

Texas Mental Health Transformation Work Group Meeting Minutes - September 20, 2006

A meeting of the Texas Transformation Work Group (TWG) was held in the Commissioner Board Room M-739 at 1100 West 49th Street, Austin, Texas on Tuesday, September 20, 2006.

Transformation Work Group (TWG) Members present:

Dave Wanser, **TWG Chair** (Texas Department of State Health Services)
Stephany Bryan (Consumer Representative)
Kathryn Kotrla (Central Texas Veterans Health Care System)
Gene Lenz (Texas Education Agency)
Luis Macias (Texas Workforce Commission)
Heidi McConnell (Office of the Governor)
Amy Herzog (Health and Human Services Commission Committee Director)
Vonzo Tolbert (Texas Juvenile Probation Commission; alternate for Vicki Spriggs)
Tom Valentine (Health and Human Services Commission; alternate for Dr. Bell)
Jon Weizenbaum (Texas Department of Aging and Disability)
Dee Wilson (Texas Department of Criminal Justice)
Erin Ferris, (Texas Department of Housing and Community Affairs)
Theresa Cruz (Office of Rural and Community Affairs)
Terry W. Smith (Texas Department of Assistive and Rehabilitative Services)
Sue Milam (Texas Department of Family and Protective Services)
James A. Cooley (Texas State House of Representatives)

New Freedom Commission Members present:

Nancy Speck (New Freedom Commission – Chair, Mental Health Subcommittee of the Strategic Health Partnership)

Implementation Team Members present:

Vijay Ganju, Project Director
Wendy Andreades (Center for Policy and Innovation, Texas Department of State Health Services)
Stacey Stevens, Subcontractor for Assessment (UT School of Social Work)
Dr. Richard Spence, Ph.D., Research Professor (UT School of Social Work)
Camille Miller, Subcontractor for Community Collaboratives (Texas Health Institute)
Sam Shore, Assistant Director (Texas Department of State Health Services)
Joe Vesowate, Assistant Commissioner to Mental Health and Substance Abuse services (Texas Department of State Health Services)
Pat Wong and Staff, Subcontractor for Assessment (LBJ School)
Amanda Broden – (Center for Communication and External Affairs, Department of State Health Services)

I. Call to order/Approval of minutes

Dr. Dave Wanser, Deputy Commissioner for the Texas Department of State Health Services (DSHS) and Chair of the Texas Mental Health Transformation Work Group (TWG), called the meeting to order at 1:40 p.m. and welcomed agency directors and representatives who constitute the membership of the Transformation Work Group. Dr. Wanser called for the approval of the minutes from the August 22, 2006 meeting. The group unanimously approved the minutes with certain changes proposed by workgroup members related to wording and persons attending the meeting.

Erin Ferris, Texas Department of Housing and Community Affairs (TDHCA), introduced herself to the group – she will be taking over for Michael Lyttle. This effort is very important to TDHCA, and they have expressed interest in further investigation of consumer priorities about housing issues, including representation on implementation workgroups and other subcommittees.

II. Consumer Voice Report

An update on Consumer Voice collaboration was provided by Stephany Bryan. The consumer voice members have had meetings, separately and collectively, and, with Wendy Andreades' support, are creating a mechanism to better support consumer voice efforts.

Erin Ferris (TDHCA) provided the following comments:

- a) She would like to request a meeting to discuss housing issues raised in the surveys from the Consumer Voice Town Hall. Even though TDHCA isn't one of the agencies that typically deals with all the mental health issues, when consumers were asked about priorities, housing came up 15 out of 32 times as the first or second priority. They would like to better understand the details behind what the consumers are looking for – housing logistics, housing location, transportation, access to information, etc. She would like to gather the detailed feedback so it can be used in the legislative process.
- b) Ms. Ferris requested that, in reference to the Action Plan for the state, TDHCA be included in the strategic and action plans, as well as committees / meetings. There are a couple strategies that TDHCA is already working on, and some others that they would like to work on. They would like to be actively involved in the Transformation Grant work and accurately reflect what the consumers are telling them.

Dr. Ganju remarked that we could provide the notes from the Consumer Voice meeting to Ms. Ferris. There is also information contained in the report on agency interviews regarding housing. We can provide that as well, and have a separate meeting to go over this information in more detail. Ms. Ferris will also read through the agency interview report and the comprehensive state plan to get more details around housing issues and priorities.

III. **State Trends that Impact Mental Health – Dr. Steve Murdock** (Department Chair, Professor and Lutch Brown Distinguished Chair in Demography and Organization Studies, UTSA College of Public Policy; Director – Institute for Demographic and Socioeconomic Research; Director – Texas State Data Center; State Demographer of Texas)

Dr. Wanser told the group that at the first TWG meeting, a suggestion was raised to invite Dr. Steve Murdock to give a presentation about population trends in Texas and how they impacts health, mental health, agencies, etc. Based on availability and meeting schedules, the first opportunity for this presentation was today.

Dr. Murdock remarked that all this information is public; the presentation given today can be found at:

- <http://txsdc.utsa.edu/>
- http://txsdc.utsa.edu/download/pdf/presentations/2006_09_20_TWG_Austin.ppt
- Contact phone: 210-458-6530, Texas State Data Center

Three Demographic Trends in Texas

Dr. Murdock indicated that Texas is facing three demographic trends which are “so important that if we fail to understand them, we will plan to fail, because they are changing Texas and the country in irreversible ways.” The trends are: 1) changes in rates and sources of population growth, 2) increases in non-Anglo population (the most important factor impacting Texas and the country, in his opinion), and 3) the aging of the population. The growth of these demographic groups will have a direct impact on the Texas economy (for example, the aging of the population impacts Medicaid, which impacts the economy).

Growth

In order to better understand the continually increasing strain on the health care system, we need to understand Texas’ expected rapid growth rates, and where that growth is coming from.

In every reporting period since 1850, Texas has grown more rapidly than the US average. That trend is expected to continue.

There are two important aspects of population growth to consider – the magnitude of growth and the source of the growth:

1. **Magnitude:** In the 1990’s, Texas grew by 3.9 million people (greater than the population of 24 of the 50 states). Nearly one out of every eight persons added to the United States in the 1990’s was added in Texas. If current growth in the 2000 decade continues, Texas will add another 3.6 - 4.0 million people. Texas is

among the top ten states with regard to numerical population increase, as well as percentage increases.

2. **Source of growth:** In addition to magnitude, there are two sources of population changes that must be considered: 1) natural increase (excess of births over deaths) and 2) immigration (from other states or other countries). Each of these responds differently to the economy. Most of Texas' growth historically has come from natural increases, with the exception of the 1970's and the 1990's, when net migration was slightly higher than natural increases. Only one other state in the country has a higher rate of natural increase – Utah. International migration is increasing in Texas, in numbers and percentages, compared to domestic migration (domestic migration is from other states).

In sheer size, not only is Texas the second largest state in the country (California is the largest), but it also has some of the fastest growing cities. Four Texas cities rank in the top ten in the nation with regard to *numerical* growth between 2000 and 2005: San Antonio (4), Fort Worth (5), Houston (7), and El Paso (10). And, four Texas cities rank in the top ten with *percentage* growth: Fort Worth (1), San Antonio (4), El Paso (7), and Austin (10).

In Texas, the four geographic areas of strongest population growth, at rates of 22 – 86% in the 1990's, are: 1) Houston, 2) Dallas / Ft. Worth, 3) San Antonio /Austin, and 4) border / valley. Growth is concentrated in urban areas, and rural areas are suffering. Rural areas are losing population overall – 68 of Texas' 254 counties lost population in the 1990's. Between 2000 and 2003, the number of counties losing population increased to 98 and now, the number is 101.

Racial / Ethnic Changes in Texas

The increasingly changing face of Texas is critical to understand, in that it will have an effect on health care needs, services and programs, the economy, and many other factors.

Not only is Texas one of the largest states in each racial / ethnic group (# 2 in the Black and Hispanic groups, # 3 with Anglos, and # 4 with Other), it also has one of the fastest growth *rates* in the country in each category (Anglo – 2nd only to Florida; Black – 3rd highest behind Florida and Georgia; Hispanic – 2nd only to California; and Other – 3rd highest behind California and New York). The Hispanic population alone grew by 2.3 million persons in Texas in the 1990's.

Diversity is increasingly a national phenomenon (not just Texas, California, New York, and Arizona). In *all* 50 states, the non-Anglo populations are growing at a faster rate than Anglo populations. Additionally, in 35 of the 50 states, in either numerical or percentage terms, one of the fastest growing populations is the Hispanic population, and that includes such states as Iowa, Idaho, and South Dakota. The Anglo population decreased in 5 of the 10 largest states in the country (California, New York, Illinois, Pennsylvania, and New Jersey). Interestingly, California, which had an overall population *increase* of 4.1 million people in the 1990's, had a *decrease* in the Anglo population of 635,635.

In the 1980's, 65% of additions to the Texas population were non-Anglo; in the 1990's, it was 80% non-Anglo (mostly Hispanic). As of 2004, Texas became one of four states with less than half of its population being Anglo (currently 49.2%).

From 1996 – 2002, 58% of all new additions to the U.S. labor force were foreign-born.

Aging of the Population

In Texas and across the US, we are getting older in the aggregate, primarily due to the aging of Baby Boomers – those born between 1946 and 1964 (~25% of the U.S. population). In 2000, 73% of persons 65 or older were Anglo and 17% were Hispanic. In the year 2040, those numbers are projected to be 40% and 37%, respectively.

Projections

With a low-growth scenario (which represents half of the growth rate of the 1990's), Texas is expected to grow by 71% between 2000 and 2040. Compare that to an expected 49% increase in the U.S. between 2000 and 2050 (*not 40 years, but 50*).

Under the scenario where Anglos grow the most, they only grow by 12%. Under the same scenario, the Black population is expected to grow by 71%, the Hispanic population by 359%, and the Other population by 569%. Based on current projections, the Hispanic population in Texas is expected to be more than 50% sometime between 2025 and 2035. Based on **any** of the scenarios presented, the 2040 populations are expected to be: Anglo: 25-33%; Black: 8-10%; Hispanic: 53-59%; and Other: 6-9%.

Projected increases in specific age groups in Texas from 2000 to 2040 (% change):

- <18 years: 88%;
- 18-24 years: 112%; and
- 65+: 296%.

We will be strained at both ends of the age continuum: at the younger ages for education and workforce development, and at the older ages for health care and long term care. Based on overall projections, all states will experience growth in these age brackets, but Texas will experience higher levels of increase than most other states.

Relationships between demographic and socioeconomic factors

- Based on 1999 figures, the median Texas household income tends to decrease beyond the age of 54, and Texas ranked 30th in the country in 1999 with respect to median household income. The numbers have gotten slightly worse since then. In general, household incomes are decreasing in Texas. Therefore, tax bases are impacted.
- Black and Hispanic median household incomes are only about 2/3 of Anglo and Other populations. With their increasing populations, tax bases are further impacted.
- Texas has ranked 49th or 50th in the last several years with respect to percentage of people 25 years or older with a high school degree, and 35th in the country on percentage with a college degree. In general, the level of educational achievement in Texas is going down, which impacts income.

- The projected percentage of Texas households in poverty is expected to increase in most demographic groups by 2040.

Health Care

- Depending on the scenario (rates of net migration), incidences of disease / disorder are expected to go up by 86 – 161% by 2040.
- The expected increase in persons with disabilities is about 202% by the year 2040.
- Number of office physician contacts is expected to go up from 55.8 million in 2000 (cost of \$7.7 billion) to 150.7 million (cost of \$20.9 billion) in 2040.
- Days of hospital care is expected to go up from 10.9 million in 2000 (cost of \$15.8 billion) to 33.6 million (cost of \$59 billion) in 2040.
- Number of nursing home residents is expected to go up from 81,337 in 2000 (cost of \$228 million) to 309,271 (cost of \$867 million) in 2040.
- Percentage increases from 2000 to 2040 in the following areas:
 - Population: 142.6%
 - Physician contacts: 170.2%
 - Days of hospitalizations: 208.9%
 - Nursing home residents: 280.2%
- Medicaid enrollment is expected to go up from 1.9 million in 2000 to 5.3 million in 2040, tripling the costs from \$4.3 billion to \$12.3 billion.

Summary Points:

- Demographics are tied to socioeconomic and other factors. They will change the economy of the state. These factors impact the private sector, the taxpayers, and the public sector. If we don't change some of the socioeconomic factors, then as the population changes, we change the very economy of Texas.
- If we're going to fix the things that need to be fixed, we need to do it now. Baby Boomers will get to a point where their income freezes (they'll start hitting the 65 year mark in 2030) and therefore, the tax base goes down. If we miss that opportunity, the window won't open again for decades.
- Based on projections of race / ethnic growth, Dr. Murdock provided the following assessment: "The Texas of today is the US of tomorrow; if you can get it right in Texas, you are ready for the future of the United States."
- Because of the sheer numbers of Baby Boomers, they have rippled through several systems in the country, including educational, and will be rippling the health care system as they age.
- **Growth:** Texas is likely to grow, but not all parts of the state will grow at the same rates. Planning for growth is very important and we don't do it very well. We must plan for specific types and rates of growth in different parts of the state.
- **Aging:** We, as a nation and a state, have very difficult decisions to make about the elderly. It may not be possible to provide the level of services they have become accustomed to, unless we spend a large percentage of the state or federal budget on just that.
- **Non-Anglo populations:** The non-Anglo populations reflect our future and we need to do everything we can to be sure that all Texans have the skills and

education needed to be competitive in an increasingly international economy. It's not just a humanitarian approach – this will affect our economy.

- If we don't address these issues, we could have a Texas that is poor and less competitive. The future of Texas is tied to its non-Anglo populations; how they do will determine how we do.

Based on Steve Murdock's presentation, TWG members expressed concern about the possible strain on the state behavioral health system that these population growth areas will cause – we need to address the financing of these issues. Specifically, Dr. Wanser asked "if we were Governor and we saw these projections, what would we do to prevent the train wreck that looks to be happening in our future? If we add mental illness and substance abuse, what would the trend line look like?" These are the questions he proposed the TWG should be asking.

Luis Macias asked about the accuracy of the data. Per Steve Murdock, this data is tied to census data, which are probably pretty accurate.

IV. Review of MHT Grant Deliverables

A. Review of Needs Assessment / Resource Inventory

Dr. Stevens has compiled all the information and materials into the draft document provided at the last meeting. She wants to make sure that each agency's information is represented accurately. She requested feedback from the TWG members by September 26.

Information provided in the Needs Assessment / Resource Inventory comes from several sources:

1. Analysis of state agency plans,
2. Results of agency interviews,
3. Consumer / family member input provided at the Consumer Voice Town Hall meeting, and
4. Results of regional hearings on crisis services redesign.

Several consistent themes were highlighted from these sources, which were provided at the last TWG meeting.

The grid used in the document is a format that is required by federal grant requirements.

B. Review of Draft Comprehensive Mental Health Plan

The Comprehensive State Mental Health Plan has been organized to provide focus areas for transformation and potential strategies for those focus areas, rather than to

provide operational details. Implementation workgroups will delve into the details of Transformation planning and implementation at a later stage. The goal of the Comprehensive Plan is to provide guidance and a framework, and a useful avenue for talking with stakeholders in an easy-to-understand way. This document will likely be used as a work-in-progress during the life of the transformation work.

Dr. Ganju informed the group that three main areas are not yet covered in the draft document in terms of specific strategies. These are: 1) racial / ethnic and geographic disparities; 2) stigma of mental health, which was brought up during the Consumer Voice meeting and the agency interviews; and 3) justice-involved persons.

Stigma

Dr. Ganju talked about anti-stigma campaigns and related efforts in other states and countries, particularly the high costs. Dr. Ganju mentioned that there could be some money available to start something like this, but not a full force program. One opportunity could be to work through the community collaboratives to initiate some of these anti-stigma programs. One idea is to learn from what other states have done, so as to not recreate the wheel, and therefore, save some money. Dr. Ganju talked about the possibility of including some money for researching this and doing an evaluation of options.

Stephany Bryan mentioned that some models are already being used in Texas – for example, over the past four years, Tarrant County has spent about \$1 million on anti-stigma campaigns, and they are evaluating its success. Erin Ferris recommended that we look at housing as a measure of success for anti-stigma campaigns – are people more able to get affordable housing as a result of lower stigmas about mental illness?

Dr. Wanser talked about different kinds of stigma – the kind that individual citizens have against one another, and the kind of stigma that plays out in terms of policy. How would this group bring that kind of information to bear and coordinate a Texas response? Dr. Wanser discussed with the group the need for more coordination and an “early warning system” so that when federal or state policy changes happen, we can coordinate a response and act accordingly. We may be able to communicate information like this via listservs, etc. Dr. Ganju talked about some research, which has shown that some of the stigma that consumers experience is from the agencies from which they get services. So, some of these anti-stigma programs should probably be focused on that. Ms. Ferris raised the question: is the issue related to a lack of resources, or a lack of awareness about existing resources?

Disparities

Dr. Ganju asked the group for potential strategies to address disparities. TWG members suggested looking at measures of success as one option – instead of measuring at the aggregate level and getting averages, we should measure effectiveness in each group, to ensure that each population group and geographic area are adequately served. There may also be cultural reasons for different levels of access – some groups may not be willing to access services, even if needed.

Additionally, the culture of the case worker can sometimes be imposed upon the family they are working with and, therefore, would have an impact on disparities – one approach could be to better match up case workers with consumers, or have more extensive training on cultural issues, to reduce that gap.

Dr. Ganju mentioned that there are a range of activities that cut across all agencies – do we want this to be a focus area in the comprehensive plan? Dr. Wanser said that at the agency level, each population group that they serve should be reviewed and measured, with regard to them reaching the goals set out by that agency. Some groups might be at a higher risk of not achieving those goals and we should identify those, with a focus on measuring and responding appropriately.

Feedback / Questions on the Comprehensive Plan

Providers not included in the TWG membership: Dr. Ganju responded that the TWG membership / structure is a result of the federal requirements for membership but that mechanisms would be developed to obtain provider input.

Measures of Success / Metrics: Will we measure the effect or the effort, or both? Dr. Ganju talked about the National Outcomes Measures that are part of the Community Mental Health Block Grant – they cover things like access to quality care, employment, housing, and many others. These were limited to the state mental health authority; some consideration was given toward expanding those measures to all the agencies involved in the TWG. The response was that to impose these measures across the board would be incredibly difficult and restricting. So, at this point, we're proposing that each implementation workgroup consider which outcome measures would be most appropriate in the different focus areas. Some proposed measures are more qualitative in nature, such as how many policies were changed as a result of the work?

As Texas moves forward with transformation, will our federal partners be looking for specific outcomes, and will they be comparing states on those outcomes? If so, are there some measures that we should implement that will help us align, given the fact that the feds are probably looking for certain outcomes as a result of this work? Dr. Wanser said that there are some from the national outcome measures that could be cross-cut: employment, housing, criminal justice involvement, and school success. To the extent that we could adopt those and work toward common definitions, then those are the things that we want to impact with the specific initiatives undertaken.

Dr. Wanser also talked about the behavioral health survey that is being put together for the state. Some of the questions in that survey are reasonable benchmarks for us to look at. They get at community indicators of mental health that are generalizable. They will be looking at community's efforts to improve those things, and could include things like: number of bad mental health days, thoughts of suicide, risk behaviors.

Dr. Ganju reviewed the PowerPoint presentation called: “Texas Mental Health Transformation: Proposed Directions and Options.” Comments and questions, in addition to those provided in the presentation, are provided here:

Transformation Objectives

A new, transformed system should include the following:

- Early intervention, population-based services – Currently, the focus is on getting people “in the door” and getting the access to services that they need. That should be expanded to include their specific needs. One approach is to look at this from a public health perspective – how to address issues so they don’t get worse? The goal is to move to an early intervention and population-based service approach, where we would look at the range of people who need services and how to provide those services in an early intervention way. This is a radical shift in focus. The traditional “mental health system” is a narrow sliver of all the activities related to services provided to people with behavioral health needs; with a population-based approach, we would look at *any* provider who might be delivering mental health services.
- Access to services from many “doors”, coordinated care
- Well-defined workforce development and training infrastructure
- Coordinated exchange of information – Build on the successes and advances already achieved with data sharing.
- Consumer and family member driven system – The state has made a lot of progress with involving consumers and families, but how do we take it to the next step with a system *driven* by consumers and families? Some ideas about how to create that kind of system have been provided by the Consumer Voice group and from the Consumer Voice meeting.
- Seamless continuity of care

Transformation Vision

Many of the components of the vision were voiced by the various “listening channels” to date: Consumer Voice meetings, Consumer Voice Town Hall, agency interviews, and the needs assessment process. The goal is to start building a system which operationalizes the partnerships across agencies on an ongoing basis, not just project by project.

As we look to the vision of where we’d like to go with transformation, we need to look at populations / services / diagnoses / programs that are different than what we’ve done in the past, and what infrastructural changes will be required to do that. We’re not looking at doing the same things better, but in doing things differently.

Assumptions of Transformation

How is Transformation going to happen? The focus is building on the strengths of the current system in a systematic way, to transform the way we deliver mental health services. This is not a cultural revolution. First, we'll need to create a climate for change and then do changes in specific areas (not statewide at the beginning). Focus on pivotal issues, use those as learning experiences, and refine them before implementing statewide. For Transformation to have an impact on the people receiving services, it needs to be approached from the local, as well as state, levels. We need to be selective in what we work on.

Approach to Transformation

Transformation is going to take time, and some transformation will require major shifts of organizational culture.

Goals of Transformation

We need to make sure we have high expectations for the system, that we don't view it as a minimalist system.

How will we make sure that there isn't overlap with existing councils / groups? For example, there is a council with the Governor's office – the Health Care Policy Council – that is currently working on some of the technology issues described here today. Dr. Ganju commented that discussions have already started to ensure that these types of linkages with existing groups provide efficient use of resources and reduce duplication.

Goal 1 – To develop the mental health system for *all* Texans

Returning Vets and their Families

Based on agency interviews, there is a focus on returning vets and Post-Traumatic Stress Disorder (PTSD). The hope is that pre-screening instruments be used to facilitate early intervention. Kathryn Kotrla agreed. Returning vets are a large population, and the impact on the community mental health system is potentially huge. There is great opportunity for advancement in this area as plans are already in motion to address veterans' needs at a practical level in the community and at a policy level in the legislature. The VHA has already identified specific areas of concern. It is likely that we could leverage federal, state, and private partnerships to bring together resources to address this area of concern. Dave Wanser talked about a regional response to Fort Hood / returning vets, which is a potential health crisis. By the end of the year, they will have a large community town hall meeting to put together a coalition of agencies and community organizations who want to help. There has been significant interest and offering of help from the private sector. We could learn from this approach and replicate to other military communities in Texas (El Paso, San Antonio, etc.). Dr. Ganju mentioned that vets could be a population focus AND an area to use technology.

James Cooley (House of Rep): There are committees in both chambers that deal with military issues – this could be of interest to those committees; they may want to help with legislation or other support. Kathryn offered that the VHA could

provide a proposal to these committees via James Cooley's office about utilization of technology for the purpose of information access and coordination of services with the goal of "No Wrong Door".

Pre-School and School Age Populations

Pre-school and school age populations have been identified as a focus area, specifically for early intervention. The thought is that the earlier the intervention, the less resources used over the lifespan.

Older Adults

Older adults have been identified due to the aging population, and the increased numbers with health issues or in nursing homes.

Measures of Success

We may want to look at different measures of success – currently, we look at things like how many people we served; may be a good idea to move toward things like how many people we kept out of ER's, prisons, and nursing homes. Dr. Ganju talked about return on investment data that shows that the cost of healthcare goes down if people have appropriate mental health intervention. Dr. Wanser mentioned that there has been a recommendation to use survey and other data at the community levels so that communities take ownership in these intervention areas.

Goal 2 – "No Wrong Door"

At the local level, we will build on the Texas Health Institute's experience and strengths with community collaboratives to work with communities to improve coordination and provide more readily accessible mental health services. At the state level, more data sharing and coordination will help facilitate the "no wrong door" concept.

Goal 3 – Consumer and family-driven system

- How do we start building a culture of hope and empowerment across agencies, as well as educate consumers about the project initiatives?
- Consumer and family groups / advocacy groups have expressed a desire to network more with each other, to provide a stronger and more unified voice.
- There has been significant feedback that people would like to see more peer-support programs, and also certification of those programs.

Goal 4 – State-of-the-Art Services

As we proceed with transformation, we'll be constantly considering how to ensure quality in the system. Each agency has a different approach to best practices – we'll need to coordinate on the meaning of evidence-based practices and which practices we want to support and purchase. We will also need to develop a common understanding of the approach to be taken.

Another important step will be to identify areas where we already have integrated services with health and mental health – disaster management, for example. Mental health is one of the risk indicators of a person's health – having a serious mental illness lowers the average lifespan by almost 25 years. With Electronic Health Records, we'll need to ensure that behavioral health elements are included, so that a person's entire set of health information is well represented.

Lastly, we'll need to coordinate with the work of Crisis Services Redesign.

Goal 5 – Workforce Development / Training

In the past, we talked about the possibility of a Higher Education Coordinating Council with the TWG, and establishing mechanisms of collaborations with colleges and universities. The UT School of Social Work is bringing together Schools of Social Work from across the country to look at how they might change the curriculum to incorporate evidence-based practices.

Another idea was to involve consumers and family members in the workforce.

How do we work with licensing agencies to make sure their requirements conform to where we need to go with workforce development?

The Hogg Foundation is interested in the area of workforce and is actively supporting efforts in workforce development and training. They are involved in projects which support the integration of health and behavioral health, including workforce issues.

Unanimous thought is that there is a need for workforce development in rural areas – could use technology to be part of the solution.

Goal 6 – Data Coordination / New Technologies

There are initiatives currently in place that provide data sharing, in addition to current levels. Goal is to build on those successes and expand the number of agencies participating in data-sharing and coordination.

Additionally, we will be looking at new technologies not yet in use.

From a consumer and family member perspective, how do we use technology to better and more efficiently provide services, and provide information and education to them?

Additional Information

Also being worked on is a way to link with the private sector – for example, the National Business Group on Health. Per Dave Wanser: He has been in communication with the National Business Group of Health; they are committing to doing a summit on behavioral health benefits as part of overall benefits packages offered by employers. They will invite large employers in Texas to this

summit and will start a dialogue around appropriate benefits. An example of this issue: A long-time employee of DSHS decided to come back to using DSHS benefits, after having used her husband's for years. She was denied because of past behavioral health treatments.

V. Senate Interim Committee Report: Next Steps

A. Senate Interim Committee Report

Dr. Ganju discussed the report due by November 1, 2006 to Senator Nelson's committee. Senator Nelson has requested that the Work Group include in the detailed report specific recommendations for the future of the Texas mental health system, including: 1) which services should be purchased or provided to consumers with public funds, and 2) how to incorporate consumer input and address consumer needs. Dr. Ganju mentioned that some of the information will come from the Comprehensive State Mental Health Plan, but additional information will be needed from Work Group members, since activities related to the Transformation Grant are somewhat different than what *policies* may be necessary for the mental health system. An important note is that this report may have an impact on legislation.

Dr. Ganju mentioned that there is an organization called the International Institute for Mental Health Leadership; their Executive Director will be in the state in early November. He has looked at transformation, mostly in other countries. Dr. Ganju will talk to him about the possibility of meeting with this group, possibly on November 3rd, about the things we've been talking about.

B. Implementation Subgroup Activities

Four workgroups will be established: 1) children, 2) adults, 3) workforce development and training, and 4) data coordination – which will also address confidentiality issues. Dr. Ganju asked again for agencies to submit names of their agency representative, if they have not already.

Please submit names of reps from your agency; haven't received many of them. Please submit by September 22, 2006. Dr. Ganju will send an e-mail to the membership delineating what the groups are and what information is needed from each agency.

The issue of confidentiality will probably fit into the group on data coordination. Some of the restrictions are federal restrictions, not state. We will need to identify these barriers and how to address them.

The issue of housing will likely be a component of one or more of the workgroups, along with other issues identified for each of the groups.

Regarding representation on implementation workgroups, the Assumption is that all agencies will be represented on all workgroups.

VI. Closing

Dr. Ganju closed by planning for the next meetings. A meeting will be set up for mid-October, and another one for November 3rd.