



LOCAL PLAN

For

Developmental Disability Services

FOR FISCAL YEARS 2025-2026

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Attachment: Quality Management Plan

VISION, MISSION, VALUES, and PHILOSOPHY

ACCESS VISION

ACCESS strives to promote holistic care and education that empowers resilience, wellness and positive outcomes with dignity and respect to individuals served, employees and our communities.

ACCESS MISSION

People can count on ACCESS

- ❖ To work hand-in-hand with those around us to assure a choice of effective, efficient programs and caregivers, and
- ❖ To offer excellent services that enhance the quality of life.

ACCESS CORE VALUES

Service to the customer.

Respect for the individual.

Respect for the **dignity** of risk.

Pursuit of **excellence** in all that we say and do.

Commitment to personal **integrity** in every facet of every relationship.

ACCESS PHILOSOPHY

The people connected to ACCESS will be proud of our community center, whether employee, contracted provider, customer, family member, volunteer, or citizen.

ACCESS PLANNING PROCESS

Overview

The central premises of the ACCESS planning process are as follows:

- Involvement of key stakeholders: consumers, family members, advocates, service providers, executive and management staff, trustees, and citizens
- Integration of planning and budgetary processes
- Monitoring and reporting of plan implementation

For the fiscal years 1997, 1998, and 1999, ACCESS used a one-year planning cycle. As a new center with start-up challenges, one-year plans provided a realistic time frame. ACCESS now uses a two-year planning cycle based on the fiscal year. This plan addresses FY2022-2023.

Members of the Board of Trustees and the Executive Council of ACCESS are committed to regular discussion of the changes in the marketplace and in the health care arena, in order for the Center to respond in a timely manner to these realities. Consumers, staff, contractors, and trustees participate in ongoing evaluation of the key concerns of customers and the community, so that the Center can continue to meet its commitment to quality services.

Internal Processes

Planning and problem-solving issues are brought to the Executive Council through its regular and frequent meetings. The Executive Council and the Management Team (mid-level managers) hold joint meetings twice a year (more often if needed) as part of the planning and budgeting process. At these meetings, decisions are made about the allocation of resources and about the priorities for operations. The meetings also address how the planning process works between the two groups, how information is communicated, and how decisions are made.

A representative from Executive Council meets regularly with the Management Team to improve communication flow and to identify needs, recommendations, or items needing decisions. The Management Team meets quarterly (more often if needed) to plan implementation of policies and procedures and to share information across organizational lines. The Management Team also develops ideas to present to the Executive Council. Planning issues may originate in either group.

At monthly meetings of the Board of Trustees, the members receive reports from managers on issues of concern to the Center, as well as recommendations about services, use of resources, or other programs.

Community Participation

ACCESS Board members and ACCESS staff listen to consumers, families, sponsoring entities, contractors, providers, advocates, advisory committees, local officials, community agencies and organizations, and interested citizens, in order to learn what the needs and priorities of our communities are and how the Center can best meet those needs, within the limitations of resources available. Annually, the Center gathers information from external and internal customers, in order to understand the perception of these groups and their suggestions for practical improvements in services.

Members of the Center's staff participate in local community groups, including: Community Resource Coordination Groups (Anderson and Cherokee Counties); Jail Diversion Task Forces (Anderson and Cherokee Counties); the Cherokee County Care Collaboration, Anderson County inter-Agency Council, and East Texas Human Needs Network (interagency groups that include representatives from schools, hospitals, home health organizations, churches, state and local agencies, and charitable organizations).

Through personal contact, members of the staff consult and collaborate with Anderson County Juvenile Probation, Cherokee County Juvenile Probation, law enforcement agencies in the two county area, the Area Agency on Aging, Workforce Commission, the Department of Family and Protective Services and Prevention and Early Intervention Services, the Crisis Center of Anderson and Cherokee Counties, the fourteen school districts in the two county area, the Jacksonville United Fund and the Palestine Area United Way, and the health departments in Anderson and Cherokee Counties.

ACCESS provides support to any local organizations that support or aid persons with developmental disabilities.

ACCESS hosts Public Forums on developmental disabilities every year in each of the two counties (Anderson and Cherokee).

ACCESS sponsors the annual East Texas Transition Conference: Door to the Future, free conference designed to answer questions that parents of children with disabilities and educators face as the transition from school into adulthood begins.

From time to time, ACCESS hosts presentations by advocacy groups, such as Disability Rights and NAMI.

The Executive Director or designee makes a presentation to sponsoring entities at least once a year: Jacksonville City Council, Anderson County Commissioners Court, and Cherokee County Commissioners Court.

Advisory Committees

On January 28, 1997, the Board of Trustees of ACCESS appointed a Developmental Disability Planning Advisory Committee (DD-PAC). The first meeting of the committees was held on February 18, 1997. The PAC focused on the following areas: 1) evaluation of the current service array, 2) expansion of services to both priority and non-priority population consumers, 3) development of alternate resources, and 4) increasing public awareness.

The DD PAC of ACCESS meets at least quarterly. The goals of the committee are as follows:

- Evaluate and address satisfaction of persons or their legally appointed representatives with services
- Solicit, address, and review complains about the operations of the program
- Review any allegations of abuse, neglect, or exploitation, in order to prevent the occurrence of these problems in the future
- Participate in quality improvement review of the program provider's operations and recommend improvements.

The Regional Planning and Network Advisory Committee (RPNAC), with representatives from all centers who are members of the East Texas Behavioral Healthcare Network, meets quarterly. The regional committee provides "arms-length" reviews of programs and deliberations about contracting out services. The RPNAC also provides feedback to the local Boards about the needs of consumers and communities. ACCESS has two representatives to the RPNAC, one for Mental Health and one for Intellectual/developmental disabilities.

ACCESS policy and procedure outline the guidelines for the membership and activities of the Planning Advisory Committees.

Planning Network Advisory Committee Information Items	Yes	No
ACCESS has a local PNAC.		x
ACCESS participates in a regional PNAC.	x	
50% or more of the PNAC membership are consumers or family members of consumers.	x	
The PNAC membership includes family members of children or adolescents.	x	
All PNAC members receive initial and ongoing training.	x	
ACCESS ensures conflicts of interest are avoided in performing the responsibilities of the PNAC.	x	
The PNAC has established outcomes.	x	
The PNAC receives information necessary to achieve expected outcomes.	x	
The PNAC meets the reporting requirement.	x	

Planning Sources

ACCESS makes use of the reports available from the local database and from the statewide database in order to guide decisions about service delivery, staffing, and use of resources. Research from a variety of professional publications is distributed to the Executive Council on a regular basis by the Executive Director. Examples of sources of data used in planning are as follows:

Consumers:	Advocacy Groups; Surveys; Suggestions; Complaints	Community:	Planning Advisory Committees; Surveys; Board Meetings; Public Forums; Interagency meetings
Staff & Contractors:	Service Delivery Data; Program Management; Administration	Experts:	Consultants; Professional organizations; Literature reviews; Models for Planning and Programming; Prevalence data
State databases (CARE & MBOW):	Performance Contract "report card"; CARE reports; MBOW reports; data on use of state facilities	Risk Management:	Legal data; Financial data; Demographic data; Performance data
Other LIDDA/LMHA Centers:	Lists and reports; ETBHN and MBOW data; Consults	Funding Sources:	Local Sponsors; HHSC –DADS & DSHS; TDFPS; PEI; Medicaid; Medicare; Insurance; Donors
Fiscal:	Budget reports; Revenue reports; Financial audits	Environmental:	Demographic predictions; Economic predictions

Costs of the planning process include at least the following items:

- Staff meeting time: Executive Council and Management Team
- Staff individual preparation time: prepare reports and participate in preparation of plans
- Public Forums: advertisements, refreshments, displays and handouts
- Surveys: mailing costs and staff time
- Planning Advisory Committees: refreshments, mailing announcements, handouts, staff time, and transportation.

The time and effort devoted to planning and budgeting result in guidelines for the center and its staff to follow in service delivery, development of programs and supports, use of resources, and incentive targets. In addition, the involvement of consumers and citizens ensures that the Center's plans address priority issues and increase the public awareness of services offered to the community.

At least once a year the Center holds a Public Forum on Developmental Disabilities in each of the two counties served. Clients, volunteers, consumer advocates, and citizens are invited to discuss their concerns. Input is welcomed regarding the quality of Center services, operational issues within particular programs, access to services, use of resources, means of communication, complaints about perceived issues, and ways to

be more involved with staff and the Board of Trustees in developing services for consumers.

The center utilizes the information available from customer satisfaction surveys mailed from State agencies, when available.

All meetings of the Board of Trustees are public, and citizen comment is encouraged at each meeting.

The Center has a designated staff person for Consumer Relations and has a "helpline" number (903-589-9000 x7380) that is a local call anywhere in the two-county area in order to reach the Consumer Relations Officer.

These formal measures support the ongoing informal needs assessment that occurs in all service areas. Program staff and management receive input from consumers regarding their particular program area, dealing with concerns such as times of service planning, consumer schedules, activity planning, and individual consumer preferences.

The Center summarizes these formal and informal inputs into annual objectives for implementation into Center operations. This occurs during annual budgetary planning, service planning cycles, staffing schedules, and when the relevant input results in capital expenditures for improvements in buildings, facilities, or equipment.

Planning Considerations

An essential component of any planning initiative is monitoring and evaluation. The process for review and monitoring of the Center's plan includes the following steps:

- The ACCESS Local Plan is subject to ongoing review. The Executive Director has the responsibility for review and delegates related activities to members of the Executive Council.
- The process for reviewing the plan incorporates the involvement of staff, consumers, and community stakeholders.
- All service areas are responsible for implementing specified goals within their program areas.
- The goals outlined in the plan are incorporated into the budgeting process.
- Questions, comments or concerns raised by the Center's administration, Board of Trustees, and Planning Advisory Committees are documented with actions taken within a specified time frame, with follow-up submitted to the Executive Director, who routes this information as appropriate to the Center's administration, Board of Trustees, and Planning Advisory Committees.

The Executive Council members assess plan compliance annually. In addition, they assess the external regulatory, administrative, and fiscal factors impacting the plan and its implementation. The review results in adjustments to the plan as required and

assignment of action teams to work on specific strategies with projected completion dates and outcomes expected.

Through the various information-gathering tools, stakeholders (staff members, trustees, consumers, contractors, Planning Advisory Committees, and community citizens) have means of providing input to the Local Plan review process. Through their input, an ongoing process of evaluation of delivery of services occurs, and the Center also identifies emerging needs and changing priorities.

Planning provides educational opportunities for stakeholders. As groups review the previous plan and evaluate the Center's progress, they learn which objectives were realistic and doable, and which objectives were vague, broad, or had some other flaw that made them less achievable. Also, they see which objectives should be continued into the future and which ones should be discontinued or revised. Planning provides a valuable learning process for stakeholders. People involved often identify skills that they need in order to do a better job, and this provides the opportunity to train people, to develop new "tools" for planning, or to develop better procedures.

In developing the Plan, ACCESS gave consideration to:	Yes	No
Criteria for assuring accountability for, cost-effectiveness of, and relative value of service delivery options.	x	
Goals to minimize the need for state supported living centers or state hospital or community hospital care.	x	
Goals to ensure a consumer with intellectual/developmental disabilities is placed in the least restrictive environment appropriate to the person's care.	x	
Opportunities for innovation to ensure that the Local Authority is communicating to all potential and incoming consumers about the availability of services of state supported living centers for persons with intellectual/developmental disabilities in the local service area of the Local Authority.	x	
Goals to divert consumers of services from the criminal justice system.	x	
Goals to ensure that a child remains with the child's parent or guardian as appropriate to the child's care.	x	
Opportunities for innovation in services and service delivery.	x	

Cost Effectiveness and Relative Value of Service Delivery Options

The ACCESS Board of Trustees and Executive Council members review financial reports monthly to track revenues and expenses and to look for ways to reduce spending. Examples include the following:

- Every position that is vacated is reviewed to see if those job functions could be redistributed so that the position could be deleted.
- The Center utilizes the ETBHN pharmacy for bulk purchasing, and also maximizes the use of Patient Assistance Programs (PAP) from pharmaceutical companies, in order to reduce the Center's expenditures on medications.
- The replacement schedule for vehicles and other equipment has been stretched over a longer time period, to get more use out of present vehicles and equipment.

Leaders at the Center use the CARE system, the Data Warehouse reports, and the local database (Anasazi) to track service delivery and to analyze staff productivity.

Least Restrictive Alternative

ACCESS supports the goal for consumers with intellectual/developmental disabilities to live in the least restrictive environment possible. The Center uses a person directed planning approach for all consumers. Consumers who want to live on their own in the community are assisted to find all resources available to make this possible.

ACCESS also provides information to consumers and family members about state supported living centers settings and larger group placements and supports whatever choice the consumer and family make. Consumers, families, and guardians are assisted in accessing desired ICF-IDD residential placements, in addition to State supported living center and waiver program admissions.

ACCESS intellectual/developmental disabilities service coordinators make sure that consumers and their families are aware of all the living options and waiver programs within the state, upon admission into services, and annually as part of the person directed planning process. Information provided by the HHSC Department of Aging and Disability Services (DADS) is given to each consumer/family, and their choices are documented. ACCESS communicates to all potential and incoming consumers the availability of services of state supported living centers for persons with intellectual/developmental disabilities in the local service area of the Local Authority

Diversion from Criminal Justice System

ACCESS has a Jail Diversion Plan. Implementation of this plan is ongoing. A Jail Diversion Taskforce meets in each county (Anderson and Cherokee). The matching of jail census reports with CARE reports is carried out on a weekly basis.

Funding is available through TCOOMMI for the Chapter 46b medication reimbursement program. Also, additional TCOOMMI funding was provided, which may be used to assist with custody and transportation in order to increase the use of appropriate screening prior to incarceration.

Ensuring Children Remain with Parents/Guardians

Keeping a family intact is a goal of services to children at ACCESS. To the extent possible, persons with disabilities remain in their homes with their families.

The Community Resource Coordination Group meets as needed to address the needs of families who require interventions or assistance from more than one agency or community organization. One of the goals of this group is to preserve family unity, whenever possible.

The FAYS (Family and Youth Success – previously STAR) program at ACCESS is funded by the Texas Department of Prevention and Early Intervention Services. One of the goals of the FAYS program is family preservation. Referrals flow both ways between the FAYS program and the ACCESS IDD Services and supports.

Provider of Last Resort Plan

Performance Contracts between ACCESS and the Texas HHSC Department of Aging and Disability Services (DADS) require ACCESS to provide services as a last resort when no other services are available in the local service area. As in the past, ACCESS will continue to respond to the requests of DADS and will comply with all legislative, regulatory and contractual requirements; plans and timelines for procurement of client services for FY 2022-2023 are no exception. ACCESS will continue in its ability to use the important resources of staff and advisory committees to its highest extent and ensure compliance with any and all requirements necessary to fulfill its mission of ensuring that intellectual/developmental disabilities services are provided to the residents of its Local Service Area.

HISTORY AND ORGANIZATIONAL OVERVIEW

Anderson County, Cherokee County, and the City of Jacksonville (the "local agencies") established the "Anderson/Cherokee Community Enrichment Services d.b.a. ACCESS," pursuant to Texas Health & Safety Code, Chapter 534, Subchapter A, via an Interlocal Agreement dated January 11, 1993. ACCESS was formed as a Community Mental Health and Intellectual/developmental disabilities Center under the auspices of a local Board of Trustees on September 1, 1995, after a three-year planning period.

ACCESS operates under Performance Contracts with the Texas HHSC Department of State Health Services, the Texas HHSC Department of Aging and Disability Services, and the Texas Department of Prevention and Early Intervention Services. The regulations of these Departments apply to some of its operations. Other state regulations include State Laws and the Texas Administrative Code. County and local regulations apply to buildings, health, and other issues. ACCESS is a qualified Medicaid/Medicare provider, and all related federal regulations apply. Other key federal regulations include the Code of Federal Regulations, in particular CFR42; the Occupational Health and Safety Act; the Americans with Disabilities Act; the Fair Labor Standards Act; the U.S. Department of Health and Human Service OMB Circular A-87; HIPAA, and OMB Circular A-133.

The first year of operations focused on the demands of start-up. The Board of Trustees took essential steps required for a new center. Staff kept services running smoothly while implementing operational changes. A significant challenge was implementation of an Information System, which involved installation of hardware and software for client data, human resources, and fiscal systems. After an executive search by the Board of Trustees, a permanent Executive Director came on board in 1996. The formal budgeting process began shortly thereafter. The Executive Director and the Board set an early goal of establishing sound fiscal practices and building financial reserves.

A formalized planning process for ACCESS began in spring 1997. As a young center with a short track record, ACCESS senior management and trustees utilized "strategic initiatives" to provide planning goals for its immediate needs. ACCESS developed initiatives to assist the Board and staff to focus on those issues of greatest importance. One-year plans were developed for FY1997, 1998, and 1999.

The Planning Advisory Committees were organized in 1997. Regional and/or local committees have met continuously since that time.

The Center added Services to At-Risk Youth to its array of services starting in 1997, after securing funding from the Texas Department of Protective and Regulatory Services.

A two-year Strategic Plan for 2000-2001 was developed in the spring of 1999 for the Center with input from the Board of Trustees, ACCESS staff, consumers, and the Planning Advisory Committees. The Strategic Plan addressed five areas: regulatory

compliance and accreditation, customer satisfaction, increased efficiencies, managed care readiness, and community participation and awareness. The Local Plan has been revised each year, to comply with State guidelines and to reflect changing community priorities.

The Strategic Plan formed the basis for many of the goals set in the Employee Incentive Plan, which was implemented in FY2000 and each year since that time. A task force develops incentive targets each year. Each eligible employee earns a bonus, depending on how many goals are met.

The Board of Trustees authorized in 1999 the expenditure of funds for a position for a substance abuse counselor, in order to respond to a critical need in the community. That position has continued to be funded through other revenues.

In 2001 the Center completed a new building in Palestine for Anderson County services. A grant from the T. L. L. Temple Foundation enabled the project to go forward. The remainder of the cost was financed through a loan.

The Center successfully bid on funding from the Telecommunications Infrastructure Fund Board on three different occasions. Funding received enabled the update and expansion of the computer network, hardware, and software that support operations.

In 2002 the Executive Director, John Gill, announced his retirement and the Board of Trustees sought a new person for that position. In January 2003 Allyn Lang became the new Executive Director. Upon Mr. Lang's retirement, Ted Debbs was selected as the new Executive Director and continues in that position today.

OVERVIEW OF SCOPE AND FUNCTION

ACCESS provides services to people of all ages in Anderson and Cherokee Counties who have problems of mental illness, developmental disability, or substance abuse. Each year that the Center is in business, more citizens become aware of the Center and the resources it has to offer.

ACCESS has positions equaling 96 full-time equivalents on the payroll, including people who provide "as needed" coverage for residential facilities, or work as part-time consumer/employees. All employees meet the requirements listed for their positions. All employees receive orientation as new employees. ACCESS utilizes on-line training for orientation and annual refresher training. This training is customized to the Center and covers a variety of topics. The center holds a center-wide training at least once a year. The turnover rate for the center has been 20-30%.

The Executive Director, Chief Administrative Officer, Chief Program Officer, Chief Financial Officer, and the Administrative Assistant make up the Executive Council. The Executive Council meets as needed to share information, make decisions, plan, and review. The next level of management is composed of Coordinators of specific areas. The Coordinators make up the Management Team, which meets quarterly. For planning and budgeting processes, the Executive Team and the Management Team meet jointly twice a year.

The ACCESS Board of Trustees has eight members, appointed by the sponsoring entities. Four trustees are appointed by the Anderson County Commissioners. Two are appointed by the Cherokee County Commissioners, and two are appointed by the City of Jacksonville. Members serve two-year, renewable, staggered terms. Representatives from the Sheriff's Department in each county have been added as ex-officio members beginning in FY20.

The administrative office of ACCESS is located at 1011 College Avenue, Jacksonville, Texas. This building houses the executive director's office and the administrative functions for the Center, as well as substance abuse services, LIDDA services, mental health services and clinics. Other sites house the FAYS program, and the Veterans' Services program.

Because the two-county area covers over 2,000 square miles and because there is no public transportation in the two counties, ACCESS maintains a fleet of vehicles for use by staff. As many services are provided in the community in natural settings, staff use Center vehicles to visit consumers in those settings.

POPULATIONS SERVED

ACCESS serves people of all ages who have problems caused by mental illness, developmental disability, or substance abuse, as well as at-risk youth. The Center is mandated through its State Contracts to serve the "Priority Population" defined in the contracts.

The Center also serves youth ages 0-18 who are truant, runaway, or in family conflict, through the "FAYS" program funded by The Texas Department of Prevention and Early Intervention. Since FY2004, the FAYS program also offers universal prevention services to the two counties to prevent child abuse and neglect.

Service Area Population Demographics

Anderson and Cherokee counties meet the federal definition for rural populations. The largest town in Anderson County has about 18,000 people, and the largest town in Cherokee County has about 13,000 people. The counties are forested with pine and hardwood, are hilly, and have many rivers, streams, and lakes. Anderson County is bound on the west by the Trinity River and on the east by the Neches River. Cherokee County is marked on the west by the Neches River and on the east by the Angelina River. The area was settled in the 1830's. The county seat of Anderson County is Palestine, and the county seat of Cherokee County is Rusk. Rusk is the site of a state mental hospital. The Texas Department of Corrections has several facilities in both Cherokee and Anderson Counties.

The economy is supported by small manufacturing and distribution, agribusiness, hunting and fishing leases, prisons, government offices, and some tourism. Minerals include oil, gas, and iron ore. Recreation in the area includes fishing, hunting, dogwood trails, historic sites, and the Texas State Railroad, which runs between Rusk in Cherokee County and Palestine in Anderson County.

The following table of demographic characteristics for the two counties is compiled from the U.S. Census 2010.

Fact	Anderson County	Cherokee County	Total or Comment
Population			
Total	55,109	46,659	101,768
Land Area	1,071	1,052	2,123
Persons per square mile (2001 basis)	44.4	51.5	48.3
Sex			
Male	61%	50%	
Female	39%	50%	

Fact	Anderson County	Cherokee County	Total or Comment
Race			
White	67.3%	75.5%	
African-American	23.8%	16.3%	
Other	10%	9.5%	
Hispanic	12.2%	13.2%	
Age (based on 2000 population)			
0-19	12,650	13,690	26,340
20-64	36,027	25,940	61,967
65 and over	6,432	7,029	13,461
Education			
Per cent high school graduate or higher	64.4%	68.4%	
Per cent bachelor's degree or higher	11.1%	11.4%	
Income			
Median Household	\$31,957	\$29,313	State median of \$34,478
Per capita	\$13,838	\$13,980	
Poverty			
Families below poverty level, 1999 model	1,444 12.7%	1,684 13.7%	
Individuals below poverty level, 1999 model	6,654 16.5%	7,823 17.9%	
Children below poverty, 1997 model	24%	29.8%	Higher than state level of 23.6%

The following statistics are based on the U.S. Census 2010 and highlight the persons who are institutionalized and the persons who are disabled but non-institutionalized. The target group is the second classification, "disabled but non-institutionalized," which totals over 19,000 persons, about 19% of the total population.

Disabled Persons			
Fact	Anderson County	Cherokee County	Notes
Population Total	55,109	46,659	101,768 combined
Disabilities			
Institutionalized*	14,551	2,419	16,970 combined

Disabled, non-institutionalized	Age 5 to 20 = 728 7.5% of age group	Age 5 to 20 = 942 8.4% of age group	19,249 Total, all ages
	Age 21 to 64 = 5,427 24.9% of age group	Age 21 to 64 = 6,192 26.5% of age group	18.9% of total population
	Age 65+ = 3,045 51.9% of age group	Age 65+ = 2,915 45.4% of age group	

** Note: This statistic is included to highlight the large number of people institutionalized in Anderson County as a result of the Texas Department of Corrections prisons located there.*

Both counties increased in population from 2000 to 2010.

A significant change in population in the last ten years has been the growth of the Hispanic population in the area. Although the percentage of Hispanic population is less than in other areas of the state, the increase over the last decade has been significant in its impact on the area, which historically has less experience than other areas of the state in accommodating Spanish language and Hispanic cultural differences.

Hispanic Population and % of Total			
	Population*	% Total	Texas
Anderson	6,723	12.20%	32.00%
Cherokee	6,159	13.20%	32.00%
Total	12,882		
<i>*Numbers calculated from percentage</i>			

The two-county area has African-American population above the state average.

African-American Population and % of Total			
	Population*	% Total	Texas
Anderson	12,951	23.50%	11.50%
Cherokee	7,465	16.00%	11.50%
Total	20,416		
<i>*Numbers calculated from percentage</i>			

The White (non-Hispanic) population is also above the state average.

White (not of Hispanic origin) Population and % of Total			
	Population*	% Total	Texas
Anderson	34,774	63.10%	52.40%
Cherokee	32,335	69.30%	52.40%
Total	67,108		
<i>*Numbers calculated from percentage</i>			

The two counties have median household incomes below the state average and a percentage below poverty level that is higher than the state average.

Median Household Income and % Below Poverty Level*			
	Income	Below Poverty	Texas
Anderson	\$29,760	20.40%	16.70%
Cherokee	\$26,928	20.90%	16.70%
<i>*1997 model-based estimate</i>			

Population projections are based on data from the State Demographer's Office at Texas A&M University. The projections are based on a migration and growth rate one-half of that experienced during the decade of the nineties.

Population 2000 and Projected Population 2005-2040
by Race/Ethnicity and Migration Scenario for
Cherokee County

YEAR	TOTAL	ANGLO	BLACK	HISPANIC	OTHER
2000	46,659	32,568	7,545	6,178	368
2005	48,286	32,743	7,680	7,466	397
2010	50,093	32,907	7,842	8,919	425
2015	52,084	33,064	8,029	10,542	449

ARRAY OF SERVICES AND SUPPORTS

Developmental Disabilities

- **Access to Intellectual Disabilities Services (Program Options)** – Individuals and/or their Legally Appointed Representatives are provided information on available services and supports that can be accessed from the HHSC - Department of Aging and Disabilities (DADS) and the Local Intellectual/developmental Disabilities Authority (LIDDA). Some individuals may be placed on a waiting list until desired services and supports are available. Assistance will also be provided individuals in accessing other community supports and services that will meet their needs.
- **Benefits and Pharmaceutical Application Assistance** - A staff person assists eligible consumers to apply for assistance from pharmaceutical companies for medication, or to apply for Medicaid or other assistance.
- **CLOIP** – The LIDDA provides information on options for community living to individuals residing in State Supported Living Centers and to their LARs.
- **Continuity of Services** –Case Coordination is provided to individuals with intellectual/developmental disabilities residing in a state intellectual/developmental disabilities facility or a state mental health facility, in order to facilitate a community placement when deemed ready for discharge. Case Coordination is also provided to admit individuals (children and adults) into state intellectual/developmental disabilities facilities, if they meet eligibility criteria.
- **Crisis Services** - Crisis services are available 24 hours a day, 7 days a week by calling a hotline. Calls to the 800 number are received by an answering service that pages a qualified staff person, who responds within minutes. As needed, face-to-face assessment and intervention services are provided. Staff persons help consumers to meet emergent needs, including medication and housing, in order to prevent more restrictive treatment or incarceration. Monitoring continues until the crisis is resolved or the person is placed in an appropriate environment.
- **Day Training Services** – these services, provided away from a person's home, help the person develop or refine skills necessary to live and work in the community, and may include vocational training or day habilitation.
- **Eligibility Determination for Intellectual/developmental disabilities Services** – A qualified staff person conducts an assessment or an endorsement to determine if a person is eligible for intellectual/developmental disabilities. Persons who do not qualify for admission are referred to other community resources.
- **Home and Community Based Services** - This Medicaid Waiver program provides community-based services and supports to eligible persons for the purpose of maintaining an individual in the community through various living arrangements to prevent institutionalization.
- **ICF-IDD Front Door Enrollment** – Persons desiring ICF-IDD admission are provided assistance by the LIDDA in accessing program placement. This

assistance includes necessary level of care assessments to determine the most appropriate residential placement for the individual. This process also identifies other supports that may assist the individual in choosing the least restrictive environment.

- **In Home and Family Support** - Grant funds aid eligible individuals or their families to purchase services, supports, adaptive devices, or architectural modifications necessary to maintain their functioning in their own home.
- **Maintenance of Interest List** – Individuals and/or their LAR are contacted no less than annually to confirm their continued status on the interest list for preferred developmentally disability services.
- **Medication Management** - A physician determines a person's symptoms or symptoms remission and prescribes the medication regime needed to initiate or maintain the person's plan of care.
- **PASRR** –PASRR is a federally mandated program that requires all states to prescreen all people, regardless of payer source or age, seeking admission to a Medicaid-certified nursing facility to ensure appropriate placement, whether in the community or the nursing home. LIDDA staff complete the screenings. People with a positive PASRR Evaluation are then eligible for a variety of specialized services and supports, through the nursing home and/or the LIDDA.
- **Permanency Planning** – The LIDDA conducts permanency planning activities for individuals under the age of 22 whose family's county of residence is Anderson or Cherokee Counties and who reside in residential programs such as ICF-IDD, HCS residential programs, or State Intellectual/developmental disabilities Facilities (state supported living centers). These activities, initiated by Senate Bill 368, focus on identifying an alternate, permanent living arrangement with the primary feature of an enduring and nurturing parental relationship including supports to return to the natural family.
- **Residential Services** – Residential services are twenty-four services provided to a person who does not live independently or with family, provided through group homes or contracts with local providers
- **Respite Services** – Respite care is provided to eligible persons through contracted services when family or caretakers need relief from their responsibilities on a temporary basis.
- **School Transitional Services** – The Center provides coordination assistance and information to families of persons with intellectual/developmental disabilities who are entering high school and those preparing to graduate from local educational services.
- **Service Coordination for Persons with Intellectual/developmental disabilities** – Assistance in accessing medical, social, educational, and other supports will help a person achieve a quality of life and community participation acceptable to the person, which is described in a Plan that is based on a person-directed process.
- **Support Services** – Services provided to a person with intellectual/developmental disabilities who is not in a residential program to foster the person's ability to perform age-appropriate functional living skills and activities. These may include community supports, respite, supported

employment, nursing care, behavioral support, and specialized therapies.

- **Supported Employment** - Individuals are assisted to choose and obtain employment in the community and are provided with the long-term supports necessary to keep employment.
- **Supported Home Living** – Individuals with developmental disabilities who live in the community are provided with training services and assistance in adaptive living skills to achieve outcomes that promote independence (such as, grocery shopping, budgeting, socialization, planning menus, accessing community resources).
- **Texas Home Living Program** – This Medicaid Waiver program provides community-based services and supports to eligible persons who live in their own home or in their family's home. Individuals receiving these services are also provided Service Coordination from the Intellectual/developmental disabilities Authority and have their program plan developed in conjunction with the program provider. Service Coordinators also monitor service provision.
- **Vocational Services** - These services assist persons with developmental disabilities to prepare for, find, and maintain employment. Job placement, vocational supports, and job coaches are provided in natural community settings. Vocational support and training for persons with long-term needs are provided in a sheltered workshop setting.
- **Waiver Enrollments** – The LIDDA facilitates the enrollment process for persons who have been approved slots for the Texas Home Living Waiver and Home Community Services Waiver programs. Individuals are provided a choice of contracted program providers throughout the state to develop their programmatic needs.

RESOURCE DEVELOPMENT AND ALLOCATION

In general, funding for ACCESS comes from the following sources: General Revenue and block grant funds from State agencies and from earned revenue from Medicaid and other third party sources.

Steps taken by the center to maximize utilization of existing funds include the following:

- Reduction of positions at the Center through attrition
- Reduction of purchases (such as, vehicles not replaced)
- Reduction of rent and utilities by closing office sites and restructuring programs
- Renewed emphasis on establishing Medicaid benefits for consumers who might be eligible
- Increase in direct service time by service providers to maximize earned revenue
- Reduction of pharmacy costs through a contract with the ETBHN pharmacy
- Expansion of patient assistance program that helps consumers apply for pharmaceutical assistance or to receive sample medications

The Executive Council engage in an ongoing process to evaluate existing direct service practices for all Center client services in order to identify and eliminate inefficiencies, clarify staff roles and redesign activities for maximum impact.

Current trends that affect budgeting include the following:

- increased medication costs;
- decreased revenue from Medicaid;
- development of reserves at a level set by the Board of Trustees;
- debt burden for buildings;
- increasing cost of insurance and other benefits for employees;
- reduced funding from State Contracts.

ACCESS focuses efforts on meeting all performance targets each year. The Center hopes that services can be provided to the communities without waiting lists or reductions in services.

ACCESS Board of Trustees supports the services offered under State contracts to the two-county area. The Board also supports additional substance abuse services.

COMMUNITY NEEDS AND PRIORITIES

ACCESS obtains input from consumers through mailed surveys, surveys in waiting rooms, telephone contacts, personal contacts, advocacy groups, and meetings of advisory committees. ACCESS reviews the surveys to consumers and reports the results to its Board of Trustees and the Planning Advisory Committees.

Longer-term requirements of consumers and the market have been impacted by the application of the private sector's managed care approach to the public sector of behavioral healthcare. The emphasis on cutting costs by controlling access to care has become a major factor in the financing and delivery of mental health and intellectual/developmental disabilities treatment. Texas has taken steps to delineate the functions of local authority and provider, to define the nature and extent of managed care plans for Medicaid recipients and others, and to overhaul the delivery and financing of programs.

Social Indicators

1) Aging Population. The 2010 Census for Anderson and Cherokee counties by age group shows a larger percentage of elderly population than the state as a whole. As people live longer due to medical advances, they require more medical and support services. Of particular concern is the aging of those persons who are primary consumers and parents or other persons who have been primary caregivers for persons with mental illness and intellectual/developmental disabilities. As these individuals age, ACCESS will be challenged to respond to their particular needs. Three possible responses to this trend include developing specialized services for older persons, working cooperatively with other agencies that also provide services to older adults, and providing training for staff and others who interact with these individuals.

2) Ethnicity. With an African-American population larger than average for the state and with a rapidly increasing percentage of Hispanic population, ACCESS faces an increasing need to provide culturally relevant services for these populations.

3) Per capita income data. In Anderson and Cherokee counties the per capita income is below the state average. These figures are in spite of the presence of large state employers for prisons and a state mental hospital in the counties. Additionally, lower income individuals tend to rely on public agencies for their health needs.

Waiting Lists

Waiting lists have not been used by ACCESS for services to persons with developmental disabilities, except for those services for which persons enter a statewide waiting list.

Community Forums

Developmental Disability Public Forums are held each year in each county served. People who attended the Forums in the past asked questions about various services offered by the Center, such as, array of services, supported employment, vocational services, youth services, and the FAYS program. People made suggestions, including the following: provide resource materials to local churches; provide more residential options for people with developmental disabilities; and provide support for after-school child care through local churches.

Planning Advisory Committees

Planning Advisory Committees have been meeting at ACCESS for several years. Part of their role is to identify needs in the community and report them to the ACCESS Board of Trustees. In discussions in the Planning Advisory Committees, on the topic of transportation needs in the two counties, the following needs for persons with developmental disabilities were identified:

- 1) People need transportation to stores to buy fresh produce and other items not available within walking distance.
- 2) People need better transportation for medical and dental appointments.
 - a. The Medicaid transportation has a waiting list.
 - b. The Palestine Medicaid van services needs reservations two days in advance, and sometimes people cannot meet that deadline.
 - c. The Jacksonville Medicaid van service is only available mid-day, because the vans transport people to and from the workshop. Therefore, people cannot go to medical or dental appointments early or late in the day.
- 3) People who live independently need a “personal shuttle service.”
- 4) Transportation services do not run after 5:00 p.m.
- 5) A survey of transportation needs of our consumers, or of the community at large, would help to identify the numbers and locations of people needing transportation and the hours at which transportation is needed. We need to know what information is already available about the transportation needs in our area.

Possible solutions identified were as follows:

- 1) A local charitable organization bought a van to be shared by local groups. The van transports people to and from the workshop, and is used in the middle of the day for transportation to the soup kitchen or other places.
- 2) There are vans at churches and agencies “sitting idle” for hours or days at a time. They are not “shared” primarily because of insurance issues and the additional costs of gas and maintenance. Also, trained staff or volunteers are not available as drivers. However, if these issues could be resolved, enough vehicles may be available already in the community without additional

- purchases.
- 3) Consumers and citizens should collaborate with others in seeking solutions to the transportation issues.

In their discussion on community needs and gaps in services, the Planning Advisory Committees discussed the following issues:

- 1) Gaps in service delivery in the community include the following: a) services for the homeless and the hungry, b) transportation to services, c) service provided in the consumer's home, such as skills training or other support.
- 2) Gaps in populations served include the following: a) People that are homebound because of their disabilities, b) People in the Hispanic community for whom language and culture may be a barrier, c) People who are elderly or infirm.
- 3) Barriers to service include a) lack of healthcare insurance and b) poverty.
- 4) Language barriers (Hispanic population, Asian population).
- 5) People in times of need may turn to other community resources, which include the clergy and folk healers. However, many people, especially the elderly, exhibit a cultural predisposition to "just do without" rather than seek aid from any source. Also, many people with developmental disabilities end up in the Criminal Justice system because their disability made them vulnerable or because they did not obtain the needed assistance.
- 6) ACCESS could reach out in the following ways: a) Provide in-service training about ACCESS services for other healthcare providers (home health care providers, hospitals, nurse training programs, emergency services, doctors, nurses, and counselors); b) Provide in-service training about ACCESS services for criminal justice and law enforcement officers and facilities.
- 7) Community issues that the members believe that citizens will "rally around" include the following: a) Prevention of drug abuse, b) Safety and crime prevention, c) Religious causes.

Other Feedback Sources

Sponsoring entities provide feedback annually through the presentations made to them by the Executive Director.

The Board of Trustees receives regular reports on feedback from consumers, citizens, staff, and others.

In addition, Center management throughout all programs support staff teams that work on improvements guided by the concerns that relate to their respective program area.

IMPACT OF KEY FORCES

Lack of Insurance

Throughout Texas many citizens remain uninsured or underinsured. “Profile of the Uninsured in Texas” by Robert W. Seifert, a 2000 publication of The Access Project, a healthcare initiative supported by The Robert Wood Johnson Foundation and the Annie E. Casey Foundation, begins with this statement:

“More than one out of every four Texans below the age of 65 (25.7 percent) had no health insurance in 1999, a proportion that has been fairly constant in recent years. The number of individuals without coverage grew steadily over the decade, reaching a peak of 4.8 million people in 1998 before declining to 4.6 million in 1999. By contrast, slightly more than one out of every six (17.5 percent) of all non-elderly people in the United States was uninsured in 1999. Texas has one of the highest uninsured rates in the country; more than one-tenth of the nation’s uninsured lives in Texas.”

The report points out other disturbing statistics. About 26 percent of Texas children have no health insurance, versus 16 percent in the U.S. In households with incomes below \$25,000 per year, the uninsured rate is 46 percent. For non-elderly Hispanics, 41% have no insurance. People of Hispanic origin account for half of the uninsured in Texas. The vast majority of the uninsured are legally in the state but have limited opportunities for health coverage. Although lack of insurance is an acute problem for non-citizens, four out of every five uninsured Texans are U.S. citizens. In the two-county area served by ACCESS, many families lack insurance coverage.

Demographic Changes

Demographic changes will affect the demand for developmental disability services, as well as how services are delivered:

- The number of persons in the priority population is expected to increase as the general population grows, although the rate of growth in rural East Texas is slower than in urban areas. Increased population will result in increased demands for services.
- The rural nature of the ACCESS service area requires that innovative approaches to service delivery be developed. One example of an innovative approach for rural areas is video-teleconferencing. When third party payors will pay for service delivery with the new technology, services will be enhanced in rural areas.
- A larger percentage of the population will be Hispanic, creating new demands for bilingual and bicultural services. The rapid growth of Hispanic population in rural East Texas is a fairly recent phenomenon. People in these counties do not have the long experience of integrating Hispanic culture that other areas of the state have, such as the south and southwest areas of the state.

- A larger percentage of the population in East Texas is elderly than in other areas of the state.
- The two counties served by ACCESS are poor in average income. There are no large corporations that bring wealth to the area. The largest employers are the prisons and the state hospital.

National and State Trends

Most nations rely on the public sector to impose capacity limits and price controls, but in the United States, citizens have not chosen to have government ration healthcare resources. The system that seems to be emerging will do a poor job of having healthy people share the cost of care for the sick. Healthy people will pay less, and sick people--especially those who need large quantities of resources, such as the developmentally disabled population--will get stuck paying huge bills out of pocket. Historically, insurers spread the costs and risks of over large populations, but the trend now is for individuals to pay for the healthcare they use.

The implication for public behavioral healthcare in Texas is clear: the "safety net" is more important than ever before. Community centers will face the ongoing challenge of navigating "the tensions between limited resources and unlimited expectations."

Community centers have sought citizen and community input, encouraged consumer self-advocacy, and developed choices for consumers. The visibility of community centers has increased, and along with that, the expectations of the community for services. However, centers now face the prospect of rationing services, when unlimited expectations clash with limited resources. More than ever, community centers will need to educate consumers, families, providers, officials, and citizens about the limits of what we can provide. Although community centers continue to strive to be the "best value" in behavioral healthcare, limits on funding mean limits on services. Ultimately, the public--through its elected representatives--must decide how to care for its citizens with brain disorders.

Changes in Texas Medicaid occur from time to time as the federal and state governments try to balance the needs of people covered by Medicaid with the funds available for services. Centers have been encouraged to maximize billing to Medicaid, in order to utilize federal sources as well as state sources for funding for services to eligible individuals. Centers set up programs according to Medicaid guidelines, and persons in these programs come to expect certain types and levels of service. When guidelines and funding streams change, centers and the people they serve often must make radical changes in service delivery within short time frames. Often the budgetary impact on a center is significant.

“SWOT” ANALYSIS

The ACCESS Executive Council and Management Team periodically perform an analysis of strengths, weaknesses, threats, and opportunities.

Strengths

Consumers

- Programs meet consumers' identified needs and achieve their desired outcomes.
- Consumers have a short wait time for most services.
- The array of services meets many needs for people who otherwise have few resources available in the community.
- The use of “screening days” increases responsiveness to community needs.
- Spanish services increase confidence among Spanish-speaking consumers.
- Center assists consumers with applications for benefits, medication programs, and other assistance programs.
- Consumers have access to internet in lobby areas.

Center

- Employees feel loyalty to their units and from their units.
- Center culture is generally positive at a local level, although employees feel challenged by many statewide changes.
- Responsibilities within units are clearly defined, and positions have current job descriptions.
- Employees and programs maintain a client-Centered focus.
- Employees have tools needed to perform their jobs (computers, vehicles, supplies).
- Executive and management level staff maintain an open door policy for any problem from any employee.
- Team and individual productivity measures continue to show improvement.
- Employees have opportunity for advancement in the Center.
- The Center is committed to its staff and has had no layoff of employees.
- Employees exhibit flexibility, creativity, and willingness to change.
- Leadership at all levels has exhibited talent and commitment.

Community

- Local law enforcement perceives ACCESS positively and works collaboratively with center staff in addressing crisis and other situations facing consumers of services.
- Schools in the area perceive ACCESS positively.
- The FAYS program in Cherokee County has been especially successful.
- Visibility in the community has been established.

Collaboration

- Center participates in collaboration at regional level through ETBHN.
- Center collaborates at the local level with other agencies and organizations.

Weaknesses

Center

- Employees experience some confusion on who does what, outside of their unit.
- Staff turnover continues to be high.
- Staff recruitment continues to be difficult in a rural area.
- The Center has no redundancy in position coverage, and programs suffer any time an employee is absent or a position is vacant.
- Provider staff and other employees need business acumen and more information about billable services.
- Supervisors need additional training on being effective managers, need better knowledge of policies and procedures, and need to develop higher level of expertise about human resource functions.
- Repairs and maintenance need to improve at all facilities.
- The Center may have untapped revenue resources.
- The Center has a history of trying to serve everyone who “walks in the door.” For some services people have to wait, but traditionally the Center’s front door has been “open.”

Community

- The Center is in a rural area that has small communities with limited resources.
- The geriatric population in our communities is growing, and few resources are designed to meet their particular needs.
- The Hispanic population has grown rapidly and is expected to continue to grow in this area, and service delivery needs to meet the needs of this population.
- Community perception continues to be that the Center provides “free” services and medications.

Threats

Center

- Resources in the community are diminishing; other agencies are cutting back services, increasing demand on the Center.
- Cost of medication increases every year.
- High employee turnover, vacant position time and increased time for training, resulting in lower over-all productivity.
- Reduced number of staff; people hold a number of key functions; if a person leaves, institutional knowledge disappears.
- As staff is reduced, the Center may have to decrease client services.
- As the Spanish-speaking population increases, the Center may not have enough staff with bilingual skills and cultural competency, along with the other required job skills.

Changes in State System

- The impact of HHSC re-organization brought additional challenges at the local level.

- The privatization of ICF-IDD or other services will impact the Center and consumers.
- The Center has served more than the targeted numbers of clients in the past but may not find it feasible to continue to do so.
- If our services decrease (which may happen with redefinition of priority population, reduction of funding, changes in contracts), community support for the Center could diminish.
- Too low a level of services may mean the Center crosses a “safety line” with clinical services.
- If future funding is based on population only, this Center would face severe reductions.

Opportunities

Resources

- The Center should increase collection of eligible co-pays and fees from consumers.
- Unused office space in the Palestine clinic could be rented to other helping agencies.
- The Center could explore other sources of funding from services, such as other health programs or grants.
- When other agency programs close in the community, the Center could look for ways to serve those clients in our programs.
- The Center should examine reimbursements to be sure the Center applies for everything for which it is eligible.
- The Center could explore the possibility of offering additional services that could be “sold” to people in the community.
- The Center should discontinue unfunded activities, where possible.

Efficiencies

- The Center should provide unit budgets for managers.
- In order to maintain services and outcomes, in spite of staff reductions, the Center will need to be more flexible and efficient and rethink the delivery of services.
- The Center should utilize computer hardware and software to address issues, such as improving inter-departmental communication through e-mail.
- The Center should add capability to its webpage with web authoring software.
- Videoconferencing equipment should be utilized for meetings.
- The Center should experiment with computer-based training for family education.

Collaboration

- The Center should continue its collaborative efforts with ETBHN, such as bulk purchasing of medications and pharmacy services.
- The Center should continue to look for other efficiencies achievable through other collaborations.

Community

- Position the Center in our communities so that services to consumers will survive, regardless of changes in organizational structures.
- Continue to seek community support from elected or appointed officials (especially if the Center faces reductions in services).
- Find new opportunities to educate the public about the importance of services for persons with developmental disabilities.
- Continue to inform referring agencies that the Center is not a free clinic with free medications.

SERVICE PRIORITIES, STRATEGIC ISSUES

#	Description of strategic issue or need	Reasons the issue has priority	Consequences of failing to address the issue
1	Compliance with applicable laws and rules and with requirements of pay sources.	Funding is necessary in order to provide services in the area, and funding depends on compliance.	Sanctions, penalties, or loss of contracts or funding
2	Competent staff with diversified backgrounds that reflect the communities ACCESS serves.	Staff should be competent. Staff should reflect the diversity of the community. Staff should be able to work with diverse populations.	Staff without proper requirements and competencies means lower quality of service provision, reduced ability to bill for services, and possible lack of compliance with contractual or ethical requirements.
3	Quality services to consumers, family, and the community.	Services should be high in quality. Consumers and families should be happy with services provided.	People will go elsewhere for services if not pleased with the quality of service.
4	Efficient work within declining resources, stretching resources through collaboration with others, and seeking out new sources of revenues.	Staff should work efficiently and effectively. Resources should be stretched through collaboration with contractors and other agencies and organizations. To remain viable, the Center should seek out new sources or revenues.	Declining resources could mean cutting positions, programs, and services. Lack of collaboration with others could result in consumers not receiving an array of services needed to meet their needs.
5	Effective, efficient infrastructure that supports the Center in fulfillment of its mission.	The infrastructure of the center (staff, buildings, vehicles, policies and procedures, fiscal practices, training, supplies, etc.) provides the means essential to doing a good job.	Inefficiencies could result in budget deficits, layoffs, program reductions. Weak infrastructure increases risk factors in all areas.
6	Reliable, accurate data for management and monitoring.	Data is essential to operations.	Inaccurate or unreliable data will lead to errors in decision-making and an inability to report on activities and costs of the Center.

NETWORK PLANNING

ACCESS is not only involved in planning for the local center but also in planning for the region. As part of the East Texas Behavioral Healthcare Network (ETBHN), ACCESS has been involved in planning on a regional level with several other centers. All member centers participated in initial training on Strategic Planning. Through the planning process with ETBHN, ACCESS hopes to move into the future with the best of managed care concepts applied to the public behavioral healthcare sector.

The Network Plan is a design for assembling the provider network. It takes a systematic view of our regional and local service area needs both today and in the near future. This plan gives direction to the types of providers needed and where providers should be located to maximize consumer choice and access to the services they need. The identification, management, evaluation, and selection of providers are made on the basis of the plan and its systematic review of regional and local area needs.

Principles used in the development of a Network Plan have been utilized by ACCESS already. For example, data has been used to review services in the resource development, allocation, and management of services. However, the mechanisms for network planning should be enhanced in order to strengthen ACCESS "arm's length" relationships, and to improve access, choice, cost efficiencies, and quality of services.

The process of assembling and managing a network of service providers was initiated by considering best value in developing and implementing a network of service providers. The development of a Local Network Plan is an ongoing process. It is assumed that it will be reviewed and modified on a regular basis. Also, it will grow in its sophistication as a tool to serve those who seek services.

ACCESS joined with other member centers of the East Texas Behavioral Healthcare Network to form a Regional Planning Network Advisory Committee (RPNAC). The RPNAC will use consumer choice, access, accessibility, quality management guidelines and resource availability to evaluate potential providers. Requests for information and proposals will be pursued, based on State guidelines.

The network plan is a logical extension of the local plan and clearly linked to the needs assessment and priorities for services and supports. The Network Plan is created by using information collected in the Local Plan process of each of the ETBHN member centers. ACCESS and the other member centers of ETBHN utilize many mechanisms to involve consumers, family members and advocacy organizations in planning, which ultimately influences policy development. ACCESS and the other member centers provide services in the area of mental health and developmental disability through both internal providers and contracted providers.

ACCESS has collected consumer and staff ethnicity data. Listed earlier in this document are tables that summarize ethnicity for the two-county area from the most

recent Census. This new data will be evaluated to determine its impact on each specific provider and the service provided. Due to the increased number of citizens who are Spanish-speaking, the Center is seeking bilingual/bicultural staff.

ACCESS services are centralized in the largest community in each county: in Jacksonville in Cherokee County and in Palestine in Anderson County. Many services are provided in natural settings, such as schools, workplaces, and homes, throughout the two-county area.

The Center gathers consumer satisfaction data, and is responsible for measuring, analyzing, summarizing and distributing the data throughout the Center. Questionnaires are utilized to obtain consumer satisfaction information and address issues causing satisfaction and dissatisfaction, consumer needs for services and what services are most useful.

ACCESS plans to continue its membership in the East Texas Behavioral Healthcare Network. The Center has no plans for mergers or relationships that will change its organizational structure or basic mission, although the Center always welcomes opportunities to collaborate and partner with others in the community. The organizational structure of the center will continue to change as necessary to increase efficiencies and to clarify authority or provider functions.

Through the ETBHN Regional Planning Network Advisory Committee (RPNAC), ACCESS will continue to prepare to add new network providers and to outsource support components through the regional association in order to obtain best value.

The Regional Network Goals and Objectives are listed below:

- 1) Maintain composition of 50% consumer and family member representation.
- 2) Operate according to procedures and bylaws that have been developed by Members and approved by Boards.
- 3) Contribute to the development and content of the Network Plan.
- 4) Address cultural and linguistic competency of providers.
- 5) Make recommendations that consider policies of public input, ultimate cost benefits, client care issues, and best use of public money in assembling provider networks.
- 6) Ensure objectivity in the development of the provider networks.
- 7) Ensure that necessary training is received by RPNAC members.

- 8) Determine if a service 1) should be provided by the local center, or 2) should be contracted to another organization, or 3) should be provided through expansion of the network of service providers through an open enrollment process.

GOALS AND OBJECTIVES

I. Regulatory Compliance

To comply with regulations of relevant oversight and funding bodies.

	Objective		Outcome Measure
1	Meet or exceed requirements of pay sources.		
		a	The Center will meet or exceed requirements of contracts with state agencies or others providing funding.
		b	The Center will meet or exceed requirements of Medicaid, Medicare, or other third-party payors.
2	Meet or exceed requirements in applicable laws and rules.		
		a	The Center's Corporate Compliance activities will be implemented and documented.
		b	The Center will comply with applicable federal and state laws as well as agency rules about confidentiality and protected health information.

II. Quality Services

To provide quality services to consumers, family members, and the community.

	Objective		Outcome Measure
1	Provide prompt and easy access to services.		
		a	Crisis response will be available within minutes, or at most, hours.
		b	Intake and screening services will be available within ten working days by appointment or sooner by open walk-in times.
		c	Staff with bilingual skills will be available as needed by Spanish-speaking consumers.
		d	Signing translation will be available for hearing-impaired consumers.
		e	Center sites will provide physical access for persons with handicapping conditions.
2	Provide satisfactory services within cost guidelines set by pay sources.		
		a	Cost analysis will indicate that services are provided within guidelines set by pay sources.
		b	Satisfaction measures by pay sources will indicate consumer satisfaction with services.
3	Provide education to the public about mental illness and developmental disabilities in order to reduce stigma.		

	Objective		Outcome Measure
		a	At least one Public Forum will be held in each county each year.
		b	Planning Committees or Focus Groups will gather information about community needs and priorities.
		c	The Center will place articles or announcements in print media regarding ACCESS and/or its targeted populations.
		d	The Center will provide at least one presentation per year to each sponsoring agent or to other interested governmental entities.
4	Support advocacy groups and advocacy education for populations served.		
		a	The Center will provide support to Texas Mental Health Consumers, NAMI, or The ARC groups for consumers, families, and citizens in the two-county area.
		b	The Center will provide training on advocacy to community groups, upon request.

III. Increased Efficiencies

To work within declining resources, to stretch resources through collaboration with others, and to seek out new sources of revenues, using strategies for increased efficiency.

	Objective		Outcome Measure
1	Decrease costs of administrative overhead.		
		a	Administrative overhead costs will be at 10% or less.
2	Achieve reduction of medication costs.		
		a	Achieve savings through the use of pharmaceutical companies' indigent medication programs, bulk purchasing, pharmacy benefit management, regional pharmacy services, or other methodologies.
		b	Ensure that the annual budgeted amount for medication is not exceeded.
		c	Track the savings to the center from the use of sample medications for eligible clients.
3	Increase the percentage of Medicaid clients.		
		a	Provide information on benefits eligibility criteria to all clinical and support staff at least once a year (to assure proper screening and referral).
		b	Assist any potentially eligible consumers to complete application for Medicaid benefits.

	Objective		Outcome Measure
4	Increase "billable hours per month" for every billable employee.		
		a	Servers will meet goals for service time or events or billable hours.
		b	Supervisors will determine effective caseload size for each position.
		c	Credentialing process for providers will be current and accurate.
		d	Billing software will accurately reflect current information about credentials of providers.

IV. Effective Infrastructure

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

	Objective		Outcome Measure
1	Improve internal communications.		
		a	E-mail communication will be available to employees.
		b	Web-page will maintain current information.
		c	Inter-office mail will be delivered promptly.
2	Assure the safety and health of staff and guests.		
		a	The Center will comply with local fire and safety codes in all facilities.
		b	The Center will maintain reasonable standards of operational safety for all vehicles.
		c	The Center will provide not less than annual training regarding safety issues to designated staff.
		d	Any incident of accident or other health or safety issue with a consumer, guest, or employee will be investigated, and recommendations will be made if needed to improve conditions.
3	Participate in collaborations, such as the East Texas Behavioral HealthCare Network.		
		a	The Center will participate in collaborations with ETBHN as appropriate to the Center's needs.
		b	The Center will participate in other collaborations, based on proximity or common interests, as appropriate to the Center's needs.

V. Accurate, Reliable Data

To implement and maintain data resources that prove accurate and reliable, for use in decision-making and monitoring.

	Objective		Outcome Measure
1	Achieve accuracy and reliability in data.		
		a	Data entry accuracy will be maintained at a high level, reflected in reliability of data-based reports.
		b	Data will be analyzed regularly to identify trends or issues.
2	Utilize data in decision-making.		
		a	Minutes of meetings at executive level will reflect consideration of data reports.
		b	Managers will have data about services provided, server hours, revenues, and expenses.
3	Utilize data in monitoring and tracking clinical and business practices.		
		a	Fiscal audits will report acceptable business practices.
		b	Clinical audits will report acceptable clinical practices.
		c	Identified significant outcomes will be measured, including, but not limited to, the following: • Cost Accounting Methodology Data • Encounter Data • Direct Service Time Data
		d	Caseloads and due dates will be tracked and reported to service delivery staff.
4	Utilize data in collaboration with other Centers or entities.		
		a	The Center will cooperate with other centers, agencies, or entities to establish common data in order to measure efficiency and effectiveness of delivery of services.
		b	The Center will cooperate with other centers, agencies, or entities to develop or revise plans for service delivery, based on data collected.

Organizational Mandates

ACCESS is contractually obligated to expend state general revenue funds for persons in the State priority populations for both mental health and intellectual and/or developmental disability services. Service targets and outcomes are set by contracts with State agencies, thus limiting the use of revenues. The contract with the Texas Department of Prevention and Early Intervention for the FAYS grant program spells out the ways in which funding shall be utilized. Federal and State laws and agency regulations govern many of the activities of the center.

- Examples of federal laws are: Americans with Disabilities Act (ADA), Medicaid eligibility and claiming, sexual harassment, Equal Opportunity, and HIPAA.
- Examples of state laws are: Open Meetings Act, laws affecting people with mental illness or developmental disabilities.
- Examples of agency regulations are: HHSC-DADS, HHSC-DSHS, DPEI, United Way, United Fund, and others.

Informal mandates get expressed primarily as expectations, and the Center receives feedback on these as praise (expectations met) or criticism (expectations not met). One purpose of campaigns for public awareness is to be sure that the public's expectations for the Center match the reality of what we do.

ACCESS Stakeholder Analysis

<i>Stakeholder</i>	<i>What Stakeholder needs from Center</i>	<i>What Center needs from Stakeholder</i>	<i>Influence on Center (5 = high)</i>	<i>Center Performance from Stakeholder's POV (5 = high)</i>	<i>Level of Importance (5 = high)</i>
Consumer	<i>Quality services that improve quality of life</i>	<i>Participation and satisfaction</i>	5	4	5
Family members	<i>Support for consumer; education</i>	<i>Satisfaction</i>	3	4	4
Staff	<i>Opportunity, equitable pay and benefits, training</i>	<i>Competent job performance</i>	5	5	5
Trustees	<i>Dependable carrying out of policies</i>	<i>Policy making and oversight</i>	5	5	5
Sponsoring Entities	<i>Activities per Interlocal Agreement</i>	<i>Political and financial support</i>	5	4	5
Taxpayers & Citizens	<i>Accountability</i>	<i>Support</i>	3	4	3
Funding sources & Payors	<i>Dependable service provision per guidelines</i>	<i>Timely payment for services provided</i>	5	5	5
Agencies	<i>Collaboration</i>	<i>Collaboration</i>	4	4	4
Schools	<i>Collaboration</i>	<i>Collaboration</i>	4	4	4
Organizations	<i>Collaboration</i>	<i>Collaboration</i>	3	4	3
Private providers	<i>Collaboration</i>	<i>Collaboration</i>	3	4	3
Contractors	<i>Dependable payment for services provided</i>	<i>Dependable performance of contracted services</i>	4	4	4
Vendors	<i>Prompt, dependable payment</i>	<i>Prompt dependable delivery of products or services</i>	3	4	3