Texas Mental Health Transformation Workgroup Meeting – November 3, 2006
Attendees

A meeting of the Texas Transformation Workgroup (TWG) was held in the Commissioner Board Room M-739 at 1100 West 49th Street, Austin, Texas on Tuesday, November 3, 2006.

Transformation Workgroup (TWG) Members present:
Dave Wanser, **TWG Chair** (Texas Department of State Health Services)
Stephany Bryan (Consumer / Family Member Representative)
Allyson Brandt (Central Texas Veterans Health Care System; alternate for Kathryn Kotrla)
Richard Poe (Texas Education Agency; alternate for Gene Lenz)
Heidi McConnell (Office of the Governor)
Tom Valentine (Health and Human Services Commission; alternate for Dr. Bell)
Dee Wilson (Texas Department of Criminal Justice; alternate for Brad Livingston)
Erin Ferris, (Texas Department of Housing and Community Affairs)
Robert Alexander (Texas Department of Assistive and Rehabilitative Services; alternate for Terry W. Smith)
Sue Milam (Texas Department of Family and Protective Services)
James A. Cooley (Representative Dianne Delisi's office)
Amy Herzog (Senator Jane Nelson's office)
Mike Halligan (Consumer / Family Member Representative)
Tom Hamilton (Consumer / Family Member Representative)
Valarie Garza (Consumer / Family Member Representative)
Theresa Cruz (Office of Rural Community Affairs)
John Fuller (Texas Workforce Commission)

New Freedom Commission Members present:

Implementation Team Members present:
Vijay Ganju, Project Director
Wendy Andreades (Center for Policy and Innovation, Texas Department of State Health Services)
Camille Miller, Subcontractor for Community Collaboratives (Texas Health Institute)
Sam Shore, Assistant Director (Texas Department of State Health Services)
Pat Wong and Staff, Subcontractor for Assessment (LBJ School)

Texas Mental Health Transformation Workgroup Meeting – November 3, 2006
Executive Summary

A meeting of the Texas Transformation Workgroup (TWG) was held on Tuesday, November 3, 2006. Meeting notes from the October 16, 2006 meeting were approved with changes.

Senate Interim Report: On November 1, 2006, the TWG submitted a report to the Senate Committee on Health and Human Services with recommendations for the future mental health system in Texas. Dr. Vijay Ganju thanked the group for providing content and feedback on the report, the major focus of which is the set of seven (7) policy initiatives to move transformation forward:

1. Recognizing that early intervention and recovery are the policy direction for mental health services across agencies in the state.
2. Requiring the TWG to develop and assess screening tools and models for early detection of mental health problems in individuals, including children and adolescents
3. Developing interagency behavioral health data sharing protocols and coordination requirements to achieve efficient and effective care.
4. Requiring the TWG to develop, pilot and present recommendations for standardized definitions, training and contracting requirements for behavioral health services to the Senate Health and Human Services by November 1.
5. Requiring the TWG to develop a report about the return on investment of mental health services, including the cost effectiveness of behavioral health interventions in emergency rooms and in adult and juvenile justice systems as well as assessments of average daily school attendance and dropout rates in schools, where behavioral health interventions are and are not used or were previously not used.
6. Developing common metrics and outcome measures related to behavioral health interventions for state agencies which provide behavioral health services.
7. Requiring the TWG to submit a report to the Senate Health and Human Services Committee on the progress made related to the mental health transformation and the strategies in the report.

Justice and MH Collaboration Grant Initiative: Dr. Wanser informed the group about a current grant opportunity (about $250,000) that looks at the intersection between juvenile justice and mental health, which is instructive to our transformation work. He may be asking TWG members for assistance with this grant.

Community Collaboratives: Dr. Ganju provided the group an update on community collaboratives. An RFA (Request for Application) will be sent out to all 254 county judges by early December. Submitted applications will be reviewed by a TWG committee, which includes Heidi McConnell (Chair), 2 TWG state agency members, 2 TWG consumers / family members, Camille Miller, and Vijay Ganju. Proposed selection criteria will include the level of participation, commitment / resources, history / experience, proposed transformation initiatives, and relationship of transformation initiatives to other TWG priorities.

Consumer Voice Update: Valarie Garza reported to the group that she will be representing consumers and family members at the National Grantee Committee meeting in Washington, D.C. Ms. Garza also reported that she and Erin Ferris are working together to pull more detailed data on housing issues that consumers have raised.

LAR for Children's Mental Health Services: Dr. Wanser gave a presentation on the Legislative Appropriation Request (LAR) for children's mental health services for FY2008 – 2009. In total, we are asking for $155 million for the biennium, which would serve about 51,588 children. Not including Crisis Service Redesign, about 2.9% of children in need of mental health services would be funded by these appropriation requests, assuming an estimated 780,000 children with mental illness in Texas.

Data Sharing to Support Early Intervention: Youth with some of the risk factors identified often have some juvenile justice involvement. Those same kids may repeat the same cycle if they become parents. Early intervention, if done well, can interrupt this multi-generational cycle.

Texas Mental Health Transformation Workgroup Meeting – November 3, 2006
Executive Summary (cont'd)

TWG members talked about the possibility of setting up a data map. Once a year, run reports with information about cross-agency involvement to better understand links, risk indicators, and child outcomes. Use that data to identify intervention points and predict places we can better invest resources.

Performance Standards for Early Intervention: It was recommended that performance standards be developed to track interventions, results, and links to other systems. Compare populations that received interventions with those that did not – what combination of interventions produced the best results? From a legislative perspective, they will want to see that something has improved.

Example of Successful Early Intervention Program: There is a program in Dallas which identifies pregnant women at risk and assigns a nurse to that woman / child for 2.5 years. Very good outcomes have been shown with this program over time, since it is less resource intensive than not intervening. This is a good example of a program that starts at the beginning of a cycle with early intervention. ROI information on this program is impressive.

Telemedicine: The group agreed that we need to be able to identify and serve the rural constituency better, and include them in the data. Examples of telemedicine usage across the state were provided. Several agencies already have videoconferencing systems; if the systems are already set up and working, then we'd only need to spend money on maintenance, and equipment for the organizations that don't have it. We would need to look at the compatibility of the different systems and possibly set a data standard.

Potential benefits of telemedicine:

- It provides a better opportunity for service provision to rural areas.
- Community MHMR centers have had some successes with telemedicine; it has worked well with kids because they feel comfortable with a TV; and in substance abuse situations because it provides a sense of privacy.
- Telemedicine is beneficial for providers, not just for clients. Rural ER's use it to access experts in other areas; ER nurses love the program and turnover rates have dropped in the areas that have started using this.
- It could be used as an advisor service – meeting with a peer who has expertise in a particular area.

Potential concerns or challenges with telemedicine:

- The cost in rural areas may still be somewhat prohibitive. Even though grants are usually available to set it up, the ongoing maintenance is expensive also.
- Issues of trauma are very personal, so it's difficult to talk about them through a TV screen or camera.
- Although it may be a necessity in rural areas now, we should consider it as a temporary solution, for follow up appointments only, until services are brought to those areas.

Workgroup Charges: Dr. Ganju stated that TWG Executive Sponsors will be established to oversee the workgroup progress, provide assistance if needed, and serve as liaisons between the larger Transformation Workgroup and the implementation workgroups. He asked members to let him know if they would like to be an Executive Sponsor.

Dr. Ganju presented the proposed charges for each of the implementation workgroups (Adults, Children / Adolescents, Data Coordination and Technology, Workforce Development, Housing, Consumer / Family Member, and Returning Veterans and Families).

The next TWG meeting will be held on Wednesday, December 6, 2006.

Texas Mental Health Transformation Workgroup Meeting – November 3, 2006
Meeting Minutes

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 Workgroup (TWG), called the meeting to order at 2:15 p.m. and welcomed agency directors and representatives who constitute the membership of the Transformation Workgroup. Dr. Wanser called for the approval of the minutes from the October 16, 2006 meeting, which were approved unanimously with recommended changes.

II. Project Director Updates

a. Senate Report

Dr. Vijay Ganju thanked the group for providing content and feedback on the report. The major focus of the report is the set of seven policy initiatives to move forward with transformation.

Dee Wilson recommended that part of the process should be to identify each agency's barriers on these initiatives.

b. Justice and MH Collaboration Grant Initiative

Dr. Wanser talked about a current grant opportunity (about $250,000) that looks at the intersection between juvenile justice and mental health, which is instructive to our transformation work. He has had a meeting with TYC and Juvenile Probation Commission about how to approach this grant application, which is due on December 12, 2006. The population that they looked at was transition-age kids, those that are transitioning out of the justice system into the community. What do we know about these kids within our respective data systems? One example of information we do not have because of constraints with looking across data systems and agencies: we know their diagnosis when they go into TYC, but we don't know their diagnosis when they leave the system. For the grant application, they will be looking at data enhancements, financing strategies, and appropriate types of interventions for this population. If we do a pilot, we will need to look at the rural phenomenon. Dr. Wanser may be asking TWG members for assistance with this grant.

c. Community Collaboratives

Dr. Ganju provided the group an update on community collaboratives. An RFA (Request for Application) will be sent out to all 254 county judges by early December. Submitted applications will be reviewed by a TWG committee, which includes Heidi McConnell (Chair), 2 TWG state agency members, 2 TWG consumers / family members, Camille Miller, and Vijay Ganju. Proposed selection criteria will include the level of participation, commitment / resources, history / experience, proposed transformation initiatives, and relationship of transformation initiatives to other TWG priorities.

Camille Miller provided additional information about the purpose and process of community collaboratives. Health care issues are primarily local in nature and collaboratives are established in individual communities to address those local issues. The Institute has extensive experience with working with and facilitating collaboratives, and will be working to include different personalities and strategies in order to consider all perspectives, similar to the jury system.

Erin Ferris suggested recognizing or including communities that: 1) are doing a great job already; 2) do not yet have specific ideas or plans but are interested in doing the work; and 3) do not know what services or challenges they have but are motivated.

Stephany Bryan mentioned that with the different SAMHSA-funded initiatives across the U.S., some do not want to address the community collaborative opportunity and there are some that do include collaboratives focused on children.

III. Consumer Voice Report

Valarie Garza reported to the group that she will be representing consumers and family members at the National Grantee Committee meeting in Washington, D.C.

Ms. Garza also reported that she and Erin Ferris are working together to pull more detailed data on housing issues that consumers have raised.

IV. Report on Exceptional Items

a. Budget Appropriations

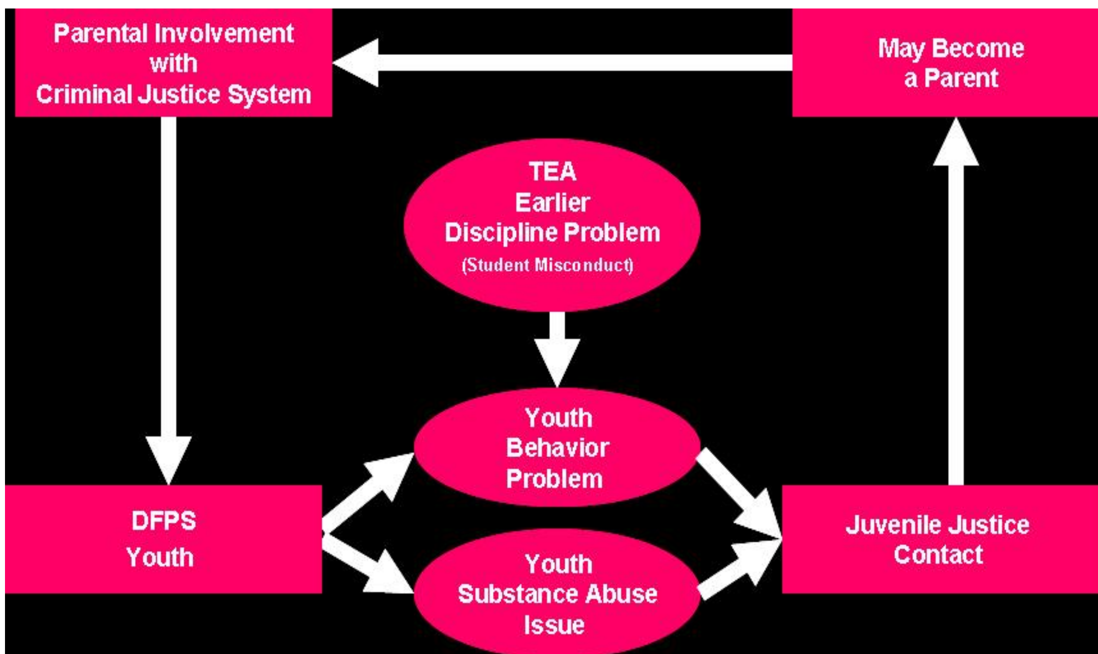
Sue Milam reported on things they are asking for – parenting education, drug treatment, and other support services. She said they are asking for 10% increase over what they had before.

Dr. Wanser asked Richard Poe if there are any mental health programs in schools, and if so, how they are funded? Mr. Poe said that most projects are pilots that are grant funded; there are no official mental health programs in the schools. The federal government pays for special education, so it's not state money.

b. Children's MH Initiatives

Dr. Wanser gave a presentation on the Legislative Appropriation Request (LAR) for children's mental health services for FY2008 – 2009. In total, we are asking for $155 million for the biennium, which would serve about 51,588 children. Not including Crisis Service Redesign, about 2.9% of children in need of mental health services would be funded by these appropriation requests, assuming an estimated 780,000 children with mental illness in Texas. What we don't know is the amount of resources spent on children's mental health represented by the member agencies here and its associated percentage of the total need.

The youth with some of the risk factors identified in the presentation (earlier discipline problem, behavior problems in school, substance abuse issue) often have some juvenile justice involvement. Those same kids may repeat the same cycle if they become parents. Early intervention, if done well, can interrupt this multi-generational cycle:



Dr. Wanser recommended that a data map be set up. Once a year, run reports with information about cross-agency involvement to better understand links, risk indicators, and child outcomes. Use that data to identify intervention points and predict places we can better invest resources. Dr. Wanser reinforced the need for a more strategic approach with data, financing strategies, and community collaboratives.

Allyson Brandt recommended that the VA be included in the "Vicious Cycle" map.

Richard Poe suggested that domestic violence be included as a risk factor in the "Vicious Cycle" map.

Dr. Wanser posed a question to the group: since we know that early intervention is an appropriate strategy, what are some ways that we can share data across agencies, make everyone aware of that information so we can begin to "connect the dots", and get the Evaluation Team involved so they can look at "before and after Transformation"?

James Cooley recommended that performance standards will need to be developed. After first identifying the populations, we would then need to track interventions, results, and links to other systems. Compare populations that received interventions with those that did not – what combination of interventions produced the best results? From a legislative perspective, they will want to see that something has improved.

Dr. Wanser brought up a question that is sometimes posed regarding measuring success: "What about the people we're not serving?" We now know who those people are and should also include them as a population group in our measurements.

Sue Milam talked about a program in Dallas that is partially funded by DFPS (somewhat like the "Healthy Families" program in Hawaii), which identifies pregnant women at risk and assigns a nurse to that woman / child for 2.5 years. Very good outcomes have been shown with this program over time, since it is less resource intensive than not intervening. Efforts are underway to get state-wide funding to expand this. Among other things, they teach the parents how to get the services that they need. This is a good example of a program that starts at the beginning of a cycle with early intervention. James Cooley said that the ROI information on this program is impressive.

Telemedicine

Based on the group discussion around data coordination, Theresa Cruz mentioned that a lot of her areas are rural and it's a challenge for them to get healthcare. We need to be able to identify the rural constituency better and include them in the data.

Dee Wilson asked if there are any LAR's asking for telemedicine or telepsychiatry to address these rural issues? She also asked if the state of Texas knows the baseline level and availability of telemedicine offerings? Different agencies have different programs, but are the data coordinated into a baseline?

James Cooley talked about an option being considered by the state – to make interpreters available via webcam or videoconferencing to rural areas, since the state is paying for interpreter services anyway.

Allyson Brandt mentioned a program that the VA is looking into – remote treatment for PTSD.

Theresa Cruz added that the cost in rural areas is prohibitive, even for telemedicine. Even though grants are usually available to set it up, the ongoing maintenance is expensive also.

Dee Wilson told the group that the state has funded some of these programs (jails, etc.). But, they don't know the baseline.

James Cooley mentioned a legislative proposal under consideration which would allow attorneys ad litem to meet with youth in rural areas via videoconferencing.

Dave Wanser mentioned that several agencies (TYC, state hospitals, some MHMR centers, DSHS, and others) already have videoconferencing systems. If the systems are already set up and working, then we'd only need to spend money on maintenance, and equipment for the organizations that don't have it. We would need to look at the compatibility of the different systems and possibly set a data standard.

Erin Ferris asked about best practices and how that information is shared with others, so the entire state can benefit from it. She suggested that the appropriate implementation workgroup

visit the community, review the best practice, and bring that information back. Dr. Wanser agreed and stated that sharing this type of information is something that Dr. Ganju is looking into with the project.

Mike Halligan raised a concern about using telemedicine for trauma issues. Those matters are very personal, so it's difficult to talk about them through a TV screen or camera. He doesn't recommend using it for trauma.

Dr. Wanser suggested an option of learning from the VA's experience, because they have been exploring telemedicine.

Valarie Garza noted that telepsychiatry may be a necessity in rural areas now, but we should consider it as a temporary solution until services are brought to those areas. Also, she recommends using it for follow up appointments, not initial ones. Ms. Garza raised the issue of telemedicine quality assessment for the group to consider as potential programs are developed.

Dr. Wanser talked about some of the successes that community MHMR centers have had with telemedicine. It has worked well with kids because they feel comfortable with a TV. It has also worked well in substance abuse situations because the person feels more comfortable, since there is not a person sitting right next to them. It provides a sense of privacy.

Richard Poe said that TEA uses video conferencing a significant amount, with students and staff.

James Cooley mentioned that telemedicine is beneficial for providers, not just for clients. Some states have implemented pilot programs using telemedicine in rural ER's to access experts in other regions; ER nurses love the program and turnover rates have dropped in the areas that have started using this. It could be used as an advisor service, meeting with a peer who has expertise in a particular area.

V. Workgroup Charges

Dr. Ganju stated that TWG Executive Sponsors will be established to oversee the workgroup progress, provide assistance if needed, and be liaisons between the larger Transformation Workgroup and the implementation workgroups. He asked members to let him know if they would like to be an Executive Sponsor. Dr. Ganju presented the proposed charges for each of the implementation workgroups:

a. Adult Workgroup

- Explore opportunities for increasing employment opportunities, incentives and supports for persons with mental illness across agencies.
- Identify evidence-based practices for adults used by TWG agencies and develop a coordinated, uniform approach to their delivery.
- Explore implementation of evidence-based practices for older adults requiring behavioral health services through both state-level and local initiatives.

Mike Halligan recommended as these strategies are worked on, that this workgroup focus on individual development for consumers. Sue Milam suggested that financing mechanism be added as a strategy.

b. Children and Adolescents Workgroup

- Assess the current situation in Texas on the availability, linkages with the community, and financing for school-based mental health services.
- Build on current initiatives related to early childhood intervention, SAMHSA–supported Systems of Care projects, and the Texas Integrated Funding Initiatives related to the objective of building a population-based, early intervention approach for children/adolescents.
- Identify evidence-based practices for children and adolescents used by TWG agencies and develop a coordinated, uniform approach to their delivery.
- Support TWG initiatives related to community collaboratives and returning veterans and their families.

Stephany Bryan recommended that this workgroup consider compiling a list of all evidence-based practices that agencies have information on, including those that are not currently being used.

c. Data Coordination and Technology Workgroup

- Build on existing data coordination projects across a broader range of agencies to obtain a better picture of client flow and service use.
- Develop recommendations for the behavioral health components of EHR initiatives.
- Propose initiatives related to telemedicine and new technologies to enhance service delivery and coordination.
- Develop common metrics and outcomes measures related to behavioral health interventions for state agencies which provide behavioral health services.

James Cooley talked about some current data legislation that focuses on establishing a state agency data sharing policy.

Sue Milam mentioned that as this work continues, we will need to address any HIPAA issues or concerns.

d. Workforce Development Workgroup

- Develop collaborations with universities and community colleges.
- Work with licensing/credentialing bodies and Texas Higher Education Coordinating Council to address curriculum requirements.
- Facilitate the credentialing and employment of consumers and family members in the workforce.
- Address rural workforce development needs through the use of telehealth and other technologies.

e. Housing Workgroup

- Evaluate the overall perspective of consumers, including children and adults, to determine what programs are serving the greatest number with the greatest need.

- Work to establish a better understanding of crisis housing that exists, and how it can be modified to work more closely with treatment phases.
- Increase collaboration among all state and local agencies so that consumers will not find a "wrong door" as they seek out care and services.
- Discourage the segregation or alienation of persons with mental health needs and their families by evaluating housing situations with the hopes of creating peer support and awareness through the community.

f. Consumer / Family Member Initiative

- Build a recovery culture through education and networking initiatives at the state and local levels.
- Build improved education, networking and information exchange opportunities for consumers, family members and their organizations.
- Initiate a state-level effort to implement peer support programs across the state.
- Explore partnership models with consumers and family members at state and local levels.

g. Returning Veterans and Families Initiative

- Develop a collaborative initiative among the Veteran's Health Administration, the Texas Veteran's Commission, the Department of State Health Services, and other agencies with the objective of early detection and intervention for returning veterans and their families. This could involve the development of appropriate screening instruments; coordination among several state agencies; and transfer of technology initiatives from the VA to the state agencies.

VI. Next Steps

The next TWG meeting will be held on December 6, 2006.