Convening of the Texas Child Mental Health Care Consortium (TCMHCC)
August 31, 2020
10:00 AM – 3:00 PM
Minutes

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I. **Call to order and roll call**
    – Dr. Lakey, presiding officer of the Consortium, called the meeting to order.
    – 30 Executive members were in attendance. See attached attendance for a full list of attendees.

II. **Review and approve the following item:**
    a. **Minutes from July 27, 2020 Executive Committee meeting**
        ➔ **Dr. Podawiltz made a motion to accept the July 27, 2020 minutes. Dr. Liberzon seconded. Minutes were unanimously approved.**

III. **Updates on the following activities associated with implementation of the TCMHCC. The full Executive Committee may review, receive and/or provide information and/or make recommendations from the items discussed and take appropriate action.**

    a. **TCMHCC communications**
        - Daniel Oppenheimer presented the updated website, which has a new URL and a content management system that will allow more flexibility. Navigation on the site will include sections 'For Primary Care Providers' for CPAN, and 'For Schools' for TCHATT.
        - UT System put out a press release on the rollout of CPAN and TCHATT and will do a few things to promote that. Daniel welcomed institutions reaching out if they wanted to put out the same or a similar press release.
        - Daniel encouraged institutions that might be developing their own communication materials to share them so they can be put on Canva and made available to all.
    b. **Program Evaluation of TCMHCC by University of Texas at Austin**
        - Molly Lopez indicated that program evaluation updates will be embedded within other items in the agenda.
    c. **External Evaluation of TCMHCC**
        - Nagla Elerian updated the group on the status of the RFP. The deadline for the RFP was extended by a week and should close Monday, September 3rd. Some Q&As were posted on the RFP site.
    d. **Community Psychiatry Workforce Expansion (CPWE)**
        - Dr. Pliszka provided an update on CPWE:
            o Work group has been focused on metrics and operationalizing them.
            o On one of the metrics – Metric 6, Number of patients seen that were initially contacted through CPAN or TCHATT – it was determined that the most efficient way to get this is to have CPAN and TCHATT record referrals to LMHAs as one of the dispositions when time in program has ended vs having LMHAs independently track who is coming in from TCHATT or CPAN. Dr. Williams confirmed that there is a field in Trayt to capture this information.
            o The work group discussed use of the CANS/ANSA as an outcome measure for performance metric 2. It was noted that the CPWE resident providers would

not be the only providers interacting with clients at the LMHA, thus changes in the CANS/ANSA couldn't be attributed to the CPWE program. It was also noted that the CANS index scoring tool isn't sensitive to change occurring over a 90-day period. As a result, the workgroup decided not to use CANS/ANSA as an outcome measure.

- o The workgroup proposed that simple outcome measures (Global improvement, ADHD, depression and anxiety rating scales) be obtained using Trayt. Patients could be enrolled in Trayt & rating scales sent out from Trayt to parents. Data would be gathered that would address the outcome measure.
- o Danette Castle indicated that the LMHAs were favorable towards this approach.

  → Dr. Pliszka made a motion that tracking metric #6 & performance metric #2 be operationalized in the manner indicated in the minutes. Dr. Tamminga seconded. Motion was unanimously approved.

- A question was raised regarding the value of the referral metric. Dr. Pliszka indicated that the metrics were voted on and went into the LBB report so must be reported. He also confirmed that the number was put in place for informational purposes without a target value that would be assessed as being too high or low.

e. **Child and Adolescent Psychiatry (CAP)**
   - Dr. Newlin provided an update:
     - o Reports have been received from everyone. The planning grants are going well.
     - o TTUHSC is planning on having 2 Fellows in 2021.
     - o Dell indicated they were interested in taking part in the CAP Fellowship program starting in July 2021. They would be adding 1 CAP Fellow. One-time funds could be used to support the request.
     - o UTRGV indicated that they're on track with their planning grant and plan to have 2 FTEs start in July 2021.
     - o UTHSCT's planning grant is on track and they hope to have 2 CAP Fellows in 2022.

f. **Texas Child Health Access Through Telemedicine (TCHATT)**
   - TCHATT updates deferred until COSH update.

g. **Child Psychiatry Access Network (CPAN)**
   - CPAN updates deferred until COSH update.

h. **Research Initiative**
   - Dr. Nemeroff indicated that IRB approval is the biggest issue. They have been providing node training in groups of 3. They are fundamentally ready to launch, pending final IRB approval. During the meeting, Dr. Nemeroff received an update that the Trauma network IRB is expected to be approved today.
   - A question was raised about the status of research funds. Lashelle Inman updated the group on the current status. She indicated that as soon as the research PIA amendments are executed, they are sent to the THECB. She has been staying in touch with the THECB on the current status of the transfers. The THECB has not yet transferred funds. Given the next fiscal year is around the corner, UT System will be providing the THECB with FY21 requests so the THECB has both FY20 and FY21 amounts.
   - Dr. Trivedi provided an update:
     - o Finished node training & nodes are ready to go.
     - o UTSW IRB approved and first participant at UTSW enrolled last week.

- o 4 nodes ready to get IRB approval this week.
- o Things are moving as planned.
- - Question was asked regarding how many HRIs were having issues getting started due to funding delays. Some HRIs can't hire until funds have been received.
- - Dr. Nemeroff indicated that startup funds might be used to hire people and then transferred back once funds received.
- - Dr. Wakefield requested that additional guidance be provided to the HRIs to help overcome the funding delay issue.

IV. **Presentation by Dr. Nancy Byatt, from the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms. The full Executive Committee may review, receive and/or provide information, ask questions, and/or make recommendations from the items discussed and take appropriate action.**

Dr. Byatt (DO, MS, MBA, FACLP) is the Medical Director of MCPAP for Moms and an Associate Professor of Psychiatry, Ob/Gyn, and Quantitative Health Sciences at the University of Massachusetts Medical School.

The MCPAP for Mom is a program that addresses postpartum depression as well as co-occurring mental health and substance use disorders. It was developed in 2014 and has been shown to be effective at improved outcomes and engagement of women needing services through different provider routes. The model is similar to CPAN except that the MCPAP for Mom is providing support to OB providers, pediatricians, and other primary care providers to diagnose and treat women with postpartum depression. The following link provides information about the program: https://www.mcpapformoms.org/ .

- - Dr. Lakey outlined that the presentation is to help assist strategic thinking for the next session.
- - Dr. Byatt provided a presentation outlining Massachusetts' MCPAP for Moms:
  - o Mental health conditions are the most common complication of pregnancy and have a negative impact on mom, child & family.
  - o The vast majority of perinatal depression is unrecognized and untreated, and a leading cause of preventable deaths.
  - o COVID-19 is increasing perinatal depression & anxiety.
  - o Perinatal mental health is recognized as a major public health problem. The perinatal period is ideal for the detection & treatment of mental health conditions.
  - o Goal for MCPAP for moms is to help front line providers, that work with pregnant and postpartum women, detect, assess and treat mental health disorders.
  - o MCPAP for moms seeks to build front line provider capacity to provide mental health care to provide a solution to the shortage of perinatal psychiatrists.
  - o In Massachusetts, in response to this public health issue, the State wanted to mandate screening, but there was resistance. Instead Massachusetts passed a Post-Partum Depression (PDD) Act and PDD commission. The commission was charged with coming up with a state-wide initiative.

- o As a result, the Massachusetts Child Psychiatry Access Program (MCPAP) was expanded to provide support for pregnant & post-partum women, creating MCPAP for Moms.
  - o MCPAP for Mom includes three elements: 1) Education; 2) Consultation; and 3) Resources & Referrals.
  - o Training & toolkits were created to help educate & engage providers in addressing mental health. Resources are available on their website and they have also developed algorithms that are publicly available. At the beginning of the program, they did grand rounds in birthing hospitals throughout the state. They also do practice level trainings at individual practices, including webinars.
  - o Telephone consultation is the primary currency of the relationship and the "engine" of access programs. The consultation is what changes practice.
  - o MCPAP for Moms never provides direct care or prescribes.
  - o Obstetric providers / midwives are highest utilizers of the service (60%), followed by Psychiatric providers (14%), Family medicine / PCPs (9%), Pediatric Providers (5%) and SUD Providers (<1%).
  - o Resources and referrals link with therapy, support groups and community resources. They contract with a referral service.
  - o Engagement is a critical component to building and sustaining the program.
  - o The MCPAP model is staffed by 1.0 FTE Perinatal Psychiatrists (made up of 5 individuals), and 2.5 FTE Resource & Referral Specialists. There are three hubs.
  - o Since the launch in 2014, they've enrolled 76% of OB practices and of those, 64% are actively using the service. 200-300 women a month are served. If someone needs a face-to-face evaluation, they can get them in within a week or two.
  - o Progression of the program has moved from Depression, to Depression & Anxiety, Bipolar disorder, Substance Use Disorder and now Health Equity.
  - o Untreated perinatal mood & anxiety disorders are estimated to cost $32,000/year. Program costs $13.89/year per woman. Costs are recuperated through legislated surcharge to commercial insurers.
  - o There are now 15 programs available across the country. They are tailored for each state or health care system.
  - o Engaging multi-level stakeholders (Perinatal Psychiatrists, DPH, DMH, Legislators, Community Partner Advocates, Resource & Referral Specialists, etc.) is critical when developing a Perinatal Psychiatry Access Program.
- A question was raised regarding the relationship with the referral entity. It was clarified that the referral entity created and maintains a referral database for use by MCPAP resources.
- In response to a question regarding the leadership needed to get the program off the ground, Dr. Byatt confirmed that the program takes a lot of time & effort, a high level of engagement and relationship development to get off the ground. Provider to provider engagement is recommended.
- Dr. Byatt was asked whether MCPAP tracks the rate of patients following through on referrals. She indicated that they don't systematically record whether patients are following through as they weren't funded to do this as part of the program. However, it has been done with research dollars.
- Dr. Byatt was asked about the penetration of the program with historically marginalized and minority communities. She indicated that the metrics are not

currently captured to allow this to be determined but they are working to start collecting this.
- Dr. Byatt was asked whether she felt there were benefits of training child psychiatrists in perinatal psychiatry. She agreed that child psychiatrists can be trained but it's adult psychiatry. Part of why they didn't do that in Massachusetts was because there were plenty of perinatal psychiatrists. Dr. Byatt mentioned that a national curriculum is available and a great resource.
- Dr. Byatt was asked about funding challenges. In Texas, pregnant women are covered by Medicaid. As soon as they deliver, they lose their coverage. Some states have found ways to create a safety net but it's very challenging. They try to work with entities that provide free care.

V. **BREAK**

VI. **If necessary, closed session for consultation with attorney regarding legal matters, related to posted items, pursuant to Section 551.071 of the Texas Government Code**

VII. **Discuss, consider, and if appropriate, approve information and updates provided by the Baylor College of Medicine in the role of the Centralized Operations Support Hub (COSH) relating to implementation of the COSH, and/or information provided by HRIs relating to CPAN and TCHATT. The full Executive Committee may review, receive, and/or provide information and/or make recommendations from the items discussed and take appropriate action.**

a. **Demonstration of TRAYT**
- Dr. Williams provided an update on Trayt:
   o The COSH took lessons learned from other national CPANs and are collecting race, age and gender where the PCP has that information.
   o The first 2 phases of Trayt development are complete. Training for HRIs has occurred on enrollment through the platform. They're moving to a system where a PCP can enroll without contacting a team. They've completed the call form. Training to use the call form is taking place over the next 2 weeks.
   o Scales that will be used for TCHATT will also be used for CPAN. A family will see the scale coming from the PCP, not CPAN.
- Trayt walked the Executive Committee through system development to date.
- Trayt confirmed that all of the HRIs have been trained, all of the trainings have been recorded, and the HRIs have access to a folder with links to the training.
b. **Other COSH related items identified by the Baylor College of Medicine and members of the Executive Committee**
- Telephony update provided: The Lantana project team has met with all but 1 HRI. They are about 50% through the setup steps. It was decided that they will not go live until all teams complete all steps. Lantana will train each HRI on how to use the system. Baylor will go live this week on the Lantana application. They're building a phone algorithm to ensure calls ring to the proper hub. Will have a specific sub-routing for the Houston-Galveston area.

- CPAN Data Management – all NDAs and BAA are in place for the CPAN project. Within the next 2 weeks all teams will be scheduled and receive training on the CPAN form. Trayt will start building out Phase 3 PCP scales next for common disorders that will connect with TCHATT.
- TCHATT – Now that all teams have agreed to utilize Trayt for TCHATT data management, updates to the COSH/Trayt BAA will be required. All data metrics needed for state reporting plus patient engagement and care outcome measures will be collected. A demo was provided to the TCHATT teams on 8/28. TCHATT/CPAN integration is being looked at. After the TCHATT team sees a family, if the family gives permission, a discharge summary can be sent to PCP. If the PCP calls in the future with CPAN, that information would be available to them.
- Data Management Governance Team – The team has collected the data points and are in the process of building definitions. Next steps include reviewing the data definitions as a team and working on a data library.
- CPAN Progress – less than 5% of PCPs enrolled across Texas. Some teams not up yet. Steadily growing. Have 1788 providers registered, 237 clinics registered and have had 203 calls (2-4 a day), including some repeat calls.
- CPAN Communications – Video presentation complete but waiting on logos from two HRIs before publishing. The Facebook page is up and will start working on Linked In next. TPS contract completed so intend to start utilizing their email list serve. A webinar for the City of Houston was provided and had a good view rate. Magnets, pens and scratch pads are being ordered in bulk to be distributed to the HRIs. 4 teams are working on content for the revised website. Thinking of developing 5-10 minute podcasts.
- TCHATT is working to standardize a consent process, prescribing guidelines, best practices, and management of emergent issues for youth who are receiving TCHATT services at home.
- Trayt was asked to provide pricing for the TCHATT buildout. The estimate includes the metrics and tracking, and the development of a screening tool available to all youth/families as another entry point into TCHATT.
- A question was asked about where the data from a screening tool will reside. Dr. Williams confirmed that the data will reside within Trayt, visible to the HRI. The family would go through a consent process before filling out a scale. The details will need to be finalized as part of the buildout. Dr. Keller emphasized that we need to have a clear consent and security process.
- The question was raised whether a separate intake form would be developed. Dr. Williams confirmed that the intake form would be a separate process.
- Jennifer Evans walked the group through two state-wide referral system options being looked at by the COSH: Welnity and Aunt Bertha.
  - Welnity is a real-time, crowdsource application. You can pose a question and if not already in the system, within about 20 minutes someone answers the question. If you haven't signed up with Welnity but someone knows of you, it initiates you being added. Welnity can create a custom dashboard. Can invite own group for CPAN and TCHATT. It can also identify resources by location,

insurance, Spanish speaking services, etc. Two to three times annually Welnity confirms that the resources they have on record are still offering services. Welnity integrates with LMHAs and 211s. It can provide a way to track how many referrals using LMHAs. Biggest difference beside cost is that they'll customize it more. They're a newer company out of UTHSCH. Welnity would need to be built out but could eventually integrate with Trayt.

- o Aunt Bertha is a more static system, has been around longer and has more resources built out. They do not confirm resources are still offering services to the same degree as Welnity.
- o Question raised whether there was any real-time wait list information. Welnity indicated that this could be built out.

VIII. **Discuss, consider, and if appropriate, approve information and updates regarding TCMHCC FY 2020 and FY 2021 planning and budgets. The full Executive Committee may review, receive, and/or provide information and/or make recommendations from the items discussed and take appropriate action.**

a. **Open discussion regarding FY 2020 - 2021 planning and budgets**
   i. **Presentation of proposed HRI budget modifications**
      - Dr. Lakey provided some background information on the budgets – UT System has met with HRIs independently to review their budgets and share ideas on how other HRIs are using their funds. Lashelle has pulled the provided information together. Some details on the budgets still need to be refined and decisions may be deferred to the next meeting. There is a need to keep an eye on recurring costs to ensure ongoing costs don't exceed what was approved by the LBB for FY21.
      - Lashelle Inman provided an overview of the budgets as received to date. Key highlights:
        - o Looking at around $235k in recurring/ongoing funds that could be reallocated.
        - o $4.5 in one-time funds are available for proposals.
        - o Some of the changes being made within individual budgets included:
          - ▪ Using an outside entity to help enroll providers into CPAN. Meadows was used by a couple of institutions, using other funding, to help bring up enrollment. Other institutions are interested in doing the same to get their numbers up. Dr. Nemeroff spoke to the benefits of using Meadows. Dr. Lakey indicated that when looking at the institutions that used them, the data shows their numbers are up. If individual institutions believe that it's in their best interest to approach any other entity to do that work, he believed it was a valid use of funds.
          - ▪ Increasing marketing to better promote services.
          - ▪ Remodeling costs related to bringing teams together in one geographic area to make their programs work more effectively.
          - ▪ Expansion of Project ECHO.
          - ▪ Movement of resource funds from CPAN to TCHATT to better support expected TCHATT volumes.

- Changes to the provider mix.
        - Technology cost increases to get iPads/tablets to schools to facilitate TCHATT telemedicine visits.
        - Training, including development of training videos.
    - A comment was made that the Executive Committee might want to think about using funds for a data warehouse to facilitate the creation of dashboards, store the data archives.

ii. **Review and discuss proposals submitted for any needed reallocation of FY 2021 funds between TCMHCC initiatives**
    - Lashelle walked through requests for additional operational funds:
        o Dell requested funding for 4 additional LPCs. They exceeded their TCHATT goal for school participation and need to expand clinical capability to meet the needs of all ISDs that have signed MOUs.
        o UTRGV requested .35 FTE of a Child Psychiatrist to increase CPAN services by 15%.
        o UTRGV requested an additional .5 of a Faculty FTE and 1 additional Resident FTE to increase LMHAs served by CPWE.
    - Requests for operational funds were greater than expected available funds and requests will need to be prioritized.
    - Lashelle walked through proposals for use of one-time funds:
        o A number of COSH costs related to Trayt development were reviewed. Dr. Williams is still in the process of finalizing the costs with Trayt.
        o Welnity or another resource management tool was added to the list.
        o Learning Collaborative proposal was discussed. Target audience is psychiatric trainees involved in CPWE. Many places don't have strong infrastructure for providing training & skills in psychosocial treatments. It's important for them to have a good understanding of principles that underly treatments, what they might expect if they refer someone. Also wanted to make it available to the extend desired, to the LMHA partnering with each site. Danette indicated that the proposal was discussed with the CPWE work group and there was a positive response to strengthening the training as long as it is in alignment with the rehabilitative services provided through the LMHA & required by agency and doesn't take away from other initiatives.
        o Stepped Care proposal was discussed. It was noted that we cover primary care with CPAN and urgent care with TCHATT but don't have a way to help people understand where to go next. The proposal would fit well with HRI infrastructure and maximize utility of specialty care resources. It would bring HRIs into the discussion to understand clinical protocols & how to implement them. This is about maximizing CPAN & TCHATT value. These costs would develop expertise over the next year.
        o 1 CAP fellow for Dell was added in response to their request to participate.
    - Within institutions, we've worked with them to redistribute funds within their program buckets.

- Final budgets are needed before recurring cost requests can be approved.
- Proposals also can't be decided until budgets finalized. We want to make sure what we do is aligned with the legislation. As long as requests are aligned and there is agreement from the consortium at the next meeting, then we can move forward.
- Dr. Lakey emphasized that if any recurring programs could be done through one-time funds somehow, talk to us so we can think through that.
- It's expected that some funds will be given back to the State.
- Recurring fund requests were prioritized. Dr. Nemeroff was asked whether the 4 LPCs could be partially funded if funds were not available. Dr. Koli confirmed that they could work with less if necessary. Dr. Escamilla prioritized the CPWE .5 Faculty FTE, followed by the additional resident FTE and then the CPAN additional psychiatrist. If they could only be partially funded, they would make do with what was available.
- Lashelle emphasized that budgets need to be finalized before the THECB can be provided with instructions for FY21 budget transfers.
   <<Action item: UTS will work with HRIs to get final numbers and come back to the group with a proposal to maximize the use of funds. >>

IX. **Adjournment**

Next meeting is scheduled for September 28, 2020 from 10:00 am to 3:00 pm Central Time.

➔ **Motion made by Dr. Podawiltz to adjourn. Dr. Wagner seconded. Meeting adjourned.**

Attendance List

Institution/ Organization	Name	Attended? Yes/No
Baylor College of Medicine	Wayne Goodman, MD	
Baylor College of Medicine	Laurel Williams, DO	y
Texas A&M University System Health Science Center	Israel Liberzon, MD	y
Texas A&M University System Health Science Center	R. Andrew Harper, MD	y
Texas Tech University Health Sciences Center	Sarah Wakefield, MD	y
Texas Tech University Health Sciences Center	Nancy Trevino, PhD	y
Texas Tech University Health Sciences Center at El Paso	Peter Thompson, MD	y
Texas Tech University Health Sciences Center at El Paso	Sarah Martin, MD	y
University of North Texas Health Science Center	Alan Podawiltz, DO, MS	y
University of North Texas Health Science Center	Mark Chassay, MD, MBA	y
Dell Medical School at The University of Texas at Austin	Charles B Nemeroff, MD, PhD	y
Dell Medical School at The University of Texas at Austin	Stephen Strakowski, MD	y
The University of Texas M.D. Anderson Cancer Center	Daniel Tan, MD	
The University of Texas M.D. Anderson Cancer Center	Rhonda Robert, PhD	
The University of Texas Medical Branch at Galveston	Karen Wagner, MD, PhD	y
The University of Texas Medical Branch at Galveston	Alexander Vo, PhD	y
The University of Texas Health Science Center at Houston	Jair Soares, MD, PhD	y
The University of Texas Health Science Center at Houston	Elizabeth Newlin, MD	y
The University of Texas Health Science Center at San Antonio	Steven Pliszka, MD	y
The University of Texas Health Science Center at San Antonio	Joseph Blader, PhD	y
The University of Texas Rio Grande Valley School of Medicine	Michael Escamilla, MD	y
The University of Texas Rio Grande Valley School of Medicine	Michael Patriarca	y
The University of Texas Health Science Center at Tyler	Jeffery Matthews, MD	y
The University of Texas Health Science Center at Tyler	Brittney Nichols, MBA, LPC-S	y
The University of Texas Southwestern Medical Center	Carol Tamminga, MD	y
The University of Texas Southwestern Medical Center	Hicham Ibrahim, MD	y
Health and Human Services Commission - mental health care services	Sonja Gaines, MBA	y
Health and Human Services Commission - mental health facilities	Mike Maples	
Texas Higher Education Coordinating Board	Stacey Silverman, PhD	
Hospital System	Danielle Wesley	y
Non-profit - Meadows Policy Institute	Andy Keller, PhD	y
Non-profit - Hogg Foundation	Octavio Martinez, Jr., MPH, MD	y
Non-profit - Texas Mental Health Counsel	Danette Castle	y
Administrative Contract – University of Texas System	David Lakey, MD	y
Other – Hospital System Representative	James Alan Bourgeois, OD, MD	y