

University of Texas System
210 W. 7th St., Room 2.206, Austin, TX 78701
**Convening of the Texas Child Mental Health Care Consortium
(TCMHCC)**

March 11, 2020
10:00 AM – 3:00 PM
Minutes

I. Call to order and roll call

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

II. Review and approve the following item:

i. Minutes from February 21, 2020

- → **Dr. Bourgeois made a motion to approve the meeting minutes. Dr. Tamminga seconded. The minutes were unanimously approved.**
- The executive committee agreed to have further discussion on the role of scientific leads, development of protocols & budget.

III. Presentation/updates on Project Definition Documents and/or Participating Institution Agreements.

- The status of each institution's PDD submission status was reviewed.
- Each institution's submitted service targets were reviewed for TCHAT & CPAN.
- Some questions were raised about the numbers and what they represent. For example, for CPAN, the question was raised whether PCPs enrolled was individual PCPs, whether a practice would count as one and whether nurse practitioners could be counted in the numbers. It was agreed that the data definitions needed to be clarified to ensure we're comparing apples to apples.
- The group was instructed to let UT System know if the targets change once the measures were further refined.

IV. Updates from each of the Workgroups and Health Related Institutions (HRIs) regarding implementation of TCMHCC Initiatives, including opportunities, challenges, questions and milestones achieved. The full Executive Committee may receive information and/or recommendations from the items discussed and take appropriate action.

- i. Texas Child Health Access Through Telemedicine (TCHAT)**
- a. Open discussion regarding TCHAT**

- Luanne Southern requested and received everyone's TCHATT questions. These were collated and passed on to Dr. Vo, Dr. Wakefield and Ms. Wesley to review and respond to. The questions and answers were reviewed during the meeting and included:
 - Types of schools permissible in TCHATT:
Discussed whether private schools should be included and came to the conclusion that public schools should be prioritized to maximize the benefit of the State funds. It was agreed that additional clarification from legislators was needed on whether private, non-profit and specialist schools should be included. It was agreed that this was something that could be discussed in the next session. In the meantime, focus should be on public schools. Any agreements made with non-public schools ok as long as they're not paid for with the LBB funds.
 - Billing insurance for child psychiatrist:
Discussed that we cannot double bill for TCHATT services. The LBB is paying for services, so billing insurance on top of this is not ok. If the school wants to bill for use of facilities/use of center, this will be up to them. This could be an issue that is raised with the legislature next time. Being able to bill those that have insurance may allow for expansion of the service. A suggestion was made to demonstrate, with amount of resources we have now, can serve this number of people; If we bill, can serve this number of people. Discussed that if a child is referred outside of TCHATT, services for ongoing care can be billed for. Discussed that no billing for CPAN is expected.
<<Action Item: Dr. Lakey will work with elected leadership to get additional clarification on billing Medicaid and third parties in the future.>>
 - HIR employee liability for anything done on school campus:
The institution is expected to assume liability for anything they do; they are responsible for what their clinicians are doing at schools. This is a cost of doing business. Discussed that this will likely come up when putting MOUs in place with the schools. Discussed that if something were to happen, the school would likely be held somewhat accountable as well. Discussed that how this is stated will be important.
<<Action Item: Dr. Wakefield will document proposed language to be reviewed by the Executive Committee for approval and subsequent publication on the website.>>
 - Getting consent from all students at the beginning of the year:
There was consensus that this is not appropriate. All students can get information on TCHATT, but not consent. Once a student is identified, then we need to ensure consent. Discussed that model consent form is currently on the website:
<https://www.utsystem.edu/pophealth/tcmhcc/resources/>
 - Use of TCHATT staff to provide clinical & operational support to independent pediatrician offices:
Discussed that it's important to create a seamless process for referral from TCHATT to CPAN but they are two separate programs.

- Purchasing LPC time / contracting with communities to provide ongoing services to TCHATT patients:
Discussed that TCHATT funds are not for ongoing care. If institutions have a separate relationship with a center, maybe through CPWE, that could be referral source, but LPC can't be funded by TCHATT for ongoing care.
- Contracting out TCHATT-funded LPCs to providers:
If LPCs fully funded by TCHATT it would not be appropriate to contract them out.
- The TCHATT work group has sub-workgroups working to put together a resource guide that's high-level enough to apply across the board and will include the guidance discussed. The resource guide is for reference and to help ensure consistency; institutions aren't being forced into using specific materials or following a specific process. It will include a crisis protocol, orientation materials to help families understand what the service is, and an operation manual.
- The question was raised whether the materials would be translated into Spanish. Because the materials are generic and meant to be customized by institutions using them, they'll also need to be translated by the HRI. A suggestion was made that perhaps the COSH could assist with translations.
- The group discussed the Ryan Haight Act, which limits prescription of controlled substances without an in-person visit and calls for special registration (through the DEA) to engage in telemedicine. The DEA was due to have the registration process complete by October 2019, but this did not occur. It was discussed that the inability to prescribe some medications would impact the effectiveness of TCHATT. The group discussed writing a letter to the DEA asking whether the TCMHCC could get an exemption from the registration process while the DEA works on developing it. It was also discussed that another entity has already done this but not yet received an answer. The group also deliberated on whether it would be better to urge the DEA to act on the special registration process, as this would benefit HRIs in general, which are already practicing telemedicine. The point was raised that waiting for a response from the DEA could introduce significant delays.
<<Action Item: UT System to talk to Legal and Government Relations and get their counsel on this issue. The issue will be discussed further at the next meeting pending this counsel. HRIs should move forward and continue to implement TCHATT.>>
- The group discussed the utilization of interpretation services and the likely need to have a BAA between the HRI & the interpretation service due to their exposure to HIPAA-protected information. The resource guide will incorporate guidelines for including medical interpreters.
- The question of LMHAs taking on the care of TCHATT students that require ongoing care was discussed. The group was told that the vast majority of LMHAs are exceeding their state targets and don't have a lot of capacity to serve new kids. There are new funds making their way out via contracts with the HHS Commission, but feedback is that most are likely to exceed capacity quickly even with new money. That said, there are places that continue to enroll.

They are taking steps to get funds out there, ahead of need, to eliminate waiting lists. Additionally, it was thought that CPAN may allow for the shifting of some kids from LMHAs to PCPs, leaving the LMHAs to handle the more complex cases.

- LMHA school engagement continues to increase. This is positive but will require some thinking in terms of how the LMHAs & TCMHCC coordinate to best meet the needs of kids. A list of schools that have LMHA programs in place will be shared so the HRIs can see where programs already exist.
- The point was raised that the group should capitalize on relationships with agencies that serve school-aged children on things like advertising, strategies, etc.
- The topic was raised that if a child was in crisis, we should be able to offer them immediate access to a psychiatrist. This kicked off a discussion around what crisis means. There was concern from some HRIs General Counsel that TCHATT might result in an Emergency Room for schools. There was further concern that if the HRI can't find a referral after 4 visits, they might be on the hook for providing care for that student.
- A delineation between an emergent situation (911) and an urgent concern (TCHATT) was made. Someone in an emergent situation doesn't need to be in school waiting for a psychiatrist; they need to be sent to an emergency room. The view was raised that there will be significant variation across schools in terms of what crisis plans look like, and how you interact with children in an emergent situation. The thought was expressed that HRIs need to make sure there's a good match between a school's crisis response, what they do and how they will interact with TCHATT. TCHATT will be very different depending on local resources of the school.

V. Updates from each of the Workgroups and HRIs regarding planning and implementation of TCMHCC Initiatives, including opportunities, challenges, questions and milestones achieved. The full Executive Committee may receive information and/or recommendations from the items discussed and take appropriate action.

i. Child Psychiatry Access Network (CPAN)

a. Open discussion regarding CPAN

- The CPAN workgroup discussed how they reviewed how others have done enrollment; they looked at various forms and made some modifications, trying to keep it easy / not overly complex. They wanted to outline what CPAN will do for the PCP and also capture who from the team might be calling.
- It's expected that the Enrollment form will go on the TCMHCC website.
- The form was reviewed during the meeting. Suggested edits included:

- Adding a statement, making it clear that CPAN provides consultation services, and is not taking over the care of PCPs' patients
- Registering Nurse Practitioners and Physician Assistants separately and capturing the supervising Physician's name against them.
- Inserting tables to capture Name as well as Email
- Striking the last statement

→ **Motion made by Dr. Podawiltz to approve form with the suggested edits outlined. Dr. Strakowski seconded the motion. It was unanimously approved.**

- Discussed whether practices would be enrolled or individual providers. Could be either / or. If a practice is enrolled, will need to capture all of the providers included.
- The question was raised regarding who has the authority to sign. It was argued that this will vary and could be a practice manager, physician, medical director, etc.
- The CPAN Workgroup is also working on a form to capture data from the call itself and hopes to show what that will look like at the next meeting.
- Dr. Williams reviewed the CPAN process map with the Consortium. Part of the process included capturing information about the patient being consulted on, including name, date of birth and zip code. The purpose of this is to ensure the history of any discussions regarding a specific patient are captured so that if a different provider is consulting with the PCP about the same patient, they can look back at that history and the Dr. doesn't have to repeat the information multiple times.
- A concern was raised regarding the level of information being captured by the HRI. Dr. Martin explained that all of the other CPANs in other states collect information on the patients they're consulting on and refer back to them. If Texas did it differently, we'd be the odd one out. The question was raised about how much further these other CPANs went beyond name and DOB. Dr. Martin responded that the forms look like medical records.
- The point was raised that two things could sink the CPAN initiative: 1) personal information getting into the wrong hands or 2) children's information was used to conduct research. We need to ensure that we're not doing anything that can be exploited.
- Advice from the CPAN national organization is to keep it simple and not create barriers. PCPs will call again and won't want to reinvent the wheel each time. Part of multiple calls is growing / learning as the patient's care progresses. Without the history, this will be difficult.
- A suggestion was made to assign a unique identifier for patients and have the PCP write that down in the patient's chart to refer to if they need to call about the patient. The CPAN would then have de-identified data.

- Dr. Tran out of Baylor Scott & White, representing the Texas Pediatric Society was in attendance at the meeting and was asked to provide input as a potential user of CPAN services. She highlighted that the use of a unique identifier for patients would not work for PCPs as they are seeing patients every 10 minutes. If they receive a call back several patients later, they won't want to have to find that patient's record to pull up the identifier. Her preference would be to use the first and last name of the patient.
- Dr. Tran was asked her opinion on the CPAN collecting information on the patient to refer to vs having to ask the PCP to provide background information each call. She stated that it's normal to consult with other specialties, and common for the PCP to provide a name, DOB and notes; she would have no issue with the specialist keeping those notes as the handoff is smoother the more information the specialist has.
- Dr. Tran also stressed that Drs. will want a quick call. If the PCP needs to open a chart, it will kill the process in a busy clinic.

<<Action Item: CPAN workgroup to ask national CPAN about the minimum information required and what process is needed to inform the family of use of their info. >>

- CPAN enrollment timing was discussed. The CPAN workgroup currently doesn't want to enroll providers until they have a telephone system in place. Once a go live date is determined, they'll back into when they want to start enrollment.
- Training was discussed. Remote training may occur in late April.
- The question of whether to combine the TCHAT & CPAN workgroups was raised. It was felt that there was still enough work to do that they should be kept separate.

ii. **Child Psychiatry Workforce Expansion (CPWE)**

a. **Open discussion regarding CPWE**

- Each HRI was asked to provide an update on where they're at with CPWE:
 - BCM – has been working with Harris Center and created a rotation schedule. Lining up fellows to participate in July.
 - TTUHSC – currently in the planning phase, talking to StarCare about the potential with some new funding they've gotten. Hopeful this can move forward in July.
 - TTUHSC EP – has met with all three partners. Two of these have faculty and residents that can start in July.
 - UNTHSC – already had cooperation with MHMR Tarrant County; working to refine this relationship by embedding faculty and increasing the number of residents completing rotations.
 - UTHSCH – expect to be in two LMHAs by July.
 - UTHSCSA - signed contract with Center for Health Care Services and expect to go live in July. Matched for residents to fill two slots. Will redeploy current faculty or hire someone in.

- UTMB - no update.
- UTRGV - working on expanding the number of residents at Tropical Texas & also letting faculty work there. Initiating talks with two other LMHAs – Nueces & Coastal. First conversations with them will be held next week. Residents should be in Tropical Texas by July.
- UTSW - in contact with the head of a mental health authority, John Burrus. Have a call before the end of the week & hope to start people there by July.
- TAMUHSC - still working to finalize partnership with MHMR Brazos.
- UTHSCT - met with center, is ready to recruit for position and pushing to start in July.

iii. Child and Adolescent Psychiatry Fellowships (CAP)

a. **Open discussion regarding CAP**

- The institutions provided a summary of where they ended up with their CAP fellowships:
 - BCM - matched 2 new fellows. Program now at 8 this year.
 - TTUHSC - submitted application for fellowship Jan 31. Awaiting committee in April to see if approved. New fellows would be starting July 2021.
 - TTUHSCPE - have several new fellows starting. Might be 1 short of two extra slots.
 - UTHSCSA - expanded to 10; previously approved for 8 but only took 7 because didn't have the funding to fill the 8th. Now have full 8, going to 10 in July. Within context of current rotations have full complement. CPWE will take up 2 starting July 1st.
 - UTHSCT - on board, on site to submit this fall & program won't start until July 2022. Funding is for planning.
 - UTRGV - starting to work with GME to put together application for fellowship. Hoping to have 2 fellows starting in 2021.
 - UTSW - expanding next year

iv. Research

a. **Open discussion regarding Research**

- Dr. Tamminga provided an update on the Research working group's progress, summarizing what's been accomplished to date:
 - Established concept of networks
 - Identified two topic areas for research: depression & childhood trauma
 - Confirmed scientific leads for each topic area
 - Requested and have received feedback from institutions on their interest in participating in each network
 - Requested and have received nominations for co-leads
- Dr. Tamminga discussed next steps:
 - Convene network members with the scientific lead and brainstorm on project ideas
 - Develop a presentation on the type of research that would come out
 - Adopt core rating scales, etc.
- It was highlighted that the primary goal of the research should be to improve the care of children in Texas, with a secondary goal of securing NIH funding (in order to help improve

care).

- It was pointed out that when the networks meet, they should include Sonja Gaines and Mike Maples. In addition, the thought was raised that the projects should be defined prior to selecting co-leads in order to identify those with the appropriate expertise.
- b. Presentation of information obtained from HRIs regarding interest in participating in the depression/suicide and/or childhood trauma health system research networks. (approval of network membership).**
- c. Presentation of names of child and adolescent psychiatrists to be considered to serve as co-leads of each of the research networks. (approval of one to serve as co-lead for depression/suicide network and one to serve as co-lead for childhood trauma network).**
- A slide was reviewed showing members' interest in participating in each of the two networks, and their nominations for co-leads. Every institution (except MD Anderson Cancer Center) will be participating. A decision was made to delay the selection of co-leads until the research proposal was more fully developed.
- It was discussed that the budget will need to change based on the increase in participation. A decision will need to be made about financial allocations to leads and co-leads that is justified / aligned to their responsibilities. Furthermore, there should be good representation across systems in leadership; there should not be just UT institutions in lead positions. Ideally there would also be geographical variation (urban/rural) in the leads & co-leads to align with the variation you see in Texas.
<<Action Item: Research work group should document roles and responsibilities of leads and co-leads>>
- It was reiterated that the research must be focused on health systems, addressing the challenges in providing services to kids. There cannot be biobanking of blood samples or clinical trials. We need to solve community problems associated with mental health in the state of Texas. The leads need both research experience and political sensitivity.
- The need to change nomenclature was discussed: Research participants and NOT research subjects. It's important to have person-centered language.
- ➔ **A motion was made by Dr. Pliszka to have: a) Dr. Tamminga contact each HRI and get two nominations for leads (one for childhood trauma & one for depression) that will represent that institution; b) have the scientific co-leads meet with those representatives and bring a research proposal back at the next meeting; c) Mike Maples and Sonja Gaines (or a representative) invited to the network meetings; and d) the Research workgroup needs to bring back proposals for the financial support of the networks. Dr. Podawiltz seconded. The motion was unanimously approved.**

v. **External Evaluation**

a. **Open discussion regarding external evaluation.**

- No update provided other than it's a work in progress and should have more detail at the next meetings.

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**

- No closed session held.

VII. **Discuss, consider, and if appropriate, approve information and updates provided by the Baylor College of Medicine and/or the Centralized Operations Support Hub (COSH), CPAN, TCHAT or CPWE Workgroups relating to implementation of the COSH, and obtainment of communications and data management systems. The full Executive Committee may review information and/or recommendations from the items discussed and take appropriate action.**

i. **COSH related items identified by Baylor College of Medicine and members of the Executive Committee**

- Dr. Williams provided an update on the telecommunications and data management system RFPs. The telecommunications RFP had gone out & they had received one proposal so far. It was determined that the RFP was still open and it was inappropriate to discuss any further details about it.
- It was discussed that the COSH could use the Executive Committee workgroup as a sounding board, if required.
<<Action Item: Luanne Southern to send out a copy of the RFP to the Executive Committee members.>>
- The question was raised whether the COSH workgroup would be reviewing submitted proposals. The point was raised that doing so would make them part of the selection committee; a conversation with their procurement department may be required.
- The data management system RFP was still be refined and under review by the COSH workgroup. Dr. Williams emphasized that privacy and security of data is essential.
- The question was raised whether the COSH workgroup could be restructured to assist the COSH with assessing the validity of the data they were getting, and assist with analysis. Dr. Lakey confirmed that this should be possible.
- **→ Dr. Ibrahim made the motion to establish a data governance committee that would work with the COSH leadership to oversee the data. Dr. Williams seconded the motion. The motion was unanimously approved.**

- A discussion was held regarding how metrics would be reported on each program. For TCHAT, institutions may be using their own EMR to document interactions. The question was raised whether an institution will need to use both the EMR and the new data management system. It was acknowledged that some manual data entry might be required in the data management system to capture the required metrics, though the intent would be to keep this to a minimum. Dr. Lakey emphasized that standardization across the metrics is needed in order to accurately report back to the legislature.
- Discussed how programs might intertwine to support each other. Suggestion made to have each HRI come up with their own plan on how to do this.
- → **Dr. Williams made a motion to move forward with the data management RFP based on the shared document shared with the Executive Committee. Dr. Bourgeois seconded. The motion was unanimously approved.**

VIII. Adjournment

- **Motion made to adjourn by Dr. Wakefield, seconded by Dr. Thompson. Unanimously approved.**

Appendix I. Executive Committee Attendance

*P = Phoned in

#	Institution/ Organization	Name	03/ 11	#	Institution/ Organization	Name	03/11
1	Baylor College of Medicine	Wayne Goodman, MD		19	The University of Texas Health Science Center at San Antonio	Steven Pliszka, MD	X
2	Baylor College of Medicine	Laurel Williams, DO	X	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	X
4	Texas A&M University System Health Science Center	R. Andrew Harper, MD	X	22	The University of Texas Rio Grande Valley School of Medicine	Michael Patriarca	X
5	Texas Tech University Health Sciences Center	Sarah Wakefield, MD	X	23	The University of Texas Health Science Center at Tyler	Jeffery Matthews, MD	P
6	Texas Tech University Health Sciences Center	Keino McWhinney, MPP	P	24	The University of Texas Health Science Center at Tyler	Daniel Deslatte, MPA, FACHE	P
7	Texas Tech University Health Sciences Center at El Paso	Peter Thompson, MD	X	25	The University of Texas Southwestern Medical Center	Carol Tamminga, MD	X
8	Texas Tech University Health Sciences Center at El Paso	Sarah Martin, MD	X	26	The University of Texas Southwestern Medical Center	Hicham Ibrahim, MD	P
9	University of North Texas Health Science Center	Alan Podawiltz, DO, MS	X	27	Health and Human Services Commission - mental health care services	Sonja Gaines, MBA	X
10	University of North Texas Health Science Center	Mark Chassay, MD, MBA	X	28	Health and Human Services Commission - mental health facilities	Mike Maples	X

#	Institution/ Organization	Name	03/ 11	#	Institution/ Organization	Name	03/11
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	X
12	Dell Medical School at The University of Texas at Austin	Stephen Strakowski, MD	X	30	Hospital System	Danielle Wesley	X
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	X
15	The University of Texas Medical Branch at Galveston	Karen Wagner, MD, PhD		33	Non-profit - Texas Mental Health Counsel	Danette Castle	X
16	The University of Texas Medical Branch at Galveston	Alexander Vo, PhD	P	34	Administrative Contract – University of Texas System	David Lakey, MD	X
17	The University of Texas Health Science Center at Houston	Jair Soares, MD, PhD		35	Other – Hospital System Representative	James Alan Bourgeois, OD, MD	X
18	The University of Texas Health Science Center at Houston	Elizabeth Newlin, MD	X				

**DRAFT REQUEST FOR PROPOSAL
CLOUD DATA MANAGEMENT AND PATIENT ENGAGEMENT SERVICES**

TEXAS SENATE BILL 11 –TEXAS MENTAL HEALTH CARE CONSORTIUM

BACKGROUND:

The 86th Texas Legislature approved SB 11, which establishes the Texas Mental Health Care Consortium to foster collaboration among health-related institutions with the goal of improving early intervention and access to mental health services, addressing psychiatry workforce issues, promoting and coordinating mental health research, and strengthening judicial training on juvenile mental health.

The purpose of Senate Bill 11 is to improve access to mental health care from the family doctor, expand the mental health workforce, and provide real-time help to families and schools for high-risk children and youth with mental health needs.

- Create a consortium to help coordinate state mental health initiatives across Texas' health-related institutions of higher education;
- Establish mental health "hubs" at our health-related institutions consisting of psychiatrists, social workers, referral specialists and other mental health professionals;
- Establish the Child Psychiatry Access Network ("CPAN"), which will allow pediatricians and primary care providers to consult with mental health experts on treatment options for their patients -- which is key because 75 percent of the time these providers are the first to detect mental health issues, yet many do not feel comfortable providing mental health care;
- Establish a program allowing youth to access services through telemedicine – Texas Child Health Access Through Telemedicine (TCHAT);
- Increase residency opportunities for psychiatry training in community settings;
- Expand and coordinate mental health research at our health-related institutions; and
- Direct that judges be educated about mental health resources in their community.

SCOPE OF WORK:

The State is inviting Vendors to provide Proposals for Data Management, Web Design and Patient Engagement system, which will be utilized across (12) twelve Hub locations throughout the State of Texas.

All Hubs will meet with pediatric primary care physicians and family care physicians in their region to enroll them in the CPAN network. Enrollment process includes enrolling the provider in the data platform that allows us to track provider and patient information.

The hours of operation will be Monday – Friday, 8:00 a.m. – 5:00 p.m. Central Time. The Mental Health Provider locations:

1. Baylor College of Medicine – 8080 N Stadium Dr, Houston, TX, 77054
2. UT Houston
3. UTMB
4. UT Dell Austin
5. UTRGV
6. UT San Antonio
7. UT Tyler
8. UTSW
9. Tech El Paso
10. Tech Lubbock
11. UNT-TCOM
12. Texas A & M and Baylor Scott & White Health

REQUIREMENTS:

An integrated system that includes an informational web presence that can connect PCPs to the correct CPAN Hub, provide mental health consultation and education to primary care physicians by allowing for the PCP and Hubs to improve patient care outcomes for mental health disorders including tracking patient symptoms and functional outcomes over time in a cloud based data platform with the ability to connect CPAN to TCHAT.

Overall goals:

- 1. Improve the care and outcomes of young people with mental health conditions by educating PCPs on mental health disorders and potential evidence-based treatment processes through direct consultation to PCP with mental health care specialist in real time.**
 - 2. Support PCPs to provide appropriate mental health care in their practices rather than relying on referral to psychiatric care**
 - 3. Increase access to psychiatric care through management of more basic mental health issues within the PCPs offices such that more complex care can be referred to specialists (i.e., optimize the use of limited psychiatric resources to best serve are children).**
 - 4. Reduce overall costs of mental health care by better using PCP and psychiatric capabilities.**
- A) Create a web Site that provides educational content to PCPs on child mental health disorder diagnosis and treatment, and directs PCPs to the correct CPAN hub
 - B) Provides a cloud-based platform that is HIPAA compliant
 - a. Define specifically how your platform is HIPPA compliant.
 - C) Provide data storage that allows access by the CPAN individual hubs and central operation hub.
 - a. Data is owned solely by the CPAN team(s) and is never used or transferred to teams outside of the Texas CPAN system for any purpose without express written permission by the Child Mental Health Consortium**
 - D) Create a portal for PCPs in each CPAN hub that enables PCPs to communicate and share patient relevant health related data with the hub's CPAN team
 - E) Provide a web portal to enable the CPAN team to document information provided by the PCP, including assessments or other diagnostic information required to more accurately assess the child or adolescents mental health needs.

- F) Create a system that enables the PCP to send assessments and links to additional forms to parent(s)/legal guardians in order to collect the data needed to improve patient care.
- G) Create de-identified patient profiles that are fully accessible to PCPs and the CPAN team.
- H) Provide the CPAN team with tools to conduct reviews and run multi-variable queries by accessing de-identified and aggregate patient data on the children and adolescents referred through CPAN at individual and central hub levels.
- I) Continuously engage patients and their families in managing and tracking behavioral symptoms and provide them feedback to seek help at the right time
- J) Enable patients and their families to share their progress with their PCPs and with the CPAN team in a de-identified manner for more efficient and effective ongoing and care and consultations
- K) If needed, **Connect** the CPAN program to the TCHAT program, for improved crisis management across systems of care with the PCP, patient and CPAN team.
- L) Provide query tools to support metrics of program effectiveness at both the individual hub and aggregate state-wide CPAN system overall *
- M) Must be available to patients in English and Spanish
- N) Data platform team will collaborate with the Texas CPAN workgroup to develop the:
 - a. User interface system
 - b. Types of encounters found in the platform
 - c. Submit examples of a and b and/or Provide the Texas CPAN Workgroup with a web “playground” to assess how the interface may be configured

*Clinical Insights, Query, and Reporting Tool

Questions to Ask:

1. Who will have access to Hub Insights?
2. Who will have access to Statewide Insights: Hub Admins or Program Admins?

Hub Insights:

Administrative Content

The goal for hub insights is to see hub-by-hub details on important metrics and answer questions such as:

- How many PCPs does the hub have?
- How many PSY does the hub have?
- How many patients had multiple consult requests?
- How many were referred (to Psychiatry vs other Local services) vs how many were only treated at PCP?
- How many received direct telepsych sessions after the consult?
- How many are tracking their symptoms on the CPAN app?
- How are patients improving over time (seen in assessments and symptoms)?

Hub Query & Report Tool:

Research Content for Psychiatry

Features that are created and can be turned on if they want to have it

- Includes simple demographic/ descriptive statistics querying tool
 - Frequency distribution of age, gender, zip code, ethnicity, etc.
 - Most severe symptom or commonly reported symptom in a specific clinic for a specific diagnosis
 - Link comorbid symptoms not listed in the DSM-5 with a specific diagnosis
 - Correlation graphs between different variables Ex. severity of symptom and a social determinants of health (environment, education, food, etc.)
- Reports can be generated for a series of customizable questions
- Has the ability to do more in depth analysis and reporting (add on feature)
 - Ex. How have all male patients in this zip code are tracking symptoms
 - Ex. How many are improving in trend line for that symptom

Statewide CPAN Insights:

Administrative Content

The goal for CPAN insights is to compare hubs and benchmark overall progress on important metrics and answer questions such as:

- How many unique PCPs does each hub have?
- How many PSY per hub?
- How many unique patients per PCP within a hub report?
-
- Which hub has the fastest rate of growth in their patient population?
- Is the program meeting its defined quantitative goals? (these can be defined within the program and Tract system and Tract can passively monitor and display)

CPAN Insights

For each Hub, and for a defined period of time:

- Number of phone consultations provided
- Number of unique children and adolescents served
- Number of pediatric, family medicine or PCP practices enrolled
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- Number of calls that are resource or referral requests
- Number of calls that are clinical care:
 - Assessment
 - Diagnosis
 - Management
 - Behavioral
 - Medical
 - Medication
- Percentage of consultative requests responded to within 30 minutes, by team and statewide
- Percentage of enrolled PCPs or pediatricians using consultation services at least once, by team and statewide

TCHAT Reports

For each hub and for a selected time period:

- Number and names of schools served
- Number of students able to access care per school campus
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- Number of students for whom an immediate referral source was not available

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For a selected time period:

- Number of faculty and residents assigned to the LMHA or community mental health provider
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Other requirements to consider:

- PCP should record zip Code of patient during patient enrollment

ADDITIONAL DETAILS

PROCESS

Physician will call the 1-800 # and ring to the appropriate Hub location by their area code and prefix. If the area code and prefix are unidentified, the physician may follow auto attendant prompts to connect with the specific Hub. The Behavioral Health Specialist (BHS) will answer the incoming call; open the data platform system to initiate documentation of the call. This initial documentation will allow for tracking of the call's purpose and if the reason for the call is resource management capture that data in one form to improve user satisfaction.

The BHS at this point, can send a link to the family to download the app via text or email. The patient/family will be provided this system in either English or Spanish. The parent/patient can then complete the initial assessment that can assist the PCP is improving accuracy of diagnosis and tracking over time.

If the physician wants resources or has a behavioral question that the Behavioral Health Specialist (BHS) can answer, the BHS takes care of the call by providing resources and/or advice on behavior and documents the call in the data cloud-based platform for quality and outcomes tracking.

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The BHS will call the Psychiatrist and relays the message. The Psychiatrist will return the phone call within (30) minutes. A linked form from the above process will assist the psychiatrist in documentation of the educational consultation and if possible send links to the now enrolled patient for completion of specific measures that were the result of the educational consult. The forms will come to the patient/family through the PCP office not the CPAN team.

The PCP will have the ability in subsequent visits to review patient outcome data in graphic form and/or provide point of service assessments (e.g. PHQ-9 A).

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Institutional Targets

Institution	TCHAT Target # of schools participating in TCHAT services by August 31, 2021	CPAN Target # of PCPs enrolled for CPAN services by August 31, 2021
Baylor College of Medicine	12	700
The Dell Medical School at the University of Texas at Austin	67	200
Texas A&M University Health Science Center	No PDD Submitted	No PDD Submitted
Texas Tech University Health Sciences Center	53	450
Texas Tech University Health Sciences Center at El Paso	36	876
University of North Texas Health Science Center at Fort Worth	20	200
The University of Texas Medical Branch at Galveston	15	50
The University of Texas Health Science Center at Houston	50	1,000
The University of Texas Health Science Center at San Antonio	11	500
The University of Texas Rio Grande Valley School of Medicine	9	20
The University of Texas Health Science Center at Tyler	75	No PDD Submitted
The University of Texas Southwestern Medical Center	110	500

Name of researchers interested in participating	Childhood Depression/Suicide Dr. Trivedi Scientific Co-Lead	Childhood Trauma Dr. Nemeroff Scientific Co-Lead	Child and Adolescent Psychiatrist/Psychologist Co-lead Recommendation(s)	Health Related Institution Represented
Kirti Saxena, MD	X			Baylor
Eric Storch, PhD	X	X	XX (depression)	Baylor
Melissa Defilippis, MD	X			UTMB
Joseph Shotwell, MD		X		UTMB
Karen Wagner, MD, PhD		X	XXXXX (trauma)	UTMB
TBD	X			TAMUHSC
Israel Liberzon, MD		X	X (trauma)	TAMUHSC
TBD		X		TAMUHSC
Charles Nemeroff, MD, PhD		CO – LEAD X		UT Dell
Roshni Koli, MD	X	X		UT Dell
Hani Talebi, PhD	X	X		UT Dell
Regina Baronia, MD	X	X		TTUHSC
Chanaka Kahathuduwa, MD	X	X		TTUHSC
Sarah Wakefield, MD	X		X (depression)	TTUHSC
Cesar Soutullo, MD, PhD	X			UTHSC Houston
Jair C. Soares, MD, PhD	X			UTHSC Houston
Leslie Taylor, PhD		X		UTHSC Houston
Segundo Robert-Ibarra, MD		X		UTHSC Houston
Elizabeth Newlin, MD		X		UTHSC Houston
Donna Roybal MD		X		UTHSC SA
Adina Campbell MD		X		UTHSC SA
Amy Garrett PhD		X		UTHSC SA
Joseph Blader, PhD	X			UHSC SA
Steven Pliszka, MD	X			UTHSC SA
Thomas Matthews, MD	X			UTHSC SA
Mercedes Ramirez, MD	X		X (depression)	UTHSC SA

Michael Escamilla, MD	X	X	X (depression and trauma)	UTRGV
TBD	X			UTRGV
TBD		X		UTRGV
Madhukar Trivedi, MD	CO-LEAD X			UTSW
Beth Kennard, PsyD	X	X		UTSW
Cecilia DeVargas, MD		X		TTUHSC El Paso
Carla Alvarado, MD		X		TTUHSC El Paso
Sarah Martin, MD	X			TTUHSC El Paso
Shivani Mehta, MD	X			TTUHSC El Paso
TBD	X			UNTHSC
TBD		X		UNTHSC
Jeffrey Wherry, PhD		X	X (trauma)	UTHSC Tyler
Declined				MDA
TOTAL	22	23	<ul style="list-style-type: none"> • 4 trauma co-lead nominees • 4 depression co-lead nominees 	

Texas CPAN Practice Participation Agreement

Practice Name:

Main Practice Address:

Practice Telephone Number:

Practice Fax:

Practice Medical Director/Physician Leader:

Practice Medical Director/Physician Leader Email:
Please add all physicians/emails within this practice

- 1.
- 2.
- 3.

Practice Office Manager(s)/Practice Office Manager Email(s):

- 1.
- 2.
3. etc

Referral or Nurse Coordinator(s)/Email/Phone Extension

- 1.
- 2.
- 3.

ACO / Physician Organization / Health System Affiliation(s):

Additional Site(s) (If applicable) #1 Address:

By enrolling in the Texas CPAN Program primary care providers will be provided with the following:

- Child and Adolescent Psychiatry Continuing Medical Education (live and webinar)
- Access to Child and Adolescent Psychiatry Consultants within 30 min via telephone during normal business hours (initial and ongoing consultations are provided)- these are provider to providers consultations
- CPAN website access (includes educational material)
- Assistance with psychiatry and related referrals

By enrolling in the Texas CPAN Program:

- I/We agree to participate in the Texas Child Psychiatry Access Network with the following Regional Team

- I/We agree to, when possible, participate in CPAN consultation, training and educational opportunities.
- I/We agree to inform patients that we may engage the CPAN program on their behalf and will share health information with the program unless the patient declines the CPAN services.
- I/We agree to complete periodic satisfaction surveys.
- I/We agree to continue to manage behavioral health care of appropriate cases for the primary care setting following consultation with the team.

Signed: _____ Title: _____ Date: _____

DRAFT

TCHATT

FAQs



Types of schools permissible in TCHATT



Billing Insurance for child psychiatrist



Liability



Initial consent



Use of TCHATT staff to provide clinical and operational support to independent pediatrician offices



Contract out some of our TCHATT LPC time to community centers

FAQs



Types of schools permissible in TCHATT

- Charter schools: Yes, charter schools are considered public schools, although managed differently than traditional public schools
- Disciplinary/Alternative schools: Yes
- Pre-K and Kindergarten: Yes
- Private, non-profit, SPED schools: This would have to be clarified by the legislators regarding what they intend; public schools would be prioritized to maximize benefit of state funds

FAQs



Billing Insurance for child psychiatrist

- Billing for child psychiatrist services is permissible by the HRIs for follow-up care after the patient has been transitioned out of the TCHATT program
- FQHCs can bill for facility fees for hosting telemedicine sessions

FAQs



Liability

- In our MOUs with the ISDs, we state that HRI assumes liability for any of their employees

FAQs



Initial consent

- Digital signature: Digital signature may be acceptable; may need to have witness sign as well
- Blanket consent form at the beginning of the school year: The established HRIs programs have not used a blanket consent form at the beginning of the school year
- Is a flyer about TCHATT enough? No, there needs to a consent for treatment

FAQs



Use of TCHATT staff to provide clinical and operational support to independent pediatrician offices

- If service is regarding case management for transition of care from TCHATT to pediatrician

FAQs



Contract out some of our TCHATT LPC time to community centers

- TCHATT funds are not for ongoing services and contracting out LPCs who are fully funded by the TCHATT may be construed as a conflict

RESOURCE GUIDE

• Orientation Materials	PENDING	Heston/Wesley
• Marketing to Schools	PENDING	Wayman/Castle
• Model Contracts/MOUs/CWAs	COMPLETED	Vo/Wesley
• Model Informed Consent	COMPLETED	Vo/Wesley
• Information Sharing/Information Release	PENDING	Wayman/Heston
• Referral Procedures	PENDING	Thyssen/Castle
• Ryan Haight Act	PENDING	Wakefield/Wagner
• Risk Stratification and Crisis Protocol	PENDING	Wakefield/Wagner

COSH TCMHCC

Laurel L. Williams, DO

Jennifer Evans

BCM Menninger Dept. Psychiatry & Behavioral Sciences

EVERYTHING



IS FINE

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Telecommunications

- ▶ RFP process:
- ▶ CPAN workgroup over the fall reviewed the capabilities of different CPAN teams telecommunications systems
- ▶ CPAN workgroup chairs then presented this information to TCMHCC Executive Committee for feedback and clarification about specs required (ie Having 1 number was seen as a key capability)
- ▶ CPAN workgroup then reviewed several different vendors who provide telecommunication systems based on the list of criteria from the above
- ▶ RFP was developed and approved by the CPAN workgroup
- ▶ The COSH workgroup then reviewed the RFP in preparation for this meeting

Real Time Data, Patient Tracking, Connection
between Sites and Teams: Yes It is Possible



Data Management and Patient Tracking

- ▶ RFP process
- ▶ CPAN workgroup over the fall reviewed the capabilities of several data management and patient tracking systems
- ▶ CPAN workgroup chairs then presented this information to TCMHCC Executive Committee for feedback and clarification about specs required
 - ▶ Discussion of firewalls between PHI to CPAN group was discussed but not decided on
 - ▶ Ability to link CPAN and TCHAT systems together ie follow the patient was considered ideal
 - ▶ Track outcomes of PATIENTS not just metrics of the call and PCP satisfaction
- ▶ CPAN workgroup then reviewed several different vendors who provide data management and patient tracking systems based on the list of criteria from the above
- ▶ RFP was developed and approved by the CPAN workgroup
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Privacy and Security of Data is Essential



Privacy and Security of Data is Essential

- ▶ Essential specifications related to vendor selection will involve privacy and security of the data
- ▶ This is clearly delineated in the RFP- any vendor selected **MUST** adhere to HIPAA standards for data storage, access, and transmission
- ▶ BAA must be completed given that the vendor would be managing PHI
- ▶ COSH will provide training to teams on privacy and security standards

Data Management and Patient Tracking

- ▶ Selected vendor will work closely with the CPAN and TCHATT workgroups to create the build out necessary for data collection
- ▶ CPAN workgroup is positioned to do this – as we have standing bi-weekly meetings that the COSH team will manage
- ▶ Cost in year 1 relates to build out for data management platform and then ongoing analytics, PDSA cycles to improve product and customer support (our team and patients)
- ▶ Yr 2 and beyond costs associated with data storage and customer support
- ▶ Patient tracking process is already created; there is not a need to build this process out
- ▶ Teams will be trained by COSH on the vendor and provide operational support to launch
- ▶ Prior to Vendor being selected- teams can use internal data systems and report data twice monthly to COSH

Data Analytics

- ▶ Vendor selected will provide TCMHCC raw data- TCMHCC is the owner of the data NOT the vendor
- ▶ Data will be made available to external evaluator (another BAA with the external evaluator team will be required)
- ▶ Vendor will create dashboard for data based on defined metrics for CPAN, TCHATT, CPWE already approved by the TCMHCC executive committee
- ▶ All HRI data will roll up to COSH; Individual HRI will have access to their data
- ▶ COSH will report at each TCMHCC meeting overview of data; providing level of detail requested by TCMHCC Executive Team (no PHI will be included in these meetings)



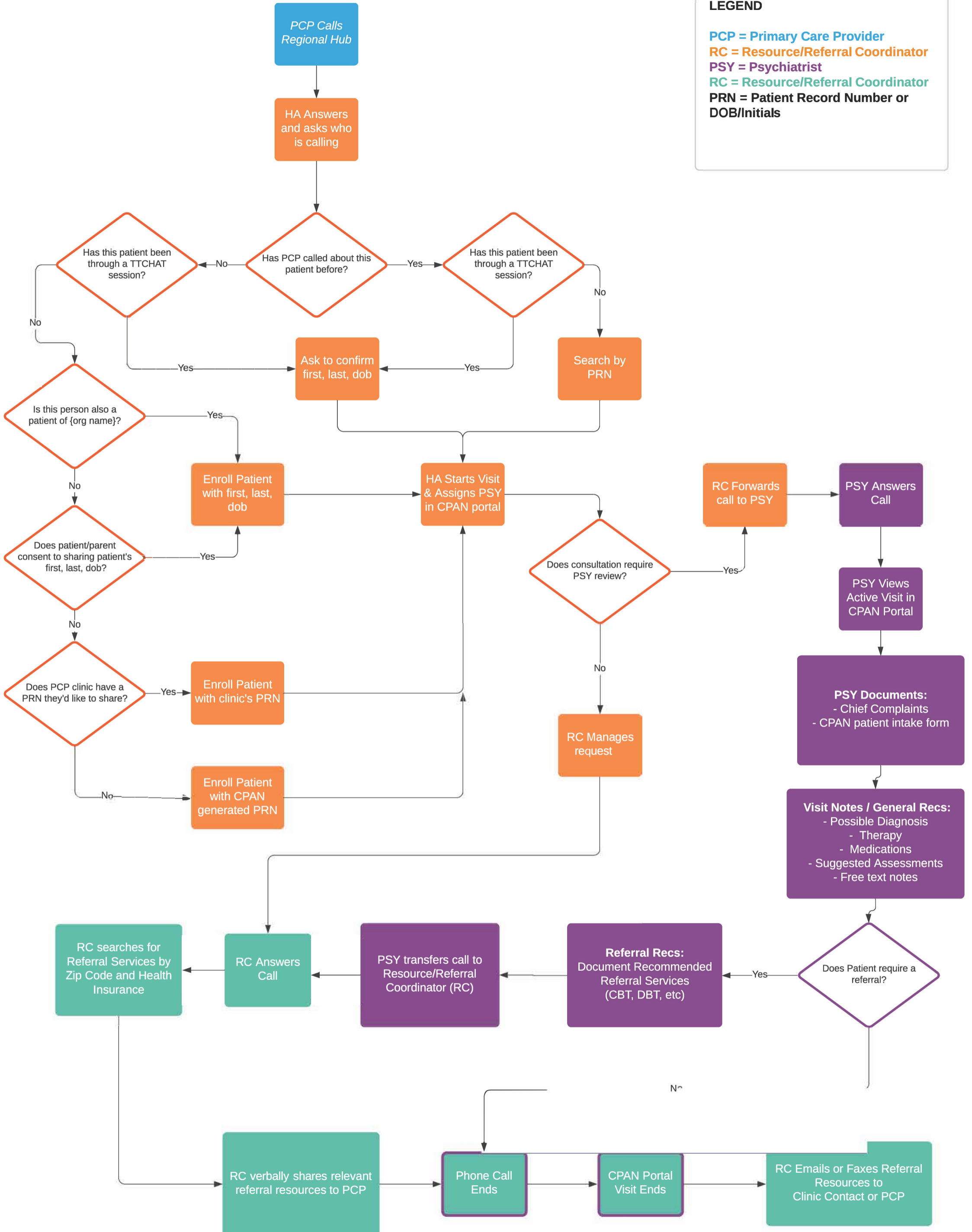
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CPAN Portal - Phase 1

Laurel Williams | March 3, 2020

LEGEND

PCP = Primary Care Provider
RC = Resource/Referral Coordinator
PSY = Psychiatrist
RC = Resource/Referral Coordinator
PRN = Patient Record Number or DOB/Initials

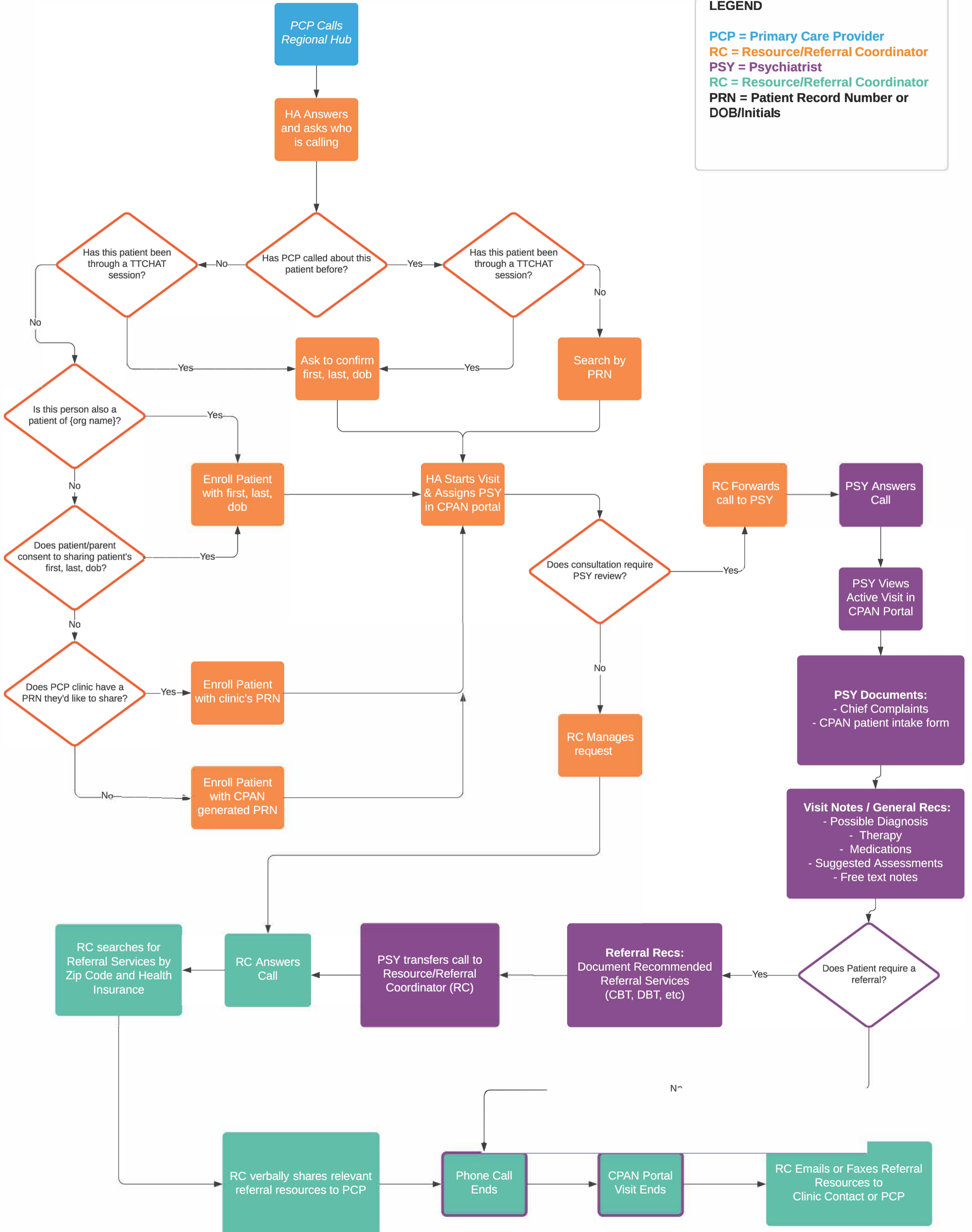


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CPAN Workgroup Update: March 11, 2020

Laurel L. Williams, DO

Sarah L. Martin, MD

CPAN Workgroup

MAKING GOOD TACTICAL PLANS



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Thanks to our Workgroup Team!

- We have met a total of 11 times since the consortium formed
- Texas Pediatric Society representative- Nhung Tran, MD is fantastic. Dr. Tran especially has been extremely helpful and is the audience today!
- The following represents the workgroup updated recommendations to the consortium

Outline

- CPAN PCP Enrollment Form
- CPAN Intake Form
- Enrollment of PCP teams strategies
- Training for Phone
- Training for Data Collection
- Training for Call

CPAN PCP Enrollment Form

- Team reviewed of CPAN forms
- Wanted to add specific info related to the entire team that may be calling
- This is to capture this data on the front end and hopefully Data Vendor can input in such a way as to have CPAN phone process work well
- Enrollment form can be done on-line with follow-up by regional hub
- Sort via county/zip to assist in getting to the right hub
- Question about last question on the enrollment form

CPAN Intake (Call) Form

- Team has reviewed a few other state CPAN forms (data collection)
- We are in the process now of working on our version using a blend of other forms
- Again want data system to help ease form (drop down menus, typing info pulls up common threads)
- Hard stops in the form such that all data needed for a call is included
- See Process Map

CPAN Enrollment Strategies

- LOCAL LOCAL LOCAL
- Educational Outreach at State Associations (Dr. Williams presenting with Luanne and later Dr. Tran at conferences across the state (April and Oct))
- TCMHCC branded swag for all teams to use when local enrollment starts
- Low hanging fruit (ie local teams already built up)
- Start about 15-20 days prior to our actual GO-LIVE date

Training

- COSH will help implement training on systems as they come available
- Training due to COVID-19 with Barry may need to be virtual- working to set that up



SOOOOOO...

ANY QUESTIONS?

**DRAFT REQUEST FOR PROPOSAL
CLOUD DATA MANAGEMENT AND PATIENT ENGAGEMENT SERVICES**

TEXAS SENATE BILL 11 –TEXAS MENTAL HEALTH CARE CONSORTIUM

BACKGROUND:

The 86th Texas Legislature approved SB 11, which establishes the Texas Mental Health Care Consortium to foster collaboration among health-related institutions with the goal of improving early intervention and access to mental health services, addressing psychiatry workforce issues, promoting and coordinating mental health research, and strengthening judicial training on juvenile mental health.

The purpose of Senate Bill 11 is to improve access to mental health care from the family doctor, expand the mental health workforce, and provide real-time help to families and schools for high-risk children and youth with mental health needs.

- Create a consortium to help coordinate state mental health initiatives across Texas' health-related institutions of higher education;
- Establish mental health "hubs" at our health-related institutions consisting of psychiatrists, social workers, referral specialists and other mental health professionals;
- Establish the Child Psychiatry Access Network ("CPAN"), which will allow pediatricians and primary care providers to consult with mental health experts on treatment options for their patients -- which is key because 75 percent of the time these providers are the first to detect mental health issues, yet many do not feel comfortable providing mental health care;
- Establish a program allowing youth to access services through telemedicine – Texas Child Health Access Through Telemedicine (TCHAT);
- Increase residency opportunities for psychiatry training in community settings;
- Expand and coordinate mental health research at our health-related institutions; and
- Direct that judges be educated about mental health resources in their community.

SCOPE OF WORK:

The State is inviting Vendors to provide Proposals for Data Management, Web Design and Patient Engagement system, which will be utilized across (12) twelve Hub locations throughout the State of Texas.

All Hubs will meet with pediatric primary care physicians and family care physicians in their region to enroll them in the CPAN network. Enrollment process includes enrolling the provider in the data platform that allows us to track provider and patient information.

The hours of operation will be Monday – Friday, 8:00 a.m. – 5:00 p.m. Central Time. The Mental Health Provider locations:

1. Baylor College of Medicine – 8080 N Stadium Dr, Houston, TX, 77054
2. UT Houston
3. UTMB
4. UT Dell Austin
5. UTRGV
6. UT San Antonio
7. UT Tyler
8. UTSW
9. Tech El Paso
10. Tech Lubbock
11. UNT-TCOM
12. Texas A & M and Baylor Scott & White Health

REQUIREMENTS:

An integrated system that includes an informational web presence that can connect PCPs to the correct CPAN Hub, provide mental health consultation and education to primary care physicians by allowing for the PCP and Hubs to improve patient care outcomes for mental health disorders including tracking patient symptoms and functional outcomes over time in a cloud based data platform with the ability to connect CPAN to TCHAT.

Overall goals:

- 1. Improve the care and outcomes of young people with mental health conditions by educating PCPs on mental health disorders and potential evidence-based treatment processes through direct consultation to PCP with mental health care specialist in real time.**
 - 2. Support PCPs to provide appropriate mental health care in their practices rather than relying on referral to psychiatric care**
 - 3. Increase access to psychiatric care through management of more basic mental health issues within the PCPs offices such that more complex care can be referred to specialists (i.e., optimize the use of limited psychiatric resources to best serve are children).**
 - 4. Reduce overall costs of mental health care by better using PCP and psychiatric capabilities.**
- A) Create a web Site that provides educational content to PCPs on child mental health disorder diagnosis and treatment, and directs PCPs to the correct CPAN hub
 - B) Provides a cloud-based platform that is HIPAA compliant
 - a. Define specifically how your platform is HIPPA compliant.
 - C) Provide data storage that allows access by the CPAN individual hubs and central operation hub.
 - a. **Data is owned solely by the CPAN team(s) and is never used or transferred to teams outside of the Texas CPAN system for any purpose without express written permission by the Child Mental Health Consortium**
 - D) Create a portal for PCPs in each CPAN hub that enables PCPs to communicate and share patient relevant health related data with the hub's CPAN team
 - E) Provide a web portal to enable the CPAN team to document information provided by the PCP, including assessments or other diagnostic information required to more accurately assess the child or adolescents mental health needs.

- F) Create a system that enables the PCP to send assessments and links to additional forms to parent(s)/legal guardians in order to collect the data needed to improve patient care.
- G) Create de-identified patient profiles that are fully accessible to PCPs and the CPAN team.
- H) Provide the CPAN team with tools to conduct reviews and run multi-variable queries by accessing de-identified and aggregate patient data on the children and adolescents referred through CPAN at individual and central hub levels.
- I) Continuously engage patients and their families in managing and tracking behavioral symptoms and provide them feedback to seek help at the right time
- J) Enable patients and their families to share their progress with their PCPs and with the CPAN team in a de-identified manner for more efficient and effective ongoing and care and consultations
- K) If needed, **Connect** the CPAN program to the TCHAT program, for improved crisis management across systems of care with the PCP, patient and CPAN team.
- L) Provide query tools to support metrics of program effectiveness at both the individual hub and aggregate state-wide CPAN system overall *
- M) Must be available to patients in English and Spanish
- N) Data platform team will collaborate with the Texas CPAN workgroup to develop the:
 - a. User interface system
 - b. Types of encounters found in the platform
 - c. Submit examples of a and b and/or Provide the Texas CPAN Workgroup with a web “playground” to assess how the interface may be configured

*Clinical Insights, Query, and Reporting Tool

Questions to Ask:

1. Who will have access to Hub Insights?
2. Who will have access to Statewide Insights: Hub Admins or Program Admins?

Hub Insights:

Administrative Content

The goal for hub insights is to see hub-by-hub details on important metrics and answer questions such as:

- How many PCPs does the hub have?
- How many PSY does the hub have?
- How many patients had multiple consult requests?
- How many were referred (to Psychiatry vs other Local services) vs how many were only treated at PCP?
- How many received direct telepsych sessions after the consult?
- How many are tracking their symptoms on the CPAN app?
- How are patients improving over time (seen in assessments and symptoms)?

Hub Query & Report Tool:

Research Content for Psychiatry

Features that are created and can be turned on if they want to have it

- Includes simple demographic/ descriptive statistics querying tool
 - Frequency distribution of age, gender, zip code, ethnicity, etc.
 - Most severe symptom or commonly reported symptom in a specific clinic for a specific diagnosis
 - Link comorbid symptoms not listed in the DSM-5 with a specific diagnosis
 - Correlation graphs between different variables Ex. severity of symptom and a social determinants of health (environment, education, food, etc.)
- Reports can be generated for a series of customizable questions
- Has the ability to do more in depth analysis and reporting (add on feature)
 - Ex. How have all male patients in this zip code are tracking symptoms
 - Ex. How many are improving in trend line for that symptom

Statewide CPAN Insights:

Administrative Content

The goal for CPAN insights is to compare hubs and benchmark overall progress on important metrics and answer questions such as:

- How many unique PCPs does each hub have?
- How many PSY per hub?
- How many unique patients per PCP within a hub report?
-
- Which hub has the fastest rate of growth in their patient population?
- Is the program meeting its defined quantitative goals? (these can be defined within the program and Trayt system and Trayt can passively monitor and display)

CPAN Insights

For each Hub, and for a defined period of time:

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- Number of unique children and adolescents served
- Number of pediatric, family medicine or PCP practices enrolled
- Reasons why practices unenroll
- Outcomes from calls (number & % for period)
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- Number of students able to access care per school campus
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- Number of encounters by provider type
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CPWE Insights

For a selected time period:

- Number of faculty and residents assigned to the LMHA or community mental health provider
- Number of patient visits
- Number of unique patients seen
- Ratio of children to total patients seen
- Number of patients seen that were initially contacted through CPAN or TCHATT
- Clinical outcome measures (rating scales) showing improvement of clients.

Other requirements to consider:

- PCP should record zip Code of patient during patient enrollment

ADDITIONAL DETAILS

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Texas A&M University Health Science Center	No PDD Submitted	No PDD Submitted
Texas Tech University Health Sciences Center	53	450
Texas Tech University Health Sciences Center at El Paso	36	876
University of North Texas Health Science Center at Fort Worth	20	200
The University of Texas Medical Branch at Galveston	15	50
The University of Texas Health Science Center at Houston	50	1,000
The University of Texas Health Science Center at San Antonio	11	500
The University of Texas Rio Grande Valley School of Medicine	9	20
The University of Texas Health Science Center at Tyler	75	No PDD Submitted
The University of Texas Southwestern Medical Center	110	500

Name of researchers interested in participating	Childhood Depression/Suicide Dr. Trivedi Scientific Co-Lead	Childhood Trauma Dr. Nemeroff Scientific Co-Lead	Child and Adolescent Psychiatrist/Psychologist Co-lead Recommendation(s)	Health Related Institution Represented
Kirti Saxena, MD	X			Baylor
Eric Storch, PhD	X	X	XX (depression)	Baylor
Melissa Defilippis, MD	X			UTMB
Joseph Shotwell, MD		X		UTMB
Karen Wagner, MD, PhD		X	XXXXX (trauma)	UTMB
TBD	X			TAMUHSC
Israel Liberzon, MD		X	X (trauma)	TAMUHSC
TBD		X		TAMUHSC
Charles Nemeroff, MD, PhD		CO – LEAD X		UT Dell
Roshni Koli, MD	X	X		UT Dell
Hani Talebi, PhD	X	X		UT Dell
Regina Baronia, MD	X	X		TTUHSC
Chanaka Kahathuduwa, MD	X	X		TTUHSC
Sarah Wakefield, MD	X		X (depression)	TTUHSC
Cesar Soutullo, MD, PhD	X			UTHSC Houston
Jair C. Soares, MD, PhD	X			UTHSC Houston
Leslie Taylor, PhD		X		UTHSC Houston
Segundo Robert-Ibarra, MD		X		UTHSC Houston
Elizabeth Newlin, MD		X		UTHSC Houston
Donna Roybal MD		X		UTHSC SA
Adina Campbell MD		X		UTHSC SA
Amy Garrett PhD		X		UTHSC SA
Joseph Blader, PhD	X			UHSC SA
Steven Pliszka, MD	X			UTHSC SA
Thomas Matthews, MD	X			UTHSC SA
Mercedes Ramirez, MD	X		X (depression)	UTHSC SA

Michael Escamilla, MD	X	X	X (depression and trauma)	UTRGV
TBD	X			UTRGV
TBD		X		UTRGV
Madhukar Trivedi, MD	CO-LEAD X			UTSW
Beth Kennard, PsyD	X	X		UTSW
Cecilia DeVargas, MD		X		TTUHSC El Paso
Carla Alvarado, MD		X		TTUHSC El Paso
Sarah Martin, MD	X			TTUHSC El Paso
Shivani Mehta, MD	X			TTUHSC El Paso
TBD	X			UNTHSC
TBD		X		UNTHSC
Jeffrey Wherry, PhD		X	X (trauma)	UTHSC Tyler
Declined				MDA
TOTAL	22	23	<ul style="list-style-type: none"> • 4 trauma co-lead nominees • 4 depression co-lead nominees 	

Texas CPAN Practice Participation Agreement

Practice Name:

Main Practice Address:

Practice Telephone Number:

Practice Fax:

Practice Medical Director/Physician Leader:

Practice Medical Director/Physician Leader Email:
Please add all physicians/emails within this practice

- 1.
- 2.
- 3.

Practice Office Manager(s)/Practice Office Manager Email(s):

- 1.
- 2.
3. etc

Referral or Nurse Coordinator(s)/Email/Phone Extension

- 1.
- 2.
- 3.

ACO / Physician Organization / Health System Affiliation(s):

Additional Site(s) (If applicable) #1 Address:

By enrolling in the Texas CPAN Program primary care providers will be provided with the following:

- Child and Adolescent Psychiatry Continuing Medical Education (live and webinar)
- Access to Child and Adolescent Psychiatry Consultants within 30 min via telephone during normal business hours (initial and ongoing consultations are provided)- these are provider to providers consultations
- CPAN website access (includes educational material)
- Assistance with psychiatry and related referrals

By enrolling in the Texas CPAN Program:

- I/We agree to participate in the Texas Child Psychiatry Access Network with the following Regional Team

- I/We agree to, when possible, participate in CPAN consultation, training and educational opportunities.
- I/We agree to inform patients that we may engage the CPAN program on their behalf and will share health information with the program unless the patient declines the CPAN services.
- I/We agree to complete periodic satisfaction surveys.
- I/We agree to continue to manage behavioral health care of appropriate cases for the primary care setting following consultation with the team.

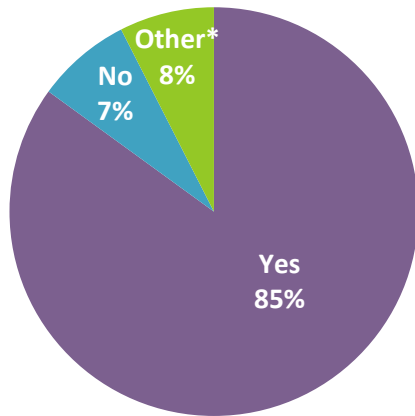
Signed: _____ Title: _____ Date: _____

DRAFT

On January 27, 2020, the Texas Council of Community Centers released a school engagement survey to the thirty-nine (39) Community Mental Health Centers (CMHCs) of Texas. This high level summary represents survey responses from all Centers.

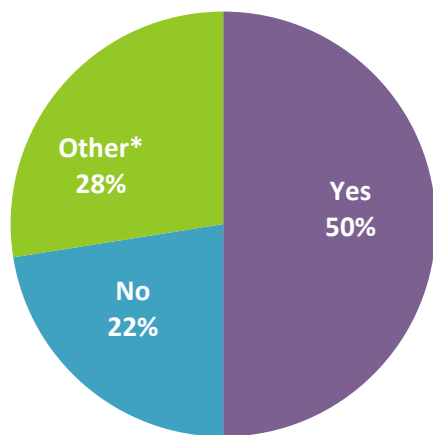
School Engagement Survey 2020

1. Is your Center currently serving children over your target number?



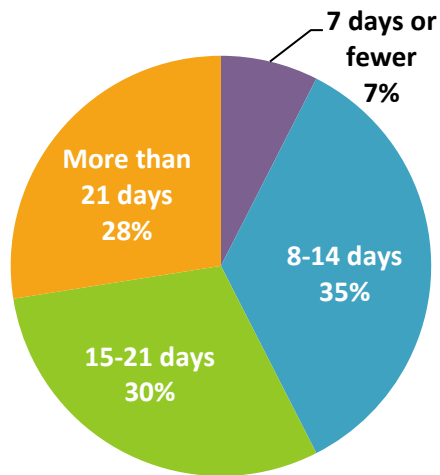
*New funds to increase capacity are slated for release by HHSC in late March 2020; however, most LMHAs are already exceeding or will quickly exceed increased capacity level in FY20.

2. Does your Center have capacity to enroll additional children in outpatient services?



*Responses include a lack of capacity absent additional funding, challenges with high caseloads, stretched resources, and workforce shortages.

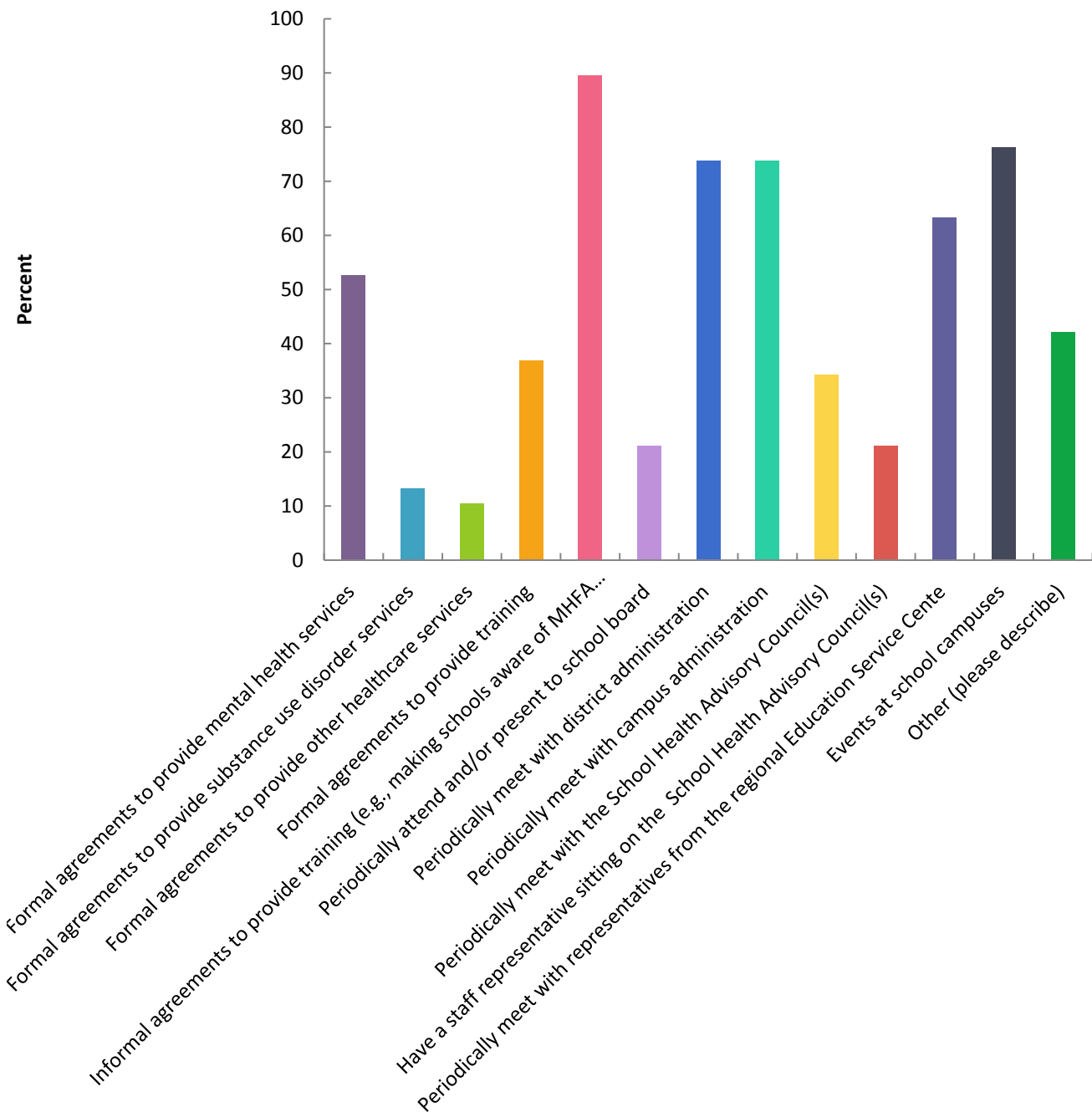
3. How long after referral is a child able to see a prescriber, on average?



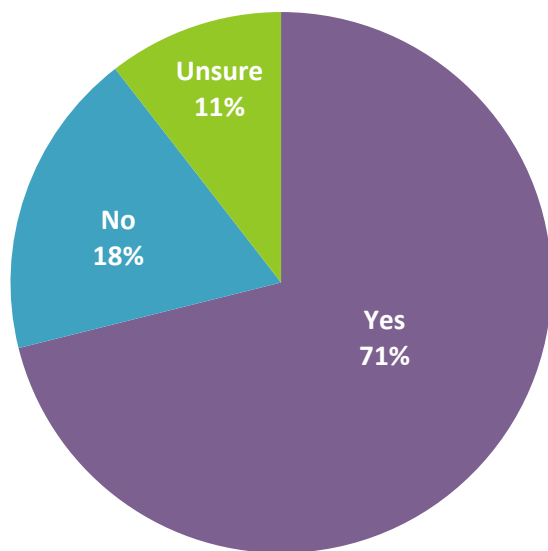
The time between a child's intake and prescriber visit varies due to a variety of factors, but most significantly due to the needs of the child. The staff who conduct initial assessments are trained to gauge a child's needs and triage services accordingly. A child with particularly acute needs (e.g., one who has just been discharged from inpatient care) would see a prescriber much more quickly than one with more moderate needs.

Additionally, once a child is assessed into care, services begin immediately, even if an appointment to see a prescriber is delayed. This is by design, so that children can receive skills training, counseling, or other services that may alleviate symptoms without medication. This also allows staff to build a relationship with the child and family and individualize care based on needs. Resource limitations and workforce challenges also influence the time it takes to see a prescriber, but generally Centers report that initiating other services first benefits children and families.

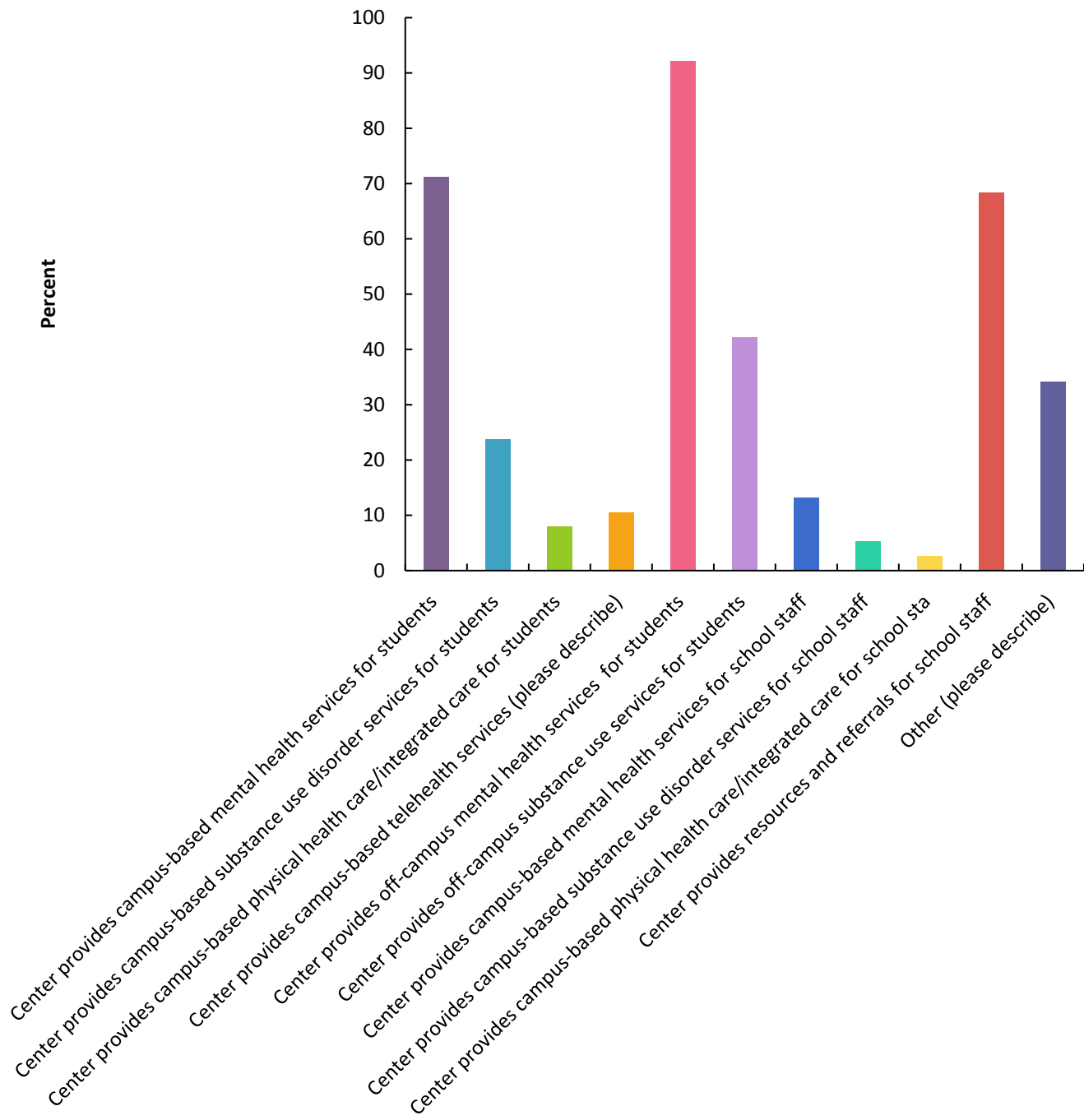
4. In what ways does your Center engage with local schools?



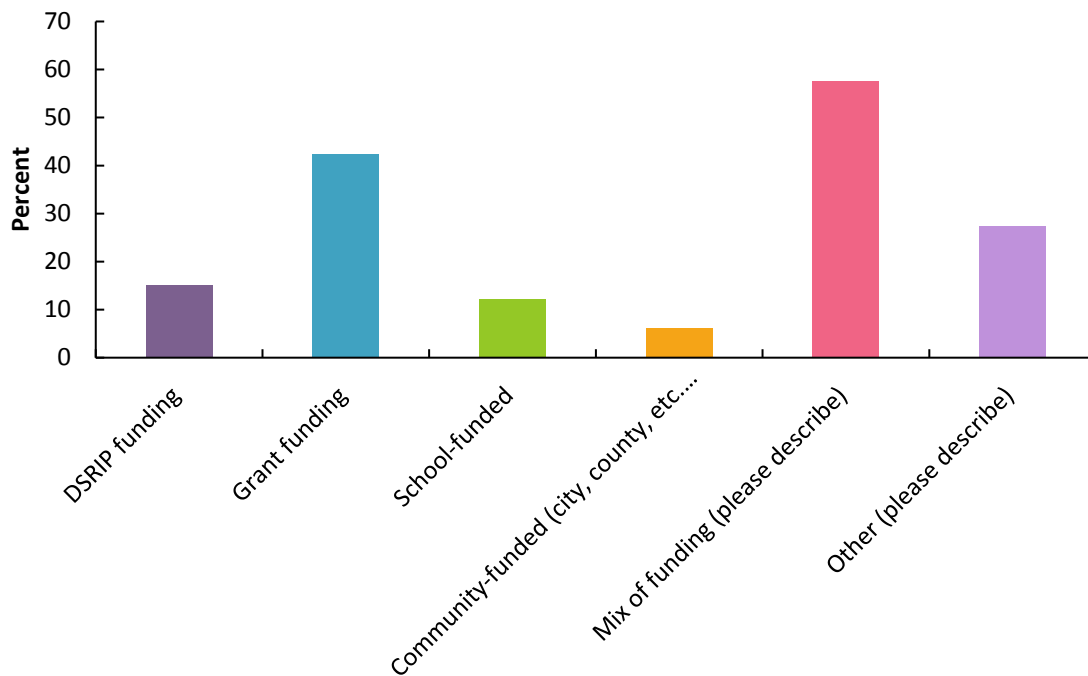
5. Has your Center's level of engagement with schools increased in the last year?



6. How does your Center work with schools to directly address health needs?

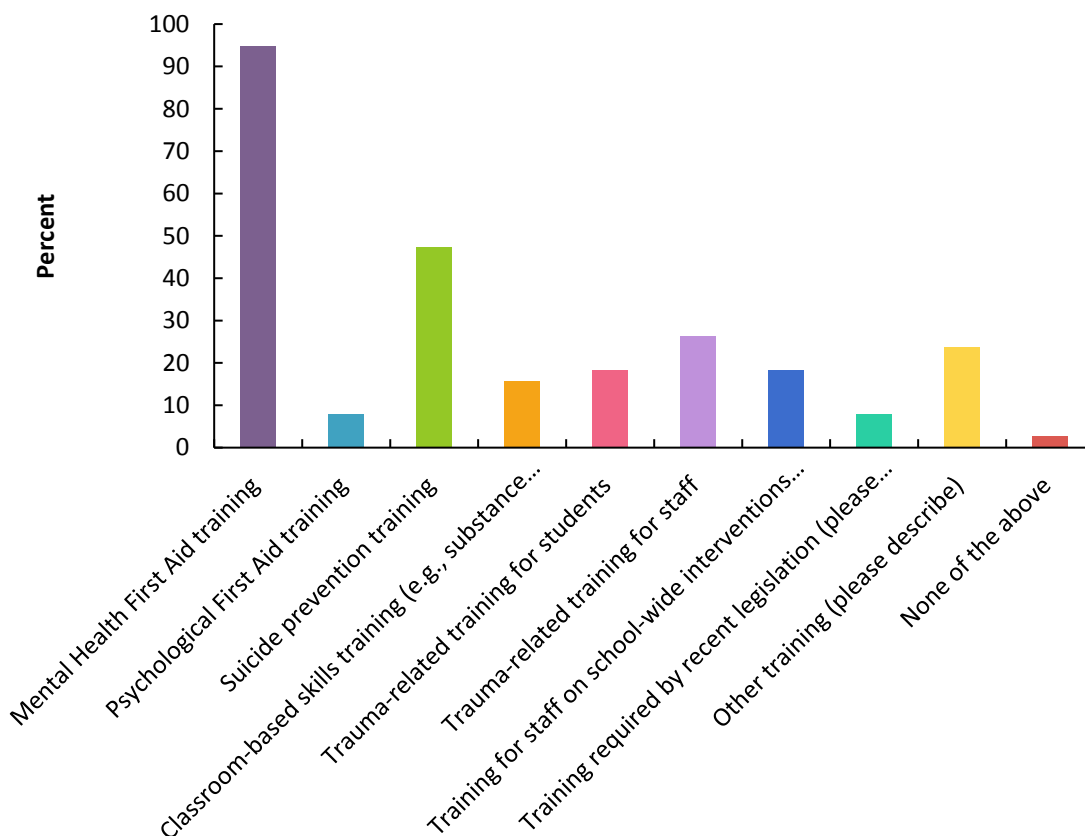


8. How are student health services based on Center and school partnerships funded?



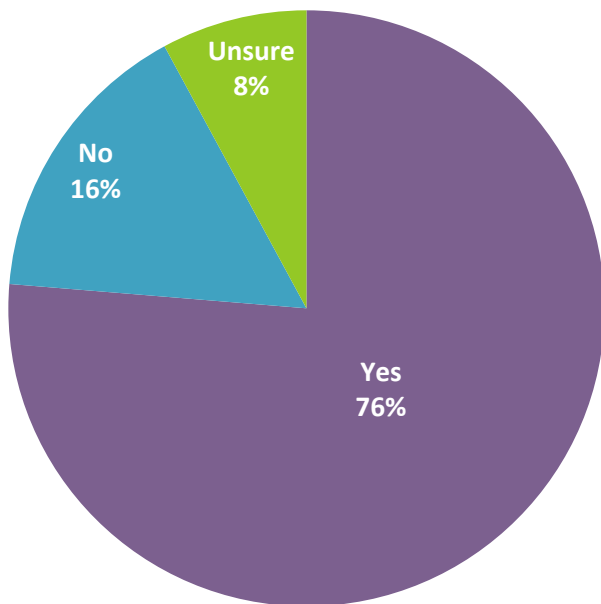
* Other funding includes HHSC contract dollars, Medicaid and other insurance billing, funds from school districts, HB 13 funds, 1115 funds, and various mixes of these. Some partnerships use grant funding from local funders, such as the Houston Methodist Community Benefits Grant, and some use federal grants from SAMHSA or VOCA

9. Which of the following training activities does your Center participate in with schools?

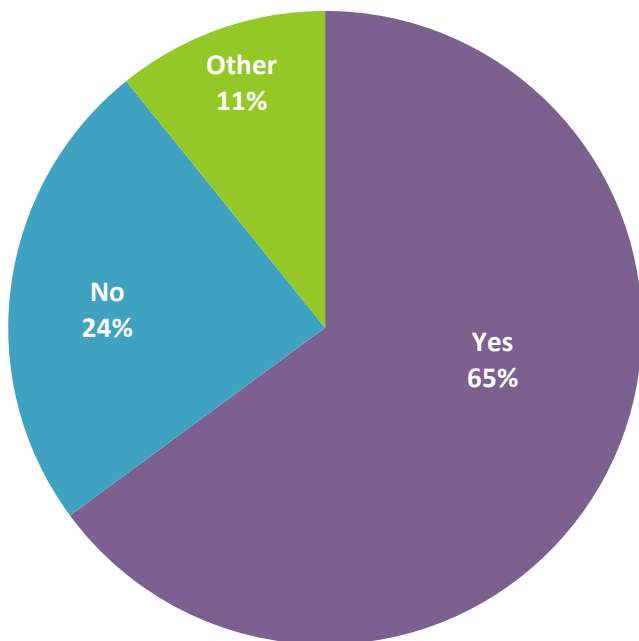


* Other training includes CISM, crisis de-escalation, stress management for students, education for staff on available resources, training on responding and supporting after a suicide

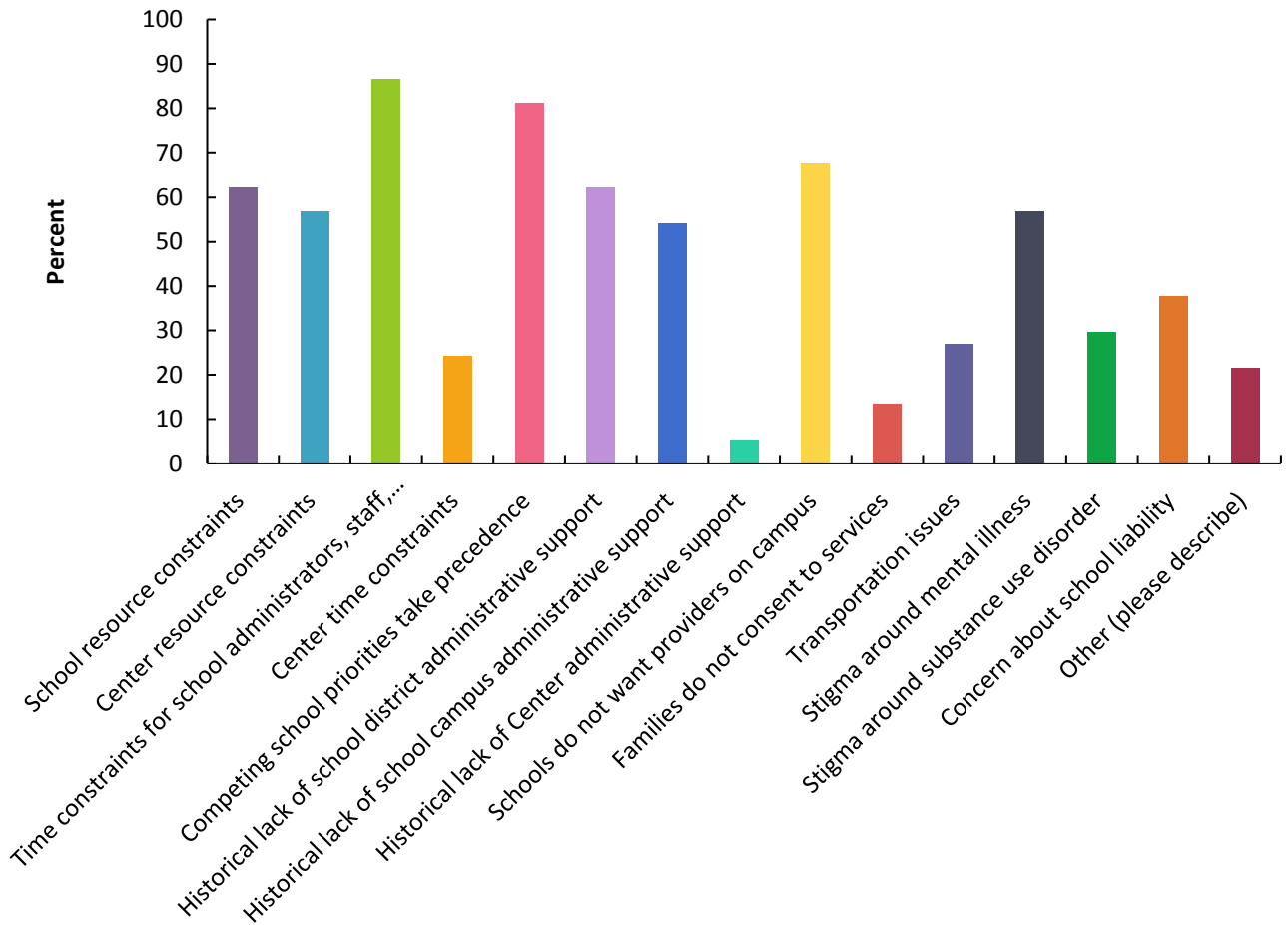
10. Have training activities increased in the past year?



11. Do you have a relationship with your local ESC(s) related to Mental Health First Aid?

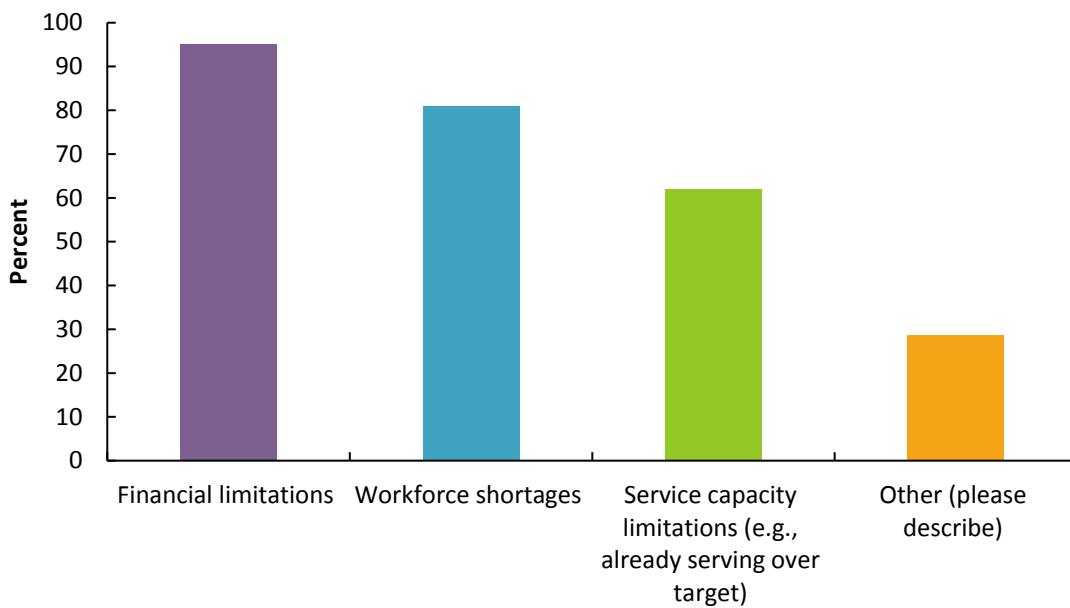


14. What barriers do you face in engaging with schools?



*Other responses included time conflicts around student testing, FERPA and HIPAA concerns, and lack of physical space

15. What types of internal resource constraints exist?

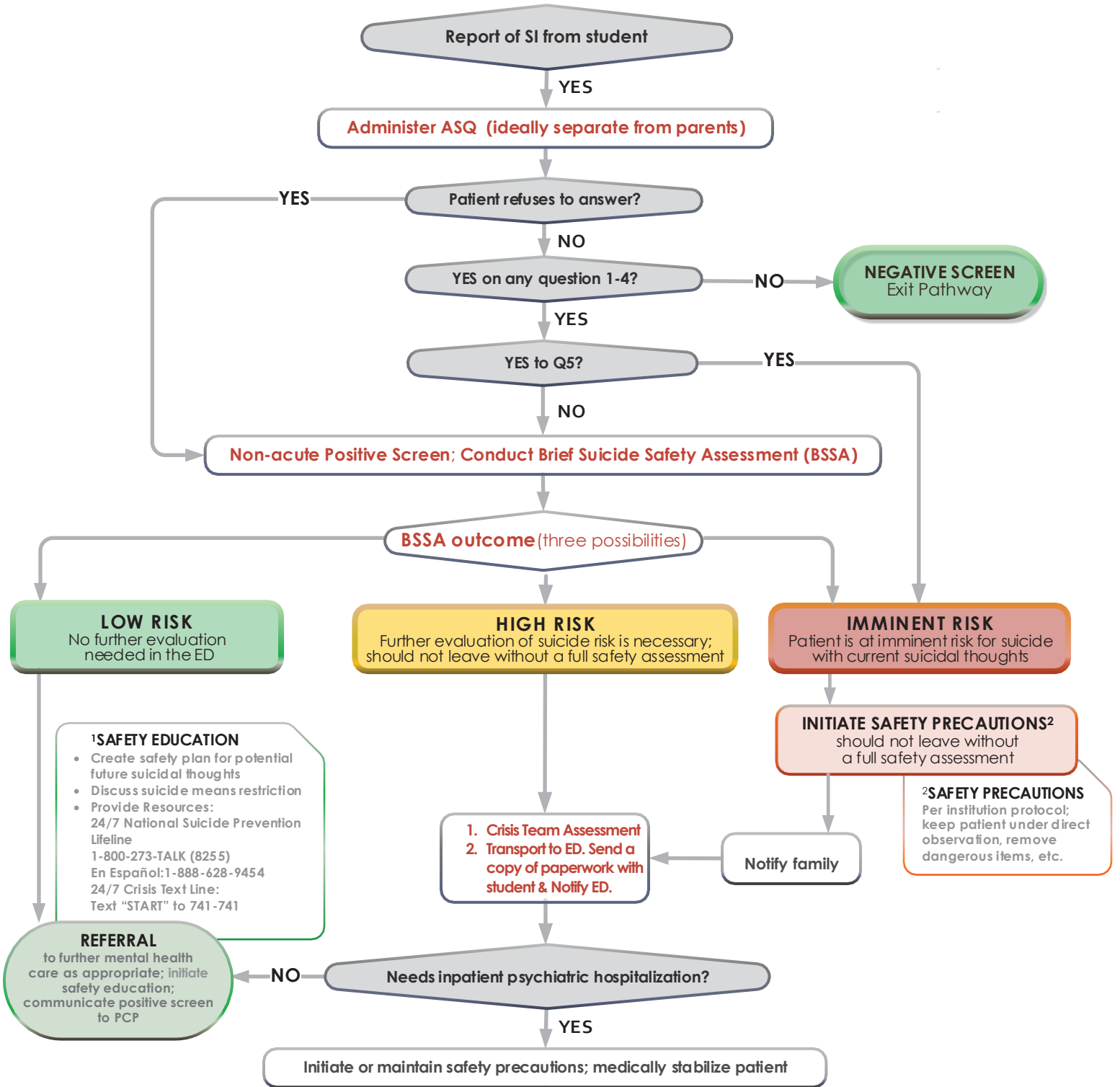


*Other responses included challenges contracting with particular ISDs, physical space limitations, the large number of districts in a service area, challenges with access to schools

SUICIDE RISK SCREENING PATHWAY

SCHOOL-BASED

Sponsored by AACAP's Abramson Grant. Created by PaCC workgroup of Physically Ill Child Committee.



TCHATT

FAQs



Types of schools permissible in TCHATT



Billing Insurance for child psychiatrist



Liability



Initial consent



Use of TCHATT staff to provide clinical and operational support to independent pediatrician offices



Contract out some of our TCHATT LPC time to community centers

FAQs



Types of schools permissible in TCHATT

- Charter schools: Yes, charter schools are considered public schools, although managed differently than traditional public schools
- Disciplinary/Alternative schools: Yes
- Pre-K and Kindergarten: Yes
- Private, non-profit, SPED schools: This would have to be clarified by the legislators regarding what they intend; public schools would be prioritized to maximize benefit of state funds

FAQs



Billing Insurance for child psychiatrist

- Billing for child psychiatrist services is permissible by the HRIs for follow-up care after the patient has been transitioned out of the TCHATT program
- FQHCs can bill for facility fees for hosting telemedicine sessions

FAQs



Liability

- In our MOUs with the ISDs, we state that HRI assumes liability for any of their employees

FAQs



Initial consent

- Digital signature: Digital signature may be acceptable; may need to have witness sign as well
- Blanket consent form at the beginning of the school year: The established HRIs programs have not used a blanket consent form at the beginning of the school year
- Is a flyer about TCHATT enough? No, there needs to a consent for treatment

FAQs



Use of TCHATT staff to provide clinical and operational support to independent pediatrician offices

- If service is regarding case management for transition of care from TCHATT to pediatrician

FAQs



Contract out some of our TCHATT LPC time to community centers

- TCHATT funds are not for ongoing services and contracting out LPCs who are fully funded by the TCHATT may be construed as a conflict

RESOURCE GUIDE

• Orientation Materials	PENDING	Heston/Wesley
• Marketing to Schools	PENDING	Wayman/Castle
• Model Contracts/MOUs/CWAs	COMPLETED	Vo/Wesley
• Model Informed Consent	COMPLETED	Vo/Wesley
• Referral Guidance	PENDING	Thyssen/Castle/Hansch
• Ryan Haight Act	PENDING	Wakefield/Wagner
• Risk Stratification and Crisis Protocol	PENDING	Wakefield/Wagner
• Interpretation Services Guidance	PENDING	Vo

University of Texas System
210 W. 7th St., Room 2.206, Austin, TX 78701
**Convening of the Texas Child Mental Health Care Consortium
(TCMHCC)**

March 11, 2020
10:00 AM – 3:00 PM
Minutes

I. Call to order and roll call

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

II. Review and approve the following item:

i. Minutes from February 21, 2020

- → **Dr. Bourgeois made a motion to approve the meeting minutes. Dr. Tamminga seconded. The minutes were unanimously approved.**
- The executive committee agreed to have further discussion on the role of scientific leads, development of protocols & budget.

III. Presentation/updates on Project Definition Documents and/or Participating Institution Agreements.

- The status of each institution's PDD submission status was reviewed.
- Each institution's submitted service targets were reviewed for TCHAT & CPAN.
- Some questions were raised about the numbers and what they represent. For example, for CPAN, the question was raised whether PCPs enrolled was individual PCPs, whether a practice would count as one and whether nurse practitioners could be counted in the numbers. It was agreed that the data definitions needed to be clarified to ensure we're comparing apples to apples.
- The group was instructed to let UT System know if the targets change once the measures were further refined.

IV. Updates from each of the Workgroups and Health Related Institutions (HRIs) regarding implementation of TCMHCC Initiatives, including opportunities, challenges, questions and milestones achieved. The full Executive Committee may receive information and/or recommendations from the items discussed and take appropriate action.

- i. Texas Child Health Access Through Telemedicine (TCHAT)**
- a. Open discussion regarding TCHAT**

- Luanne Southern requested and received everyone's TCHATT questions. These were collated and passed on to Dr. Vo, Dr. Wakefield and Ms. Wesley to review and respond to. The questions and answers were reviewed during the meeting and included:
 - Types of schools permissible in TCHATT:
Discussed whether private schools should be included and came to the conclusion that public schools should be prioritized to maximize the benefit of the State funds. It was agreed that additional clarification from legislators was needed on whether private, non-profit and specialist schools should be included. It was agreed that this was something that could be discussed in the next session. In the meantime, focus should be on public schools. Any agreements made with non-public schools ok as long as they're not paid for with the LBB funds.
 - Billing insurance for child psychiatrist:
Discussed that we cannot double bill for TCHATT services. The LBB is paying for services, so billing insurance on top of this is not ok. If the school wants to bill for use of facilities/use of center, this will be up to them. This could be an issue that is raised with the legislature next time. Being able to bill those that have insurance may allow for expansion of the service. A suggestion was made to demonstrate, with amount of resources we have now, can serve this number of people; If we bill, can serve this number of people. Discussed that if a child is referred outside of TCHATT, services for ongoing care can be billed for. Discussed that no billing for CPAN is expected.
<<Action Item: Dr. Lakey will work with elected leadership to get additional clarification on billing Medicaid and third parties in the future.>>
 - HIR employee liability for anything done on school campus:
The institution is expected to assume liability for anything they do; they are responsible for what their clinicians are doing at schools. This is a cost of doing business. Discussed that this will likely come up when putting MOUs in place with the schools. Discussed that if something were to happen, the school would likely be held somewhat accountable as well. Discussed that how this is stated will be important.
<<Action Item: Dr. Wakefield will document proposed language to be reviewed by the Executive Committee for approval and subsequent publication on the website.>>
 - Getting consent from all students at the beginning of the year:
There was consensus that this is not appropriate. All students can get information on TCHATT, but not consent. Once a student is identified, then we need to ensure consent. Discussed that model consent form is currently on the website:
<https://www.utsystem.edu/pophealth/tcmhcc/resources/>
 - Use of TCHATT staff to provide clinical & operational support to independent pediatrician offices:
Discussed that it's important to create a seamless process for referral from TCHATT to CPAN but they are two separate programs.

- Purchasing LPC time / contracting with communities to provide ongoing services to TCHATT patients:
Discussed that TCHATT funds are not for ongoing care. If institutions have a separate relationship with a center, maybe through CPWE, that could be referral source, but LPC can't be funded by TCHATT for ongoing care.
- Contracting out TCHATT-funded LPCs to providers:
If LPCs fully funded by TCHATT it would not be appropriate to contract them out.
- The TCHATT work group has sub-workgroups working to put together a resource guide that's high-level enough to apply across the board and will include the guidance discussed. The resource guide is for reference and to help ensure consistency; institutions aren't being forced into using specific materials or following a specific process. It will include a crisis protocol, orientation materials to help families understand what the service is, and an operation manual.
- The question was raised whether the materials would be translated into Spanish. Because the materials are generic and meant to be customized by institutions using them, they'll also need to be translated by the HRI. A suggestion was made that perhaps the COSH could assist with translations.
- The group discussed the Ryan Haight Act, which limits prescription of controlled substances without an in-person visit and calls for special registration (through the DEA) to engage in telemedicine. The DEA was due to have the registration process complete by October 2019, but this did not occur. It was discussed that the inability to prescribe some medications would impact the effectiveness of TCHATT. The group discussed writing a letter to the DEA asking whether the TCMHCC could get an exemption from the registration process while the DEA works on developing it. It was also discussed that another entity has already done this but not yet received an answer. The group also deliberated on whether it would be better to urge the DEA to act on the special registration process, as this would benefit HRIs in general, which are already practicing telemedicine. The point was raised that waiting for a response from the DEA could introduce significant delays.
<<Action Item: UT System to talk to Legal and Government Relations and get their counsel on this issue. The issue will be discussed further at the next meeting pending this counsel. HRIs should move forward and continue to implement TCHATT.>>
- The group discussed the utilization of interpretation services and the likely need to have a BAA between the HRI & the interpretation service due to their exposure to HIPAA-protected information. The resource guide will incorporate guidelines for including medical interpreters.
- The question of LMHAs taking on the care of TCHATT students that require ongoing care was discussed. The group was told that the vast majority of LMHAs are exceeding their state targets and don't have a lot of capacity to serve new kids. There are new funds making their way out via contracts with the HHS Commission, but feedback is that most are likely to exceed capacity quickly even with new money. That said, there are places that continue to enroll.

They are taking steps to get funds out there, ahead of need, to eliminate waiting lists. Additionally, it was thought that CPAN may allow for the shifting of some kids from LMHAs to PCPs, leaving the LMHAs to handle the more complex cases.

- LMHA school engagement continues to increase. This is positive but will require some thinking in terms of how the LMHAs & TCMHCC coordinate to best meet the needs of kids. A list of schools that have LMHA programs in place will be shared so the HRIs can see where programs already exist.
- The point was raised that the group should capitalize on relationships with agencies that serve school-aged children on things like advertising, strategies, etc.
- The topic was raised that if a child was in crisis, we should be able to offer them immediate access to a psychiatrist. This kicked off a discussion around what crisis means. There was concern from some HRIs General Counsel that TCHATT might result in an Emergency Room for schools. There was further concern that if the HRI can't find a referral after 4 visits, they might be on the hook for providing care for that student.
- A delineation between an emergent situation (911) and an urgent concern (TCHATT) was made. Someone in an emergent situation doesn't need to be in school waiting for a psychiatrist; they need to be sent to an emergency room. The view was raised that there will be significant variation across schools in terms of what crisis plans look like, and how you interact with children in an emergent situation. The thought was expressed that HRIs need to make sure there's a good match between a school's crisis response, what they do and how they will interact with TCHATT. TCHATT will be very different depending on local resources of the school.

V. Updates from each of the Workgroups and HRIs regarding planning and implementation of TCMHCC Initiatives, including opportunities, challenges, questions and milestones achieved. The full Executive Committee may receive information and/or recommendations from the items discussed and take appropriate action.

i. Child Psychiatry Access Network (CPAN)

a. Open discussion regarding CPAN

- The CPAN workgroup discussed how they reviewed how others have done enrollment; they looked at various forms and made some modifications, trying to keep it easy / not overly complex. They wanted to outline what CPAN will do for the PCP and also capture who from the team might be calling.
- It's expected that the Enrollment form will go on the TCMHCC website.
- The form was reviewed during the meeting. Suggested edits included:

- Adding a statement, making it clear that CPAN provides consultation services, and is not taking over the care of PCPs' patients
- Registering Nurse Practitioners and Physician Assistants separately and capturing the supervising Physician's name against them.
- Inserting tables to capture Name as well as Email
- Striking the last statement

→ **Motion made by Dr. Podawiltz to approve form with the suggested edits outlined. Dr. Strakowski seconded the motion. It was unanimously approved.**

- Discussed whether practices would be enrolled or individual providers. Could be either / or. If a practice is enrolled, will need to capture all of the providers included.
- The question was raised regarding who has the authority to sign. It was argued that this will vary and could be a practice manager, physician, medical director, etc.
- The CPAN Workgroup is also working on a form to capture data from the call itself and hopes to show what that will look like at the next meeting.
- Dr. Williams reviewed the CPAN process map with the Consortium. Part of the process included capturing information about the patient being consulted on, including name, date of birth and zip code. The purpose of this is to ensure the history of any discussions regarding a specific patient are captured so that if a different provider is consulting with the PCP about the same patient, they can look back at that history and the Dr. doesn't have to repeat the information multiple times.
- A concern was raised regarding the level of information being captured by the HRI. Dr. Martin explained that all of the other CPANs in other states collect information on the patients they're consulting on and refer back to them. If Texas did it differently, we'd be the odd one out. The question was raised about how much further these other CPANs went beyond name and DOB. Dr. Martin responded that the forms look like medical records.
- The point was raised that two things could sink the CPAN initiative: 1) personal information getting into the wrong hands or 2) children's information was used to conduct research. We need to ensure that we're not doing anything that can be exploited.
- Advice from the CPAN national organization is to keep it simple and not create barriers. PCPs will call again and won't want to reinvent the wheel each time. Part of multiple calls is growing / learning as the patient's care progresses. Without the history, this will be difficult.
- A suggestion was made to assign a unique identifier for patients and have the PCP write that down in the patient's chart to refer to if they need to call about the patient. The CPAN would then have de-identified data.

- Dr. Tran out of Baylor Scott & White, representing the Texas Pediatric Society was in attendance at the meeting and was asked to provide input as a potential user of CPAN services. She highlighted that the use of a unique identifier for patients would not work for PCPs as they are seeing patients every 10 minutes. If they receive a call back several patients later, they won't want to have to find that patient's record to pull up the identifier. Her preference would be to use the first and last name of the patient.
- Dr. Tran was asked her opinion on the CPAN collecting information on the patient to refer to vs having to ask the PCP to provide background information each call. She stated that it's normal to consult with other specialties, and common for the PCP to provide a name, DOB and notes; she would have no issue with the specialist keeping those notes as the handoff is smoother the more information the specialist has.
- Dr. Tran also stressed that Drs. will want a quick call. If the PCP needs to open a chart, it will kill the process in a busy clinic.

<<Action Item: CPAN workgroup to ask national CPAN about the minimum information required and what process is needed to inform the family of use of their info. >>

- CPAN enrollment timing was discussed. The CPAN workgroup currently doesn't want to enroll providers until they have a telephone system in place. Once a go live date is determined, they'll back into when they want to start enrollment.
- Training was discussed. Remote training may occur in late April.
- The question of whether to combine the TCHAT & CPAN workgroups was raised. It was felt that there was still enough work to do that they should be kept separate.

ii. Child Psychiatry Workforce Expansion (CPWE)

a. Open discussion regarding CPWE

- Each HRI was asked to provide an update on where they're at with CPWE:
 - BCM – has been working with Harris Center and created a rotation schedule. Lining up fellows to participate in July.
 - TTUHSC – currently in the planning phase, talking to StarCare about the potential with some new funding they've gotten. Hopeful this can move forward in July.
 - TTUHSC EP – has met with all three partners. Two of these have faculty and residents that can start in July.
 - UNTHSC – already had cooperation with MHMR Tarrant County; working to refine this relationship by embedding faculty and increasing the number of residents completing rotations.
 - UTHSCH – expect to be in two LMHAs by July.
 - UTHSCSA - signed contract with Center for Health Care Services and expect to go live in July. Matched for residents to fill two slots. Will redeploy current faculty or hire someone in.

- UTMB - no update.
- UTRGV - working on expanding the number of residents at Tropical Texas & also letting faculty work there. Initiating talks with two other LMHAs – Nueces & Coastal. First conversations with them will be held next week. Residents should be in Tropical Texas by July.
- UTSW - in contact with the head of a mental health authority, John Burrus. Have a call before the end of the week & hope to start people there by July.
- TAMUHSC - still working to finalize partnership with MHMR Brazos.
- UTHSCT - met with center, is ready to recruit for position and pushing to start in July.

iii. Child and Adolescent Psychiatry Fellowships (CAP)

a. **Open discussion regarding CAP**

- The institutions provided a summary of where they ended up with their CAP fellowships:
 - BCM - matched 2 new fellows. Program now at 8 this year.
 - TTUHSC - submitted application for fellowship Jan 31. Awaiting committee in April to see if approved. New fellows would be starting July 2021.
 - TTUHSCPE - have several new fellows starting. Might be 1 short of two extra slots.
 - UTHSCSA - expanded to 10; previously approved for 8 but only took 7 because didn't have the funding to fill the 8th. Now have full 8, going to 10 in July. Within context of current rotations have full complement. CPWE will take up 2 starting July 1st.
 - UTHSCT - on board, on site to submit this fall & program won't start until July 2022. Funding is for planning.
 - UTRGV - starting to work with GME to put together application for fellowship. Hoping to have 2 fellows starting in 2021.
 - UTSW - expanding next year

iv. Research

a. **Open discussion regarding Research**

- Dr. Tamminga provided an update on the Research working group's progress, summarizing what's been accomplished to date:
 - Established concept of networks
 - Identified two topic areas for research: depression & childhood trauma
 - Confirmed scientific leads for each topic area
 - Requested and have received feedback from institutions on their interest in participating in each network
 - Requested and have received nominations for co-leads
- Dr. Tamminga discussed next steps:
 - Convene network members with the scientific lead and brainstorm on project ideas
 - Develop a presentation on the type of research that would come out
 - Adopt core rating scales, etc.
- It was highlighted that the primary goal of the research should be to improve the care of children in Texas, with a secondary goal of securing NIH funding (in order to help improve

care).

- It was pointed out that when the networks meet, they should include Sonja Gaines and Mike Maples. In addition, the thought was raised that the projects should be defined prior to selecting co-leads in order to identify those with the appropriate expertise.
- b. Presentation of information obtained from HRIs regarding interest in participating in the depression/suicide and/or childhood trauma health system research networks. (approval of network membership).**
- c. Presentation of names of child and adolescent psychiatrists to be considered to serve as co-leads of each of the research networks. (approval of one to serve as co-lead for depression/suicide network and one to serve as co-lead for childhood trauma network).**
- A slide was reviewed showing members' interest in participating in each of the two networks, and their nominations for co-leads. Every institution (except MD Anderson Cancer Center) will be participating. A decision was made to delay the selection of co-leads until the research proposal was more fully developed.
- It was discussed that the budget will need to change based on the increase in participation. A decision will need to be made about financial allocations to leads and co-leads that is justified / aligned to their responsibilities. Furthermore, there should be good representation across systems in leadership; there should not be just UT institutions in lead positions. Ideally there would also be geographical variation (urban/rural) in the leads & co-leads to align with the variation you see in Texas.
<<Action Item: Research work group should document roles and responsibilities of leads and co-leads>>
- It was reiterated that the research must be focused on health systems, addressing the challenges in providing services to kids. There cannot be biobanking of blood samples or clinical trials. We need to solve community problems associated with mental health in the state of Texas. The leads need both research experience and political sensitivity.
- The need to change nomenclature was discussed: Research participants and NOT research subjects. It's important to have person-centered language.
- ➔ **A motion was made by Dr. Pliszka to have: a) Dr. Tamminga contact each HRI and get two nominations for leads (one for childhood trauma & one for depression) that will represent that institution; b) have the scientific co-leads meet with those representatives and bring a research proposal back at the next meeting; c) Mike Maples and Sonja Gaines (or a representative) invited to the network meetings; and d) the Research workgroup needs to bring back proposals for the financial support of the networks. Dr. Podawiltz seconded. The motion was unanimously approved.**

v. **External Evaluation**

a. **Open discussion regarding external evaluation.**

- No update provided other than it's a work in progress and should have more detail at the next meetings.

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**

- No closed session held.

VII. **Discuss, consider, and if appropriate, approve information and updates provided by the Baylor College of Medicine and/or the Centralized Operations Support Hub (COSH), CPAN, TCHAT or CPWE Workgroups relating to implementation of the COSH, and obtainment of communications and data management systems. The full Executive Committee may review information and/or recommendations from the items discussed and take appropriate action.**

i. **COSH related items identified by Baylor College of Medicine and members of the Executive Committee**

- Dr. Williams provided an update on the telecommunications and data management system RFPs. The telecommunications RFP had gone out & they had received one proposal so far. It was determined that the RFP was still open and it was inappropriate to discuss any further details about it.
- It was discussed that the COSH could use the Executive Committee workgroup as a sounding board, if required.
<<Action Item: Luanne Southern to send out a copy of the RFP to the Executive Committee members.>>
- The question was raised whether the COSH workgroup would be reviewing submitted proposals. The point was raised that doing so would make them part of the selection committee; a conversation with their procurement department may be required.
- The data management system RFP was still be refined and under review by the COSH workgroup. Dr. Williams emphasized that privacy and security of data is essential.
- The question was raised whether the COSH workgroup could be restructured to assist the COSH with assessing the validity of the data they were getting, and assist with analysis. Dr. Lakey confirmed that this should be possible.
- **→ Dr. Ibrahim made the motion to establish a data governance committee that would work with the COSH leadership to oversee the data. Dr. Williams seconded the motion. The motion was unanimously approved.**

- A discussion was held regarding how metrics would be reported on each program. For TCHAT, institutions may be using their own EMR to document interactions. The question was raised whether an institution will need to use both the EMR and the new data management system. It was acknowledged that some manual data entry might be required in the data management system to capture the required metrics, though the intent would be to keep this to a minimum. Dr. Lakey emphasized that standardization across the metrics is needed in order to accurately report back to the legislature.
- Discussed how programs might intertwine to support each other. Suggestion made to have each HRI come up with their own plan on how to do this.
- → Dr. Williams made a motion to move forward with the data management RFP based on the shared document shared with the Executive Committee. Dr. Bourgeois seconded. The motion was unanimously approved.

VIII. Adjournment

- Motion made to adjourn by Dr. Wakefield, seconded by Dr. Thompson. Unanimously approved.

Appendix I. Executive Committee Attendance

*P = Phoned in

#	Institution/ Organization	Name	03/ 11	#	Institution/ Organization	Name	03/11
1	Baylor College of Medicine	Wayne Goodman, MD		19	The University of Texas Health Science Center at San Antonio	Steven Pliszka, MD	X
2	Baylor College of Medicine	Laurel Williams, DO	X	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	X
4	Texas A&M University System Health Science Center	R. Andrew Harper, MD	X	22	The University of Texas Rio Grande Valley School of Medicine	Michael Patriarca	X
5	Texas Tech University Health Sciences Center	Sarah Wakefield, MD	X	23	The University of Texas Health Science Center at Tyler	Jeffery Matthews, MD	P
6	Texas Tech University Health Sciences Center	Keino McWhinney, MPP	P	24	The University of Texas Health Science Center at Tyler	Daniel Deslatte, MPA, FACHE	P
7	Texas Tech University Health Sciences Center at El Paso	Peter Thompson, MD	X	25	The University of Texas Southwestern Medical Center	Carol Tamminga, MD	X
8	Texas Tech University Health Sciences Center at El Paso	Sarah Martin, MD	X	26	The University of Texas Southwestern Medical Center	Hicham Ibrahim, MD	P
9	University of North Texas Health Science Center	Alan Podawiltz, DO, MS	X	27	Health and Human Services Commission - mental health care services	Sonja Gaines, MBA	X
10	University of North Texas Health Science Center	Mark Chassay, MD, MBA	X	28	Health and Human Services Commission - mental health facilities	Mike Maples	X

#	Institution/ Organization	Name	03/ 11	#	Institution/ Organization	Name	03/11
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	X
12	Dell Medical School at The University of Texas at Austin	Stephen Strakowski, MD	X	30	Hospital System	Danielle Wesley	X
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	X
15	The University of Texas Medical Branch at Galveston	Karen Wagner, MD, PhD		33	Non-profit - Texas Mental Health Counsel	Danette Castle	X
16	The University of Texas Medical Branch at Galveston	Alexander Vo, PhD	P	34	Administrative Contract – University of Texas System	David Lakey, MD	X
17	The University of Texas Health Science Center at Houston	Jair Soares, MD, PhD		35	Other – Hospital System Representative	James Alan Bourgeois, OD, MD	X
18	The University of Texas Health Science Center at Houston	Elizabeth Newlin, MD	X				