. The voice and participation of consumer/survivors should be at the core of all activities, from service development and delivery to evaluation.

Emphasize Early Screening. Make early screening for trauma, assessment of the impact of trauma, and referral for integrated trauma services common practice.

Develop Your Workforce. Create workforce orientation, training, support, competencies, and job standards related to trauma. Don't just train clinical staff — train and educate everyone who comes into contact with consumers, from the receptionist to the maintenance staff.

Institute Practice Guidelines. Centralize clinical practice guidelines for working with people that have trauma histories. Develop rules, regulations, and standards to support access to evidence-based and emerging best practices in trauma treatment.

Avoid Recurrence. Implement procedures to avoid re-traumatization and reduce impacts of trauma.

Cultural Competency/Inclusion

Language differences, cultural barriers and stigma continue to prevent many individuals from appropriate care. There are serious clinical and community consequences for not having staff, at all levels of the organization, adequately prepared and trained. A lack of understanding of the individual seeking treatment can lead to misdiagnosis, inadequate or inappropriate treatment. If quality health outcomes are desired, cultural competency must be a high priority for the organization.

For sustainable success to occur in combating health disparities, Community Centers must commit to support clinical and non-clinical staff through more comprehensive and active engagement in caring for diverse patients. Unfortunately, beyond a few studies and positive evidence around addressing the needs of patients with limited English proficiency, there is limited information on best practices for our unique setting.

For more information about Cultural Competency, see Additional Resource #6-9 on page 37.

The Affordable Care Act (ACA) creates a new focus on health disparities, cultural competency and inclusion. It supports ensuring the safety of and accessibility to public transportation, language services, employment opportunities and other wrap-around and support programs along with more innovative approaches such as the promotion and development of clinical tools to improve identification of and communications with at-risk patients.

The ACA expands initiatives to increase racial and ethnic diversity in healthcare professions. It also strengthens cultural competency training for all healthcare providers. Centers can consider a variety of cultural competency and inclusion strategies including:

- Creating leadership training and mentoring opportunities for entry-and mid-level professionals;
- Increasing recruitment and retention of racially, ethnically and culturally diverse individuals reflective of local communities;
- Including cultural and linguistic competency training and continuing education as part of information in new employee orientation and job performance requirements;
- Requiring interpreters, translators and staff providing services in languages other than English to follow codes of ethics and standards of practice.

Peer Support and Recovery

In 2003, the President's New Freedom Commission proposed transforming the mental health system from a traditional medical model to a consumer and family driven recovery model. The ultimate goal for everyone in the transformed mental health system is recovery, with treatment and supports tailored to the needs of the individual. In response to the New Freedom Commission recommendations, SAMHSA awarded multi-year transformation grants to several states, including Texas, to begin building the new infrastructure required to support a recovery oriented system. Via Hope is part of the new infrastructure created in Texas.

Via Hope provides training and consultation for individuals in recovery from and with mental illness, their family members, youth who are interested in mental health, provider organizations, and mental health professionals throughout the state of Texas. Via Hope provides information and education that assists individuals with their recovery, enables them to better navigate public and private mental health systems, and explains the supports that are available in the community. Via Hope helps organizations develop a recovery orientation in service delivery.

Via Hope is administered as a collaborative effort of Mental Health America of Texas and the National Alliance on Mental Illness of Texas and is funded by grants from the Department of State Health Services and the Hogg Foundation for Mental Health. Following is a summary of several major initiatives and programs currently operated by Via Hope.

Recovery Institute. The Recovery Institute builds on past collaborative learning projects that promoted recovery-oriented practice throughout Texas by using a variety of education and transformation strategies. Beginning in 2012, there are four major components to the Institute. The first is a series of webinars, open to anyone, to provide basic information and education on recovery principles. The second component is regional recovery seminars for key organizational decision makers to learn the basics of becoming a recovery oriented organization. Third are monthly conference calls, webinars and technical assistance as requested for current Learning Community members to continue their work. The fourth component is a program incubation process to enable organizations to take their recovery practice to the next level. This is open to a small group of organizations with a high level of initiative and commitment to transformation.

COSP Institute. Consumer Operated Service Providers (COSPs) play an invaluable role in a recovery-oriented public mental health system. Public mental health agencies primarily provide clinical services, while COSP services are comprised of a variety of peer-facilitated supports. Working collaboratively, Local Mental Health Authorities (LMHAs) and COSPs can offer a comprehensive array of services that promote recovery. There are currently seven COSPs in Texas that receive funding from the Department of State Health Services. Via Hope is providing technical assistance to these agencies to help them refine their individual and collective identity, expand and strengthen the services they provide, and develop sustainability plans to help them thrive.

Certified Peer Specialist Training and Certification. Certified Peer Specialists (CPSs) are individuals in recovery from and with mental illness who have participated in

specialized training on how to effectively tell their recovery story and use their own experiences in recovery to provide hope to other individuals. They develop knowledge, skills, and abilities that make them valuable partners with mental health professionals. CPSs must pass an exam following training to demonstrate mastery of the required competencies and must meet continuing education requirements to maintain certification.

Family Partner Training and Certification. Family Partners are parents or guardians of children with emotional difficulties who have received services through the public mental health system and who are trained to use their experience to assist other parents facing these issues for the first time. Like peer specialists, Certified Family Partners must pass an exam following their training to demonstrate mastery of required competencies and meet continuing education requirements to maintain certification.

Youth Engagement. Via Hope believes the youth voice has value and should be supported in the mental health system. Via Hope has several initiatives to engage youth and young adults to create an effective, mobilized statewide network of young people empowered to speak out about mental health issues and, conversely, to help organizations engage with youth.

Consumer Engagement. A strong collective consumer voice is an essential element of a consumer driven, recovery oriented system. Via Hope encourages the development of a statewide grassroots consumer network, and is providing staff support to a group of consumer leaders trying to develop such a network under the name Texas Catalyst for Empowerment.

WRAP Across Texas. In a recovery model, consumers take responsibility for their own recovery. One of the most effective self help tools for maintaining wellness is Wellness Recovery Action Plans (WRAP), developed by Mary Ellen Copeland. WRAP Across Texas is an initiative designed to train more people to become WRAP facilitators. Via Hope provides training for new WRAP facilitators; in exchange, partner organizations agree to provide the ongoing support system that facilitators need to help other consumers.

Integration of Physical and Behavioral Health

As states look for ways to improve healthcare for people with chronic conditions in order to enhance outcomes and contain long-term costs, the Patient Protection and Affordable Care Act (ACA) offers an important opportunity. Section 2703 of the ACA provides enhanced federal funding for two years for "health homes" serving Medicaid beneficiaries with chronic conditions. A state's designated health home population must include individuals who have at least two chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition.

The ACA describes six core health home services provided by a designated provider or health team to individuals with chronic conditions:

- comprehensive care management;
- care coordination and health promotion;
- comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- support for patients, their families, and their authorized representatives;

- referral to community and social support services, when needed; and
- use of health information technology to link services, as feasible and appropriate.

CMS has further clarified that services coordinated by health homes should include:

- High-quality healthcare services informed by evidence-based clinical practice guidelines;
- Preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Mental health and substance use disorder services;
- Comprehensive care management and care coordination;
- Transitional care across settings including appropriate follow-up from inpatient to other settings, such as participating in discharge planning and facilitating transfer from a pediatric to an adult system of healthcare;
- Chronic disease management, including self-management support to individuals and their families;
- Individual and family supports, including referral to community, social support, and recovery services; and
- Long-term care supports and services.

For more information about Integrated Health Homes, see Additional Resource #10-12 on page 37.

According to CMS, the goal of health homes is to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral healthcare. The health home should operate under a "whole-person" philosophy—caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services, and family services.

There can be a range of options to consider in promoting the "whole-person" philosophy of care through a health home model, such as:

With or without ACA funding for integrated health homes, Centers are working diligently to find paths to primary and behavioral health integration for the customers we serve.

Full Integration. Under a single corporate umbrella, the Center provides primary care, mental health and substance use services to consumers. This is achieved through merger with a primary care clinic or by developing full scope primary care capacity at the Center. Clinical integration and collaborative care is the mission of the organization. The local community is aware that all medical conditions are treated at the Center. This model includes pursuing the principles identified by the National Committee for Quality Assurance (NCQA) certification for a Patient-Centered Medical Home.

In order to determine whether a Center is prepared to operate a fully-integrated health home, the following questions should be addressed. Does the Center:

- Have a provider team with a full range of clinical expertise (including primary and behavioral healthcare)?
- Coordinate consumers' care with their health providers in other organizations?
- Engage patients in shared decision-making?
- Collect and use practice data?

- Analyze and report on a broad range of outcomes?
- Have a sustainable business model for these activities?

Partnership. An alternative to the full integration model can be found in focused partnerships between primary care and behavioral health providers that are based in local problem solving. In a partnership model, the Center develops close working relationships with one or more primary care clinics to achieve the clinical integration of primary care, mental health and substance use services in both the primary care clinics and the behavioral health clinics. Because the organizations remain separate entities, an emphasis must be placed on mission alignment and focused on designing clinical mechanisms for collaboration. This model typically includes co-location of staff and/or cross training of staff. Routine medical appointments include basic primary and behavioral healthcare. This model includes pursuing the principles identified by NCQA certification for a Patient-Centered Medical Home.

Linkages (MH/SU Providers). In a linkage model, the behavioral health organization actively works with primary clinics in the community to ensure that all consumers have a relationship with a primary care provider (PCP) and supports consumers in obtaining regular access to their PCP. The following capabilities are built into the ongoing clinical workflows:

- Ensure regular screening and tracking at the time of psychiatric visits for all mental health consumers receiving psychotropic medications;
- Establish specific methods for communication and treatment coordination with primary care providers and ensure that timely information is shared in both directions; and
- Provide education and link individuals to self-management assistance and support groups.

Adopt Effective New Technologies

Technology in healthcare is changing rapidly and has received enhanced federal funding and policy support through the American Recovery and Reinvestment Act and the HiTECH Act. Health Information Technology concepts include Electronic Health Records (EHRs) and Electronic Medical Records (EMRs); Health Information Exchange (HIE); and other clinical HIT tools such as electronic prescribing, computerized provider order entry and clinical decision support. In addition to health IT, Centers are also facing technology changes brought about by interactive communication devices such as social media, smart phones and texting.

The goals of meaningful use of technology in healthcare are:

- Improve quality, safety, efficiency, and reducing health disparities;
- Engage patients and families in their healthcare;
- Improve care coordination;
- Improve population and public health; and
- Ensure adequate privacy and security protections for personal health information.

The impact of technology is far reaching and Centers should carefully analyze its potential use and impact on clinical functions, communication strategies and administrative functions.

Clinical Functions. Much of the American Recovery and Reinvestment Act (ARRA) and the HITECH Act are directed at clinical efficiencies, safety, and quality care. Centers that intend to pursue meaningful use incentive dollars are already on a path to attain many of the anticipated benefits in this area. Centers that do not intend to pursue meaningful use incentive dollars should still pay close attention to many of the meaningful use measures and be prepared to achieve those that will have the most benefit for the people they serve. As payers have more provider choices, the meaningful use of certified EMRs may well play a factor in the selection process.

There is also the integration of physical and behavioral health. Today, most of the physical and behavioral healthcare is provided by different entities with little or no integration. As time proceeds, this is expected to change. So Centers must ask, "How will we integrate these into one cohesive healthcare delivery system and stay away from the silos of behavioral and physical health?"

A fully implemented electronic health record is the key to data being stored in a structured data format. This structured data format enables data to be processed and delivered in the standardized transactions necessary to achieve the required communication goals of meaningful use.

Changes in technology have also improved the ability for healthcare services to be provided in homes and underserved areas via telemedicine. Texas provides more clinic-based telemedicine services than any other state. Many Centers have been utilizing video technology for a number of years to provide telemedicine services. It is anticipated that the demand for this will not only grow, but the demand will likely begin to change as well. This change is likely to be driven by other forms of social networking such as Skype and other consumer video chat applications. Centers should be aware of these changes as they emerge so this technology can be used as a tool for success.

Treatment outcomes will likely be reportable in the future and treatment outcome data will be available to both patients and payers. Patients and payers are likely to make provider choices based on this data.

Communication. How to appropriately communicate with staff and customers has become an increasing complex issue in the digital age. It is no longer as simple as using the telephone or sending a letter. Meaningful use standards require certain elements of communication through technology; the rest has been brought about by the technology.

Meaningful use requirements include:

- How providers communicate with each other (Continuity of Care Document);
- How providers communicate with customers (Clinical summary for patients for each office visit); and
- How providers record patient preferences for communication (email, telephone, text or some other medium for appointment reminders, laboratory results, medication reminders).

For more information about Meaningful Use Implementation, see Additional Resource #13 on page 38.

Technology advancements requires Centers to consider how to leverage traditional and new media approaches, as well as information technology to reach multi-tier audiences with a focus on reducing health disparities. This includes:

- Encouraging strategic partners to support health equity platforms and informational campaigns to mainstream and mass-distribute messaging;
- Sharing data and information to media representatives specifically used by underserved populations; and
- Developing and tailoring messages and solutions relevant to underserved populations.

This means Community Centers must learn how to create messages and use communication tools tailored for specific audiences across various life-stages (booming elderly and young populations) and presenting varied views of the consequences of health disparities that will encourage individuals and organizations to act and reinvest in public and personal health. This includes:

- Mass communication of the cost of health disparities to a society as a whole;
- State-wide or joint campaigns with common messages during various national observances (National Women's Health Month);
- Facilitation of conversations with community leaders and educators; and
- The use of blogs, podcasts, text messaging, online and mobile video, e-games, social networks and other interactive technologies to engage underserved groups in conversations and forums about preventing chronic and infectious diseases.

Most Community Centers (like most businesses) have avoided interactive communication devices such as social networking (Facebook, Twitter, Linked-In, etc.), text messaging and E-therapy. The public's skyrocketing adoption rate of this media will soon force more entities, including Community Centers, to develop policies to address the appropriate use of social networking. What can Centers do now?

- Hold focus groups with customers to determine their use of and interest in social media;
- Involve staff in discussions of how best to use social media with customers and how to draw lines between interactive communication devices for work versus personal life;
- Develop strategies for use of social media;
- Discuss potential issues with Legal and Human Resources management staff; and
- Develop policies and procedures to direct staff and customers on how these tools will be used.

Administrative – Back Office/Front Desk/Billing. In preparation for a Managed Care environment, back office functions and how they are impacted by front desk actions must be closely scrutinized. First, Centers must be able to bill payers electronically whenever that is a payer option. This may mean establishing a relationship with a billing clearinghouse since many payers will only accept electronic claims via a clearinghouse. Secondly, Centers must be able to submit electronic remittance and electronically apply

payments to charges. There are still many payers that do not support electronic remittance, but this appears to be changing.

The key to effective electronic billing and remittance processing is getting the electronic bills to the correct payer. Achieving this requires well-defined procedures at the front desk. The front desk activities should be streamlined to only collect necessary information and only collect it once. Electronic forms are an ideal method for achieving this objective. If front desk staff can quickly and accurately collect payer information, this will facilitate all back office functions with cleaner claims that are paid more timely.

This also reduces the burden on patients when they only need to bring relevant financial information to appointments. When patients are choosing providers, they are more likely to choose providers that present less "hassle" at the front desk.

SECTION III – STAKEHOLDER IMPERATIVES

One of the hallmarks of success for the Community Center system is the ability to reduce or prevent the need for institutional care. Centers have a proven track record of providing lower cost, community based care that saves money and provides a better customer experience. This will be a strength of the system headed into healthcare reform.

Centers do face some distinct disadvantages. Centers are relatively disconnected from the rest of the healthcare system: they are seldom invited to the planning table at the local or regional level for topics outside of traditional behavioral health. They need to do a better job demonstrating how Center services help reduce the total healthcare cost, how services can "bend the cost curve" in a fact based, data-driven way. Finally, the system is perceived as overburdened and unable to provide timely access to care.

In order for Community Centers to have a significant role in the changing healthcare landscape, Centers must highlight the advantages and address the perceived disadvantages of the system of care. Towards that end, the HOW recommends the following strategies be addressed.

Provide a Customer Experience That Leads to Clinical Success and Business Retention

One of the three components of the "Triple Aim" in healthcare is increasing the quality of the customer experience. Throughout the healthcare delivery system in this country, patients are rarely treated as customers. Traditionally office hours have been built around the practitioner's schedule; fees for services rendered are unclear and educational information has not been a priority. As practitioners continually reevaluate how to improve clinical outcomes and reduce cost, the need to improve the customer experience is required.

Centers are no exception to the rule. Due to the public nature of our business, the mission of our organizations and our role as Local Authorities, we may have an even greater responsibility to improve the customer experience.

Improve Access to Care

Centers should consider adoption of the Open Access Model, which changes practice management to establish expectations that Centers respond to the customer on the same day services are requested and then engage the customer in an episode of care. Throughout the country, implementation of an open access model has led not only to improved access but also to increased system capacity due to decreases in no-show appointments. Steps in this model include:

Customer Engagement. Develop a focused "Engagement Strategy" plan and get clinical staff on board. The plan should include approaches to the collaborative development of person-centered treatment plans, solutions addressing specific attendance/engagement barriers, alternate service schedule options, and awareness of customer service issues.

Centralized or Managed Schedule. Set performance expectations, appointment rates, and cancellation back fill protocols. Decide who manages the schedule.

No-Show Management. Implement no-show/cancellation management principles and practices using an engagement specialist to provide qualitative support. Define number of

no shows allowed per episode of care, develop a Will Call list, and confirm appointments 48 hours in advance. Fill cancelled appointments from a Will Call list.

Improve the Customer Experience

As a matter of good business practice, both in the current system and the future system, Centers should continually work to improve the customer experience. In the future, as people get access to health insurance coverage, their choice of providers expands and Community Centers must be competitive in the new healthcare marketplace.

Center Facilities. Do a walkthrough and take a fresh look at clinic buildings, landscaping, and amenities. Make an improvement plan.

Hours. Consider extended hours and weekend availability.

Customer Service. This ongoing challenge is increasingly important in the new healthcare landscape. What is your Center doing to enhance customer service? Listed below are some measurement tools available to Centers:

For more information about Improving the Customer Experience, see Additional Resource #14-16 on page 38.

- MHCA Customer Satisfaction Survey – this statistically valid and reliable survey gives actionable information that is benchmarked against national norms.
- The Recovery Oriented Service Evaluation– developed by the American Association of Community Psychiatrists in 2007.

Uphold Role as a Valued Partner in the Healthcare Community

Studies clearly show total health expenditures are three times greater for people with serious mental illness compared to the population without a serious mental illness. Healthcare delivery systems will have great difficulty improving quality and managing the growth in healthcare expenditures without expanding access to behavioral healthcare, integrating primary care and behavioral health at the provider level, and addressing the financing barriers that currently exist.

Leadership from Centers at the local level will be critical to our success in achieving the Triple Aim. Because all healthcare is local, Centers will need to work with county officials, health department staff, health plans, FQHCs, hospital systems and provider organizations to craft a set of local solutions that will take advantage of the opportunities that will unfold in the changing healthcare environment. Centers need to leave the traditional comfort zone and become active participants in the broader healthcare community.

Build Relationships. Each Center will need to develop a plan that fits the local situation. Identify the thought leaders in the community and in the healthcare marketplace who are essential to the Center's success. Board members can be key assets in this process.

Build the Local Business Case. Can you articulate how your Center is a valued partner? Experts say you need a 30 second elevator speech, a 2 minute hallway speech, and a 20 minute Rotary Club talk.

Step up to the Plate. Behavioral health services will be needed if the cost savings and care improvements fueling reform are to be realized. Community Centers have competencies that can be invaluable in the larger healthcare arena. Determine your Center's strengths in best meeting emerging local needs and secure a position of strength in the marketplace.

SECTION IV – OPERATIONAL IMPERATIVES

Understanding Operational Imperatives for the future will allow Centers to successfully design and implement programs that can operate under the available revenue and deliver expected outcomes.

Design and Implement Programs That Can Operate Within the Rates Being Paid

When the 2014 Medicaid Expansion occurs, the financing to Centers will change significantly. Centers must prepare for operational changes before the financial changes occur to improve the likelihood for a smooth transition.

In addition, prior to the January 2013 legislative session, Centers should be prepared to make a case for the services and populations served through General Revenue (GR) funds or Block Grant funds. There is great risk the Legislature may believe that when a person receives Medicaid coverage, there is no longer a need for GR or other discretionary funding, except for GR Match for Medicaid. Well in advance of January 2013, Centers need data to clearly articulate who we serve, how we serve them and what services cost.

In a recent Urban Institute analysis of the potential health status of new Medicaid enrollees, the researchers conclude that on average, new Medicaid enrollees will be healthier than the majority of adults currently covered by Medicaid, who are disabled. On average, this is accurate but for persons with serious mental illness and/or developmental disabilities that come into the new Medicaid program based on income it is highly likely they will look much like the disabled population currently in Medicaid. Texas must account for the specialized healthcare needs among the newly eligible when determining the most appropriate benefit design.

To better understand how the uninsured individuals currently receiving services compare to the current Medicaid system, the HOW reviewed data on insurance status, diagnosis, basic profile of functioning, and services received. The majority of Medicaid enrollees currently participating in the Community Center system now receive Medicaid eligibility due to disability. In the future, Medicaid enrollees will include the SSI population but also persons with low incomes but without disability status.

In the data analysis conducted by the HOW, the Medicaid and Indigent populations served by the adult and children's mental health system look much the same. Although we see some differences, they are not enough to warrant a different benefit package for the two populations and show a great need for more intensive, less traditional mental health benefits.

For the specialized population served through the Community Center system, there are significant implications if HHSC treats all individuals new to Medicaid as a healthier population and provides a benefit package limited to commercial mental health benefits with little or no care coordination.

Adults Receiving Community Center System Services	Medicaid	Non-Medicaid
Insurance Status	**35%**	**65%**
Diagnosis		
Affective Disorders - BiPolar	32%	39%
Affective Disorders - Major Depression	26%	38%
Schizophrenia & Related Disorders	42%	20%
Attention Deficit Disorder	NA	NA
Affective Disorders-Other	NA	NA
Disruptive Behavior Disorder	NA	NA
Other	1%	2%
Assessment		
Suicidal/Homicidal	4%	6%
Very Few/ No Supports	3%	4%
1+ MH Hospitalization in last 12 months	11%	12%
Substantial Functional Impairment	25%	29%
Unemployed	5%	11%
Homeless	2%	4%
Criminal Involvement	9%	12%
Substance Abuse Disorder	18%	23%
Crisis During Year	21%	33%
Services		
Psychiatric Rehabilitation	58%	32%
Routine Case Management	9%	11%
Medication Related Services	8%	10%
Skills Training	6%	7%
Crisis Intervention Rehabilitation	4%	11%
Medication Training & Supports	4%	5%
Psychiatric Diagnostic Interview Examination	3%	6%
Continuity of Service	2%	2%
Counseling & Psychotherapy	1%	3%
Screening	1%	3%
Benefit Eligibility Determination	1%	3%
Other	4%	9%

Source: Analysis of MBOW Encounter Data, September 2010 through April 2011.

Children Receiving Community Center System Services	Medicaid	Non-Medicaid
Insurance Status	**77%**	**23%**
Diagnosis		
Affective Disorders - BiPolar	7%	7%
Affective Disorders - Major Depression	6%	10%
Schizophrenia & Related Disorders	0.3%	0.6%
Attention Deficit Disorder	54%	43%
Affective Disorders-Other	10%	13%
Disruptive Behavior Disorder	13%	13%
Other	11%	14%
Assessment		
Suicidal/Homicidal	0.6%	0.6%
Caregiver Overwhelmed or Unwilling	4%	3%
1+ MH Hospitalization in last 12 months	7%	5%
Disciplined at School for Behavior	22%	16%
Serious Substance Abuse	3%	4%
On probation or recently arrested	7%	8%
Threatening or Violent Behavior	6%	4%
Poor Daily Living Skills	32%	22%
Crisis During Year	19%	31%
Services		
Skills Training	48%	41%
Routine Case Management	15%	16%
Intensive Case Management	6%	6%
Medication Training & Supports	6%	6%
Medication Related Services	5%	5%
Counseling & Psychotherapy	5%	8%
Psychiatric Diagnostic Interview Examination	4%	5%
Crisis Intervention Rehabilitation	3%	7%
Family Partner	3%	2%
Other	6%	6%

Source: Analysis of MBOW Encounter Data, September 2010 through April 2011.

Build Workforce Capacities

Centers must have experienced and competent staff to deliver services that improve the health conditions and independence for persons with serious mental illness, developmental disabilities and substance use issues. As we prepare for the changing healthcare landscape, Centers should enhance current practice and develop new strategies for creating learning models. These efforts will ensure the workforce has the information, supervision, technical assistance and culturally relevant training to effectively implement improved practices.

Culture Change

The United States has initiated the process of systemic changes in healthcare delivery, funding mechanisms and regulatory requirements. While debate continues on the ultimate form this will take, specifically as it relates to the Patient Protection and Affordable Care Act, significant changes are already underway in Texas.

Significant culture change will be required throughout the healthcare community. Unfortunately, many organizations, Centers included, are designed to seek alignment, stability and equilibrium. Community Centers pride themselves on identifying and implementing best practices, increasing predictability and getting processes under control. While this supports the development of enduring values and missions, along with stable strategies in our organizations, it also encourages the development of bureaucratic structures which may resist change.

In order to secure a vital role in the evolving healthcare environment and avoid irrelevance, Community Centers must use their best adapting skills in adjusting to and shaping new realities. Centers must understand that change should be expected and embraced in our organizations. Since large scale culture changes in complex organizations can often take three to five years or more, Community Centers must begin now.

There are many models for achieving and managing change and an even larger number of consultants available to assist organizations in this area. However, there are several consistent elements that appear to be part of many of the more popular change models. Three of those are highlighted below:

- Most models have some variation of the Kubler Ross - Stages of Grief as applied to organizational change. Understanding the stages individuals move through during complex organizational changes is crucial to the change process since staff throughout an organization move through these stages differently and at different speeds. Leaders must learn the most effective ways to manage staff at the various stages in the change process.
- Another significant component of many change models involves “complexity theory” and “chaos theory” or principles of “self organization”. Since the long-term future of an organization cannot be predicted to any useful extent, leaders need to learn how to manage the unknowable. Learning to become more comfortable and even embrace unpredictability, can result in leaders adopting new ways to manage change and challenge practices in their organizations that are specifically focused on maintaining equilibrium and the status quo.
- Finally, another component of change models that has become more prevalent in the last ten years involves covert processes and managing the hidden dimensions of

organizational change. Exploring these dimensions can help leaders and managers detect an array of hidden elements in any change effort and address these in a manner that ensures they do not derail a potentially positive change.

Building Incentives for Higher Levels of Productivity and Clinical Outcomes

In strengthening workforce capacities, understanding staff productivity levels and setting expectations for staff productivity are critical. However, the discussion on staff productivity also leads to an examination on process requirements, staffing patterns, caseloads, technology, leave policies, fringe benefits and employee satisfaction.

Calculate the Cost of Each Position at the Center. Although a productivity standard cannot reasonably be based on the cost of a position, understanding what a position costs and how those costs will be covered is important. For each position, a full cost includes base salary, cost of fringe and cost of overhead.

Establish a Standard for Billable Hours. Staff must understand the definition of a billable hour and how the billable hour standard is set for each type of position. As a general rule, the billable hour is defined as a unit of service delivered by clinical staff that will be funded by a payer (e.g., Medicaid, Medicare, General Revenue, Block Grant, and County). In establishing the billable hour standard, the Center must clearly identify for staff what constitutes a billable service. Once the billable hour is defined, a standard for performance is established.

A typical formula would be:

Total Work Hours Per Year	2,080
Vacation and Sick Leave	-240
Total Available Hours per Year	1,840
Percentage of Billable Hours to Available Hours	60%
Total Billable Hours Per Year (Productivity Standard)	1,104

Review the Cost and Benefit of Leave Policies. When a staff person is not in the office, time is paid but revenue is not created. Centers should review leave policies and understand the economic impact to the Center. In addition to the amount of leave time, practices for notice on leave time must also be reviewed. With enough notice, most clinicians can take as much time as allowed under the leave policy without a problem. However, a clinician cannot give short notice for leave which then requires a rescheduling of customers for clinical appointments.

Use Technology to Improve Productivity. To increase productivity standards, Centers must support staff through the increased use of technology to improve productivity. In rural areas, this may be a particular challenge when technology and speed are not always linked. If staff are required to use an electronic medical record but internet speed is slow or computers are outdated, staff will waste time waiting for the technology.

Identify and Reduce Barriers to Achieving the Billable Hours Standard. When a Center actively addresses productivity issues, it must address barriers to achieving the

target for billable hours. Clinical staff cannot be saddled with non-clinical activities. For example, Centers should review non-billable travel time, non-clinical meetings, no-show rates, documentation requirements, support staff functions, and non-billable services. A full scale review of Center operations should be conducted with the requirements for productivity in mind.

Produce Clinical Report Cards. Accountability for productivity must go hand in hand with accountability for clinical outcomes. Centers do not want to create an environment of billing that does not take into account the clinical outcomes for customers. Billing more of the wrong thing does nothing for the customer, the clinician or the Center. A small group of outcomes measures for clinical staff should be agreed on and should be reported.

Create Incentives and Disincentives for Performance. Incentives and Disincentives for performance should be clearly outlined in a Board-approved policy. The goal of the policy and procedures are to emphasize the need for staff to spend significant time providing clinically appropriate billable services to consumers rather than in other non-direct service activities, to establish clear performance standards and reward performance that enhances quality of care and decreases cost of care.

Use of Mid-Level Practitioners

The use of mid-level practitioners is an important opportunity to expand medical capacity and increase access to quality healthcare services, while reducing the cost of care. Access to practitioners is already limited for Texas Medicaid beneficiaries and access is seen as one of the greatest challenges in the anticipated growth in enrollment in 2014.

For more information about Using Mid-Level Practitioners, see Additional Resource #17 on page 38.

Texas law allows for expanded use of mid-level practitioners in general medical and behavioral health services. Centers should analyze the availability of appropriately trained mid-level practitioners, along with potential cost savings and cost-effectiveness of delivery designs that change staffing mix and division of labor among clinical disciplines.

Number of Physician Assistants (PAs) and Advanced Practitioner Nurses (APNs) to Whom Physicians May Delegate Prescriptive Authority. Physicians may delegate prescriptive authority to a total of four PAs or APNs (or their full–time equivalents) at primary practice, alternate practice sites and long–term care facility–based practice sites. The previous limit was three. Tex. Occ. Code, Sections 157.053(e)(1), 157.053(b)(4) and 157.0541(e)(4).

Additionally, physicians may delegate prescriptive authority to a total of four PAs or APNs (or their full–time equivalents) to PAs offering obstetrical services or APN nurse midwives to administer/provide controlled substances to their clients during intrapartum and immediate postpartum care. Tex. Occ. Code, Sec. 157.059(f)(1)

Prescription Refills and Periods. Delegated prescriptive authority for Schedules III, IV, and V controlled substances may now include refills. Tex. Occ. Code, Sec. 157.0511(b)(2).The period of the prescription for Schedules III, IV, and V controlled substances, including refills, is extended from 30 days to 90 days. Tex. Occ. Code, Sec. 157.0511(b)(2).

Additional Primary Practice Site Location. A physician's primary practice site also includes a location where a PA or APN who practices on–site with the physician more than 50 percent of the time and provides:

A. healthcare services for established patients;

B. without remuneration, voluntary charity healthcare services at a clinic run or sponsored by a nonprofit organization; or

C. without remuneration, voluntary healthcare services during a declared emergency or disaster at a temporary facility operated or sponsored by a governmental entity or nonprofit organization and established to serve persons in this state. Tex. Occ. Code, Sec. 157.053(a)(6).

Increased Distance to Alternate Site Allowed. An alternate practice site may be located up to 75 miles from either the delegating physician's residence or primary practice site. The previous maximum distance was 60 miles and the physician's residence was not part of the definition.

Fewer Hours Required On-Site by Physicians at Alternate Practice Sites. Physician supervision on–site requirement for alternate practice sites is reduced from 20percent to 10 percent. The delegating physician must:

- Be on–site 10 percent of the hours of operation of the site each month that the PA or APN is acting with delegated prescriptive authority and is available while on–site to see, diagnose, treat, and provide care to those patients for services provided or to be provided by the PA or APN to whom the physician has delegated prescriptive authority; and
- Not be prohibited by contract from seeing, diagnosing, or treating a patient for services provided or to be provided by the PA or APN under delegated prescriptive authority. Tex. Occ. Code, Sec. 157.0541(c)(1).

Electronic Review of Charts Allowed at Alternate Practice Sites. The delegating physician's review at least 10 percent of the medical charts for each APN or PA at the site allows electronic review of the charts from a remote location. Tex. Occ. Code, Sec. 157.0541(c)(2).

Registration of Prescriptive Delegation. Registration by physicians of delegated prescriptive authority to PAs or APNs is once again required. The effective date is 1/31/2010. Physicians who have already notified Texas Medical Board (TMB) that they supervise PAs and/or APNs will be provided information on registration prior to the effective date. New notice of supervision forms submitted to the TMB will include an option for designating delegated prescriptive authority. Tex. Occ. Code, Sec. 157.0511(b1).

Waivers on Number of PAs, APNs to Whom Physician Delegates Prescriptive Authority Allowed at Primary and Alternate Practice Sites. Waivers may be granted by the TMB for the number of PAs and APNs to whom a physician delegates prescriptive authority at both primary and alternate practice sites. The board may not allow a physician to delegate prescriptive authority to more than a total of six PAs or APNs (or their full–time equivalents). Before granting the waiver, the TMB must determine that the types of healthcare services provided by the PAs and APNs are limited in nature and

duration, within the scope of delegated authority, and that patient healthcare will not be adversely affected. Tex. Occ. Code, Sec. 157.0542.

Waivers on Mileage Limit and On-Site Supervision Requirements at Alternate Practice Sites. Waivers may now be granted by the TMB for the mileage limitation between a supervising physician's primary practice site and alternate practice site and for on–site supervision requirements, except that the physician must be available onsite at regular intervals and when on–site the physician must be available to treat patients. Before granting a waiver, the TMB must determine that the types of healthcare services provided by the PAs and APNs are limited in nature and duration, within the scope of delegated authority, and that patient healthcare will not be adversely affected. Tex. Occ. Code, Sec. 157.0542.

Define and Deliver Expected Outcomes

Due to the nature of the contracts Centers typically hold with funding entities, the expected outcomes are often defined for us. Each Center must understand and operate in a manner that delivers the expected outcomes. As health reform continues to move forward, and the focus on quality outcomes and measuring performance intensifies, Centers must be a part of the discussion on how to define quality outcomes for specialized populations.

In addition, Centers as a System may want to identify a joint Quality Improvement Project, on an annual basis, for a system-wide, locally driven plan for improvement. By incorporating this into the Texas Council structure as a Texas Council initiative, the system of care can select and participate in a project intended to encompass a topic for improvement for all customers, regardless of payer.

The basic elements of a Quality Improvement Project include:

- Select a clinical topic;
- Identify quality of care measure(s). Quality of care measures (or quality measures) are also referred to as quality indicators;
- Measure baseline performance on quality measures;
- Develop and conduct interventions designed to affect the quality measure in the desired manner;
- Re-measure performance on the quality measures; and
- Document and disseminate results.

For more information about Quality Improvement Projects, see Additional Resource #18 on page 38.

At this time, the Readiness Guide does not attempt to define new measures in addition to the ones required by current funders. One informational item has been included to highlight current DSHS measures that are also measured by HHSC for HMO performance. None of the measures are identical but attempt to measure the same type of outcomes.

Behavioral Health Outcome Measures

DSHS Criteria	DSHS Definition	DSHS Target	HHSC HMO Criteria
State MH Facility Readmissions	Readmission rate for adults and children are less than or equal to 5% in the 1st quarter; 10% in the 2nd quarter; 15% in the 3rd quarter; and 20% in the 4th quarter	≤ 10% SFY 2010 Center performance: 7.6% at 30 days; 19.3% at 180 days	Readmission Within 30 Days after an Inpatient Stay for Mental Health SFY2008 HMO performance: Range of 16.3%-26.4%
Face-to-Face Follow-Up	Face-to-face follow-up with adults and children within 7 days of discharge from state centers, state facilities, State-funded community hospital and local authority-operated or contracted inpatient facilities	≥ 75% SFY 2010 Center performance: 76.3%	Follow up after Hospitalization for Mental Illness at 7 days and at 30 days HEDIS National mean: 43% at 7 days; 61% at 30 days
Time between Assessment and First Service Encounter	Children served receive their first (not screening assessment) service encounter within 14 days of their intake assessment	≥ 65% SFY 2010 Center performance: 75%	Initial outpatient behavioral health visits must be provided within 14 days of request
Time between Assessment and First Service Encounter	Adults served receive their first (not screening/ assessment) service encounter within 14 days of their intake assessment	≥77% SFY 2010 Center performance: 79%	Initial outpatient behavioral health visits must be provided within 14 days of request

SECTION V – FINANCIAL IMPERATIVES

Centers will need to meet new financial imperatives in order to be successful in the new environment, which includes both an expansion of Medicaid Managed Care in the short-term (2011 and 2012); a significant increase in the percentage of Medicaid consumers with a corresponding decrease in the DSHS general revenue allocation in 2014; and the opportunities and challenges of expanding the business model to include new payers.

As set forth in the Affordable Care Act, all persons up to 138% of the federal poverty level (about $30,000 for a family of four or $15,000 for an individual) will be eligible for Medicaid in January 2014. Texas Medicaid will no longer require a disability for adults to qualify for coverage, rather eligibility will be based solely on income. This significantly shifts the indigent uninsured population in Texas into insurance through Medicaid. Although the new Medicaid benefit package has not been defined, Medicaid will be the predominant payer among the current customers receiving services at Community Centers. And, with the current managed care expansion, for managed care covered services Centers will bill HMOs for the Medicaid services. This will mean more claims based payment and a significantly reduced general revenue allocation.

Define True Costs of Services, Productivity Requirements and Required Reserves

To understand the true cost of each service provided, a Center must know its "layers of cost". By using the components listed below, a Center will be able to create its cost structure. A Center must be able to allocate all costs to the appropriate contracts using accepted cost accounting standards. A Center's service cost profile (CAM or other tools) is a start, but it may not always be in the form needed for a contract negotiation.

Understanding the true costs of a service allows decisions to be made on rate negotiations and gives a Center the flexibility to quickly establish a cost for a new service that may be of interest to payers. Each Center may approach this differently but all must have a tool that allows them to adjust variables to understand what rate structure is needed to successfully cover the cost of doing business.

Direct Salary/Benefits. Determine the direct providers (MD, DO, RN, LVN, QMHP, etc.) needed to provide the service.

Non-Direct Program Costs. Determine other costs such as clerical support, front desk, travel costs both in provider time and travel reimbursements, and other operating expenses.

Determine if medications are part of the contracted service array. Be sure to distinguish between oral and injectable medications, samples, new generation medications, and pharmaceutical assistance programs.

Administrative Costs. Determine General and Administrative costs associated with each service, service package or contract.

Authority Costs. Determine the costs for Quality Management, Utilization Management, Contract Negotiation and Crisis Services if not already included in Direct Salaries.

There are additional components to the cost categories above to be considered:

Non-Billable Service Activities. These activities must be reviewed for potential payment sources. Some health plans will pay for non-traditional services if the service will reduce cost elsewhere in the system or increase the health outcomes of members. There may be other sources of support in the local community, grant opportunities or other creative financing. If financial support for value-added services cannot be identified, eliminate or limit them, while continuing contract compliance.

Productivity. A significant contributor to "true cost" is identifying the required productivity levels of staff required to cover the cost of the service provided. Understanding staff productivity levels and setting expectations for staff productivity are critical. For a detailed discussion on building incentives for higher levels of productivity and clinical outcomes, see the Operational Imperative section of the Guide. In setting cost expectations for services, Centers will need to assume a certain productivity standard to determine cost. If a Center's cost is unreasonable for the reimbursement levels offered, then the Center must examine options of adjusting productivity expectations, decreasing expenses to manage the reimbursement or declining the contract based on unreasonable reimbursement rates.

Reserves. Lastly, a Center must identify the cash reserves required when the move from an allocation to fee-for-service methodology occurs. As Community Centers, we have learned how to manage cash well when we receive funding quarterly in advance of service delivery. In the changing healthcare landscape, Centers will be required to manage cash in a different way. Cash must be adequate to cover a significant lag time from service to payment. Services will be delivered, claims will be submitted, insurance companies will adjudicate claims which may be paid, denied or pended. In establishing adequate reserve levels, Centers must maintain adequate cash reserves or working capital, in order to fund payroll or other operating expenses until insurance claims are paid. There are a few sources for benchmarks on cash reserve ratio that quote a broad range of cash reserve ratios but an organization's specific ratio depends on what is needed to accommodate moving from a prospective payment to a payment after the service is delivered and a claim is paid.

For more information about Establishing Adequate Reserves, see Additional Resource #19-20 on page 38.

Negotiate Contracts with Payers at Reasonable Rates and Terms

In contracting with health plans, including Medicaid managed care companies, everything is negotiable. Centers must understand their role in a health plan network, the goals of the health plan, the contractual requirements of the health plan along with your specialized services and ability to add value to the relationship. As with any negotiation, knowledge is a key component of success. The following concepts are important for Centers to understand in the negotiation process:

Rate Schedule. For each service provided, or through a bundled payment, the health plan and Center will negotiate a rate schedule for the contracted services. In order to establish reasonable rates, Centers must know their costs. In addition to costs, market indicators of appropriate payment and the availability of other providers for similar services will influence the rate acceptable to both parties. In addition, understanding costs allow a

Center to add and delete services quickly in a contract negotiation based on the reasonableness of the rates.

Health Plan Contractual Responsibilities, Limitations and Flexibility. Center staff negotiating Medicaid health plan contracts should be familiar with HHSC contracts, RFPs, financial documents and quality reports. These are important drivers in the health plan's contracting process. For example, if a health plan has a high medical loss ratio (total medical expense as a percentage of total premiums), the plan may be more aggressive in pricing to bring down their overall medical expenses. In this case, it is important to discuss the high value of a community based service compared to an emergency department visit or inpatient stay.

Consumers as Members. An important point to remember is that Center consumers are Health Plan members. From examining Center data, an estimate can be made as to the percentage of Center consumers as a total of all Health Plan members. In addition to the percentage of total members served by the Center, the cost of the consumers/members served is very important. And, addressing what a Center can do to bring down the overall healthcare costs while improving quality outcomes is important in relaying the value of the service to the health plan.

Volume of Services. A Center should have the ability to utilize internal data systems to identify consumers with specific payers and identify the services provided under the contract. If a contract will lead to low volume services, higher rates will be necessary to cover program costs. Low volume services tend to cost more to deliver due to the inability to cover program and administrative overhead.

IT Systems. In contract negotiations, Centers should ask questions to better understand potential contractor's data processing capabilities. If the technology offered is not compatible to your technologies, include items needed in your negotiations such as third party claims processing.

Innovative or Bundled Services. Centers must think beyond traditional payment structures, service arrays and populations. Consider the skills and expertise the Center has and how that might increase health quality and decrease costs across the continuum of healthcare services for all members of a health plan. For example, integrated health homes, accountable care organizations and partnerships with Federally Qualified Health Centers may offer opportunities for innovation.

In negotiating contracts with payers at reasonable rates and terms, a Center is not negotiating contracts to equal the Medicaid rate, but instead negotiating to cover costs and allow for a reasonable margin. In addition, Centers should negotiate terms that impact administrative time and effort, which impact general and administrative costs. Work to develop a relationship with the plan when possible so the plan understands your network of providers, your value in the community, the complete array of services and how Center services impact their bottom line.

Successfully Collect All Claims

Successful collection of claims starts at the front door. Procedures must be in place to immediately identify insured consumers and quickly route information to both the provider and billing staff. This procedure should include steps to insure out of network payments as well as in network payments. All staff must be trained. Centers should recognize this may be a skill set not currently available among staff.

Good Collection Protocol:

- Establish a non-negotiable deadline for service and progress note entry and have consequences if not met. This will determine your cash flow and can affect your working capital.
- Establish a non-negotiable deadline for claims filing after a service has been rendered.
- Track the number and types of authorized and available services.
- Identify current rate of collection on claims.
- Identify the current time lag between services rendered and billed.
- Define a claims denial and appeals process – make sure you know what is presented in the contract for the denial and appeals process and follow it exactly.
- Create a variety of reports available to track billed vs. collected insurance claims for any given period of time.
- Age accounts and stratify aging by terms of the contract, by payer, by service, by patient.
- Identify services which are billable but not billed.
- Recognize that charges for the Community Based Services Rule do not apply to health plan contracts.
- Collect co-pays at the time of service when required in a contract. Co-pays are part of your rate.
- Manage your data. What fell through the cracks? What is not getting documented? This starts with front desk and continues until claim is paid in full.

Additional Claims Collection Processes:

- All providers need to be in the network.
- The earlier you begin collections the more likely you are to get paid.
- Look for opportunities to modify and resubmit denied claims.
- Network set-up concerns – make sure you know which providers are billable.
- Be aware of frivolous tactics to delay payment – act quickly, do not let non-payment continue.
- Know the timeframe under contract between HHSC and MCOs for processing claims.
- The Center-Health Plan Contract should have protection for delays of payment in the form of penalties for late payments.

When establishing policies for successfully collecting all claims, a Center should also establish a policy or procedure for formal complaints and appeals. Often health plans create an informal process, which works well with some partners; however an informal discussion of unpaid claims can continue for months and/or years without ever reaching a formal process if the Center does not have a policy on how staff should proceed. Centers should adopt a policy and procedure that clearly outlines timeframes and reasons for filing a formal complaint related to denials and contract violations. This provides clear guidelines to billing staff and provides them an easy way to defend moving forward with a formal complaint because "the Board/CEO requires it".

In addition to a standardized claims collection process, Centers will need staff dedicated to insurance collections. This is tedious work and requires excessive telephone and chart work to be successful. Each Center needs to determine the number and location of staff. Outsourcing is an option, but should be closely managed so the Center knows what is taking place.

SECTION VI – ADDITIONAL RESOURCES

The following resources provide more detail on many of the issues raised in this report. Many of them are available on the Texas Council Intranet site. Others are independent papers, online resources, books or experts.

They are presented here in the order they are addressed in the report.

Medicaid Managed Care

1. For more information on Medicaid Managed Care, see the Texas Council Intranet, Managed Care Page at www.txcouncil-intranet.com/texas-council-initiatives/managed-care-page

Corporate Healthcare Structures: Regional Behavioral Health Network

2. For more information on ETBHN, see ETBHN Programs and Services on the Healthcare Opportunities Workgroup page of the Texas Council Intranet site. www.txcouncil-intranet.com/health-care-opportunities-workgroup

Trauma-Informed Care

3. SAMHSA National Center for Trauma-Informed Care www.samhsa.gov/nctic/
4. National Council Trauma-Informed Care: A Call to Arms www.thenationalcouncil.org/cs/traumainformed_care_a_call_to_arms
5. Cenpatico and Texas Foster Care www.cenpatico.com/providers/forms/texas-and-foster-care/

Cultural Competency/Inclusion

6. U.S. Department of Health and Human Services, National Partnership for Action to End Health Disparities www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285
7. Joint Center for Political and Economic Studies www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
8. The Manager's Electronic Resource Center http://erc.msh.org
9. Mental Health America Centers for Technical Assistance www.ncstac.org

Integration of Physical and Behavioral Health

10. Primary and Behavioral Healthcare Integration Projects in Texas www.txcouncil-intranet.com/health-care-opportunities-workgroup
11. SAMHSA Grant (October 2009 through September 2013) www.txcouncil-intranet.com/health-care-opportunities-workgroup

12. A Case Study: Missouri Medicaid (MO HealthNet)
    www.txcouncil-intranet.com/health-care-opportunities-workgroup

Adopt Effective New Technologies

13. Meaningful Use Implementation Tracking Tool (template)
    www.txcouncil-intranet.com/health-care-opportunities-workgroup

Improve the Customer Experience

14. MHCA Customer Satisfaction Survey
    http://www.mhca.com/2CustomerSatisfaction.asp
15. The Recovery Oriented Service Evaluation (American Association of Community Psychiatrists, 2007)
    http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/AACPROSEIII.pdf
16. There are a number of resources available to Centers on the topic of customer experience. Two in particular are David Lloyd with MTM Services and NIATx
    www.mtmservices.org and www.niatx.net

Build Workforce Capacities: Use of Mid-Level Practitioners

17. Protocol for Physician Assistants and Advanced Practice Nurses
    www.txcouncil-intranet.com/health-care-opportunities-workgroup

Define and Deliver Expected Outcomes

18. Performance Improvement Project
    www.txcouncil-intranet.com/health-care-opportunities-workgroup

Define True Costs of Services, Productivity Requirements and Required Reserves

19. "Financial Management for Non-Profit Organizations: Policies and Practices," by John Zietlow, Jo Ann Hankin, and Allen G. Sneider
    http://www.amazon.com/Financial-Management-Nonprofit-Organizations-Practices/dp/0471741663
20. Risk Management Association's Financial Ratio Benchmark Report
    http://ebiz.rmahq.org/eBusPPRO/Default.aspx?TabId=55&ProductId=26967

Additional resources, including a downloadable version of this report, are available on the Texas Council website.
www.txcouncil.com

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