

**University of Texas System  
Thompson Conference Center  
2405 Robert Dedman Dr. Room 2.102  
Austin, TX 78712**

**Convening of the Texas Child Mental Health Care Consortium  
January 17, 2020  
10:00 AM – 3:00 PM**

## **Minutes**

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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 members were in attendance. See attached attendance for full list of attendees.

**III. Review and approve minutes from November 22, 2019**

→ Dr. Wagner made motion to approve minutes. Dr. Tamminga seconded motion. Minutes unanimously approved.

**IV. Presentation from Dr. Barry Sarvet, Medical Director, Massachusetts Child Psychiatry Access Program <https://www.mcpap.com/>**

Dr. Barry Sarvet shared his lessons learned regarding the construct, rollout and continued operation of the Massachusetts Child Psychiatry Access Program:

- They have 7 institutions/sites organized into 3 hubs. Each team has own call center / hot line.
- The hubs are virtual - work is done at the institutions not at a centralized site. Any face to face evaluations are done at the site. Face to face evaluations are needed around 20% of the time. They also do some telepsychiatry.
- Each team has 2FTE child psychiatrists, 1FTE behavioral health clinician, 1 FTE resource & referral specialist, 1 FTE program coordinator. About 7 different people make up 2FTE psychiatrists. Currently have 24 child psychiatrist providing services for program.
- Interim psychotherapy can be provided when patient can't wait to find a therapist.
- Training & education is a big part of the program, with telephone consult making up most of the educational activity. They also do webinars, conferences and newsletters.
- Telephone consultation is the primary currency of the relationship & engine of CPAN.
- Face to face interactions are time intensive. You also don't want to overutilize, so it limits the learning for the PCP. When face to face assessments occur, they need to be followed by a consult letter to the pediatrician within 48 hours.
- Face to face interactions are sometimes needed to make sure it's appropriate for the pediatrician to take care of the patient. If they have a complex patient, you may need to let the PCP know specialty care is needed. If you never see the patient (direct patient eval) can't evaluate whether PCP appropriately evaluating / developing assessment skills.
- Second opinion consults are sometimes requested, where the parent is not confident in the decision of the provider & the pediatrician may not be confident either.
- The percentage of calls that end up being referred to a psychiatrist as primary care vs PCP are around 25-35%.

- Standard response time is 30 minutes - obtain 98% compliance with standard.
- Three legs of CPAN: telephone consultation, referral resources, direct patient evaluation.
- Education - no one size fits all - different pediatricians/PCPs like different modes of learning.
- Operational improvement challenge - how to do outreach, cultivate relationships with PCPs. Longitudinal relationship is important.
- Startup issues: didn't have grand opening and open it up to everyone. When opening up the program, they thought practices would want an introduction. They also wanted to make sure the practices understood the parameters of the program. They drove out to practices, met people in person. They would invariably end up talking about a sample patient with the PCP, which helped with getting them on board. It took them 2 years to get practices enrolled.
- Other states that took the grand opening approach didn't do as well in terms of utilization.
- Program marketing happened through press releases, Grand Rounds, AAP chapter meetings, direct to consumer marketing, and presentations to community mental health providers. Didn't think about community mental health agencies initially but helpful. Have also been doing more direct consumer marketing. If patients go to their PCP and reference resources, it can help get the PCP using the program.
- Lessons learned regarding the type of staff that are suitable for the program - need someone flexible, practical, confident, gregarious, creative. Less suitable - perfectionistic, ponderous, risk-adverse, socially avoidant, haughty.
- Not doing prescriptions is important – the PCP needs to write these. As part of the enrollment process, program materials make this clear.
- Important to train psychiatrists with a focus on telephone consultation skills. They developed curriculum to sensitize psychiatrists to the challenges of that type of work.
- Train the care navigation & administrative staff. Important to make sure you have rigor in preparation of those staff members. Biggest issues for non-psychiatry staff is reliability - make sure phones answered & voice mail being picked up right away, making sure schedules good. There's stuff that has to happen after calls. The admin staff may be helping with scheduling face to face visits, referrals (calling patient back with resources). If try to contact family & don't get call back have to make sure PCP aware.
- Discovered that need to have practice guidance algorithms to help PCPs make decisions. Developed clinical algorithms for them. Not in EMR.
- Measuring engagement - how often do PCP call? If not calling frequently, probably don't feel connected. Need to capture every call. Want to measure volume of calls, frequency of calls, by provider, practice, network.
  - Presence / absence of embedded resources for care coordination
  - Presence / absence of adjacent child psychiatry resources
  - Variability by hub
- Allow therapists to call if in PCP practice. Engage with whole team, not just provider.
- Outcomes hard to measure. If you build in from beginning & use sample methodology makes it easier.
- Distance from hub to practice - inverse proportion of utilization of program. However, rural programs tend to like them better. Lower call volumes from practices further from hub.
- In some instances have shared care - pediatrician main, but see patient - pediatrician prescribes.

- Operational question - who is lead of hubs? In such a large state, need to think how will service be coordinated. Need tactics to do that. In MA had MLT (Medical Leadership Team). They meet remotely regularly (monthly). Talk about variations, interests people have in changing, make sure achieving consensus. Each team has medical director. Each site has lead clinician that's site director, then have state-wide leadership. State-wide is made up of a few people. Each team has medical director at .1 FTE. Site directors more limited role. Annually, have all-day meeting to bring everyone together.

**<<Action Item>> Dr. Sarvet to share his presentation with Luanne so she can share with group.**

**V. Lunch (11:30 – 12:30)**

**VI. Action Items:**

- LBB Report – approval of recommendations from LBB**  
LBB approval received; there were no recommendations. No changes in report required.
- Approve process for selection of Centralized Operations Support Hub including creation of workgroup and selection of members of workgroup**  
Institutions were asked about their interest in being a Hub prior to the meeting and 2 expressed interest. A list of members interested in being on the workgroup that will help define the selection process was reviewed during the meeting.  
→ **Dr. Wagner made motion to approve the membership of the workgroup Dr. Ibrahim seconded. Unanimous approval received.**
- Approve process for purchase of communications system and data management system including creation of workgroup and selection of members of workgroup**  
→ **A motion was made by Dr. Williams to combine the work of the COSH work group & systems procurement work group. Dr. Tamminga seconded. Motion unanimously approved.**
- Approve creation of External Evaluation Workgroup and selection of members of workgroup**  
Discussed that UTS will contract with a Texas university or coalition of Texas universities. Texas schools of medicine will not be eligible to apply. A workgroup is needed to develop documents that applicants will use to apply & will be used to evaluate applicants by the Executive committee. Potential members for the workgroup were distributed during the meeting. No concerns were raised with identified members.  
→ **Motion to approve the workgroup members as listed made by Dr. Podawiltz. Dr. Nemeroff seconded. Motion unanimously approved.**

**VII. Discussion Items**

- Update on status of Memoranda of Understanding and Statements of Work**  
Discussed that the MOUs went out to the institutions 1/16. Once the MOUs are returned, they will need to be reviewed/approved. They will be sent to THECB once all received.

Question raised regarding the reimbursement of any expenses incurred as part of the

program development prior to the MOUs being in place. Dr. Silverman emphasized that this is a service agreement, so institutions are not allowed to expend funds until the agreement is in place. Once the agreements are in place, will need to spend funds as quickly as possible so there isn't unexpended money. Given that we're halfway through the fiscal year, institutions will need to have a plan so they're ready to run once the agreement is in place.

Question raised about the need to notify Boards since the appropriations will be more than \$2.5M.

**b. Workgroup member updates on the status of planning for implementation of initiatives:**

**i. CPAN**

- Reviewed timeline slides presented by Dr. Williams.
- Question raised about feasibility of marketing materials going out if these are being produced by HUB. Group plans on using CPAN US-wide group materials with permission.
- Suggestion made to book training day before/after April executive meeting.

**ii. TCHAT**

- Dr. Vo discussed how they've reviewed consent forms, MOUs, etc. from other programs, putting them together & seeing what common elements are to provide a general framework.
- Dr. Wakefield discussed that group is looking at how to advertise and educate the school districts (coordinating with TEA and Danette Castle). They are being contacted by schools who are hearing about the program and they need to know where to direct them, what to say.
- Also looking at the referral process through the program: from and to. Who is identified in the school as the point-person when a teacher is concerned, how are students screened to see if they want to be a part of the program and how are the child/family referred to the program. If they need ongoing services, what are the options for referral?
- Danette is sending out a survey to LMHAs to identify what programming they already have at the schools and what capacity they have to take a child for referral after the TCHAT services end.
- 2 resources need to be developed:
  - Crisis protocol – what happens when a child is in crisis
  - Brian Hyatt Act – cannot prescribe medication through telemedicine if did not see child in 1 year. Trump signed act last year that said by this October Congress has to have a registry that people can join & allow prescription of controlled substances via telemedicine. Haven't seen this yet. **<<Action Item>> Need to talk to Texas medical board about status of Registry.**
- UTMB - building in time for Psychiatrist to travel to school if prescription required.
- Question raised - since only seeing someone up to 4 times, does it make sense to prescribe? Discussed that if we can combine TCHAT/CPAN we may be able to work through some of this. Discussed that it will be up to each institution to decide whether prescribing medicine or not. However, if they prescribe, they will need to do follow up.
- Consent process – Question raised as whether consent can be done electronically on all kids up front. Point raised that even if consenting at beginning of year,

parents get a lot of information and program will need to make sure they understand consent.

**iii. CAP Fellowships**

- Discussed that the match just happened, and some people may be filling slots that were unfilled.
- Updates on current status received:
  - THSCSA - filled 1 additional slot;
  - BCM - filled 2 additional slots;
  - UTHSCH - did not fill extra slot;
  - TTUHSC EP- didn't fill slots, but got contacted by pediatrician asking for an interview, so working on it. Expansion approved by ACGME.
  - Wakefield - application open (for new program) rotation schedule, faculty approved it. Units will be completed by start date.

**iv. CPWE**

- Discussed working with non-profits in addition to LMHAs. Think that's ok, but LMHA should take priority.

**v. Research**

- The Research workgroup gave an update on their progress. The plan is to have two research networks & two research projects, focusing on depression & suicidality of children and trauma. The projects would be undertaken in whatever network sites want to join in.
- Discussed that the research can't use personal data from CPAN or TCHAT or use it as a recruitment mechanism.
- Discussed that the research needs to focus on improving systems of care & impact in Texas.
- Question raised, if conducting research & identify children that would benefit, do we refer to services?
- **<<Action Item:>> For next meeting research group needs to bring back what their justification for areas of research are based on needs of the state of Texas. What are their key research questions? Focus on public health / mental health systems, answer policy to improve systems of care. Need presentation by next meeting so committee can vote on areas of research.**

**c. Discussion on billing for services provided by TCHAT**

- Discussed that billing is not allowed. If a school is incurring costs, they may bill. But physician can't use funds & bill.
- When patient no longer part of TCHAT but referred out, into services then physician time is no longer TCHAT & can bill through normal mechanisms.
- Need to make sure time is clearly segmented - not taking normal patients during TCHAT / CPAN time.
- Question raised about billing in order to create a sustainable program, reduce tax payer money needed to continue program.
- TCHAT - want to ensure child can get services regardless of payer. Maybe look at investigating this during next session to introduce billing? Would likely be hybrid. Would need some sustainability language in next biennium. Right now, run as clean as possible accounting wise. No billing.

**VIII. Review next steps and next meeting**

Discussed that next meeting is February 21, 2020, 10:00 – 3:00 at the UT System Building Room 2.206 A&B

**<<Action Item:>> Executive members to provide Luanne their pictures, bio, and conflicts of interest forms.**

**IX. Adjournment**

**Executive Committee In-Person Attendance – 27 Attended**

#	Institution/ Organization	Name	1/17	#	Institution/ Organization	Name	1/17
1	Baylor College of Medicine	Wayne Goodman, MD	Y	19	The University of Texas Health Science Center at San Antonio	Steven Pliszka, MD	
2	Baylor College of Medicine	Laurel Williams, DO	y	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	Y	21	The University of Texas Rio Grande Valley School of Medicine	Michael Escamilla, MD	y
4	Texas A&M University System Health Science Center	R. Andrew Harper, MD	Y	22	The University of Texas Rio Grande Valley School of Medicine	Michael Patriarca	Y
5	Texas Tech University Health Sciences Center	Sarah Wakefield, MD	Y	23	The University of Texas Health Science Center at Tyler	Jeffery Matthews, MD	
6	Texas Tech University Health Sciences Center	Keino McWhinney, MPP	y	24	The University of Texas Health Science Center at Tyler	Daniel Deslatte, MPA, FACHE	Y
7	Texas Tech University Health Sciences Center at El Paso	Peter Thompson, MD	Y	25	The University of Texas Southwestern Medical Center	Carol Tamminga, MD	Y
8	Texas Tech University Health Sciences Center at El Paso	Sarah Martin, MD	Y	26	The University of Texas Southwestern Medical Center	Hicham Ibrahim, MD	Y
9	University of North Texas Health Science Center	Alan Podawiltz, DO, MS	Y	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	Y	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	Y	29	Texas Higher Education Coordinating Board	Stacey Silverman, PhD	y

#	Institution/ Organization	Name	1/17	#	Institution/ Organization	Name	1/17
12	Dell Medical School at The University of Texas at Austin	Stephen Strakowski, MD		30	Hospital System	Danielle Wesley	Y
13	The University of Texas M.D. Anderson Cancer Center	Daniel Tan, MD		31	Non-profit - Meadows Policy Institute	Andy Keller, PhD	Y
14	The University of Texas M.D. Anderson Cancer Center	Rhonda Robert, PhD		32	Non-profit - Hogg Foundation	Octavio Martinez, Jr., MPH, MD	Y
15	The University of Texas Medical Branch at Galveston	Karen Wagner, MD, PhD	Y	33	Non-profit - Texas Mental Health Counsel	Danette Castle	Y
16	The University of Texas Medical Branch at Galveston	Alexander Vo, PhD	Y	34	Administrative Contract – University of Texas System	David Lakey, MD	Y
17	The University of Texas Health Science Center at Houston	Jair Soares, MD, PhD	y	35	Other – Hospital System Representative	James Alan Bourgeois, OD, MD	Y
18	The University of Texas Health Science Center at Houston	Elizabeth Newlin, MD	y				