# University of Texas System
UTS Building
210 W. 7th St., Austin, TX  78701

## Convening of the
## Texas Child Mental Health Care Consortium
October 4, 2019
10:00 AM – 3:00 PM
Room 2.206

## Agenda

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I. Call to order and welcome

   Dr. Lakey, presiding officer of the Consortium, called the meeting to order.

II. Roll call

   27 Executive Committee members attended.  See Appendix I.

III. Review and approve minutes from September 12th meeting

   Dr. Podawiltz made the motion to approve with changes (correction of institutional affiliations of workgroup chairs).  Dr. Thompson seconded. The minutes were approved unanimously.

IV. Review work on a proposed web site for the Consortium

   Requested a change in the photos used to incorporate happy children to align with the intended outcome of the Consortium.

V. Discussion on the process for compiling the LBB report due November 30th

   Tabled

VI. Lunch (11:30-12:00)

VII. If necessary, closed session for consultation with attorney regarding legal matters, pursuant to Section 551.071 of the Texas Government Code

   No closed session was held.

VIII. Workgroup discussions to include process of funds distribution, capacity for each institution, minimum infrastructure, unit cost, metrics to evaluate success, and

identified issues. The full Executive Committee may receive recommendations from the workgroups and take appropriate action.

**Child Psychiatry Access Network (CPAN):** A network of child psychiatry access centers that provide consultation services and training opportunities for pediatricians and primary care providers to better care for children and youth with behavioral health needs.

**Key discussions:**

- **Program Name**
  The name CPAN is owned by someone else so may have to find a new name for the group.

- **Call back time targets**
  Initial call back time target team landed on was 4 hours, however, there was concern that if pediatricians didn't get a quick response the program would fail. Discussed the fact that the Massachusetts model has a 30-minute target; if Texas wants to be transformative, it needs to also target a 30-minute response time. If the program doesn't hit that target in the first 6 months, it will work towards it. There was a discussion surrounding the fact that not every call will require a response from a psychiatrist. The group agreed that a lot of calls could be handled by a resource specialist instead. The 30-minute target would be for the physician to get a response from whichever resource was appropriate to the situation. Discussed that the physician's availability to take a call (if seeing patients) could affect how quickly contact could be made.
  → **23 members were in favor of a 30-minute target**
  Discussed the potential bifurcation of the metric so that if a physician was in a room with a patient, they could expect a 30 minute response time; if it was a general question then the response time could be longer.

- **Other Metrics**
  The working group provided some potential metrics in a handout. Feedback from the executive committee included potentially consolidating some of the metrics – one to focus on utilization of providers, answer time, and provider satisfaction – and making sure the metrics were realistic.

- **Team composition & Sizes**
  Team composition & size will be population based. The point was raised that psychiatrists are the least available and most expensive resource and the work force needs to balance program needs with fiduciary responsibilities. The working group confirmed that a triage method of engagement would be used to identify which resources were appropriate to the situation.

- **Standardization and connectivity of hubs**
Expect some training to be conducted at hubs to ensure consistency across the sites. Want flexibility for hubs but standardized metrics. Hubs will be set up to be able to take calls for each other via a centralized telephony system. A website will be created to point physicians to the right hub. A central marketing strategy will be developed.

- **Electronic means of contact/referral**
Discussed use of alternative means of contact/referral such as text, IM, digital referrals, etc. The working group will spend more time looking at this.

- **Central hub roles & UT System Administration's contribution to those roles**
A central hub will help organize what the other hubs are doing There are some roles / functions within the hub that appear to be more administrative in nature and the question was raised whether these would be handled via UT System Administration. Dr. Lakey confirmed that UT System will hire a Project Director to assist with collaboration. He also confirmed that UT System could assist with the marketing strategy. UT System could also assist with data analysis and reporting. UT System will not be able to provide a Medical Director or run the telephony system.

- **Overlap between CPAN, TCHATT & Other Programs**
The group discussed that they don't want a PCP to be confused about where to go. Will need to learn and adjust as we identify issues. The goal is to work across institutions and systems to get people on their feet and the group will support each other to make this happen.

- **Budget**
The current high-level estimated budget needed for the program is around $14M. A question was raised around how indirect costs will be budgeted.  The group agreed that these should be kept to a minimum. However, it was also discussed that the budgets shouldn't be written in such a way that the institutions are having to underwrite costs to such an extent that it's creating a hardship for the institution. It's important to ensure consistent rates are used across all institutions.
<<**Action Item:** Dr. Lakey to talk to legislative leadership offices to determine how other state agencies are handling indirect costs.>>
<<**Action Item:** Each health institution to assess any differences in budgets from the basic budget modeled after Massachusetts.>>

- **Allocation of Funds & Reimbursement**
The question was raised whether contracts would be structured as cost reimbursement or more like a typical grant. Dr. Lakey acknowledged that this was

still being worked through, though reimbursement to 13 institutions would likely be too time-consuming. The group discussed that some programs may need money up front.

- **Data Management System**
  Discussed the need for a data management system that spans CPAN & TCHATT. The idea was raised that instead of engaging an external company, development of the system.

**Texas Child Health Access Through Telemedicine (TCHATT):** Telemedicine or telehealth programs for identifying and assessing behavioral health needs and providing access to mental health care services, prioritizing the behavioral health needs of at-risk children and adolescents and maximize the number of school districts served in diverse regions of the state.

**Key Discussions:**

- **Program Vision**
  The working group talked through the vision statement with their Meadows liaison and they helped clarified what the vision is for the program. After some discussion there was still some concerns raised around the clarity of the vision.

- **Scope of Program**
  Discussed whether the program needs to be implemented in every school. Agreed that it needs to be state-wide but not in every school. Also agreed that there would be overlap between this program and CPAN.

- **Purpose of Program**
  Program is about assessment with a focus on crisis prevention, intervention & referral. Discussed the need to define what crisis means. For long term care, there is not enough funding to roll out in a meaningful way. For long term care would either need to bill or go on somewhere else. The question was raised whether this model would meet the legislative intent.

- **Program Rollout**
  Given the tight timeline to turn around the program, the initial push will be to rollout to areas that already have programs in place that can be modified /expanded and/or relationships with schools. There are some good programs that exist that don't exactly align with what the legislature is looking to accomplish with TCHATT that can be leveraged as a starting point.

- **Potential Barriers to Overcome**
  *- Lack of Specialists*

If there are no specialists within a given area, then you can't refer. Also, if you refer a patient & they have to wait a month to see someone then there's a risk you won't see the results. The comment was made that some services are better than none at all, and if you can get into a school to do crisis prevention & stabilization it's an improvement.

***- Ensuring resources aren't placed where there are already successful programs in place (can't supplant)***
Need to survey and identify what's already place & working. May use this to identify scalable models. The program cannot fund existing programs but it may fund programs that would have to otherwise stop if they had time-limited grant funding.

***- Ability to spin up a new program within the timeframe given***
Funding will not be provided to develop a program given the very short turnaround time to show progress. It's important to expand existing programs and be realistic about what can be developed in the next year.

- **Program Budgets**
  A spreadsheet was provided to people to help them draft budgets. Term covered lives was discussed and agreement reached that covered students would be a more accurate term. Each program needs to determine how many students can be served and budget for that.
  <<**Action Item:** Anyone that has similar programs should provide costs to the working group>>

**Community Psychiatry Workforce Expansion:** One full-time psychiatrist to serve as academic medical director at a facility operated by a community mental health provider and two new resident rotation positions at the facility.

**Key Discussions:**

- **Purpose of Program**
  Workforce development was the original intent. We need more public health psychiatrists and early exposure makes it more likely that certain percentage will be interested. Discussed that we will need to measure how many new psychiatrists have been trained.

- **Scope of Program**
  A graph was distributed that identifies the community centers that are interested in working with the program. The working group has also identified which institutions may be best placed to work with each community center. A few LMHAs are in two HRIs. In some areas there are very few psychiatrists in the region.

- **Next Steps**
Working group needs to pull information together, identify potential budgets and outline program details such that they can be placed into the master plan.
<<**Action Item**: Institutions that are looking to participate should outline their costs & feed it back to the working group.>>


**Child and Adolescent Psychiatry Fellowships:** Additional child and adolescent psychiatry fellowship positions at health-related institutions.


- **Important Deadlines & Impact on Program Rollout**
Deadline for posting complement size for national residency is December 4th and budget deadline is November 30th. Discussed that it doesn't seem realistic for any programs that haven't already had approval for more fellows than what they're filling to be able to increase their complement size this cycle.

- **Quick Wins**
Some programs already have approved spots that they're not using due to lack of funding. By funding these positions, these slots can be opened up this year. Some programs are just waiting on ACGME approval and assuming they get this, should be able to start their programs this year.

- **Concerns Raised**
  - *Funding Slots/Programs that don't actualize*
The working group doesn't want to hold funds for slots or programs that won't actualize. It can be cumbersome to set up a new program and there is a concern that we risk allocating funding to new programs that might not hit their deadlines. For fellowships, there is no guarantee that slots will be filled. Will need to give institutions a promissory note of funding pending a successful match. Unused funds can be moved into the research program.
  - *Planning Grants*
Also raised was the issue of whether the legislature would be ok with using money for planning grants. Discussed that intent of the program was to leverage the existing infrastructure of the medical schools. If we spend too much money on planning & only bring in a few slots it won't look good. Need to think strategically about where to expand so it supports the other programs.
  - *Managing Expectations*
The working group discussed their worry about over promising what can be delivered within the timeframe. If you manage to capture candidates while they're medical students, it will take a number of years before they enter the program; it won't be an immediate win. It's questionable about how many students can be brought in from out of state.

**Research:** Development of a plan to promote and coordinate Mental Health research across state university systems in accordance with the statewide behavioral health strategic plan.

**Key Discussions:**

- **Research Areas**
Discussed having the program focus on important mental health issues for the state that can be addressed through research – depression, suicide, trauma, etc. Will want to pick areas where we can build up from expertise already in centers to make the group nationally competitive and more likely to result in federal funds. It was highlighted that research is the one component that legislators will be closely scrutinizing to ensure funds used appropriately. Will need a firm wall between CPAN & TCHATT but the research should align with the goals of those two programs.
- **Research Networks**
Discussed utilizing a network approach where the institution resources can be leveraged for maximum impact. Want to make sure every institution that wants to be involved has the opportunity to do so. The focus will be on collaboration. We want to take the things that are really good & link up institutions in the state to get the research to market sooner.
- **Budget**
The working group was estimating a 2 year of budget of around $15-20 million. It was also discussed that they would like to fund 2-3 research networks. The budget may need to be tailored based on remaining dollars.

IX. Review timelines and action items for next meeting

Next meetings are October 28th and November 22nd.

X. Adjournment

## Appendix I. Executive Committee In-Person Attendance

| # | Institution/ Organization | Name | | | # | Institution/ Organization | Name | |
|---|---|---|---|---|---|---|---|---|
| 1 | Baylor College of Medicine | Wayne Goodman, MD | ✓ | | 19 | The University of Texas Health Science Center at San Antonio | Steven Pliszka, MD | |
| 2 | Baylor College of Medicine | Laurel Williams, DO | ✓ | | 20 | The University of Texas Health Science Center at San Antonio | Joseph Blader, PhD | ✓ |
| 3 | Texas A&M University System Health Science Center | Israel Liberzon, MD | ✓ | | 21 | The University of Texas Rio Grande Valley School of Medicine | Michael Escamilla, MD | ✓ |
| 4 | Texas A&M University System Health Science Center | R. Andrew Harper, MD | ✓ | | 22 | The University of Texas Rio Grande Valley School of Medicine | Michael Patriarca | ✓ |
| 5 | Texas Tech University Health Sciences Center | Sarah Wakefield, MD | ✓ | | 23 | The University of Texas Health Science Center at Tyler | Jeffery Matthews, MD | |
| 6 | Texas Tech University Health Sciences Center | Keino McWhinney, MPP | ✓ | | 24 | The University of Texas Health Science Center at Tyler | Daniel Deslatte, MPA, FACHE | |
| 7 | Texas Tech University Health Sciences Center at El Paso | Peter Thompson, MD | ✓ | | 25 | The University of Texas Southwestern Medical Center | Carol Tamminga, MD | |
| 8 | Texas Tech University Health Sciences Center at El Paso | Sarah Martin, MD | ✓ | | 26 | The University of Texas Southwestern Medical Center | Hicham Ibrahim, MD | ✓ |
| 9 | University of North Texas Health Science Center | Alan Podawiltz, DO, MS | ✓ | | 27 | Health and Human Services Commission - mental health care services | Sonja Gaines, MBA | ✓ |
| 10 | University of North Texas Health Science Center | Mark Chassay, MD, MBA | ✓ | | 28 | Health and Human Services Commission - mental health facilities | Mike Maples | |
| 11 | Dell Medical School at The University of Texas at Austin | Charles B Nemeroff, MD, PhD | | | 29 | Texas Higher Education Coordinating Board | Stacey Silverman, PhD | ✓ |

| # | Institution/ Organization | Name | | | # | Institution/ Organization | Name | |
|---|---|---|---|---|---|---|---|---|
| 12 | Dell Medical School at The University of Texas at Austin | Stephen Strakowski, MD | ✔ | | 30 | Hospital System | Danielle Wesley | ✔ |
| 13 | The University of Texas M.D. Anderson Cancer Center | Daniel Tan, MD | ✔ | | 31 | Non-profit - Meadows Policy Institute | Andy Keller, PhD | ✔ |
| 14 | The University of Texas M.D. Anderson Cancer Center | Rhonda Robert, PhD | | | 32 | Non-profit - Hogg Foundation | Octavio Martinez, Jr., MPH, MD | ✔ |
| 15 | The University of Texas Medical Branch at Galveston | Karen Wagner, MD, PhD | | | 33 | Non-profit - Texas Mental Health Counsel | Danette Castle | ✔ |
| 16 | The University of Texas Medical Branch at Galveston | Alexander Vo, PhD | ✔ | | 34 | Administrative Contract – University of Texas System | David Lakey, MD | ✔ |
| 17 | The University of Texas Health Science Center at Houston | Jair Soares, MD, PhD | ✔ | | 35 | Other – Hospital System Representative | James Alan Bourgeois, OD, MD | ✔ |
| 18 | The University of Texas Health Science Center at Houston | Elizabeth Newlin, MD | ✔ | | | | | |