Convening of the Texas Child Mental Health Care Consortium (TCMHCC)
November 30, 2020
10:00 AM – 1:00 PM
Minutes

I. Call to order and roll call

- Dr. Lakey, presiding officer of the Consortium, called the meeting to order.
- 29 Executive members were in attendance. See attached attendance for a full list of attendees.

II. Review and approve the following item:

a. Minutes from October 29, 2020 Executive Committee meeting

➔ **Dr. Podawiltz moved to approved minutes. Dr. Tamminga 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 and marketing

There was no update currently.

b. Program Evaluation of TCMHCC by University of Texas at Austin

- Dr. Molly Lopez informed the group that the internal evaluation team was currently wrapping up the year-end evaluation report. She thanked all for their efforts to share data & provide information to the team. This year, quarterly updates will be provided to keep track of data now that various components are up & running at different locations.
- Dr. Lakey mentioned that the team had a legislative deadline of December 1st to put together a biennial report summarizing consortium activities in the last year. He thanked Dr. Lopez & her team for their help in providing information for the report.
- Dr. Tamminga asked if this was the last opportunity to update the Legislature. Dr. Lakey shared that there is a rider that helps determine our formal input so we will need to wait to see what they put in the rider. Dr. Lakey indicated that we are staying in close contact with the LBB and they are aware of all the ongoing work. He also said several legislative offices may listen in to Consortium webcasts.

c. Research Initiative

- Dr. Tamminga provided an update:
  - UTSW is the common site for protocol approval. Approvals were received in July for the Depression / Suicide Network and September for the Childhood Trauma Network.
  - UT System has a shared IRB approval, so it was easy to get all the UT Sites approved but has taken longer for non-UT schools. This was part of the project, to create the networks around the State of Texas.

  - All 12 sites decided to participate in the networks. There are 5 nodes that are already involving participants.
  - All nodes are fully staffed & trained. Assessment tools have been shared. Most nodes that aren't entering still have some IRB issues.
  - Both nodes have an electronic dashboard.
  - For the childhood trauma network, they have had 66 participants enrolled and are projecting 2400 cases. The pace of engagement has started & is increasing exponentially.
  - There are 35 individuals enrolled in the depression network and they will be followed over time. They are projecting to have 1800 individuals engaged.
- Dr. Nemeroff provided an update on the Childhood Trauma network:
  - They have 3 subcommittees that involve members from nodes outside of the hub. These include the protocol committee, acculturation, ethnicity & participant advisory committee and the pilot projects & external grants committee.
  - For first time ever, a state-wide trauma network has been established - no other state has done this. We are now poised to be used in subsequent studies with other funding.
  - As a result of the network, kids who have experienced one or more types of trauma are being engaged. If it were not for the trauma network none of these children would ever have received any psychological attention. The types of trauma being identified include severe accident, natural disaster, witnessing a severe accident, emergency surgery, separation of family, sexual abuse, attack from an animal and bullying. They are seeing a severe level of anxiety, depression & imminent PTSD.
  - Have 5 nodes engaging children and families currently, others poised & ready. Received a bit of an obstacle with local IRB approval, but otherwise doing great. Want to give credit to Hub personnel & all for their support.
- Dr. Wagner added that she was impressed with the collaborative nature of the participating institutions. The network is helping identify traumas that would not have otherwise been identified and is so good for the mental health of children in the state of Texas.
- Dr. Trivedi provided an update on the Childhood Depression and Suicide Network:
  - The network has been stood up across all 12 HRIs in Texas and they have a significant number of people trained and certified in research & procedures. About 40 research assessors have been certified in several measurement tools in depression / suicide. There is a lot of shared training & procedures.
  - Now that the procedures are in place, expect engagement of children and families to speed up quite a bit. Now have 51 people that have fully finished screening assessments & will be in the study.
  - The network will institute a longitudinal follow up for those in the study with measurement-based and collaborative care. One of the Committees is chaired by Drs. Wakefield, Storch and Hughes to implement measurement-based care and collaborative-based care. They have trained over 50 clinicians across the 12 nodes to implement measurement-based care & collaborative care as outlined in national protocols. Twenty patients have finished their first month, and the network has records of measurement-based care & associated outcomes.
  - The network has several committees that involve a lot of folks from all the nodes.
  - Kickoff training was held July 29th and two-part Assessor training was held July 31st and August 7th.

- Database training was provided. The database is now functioning and has all elements of safety monitoring and data capture.
- Monthly hub/node leadership training is held. Have had 9 so far.
- The idea of using measurement-based care in clinical practice settings across 12 HRIs hasn't been implemented anywhere else across the country. Sample we're getting - these would not normally get the attention they're getting. In our sample, half the teens that have been engaged to participate in the study have had a previous suicide attempt.
- The database is there, have a dashboard that allows people to know what's happening in their nodes & across the network and add additional information as they get new patients.

- Dr. Wakefield expressed support for Drs. Wagner, Trivedi and Nemeroff's comments and agreed that the establishment of a Texas-wide network to improve screening & response for both trauma & depression for youth is phenomenal in and of itself. She was impressed by Hub team's ability to take a snapshot of what's going on right now, improve things in real-time with measurement-based care training & help elucidate targets for an improved system in the future. All of this will improve care for our youth in Texas.
- Danette spoke out on her interest in understanding the primary ways families are becoming involved as participants. Dr. Nemeroff clarified that it varies from node to node, but some of the nodes, like Dell, are recruiting through the trauma service and emergency department. These are kids coming in from accidents, emergency surgery, dog bites, burns. Dr. Wagner, on the other hand, has recruited largely from the psychiatric clinic which includes more traditional trauma, including loss of parent, bullying, sexual assault, physical assault, etc. As you look at nodes, there's a difference in age across the nodes, Dr. Liberzon is focusing on the adolescent population - 16-20-year olds, which will have different types of trauma. There is also ethnicity – they have recently completed Spanish translations for scales & submitted to the IRB as a modification so will begin seeing that population soon. They are also working on Vietnamese translations. By recruiting from these different sites, it allows a variety of trauma to be seen.
- Dr. Tamminga added that this doesn't happen in any other state in the country but the reason we've been able to make these types of advances that everyone has talked about is because all of the sites /HRIs that are participating.
- Dr. Podawiltz expressed how proud he was of what's been built in such a short amount of time.
- Dr. Trivedi added that we've created a shovel ready set of networks that will be ready for extramural funding & will be competitive against any network across country.

d. External Evaluation of TCMHCC by University of Texas Health Science Center School of Public Health

- Dr. Peskin provided an overview of the proposed evaluation plan:
  - Goals for year 1 are to develop infrastructure to support a rapid cycle evaluation framework that allows for real-time program monitoring & improvement, increase understanding of best practices for program implementation across sites and potential impact of programs on equitable access to mental health assessments & ongoing services. They will provide monthly, quarterly and a final report.

    - Guiding frameworks: Basing frameworks on CDC conceptual framework for program evaluation which includes, engaging stakeholders, describe the program, focus the evaluation design, gather credible evidence, justify conclusions, ensure use & share lessons. Also working with logic models. Looking at reach, effectiveness, adoption, implementation and maintenance (RE-AIM).
    - Thinking about goals, planning to conduct a formative evaluation, process evaluation and outcome (summative evaluation). From now until the end of January will focus on formative evaluation. February through the end of year, will conduct a multi-level process evaluation to examine reach, adoption, implementation & maintenance of the programs and conduct a multi-level outcome (summative) evaluation & cost analysis of TCHATT, CPAN and CPWE.
    - During the formative evaluation (the current stage) will engage with stakeholders, document current practices through use of process mapping. Are currently working to understand existing data sources and develop a matrix of these sources along with a comprehensive overview. The goal is to design & develop a database of existing data for analysis.
    - Another major activity is to create a process mapping protocol. Will document the baseline current practice for initiatives, HRIs, clinics/schools engaged in program. Will review implementation plan, complete process maps & build on process maps that have already been developed. Will get input from stakeholders & a sample of informants involved. Will start to identify people to interview, starting with the Executive committee. They will reach out to members and ask who else should be interviewed as part of this process. Will have a high-level understanding of how it should be working across HRIs & schools. Will update logic models as needed. Goal is to understand the program and the outcomes that will be collected.
- Dr. Savas added:
    - After the formative evaluation, they will be able to establish measures & preliminary outcome evaluation effectiveness measures. Goals of two phases are to increase understanding of the intervention following REIM framework.
    - Will also look to build characteristics of different participants and look at engagement in different program components. Will also work to identify facilitators and barriers to implementation at the organizational & patient-level.
    - Then will examine preliminary program effectiveness.
    - Will set up the evaluation as a framework to ensure plan can carry forward in the future.
- Dr. Liberzon asked whether the logic model would be presented to the Executive Committee. Dr. Savas answered that the logic models would be brought to the stakeholders as part of formative work. Dr. Israel thought it should eventually be brought back to the Executive Committee for discussion when it is ready. Dr. Savas agreed and confirmed that they want to ensure the logic models are correct as they will serve as the blueprint/guide for the evaluation plan.
- Dr. Savas continued that as part of formative work they will identify data sources to build a database, then will start using that for reports that will be brought forward monthly. As monitoring metrics for implementation that will be an important component of our comprehensive evaluation plan.
- For CPAN process and outcome data collection, will develop online quantitative surveys, currently planned for mid-year to end-year. Want around 100 clinics with about 5 people per clinic (representative sample) to get different perspectives.

Currently working with some implementation researchers on developing the surveys. Will have 5 focus groups for clinic staff to get an in-depth perspective. This comprehensive approach will help us answer the evaluation questions. Some of the example outcomes include: measuring fidelity & level of implementation, satisfaction and contextual factors associated with implementing the program, determinants of implementation (looking at attitudes, knowledge and skills), implementation practices that increase equitable access, and proportion of unique children/patients served by PCPs and from medically underserved and/or vulnerable populations.

- For TCHATT process and outcome data collection, will use same approach in terms of quantitative & qualitative analysis. Will build databases &analyze existing data, develop qualitative surveys, get a representative sample of around 250 school district stakeholders, will have 5 virtual focus groups with school district staff. Example outcomes include: level of implementation, determinants of implementation, experiences with the program, implementation maintenance, proportion of students served (total), by provider type, from medically underserved and/or vulnerable populations.
- CPWE & CAP process and outcome data collection will have the same approach. Currently in the formative stage, building database based on existing sources, planning & conducting 30 in-depth interviews by the end of the year. Example outcomes include: experience providing mental health care in community settings, experience providing additional child & adolescent psychiatry fellowship opportunities, contextual factors associated with implementing & maintaining the workforce expansion programs, number of unique patients seen at LMHAs, number of child and adolescent patients (and those from vulnerable and/or underserved populations) seen in CAP open and filled institutions.
- Key deliverables for process & outcome analysis include: Evaluation of reach, implementation, and adoption of initiatives across sites and organization & individual-level influencing factors; Evaluation of whether implementation practices result in equitable participation of practices that reflect the racial & economic diversity of the population served; Comparison of implementation by the HRIs and between TX model & other states; Program satisfaction; Comparison of program outcomes across the one-year time period; Evaluation of barriers to mental health services for various vulnerable populations; Budget analysis to examine the initiatives' costs, focusing on cost of implementation & costs associated with numbers of people served.
- Dr. Liberzon commented that while thinking about the complex evaluation structure it will be important to align timing with legislative reporting deadlines. When the executive committee must prepare interim reports, it will be very useful to provide data early to support this. It is also important to make sure the critical issues the legislature is looking at are incorporated.
- Dr. Vo asked whether the team, when conducting their cost analysis, planned on distinguishing between the setup phase vs programmatic phase. Dr. Savas confirmed that yes, there are one-time costs that come with new programs and they will differentiate between one-time costs vs ongoing implementation costs.
- Dr. Liberzon asked about the level of overlap between the internal and external evaluation teams.
- Dr. Peskin confirmed that they had spoken to Dr. Lopez to understand the overlap between Internal Evaluation vs External Evaluation. There may be some repetitiveness going on but would love feedback on this. Expect some degree of overlap.

- Dr. Lakey emphasized that he sees these two groups as being different. Dr. Lopez is like internal management team. The external evaluation should be at arms' length from us and not be confined by conflict of interest so can be a voice to legislature. They will also provide ongoing input on improving projects.
- Nagla added that we are trying to coordinate so not collecting the exact same information twice. There will be sharing of information between the two groups. If the internal team is collecting data, they will have the external team weigh in to make sure collecting information they might need. As much as we can, we will try to avoid duplicating efforts, but they are looking at things from two different perspectives.

e. Additional updates (if needed) on other activities associated with implementation of TCMHCC initiatives

- Lashelle confirmed that she had sent out a link to the PowerBI reports and asked for feedback on how she can make them more useful for the teams. She added that the intent is to export the reports to PDFs and distribute them, so we have a snapshot of progress over time. She also requested that in December, after month-end close, everyone send her the next quarter's updates. She highlighted that at this point, everyone should have received their funding, so if anyone has questions or concerns about funding please reach out to her.
- Dr. Wakefield updated the committee that her institution had submitted their application for accreditation for their child fellowship program.
- Dr. Matthews announced that he's leaving UTHSCT & going to Austin to take over the role of Chief Medical Officer for the HHSC State Hospital System. Will have interim chair - Dr. Bryant - who will take over Dr. Matthew's role on the Consortium.
- Danette noted that the group had talked/deliberated about the importance of using person-centered language as we think about the unique way we're approaching research in this initiative. The group had agreed to use language of participant vs subject, and engagement instead of recruitment. She asked that we take great care in making that change in language & give consideration to that as we move forward. Dr. Tamminga acknowledged that they will work on this.
- Luanne Southern thanked the group for their assistance in providing information for the biennial report. As soon as the report is ready to go, will make sure everyone receives the information.

IV. 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

V. 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, TCHATT, or CPWE. The full Executive Committee may review, receive, and/or provide information and/or make recommendations from the items discussed and take appropriate action.

a. COSH related items identified by the Baylor College of Medicine and members of the Executive Committee (may include Trayt and/or Lantana updates)

- Dr. Williams provided an update:

    - For Lantana, 11 hubs have been trained & 10 are operational. 2 Hubs are not using Lantana, 1 is moving to it in the new year, the second is working to get their team fully staffed then will move forward.
    - Moved to the auto-attendant so COSH is no longer the switchboard. Have a standardized message and standardized holiday schedule based on state-holiday schedule. It was agreed that the team wanted a consistent process for providers across state. If an HRI is closed, teams can cover when needed.
    - Now that Lantana is the switchboard, hope to be able to report out metrics on calls across the state at the next meeting. Metrics being tracked are calls to CPAN results in provider being responded to within 5 minutes or less. Second metric is if they ask to talk to a psychiatrist, we do so within 30 minutes. Lantana tracks the first, 5-minute, metric. Trayt will track the 30-minute metric.
- Working on an updated Trayt contract that includes new tasks. Have done payment for services related to the initial buildout. CPAN 1.0 is up & operational. Trayt is working with each HRI & COSH to put out stage releases/fixes. They're in phase 3 currently of the overall process.
- For TCHATT teams using Trayt, all outcome metrics are available for teams to use. Have a few outstanding Joinder agreements. These allow for the TCHATT /Trayt process to move forward. Would like to have this done by the close of the calendar year.
- Had first meeting with CPWE teams to start discussing how to implement Trayt for the CPWE programs.
- Plan on working with the Trayt team and Lashelle on federated authentication in December.
- Will start work on the TCHATT school screening process in new year.
- Data Governance Council - next meeting scheduled for early December. Will review the data definitions for TCHATT & CPWE. Once the data definitions complete will start library build. Molly's team has been very helpful. Whenever appropriate for external evaluation team to be involved, please let us know as we don't want to do duplicate work.
- For internal review team, collaborated with Molly to create surveys for CPAN. Finalized process for enrollment. Once enrolled, a specific survey is sent out surveying their comfort level treating mental health. Another is sent out after first use of CPAN. An end of year survey will also go out. Another survey being developed is for CPAN providers that use the service frequently but still trying to figure out frequency.
- TCHATT surveys will be next. The providers are the schools and families getting the service. Will work with Molly's team as those surveys are designed.

b. CPAN update

- Educational materials have been sent to all HRI teams. With the COVID resurgence again, it will limit the time staff can go in person to practices. However, the materials will help increase the visibility of CPAN to providers.
- All teams are seeing a steady increase in activity.
- Great outreach efforts across HRIs. Using Facebook & LinkedIn to promote activities. If HRIs let the COSH know what they are doing it will be highlighted on social media.
- Dr. Williams presented to NAMI North Texas on both CPAN and TCHATT in November. There was also a Brain Summit Presentation completed with Drs. Lakey and Williams discussing initiatives in November 2020.

- Today have over 2400 providers across Texas registered in CPAN.
- All teams have completely migrated from Red Cap or other systems into Trayt.
- 279 clinics are registered.
- Have had 747 calls to date. Last month had a 40% increase in calls. However, expect with holiday season to see a dip in calls.
- Physicians are the ones primarily calling. Reason for call is largely medication management and referrals.
- There are still upwards of half of calls asking for psychiatrists. Other half is either therapist or resource coordinator. It's hoped that as providers start feeling more comfortable, they will start to ask for different things. MCPAP have shared that when they surveyed their pediatricians in Massachusetts, as they used the program over time, they felt more comfortable doing new & different things. That's what we hope to see as well.
- 44% of the time, we're not recommending a medication be used.

c. TCHATT update

- Currently providing services to 96 ISDs across the state. Each HRI is looking to expand out to additional ISDs in coming months. Some are in progress, others working with the TEA to identify ISDs with low resources. Trying to be mindful to provide to under and low-resource areas as possible.
- Total referrals as of November 16, 20202 is 878. Two teams haven't started yet and metrics from 1 HRI are still outstanding. Average age of youth being seen is 11 or 12.
- More detailed TCHATT metrics will be available in January 2021.
- COSH hired a project manager who will be starting in December. She will be able to provide a more detailed breakdown at the next meeting including a report out at grade level, gender, status at completion of services and service provider type. Teams are providing metrics in somewhat disparate ways today so the new PM will help pull this together.
- Many of the services are ongoing - kids can have up to 4 visits. Not many have run through the entire service delivery yet.
- A TCHATT map was displayed showing locations of schools the HRIs are currently working with.

d. CPWE update

- Dr. William's provided a CPWE update:
  - Working with the CPWE team leads and once we have good sense of how we will utilize Trayt, will meet with Trayt. The plan is to utilize Trayt as is, using the same measures used in TCHATT/CPAN. Will use same scales so there is an opportunity over time to look at how youth are doing across services.
- Jennifer Evans provide an update on the Welnity Platform:
  - It is a platform being used to share resources across Texas, whether covering for each other or identifying resources in rural areas. Will work with LMHAs, insurance providers, etc. to get them into one database.
  - At the next State meeting will present proposed search queries. For example, would you like a search by insurance, telemedicine offered, etc. Want to identify what HRIs

would find most useful. Once that is done it will not take long to build & put together.
    - Will start asking for resources HRIs already have, then work with LMHAs & other people throughout the state to get additional resources add to the database.
    - Will have a dashboard so the team can track how many referrals were looked up / searched for in which locations and identify referrals where we could not find a resource. Can search by distance & location to identify how far away referrals are.
    - Have heard from some HRIs that the ability to contact parents would be useful. Counsellors try to reach out families first, then HRIs reach out but they are sometimes struggling to connect with parents. Welnity has a texting application, where a text message can be sent to a parent if they opt in to receive it, asking if they are interested in receiving TCHATT services or not, and if so, the best times to speak with them. Will present this at one of the state meetings & see if HRIs think this will be useful. Will be another communication method that can be utilized.
    - Dr. Podawiltz thought this would be a great option to offer parents.
- A CPWE update was provided by Dr. Pliszka. A spreadsheet was displayed with CPWE numbers.
    - Dr. Pliszka noted that the data set was not yet complete; they needed to add JPS. Gives overview of which entities HRIs have approached and have a MOU are in process.
- Dr. Harper confirmed that they have a MOU signed with Brazos Valley MHMR. They will not have residents until 2021, just 0.5 faculty initially. Dr. Pliszka noted he needed to add a column for faculty FTE.
- Dr. Liberzon mentioned that they just had their residency training program approved thanks to Andy Harper's efforts.
- Dr. Pliszka asked if UTRGV's program was primarily adult. Dr. Escamilla confirmed that it is, but that they see quite a lot of children and adolescents. The .102 number in the spreadsheet was changed to 10.2%.
- Dr. Podawiltz confirmed that UNTHSC's MOU with Tarrant County MHMR is being developed. Should have residents there sometime early March.

VI. **Adjournment -** Next meeting January 15, 2021 10:00 – 3:00.

Texas Child Mental Health Care Consortium

Attendance List - November 30, 2020

#	Institution/ Organization	Name	Attended?
1	Baylor College of Medicine	Wayne Goodman, MD	y
2	Baylor College of Medicine	Laurel Williams, DO	y
3	Texas A&M University System Health Science Center	Israel Liberzon, MD	y
4	Texas A&M University System Health Science Center	R. Andrew Harper, MD	y
5	Texas Tech University Health Sciences Center	Sarah Wakefield, MD	y
6	Texas Tech University Health Sciences Center	Nancy Trevino, PhD	y
7	Texas Tech University Health Sciences Center at El Paso	Peter Thompson, MD	y
8	Texas Tech University Health Sciences Center at El Paso	Sarah Martin, MD	y
9	University of North Texas Health Science Center	Alan Podawiltz, DO, MS	y
10	University of North Texas Health Science Center	Mark Chassay, MD, MBA	y
11	Dell Medical School at The University of Texas at Austin	Charles B Nemeroff, MD, PhD	y
12	Dell Medical School at The University of Texas at Austin	Stephen Strakowski, MD	y
13	The University of Texas M.D. Anderson Cancer Center	Daniel Tan, MD	
14	The University of Texas M.D. Anderson Cancer Center	Rhonda Robert, PhD	
15	The University of Texas Medical Branch at Galveston	Karen Wagner, MD, PhD	y
16	The University of Texas Medical Branch at Galveston	Alexander Vo, PhD	y
17	The University of Texas Health Science Center at Houston	Jair Soares, MD, PhD	y
18	The University of Texas Health Science Center at Houston	Elizabeth Newlin, MD	y
19	The University of Texas Health Science Center at San Antonio	Steven Pliszka, MD	y
20	The University of Texas Health Science Center at San Antonio	Joseph Blader, PhD	y
21	The University of Texas Rio Grande Valley School of Medicine	Michael Escamilla, MD	y
22	The University of Texas Rio Grande Valley School of Medicine	Michael Patriarca	y
23	The University of Texas Health Science Center at Tyler	Jeffery Matthews, MD	y
24	The University of Texas Health Science Center at Tyler	Brittney Nichols, MBA, LPC-S	y
25	The University of Texas Southwestern Medical Center	Carol Tamminga, MD	y
26	The University of Texas Southwestern Medical Center	Hicham Ibrahim, MD	y
27	Health and Human Services Commission - mental health care services	Sonja Gaines, MBA	
28	Health and Human Services Commission - mental health facilities	Mike Maples	
29	Texas Higher Education Coordinating Board	Stacey Silverman, PhD	
30	Hospital System	Danielle Wesley	y
31	Non-profit - Meadows Policy Institute	Andy Keller, PhD	y
32	Non-profit - Hogg Foundation	Octavio Martinez, Jr., MPH, MD	y
33	Non-profit - Texas Mental Health Counsel	Danette Castle	y
34	Administrative Contract – University of Texas System	David Lakey, MD	y
35	Other – Hospital System Representative	James Alan Bourgeois, OD, MD	