FY 2025 EXECUTIVE SUMMARY

External Evaluation of the Texas Child Mental Health Care Consortium

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The FY 2025 External Evaluation report describes evaluation findings from two programs established by the 86th Texas Legislature under the Texas Child Mental Health Care Consortium (TCMHCC), designed to expand access to child and adolescent mental health services in Texas:

- **Texas Child Access Through Telemedicine (TCHATT)** – School-based telepsychiatry services for students
- **Texas Child Psychiatry Access Network (CPAN)** – Consultation support for primary care providers treating pediatric mental health

Together, these programs aim to increase access to mental health services through coordinated implementation across 12 higher education health-related institutions (HRIs).

TCMHCC Health-Related Institutions

BCM | Baylor College of Medicine
TAMUHSU | Texas A&M University System Health Science Center
TTUHSC | Texas Tech University Health Sciences Center
TTUHSC-EP | Texas Tech University Health Sciences Center at El Paso
UNTHSC | University of North Texas Health Science Center Fort Worth
UT Dell | The Dell Medical School at the University of Texas at Austin
UTHSCH | The University of Health Science Center at Houston
UTHSCSA | The University of Health Science Center at San Antonio
UTHSCT | The University of Texas Health Science Center at Tyler
UTMB | The University of Texas Medical Branch at Galveston
UTRGV | The University of Texas Rio Grande Valley School of Medicine
UTSW | The University of Texas Southwestern Medical Center

During FY 2025, **360 stakeholders** participated in the evaluation through surveys (quantitative and qualitative open-ended questions) and in-depth qualitative interviews:

- **TCHATT:** 137 school staff who used TCHATT in the past year and 24 HRI staff supporting TCHATT implementation
- **CPAN:** 109 providers who used CPAN in the past year, 73 providers who received direct patient consultations, and 21 HRI staff supporting CPAN implementation

The sections that follow summarize key findings for each program, highlighting strengths and implementation challenges that shape stakeholder experiences.

TCHATT Program Findings

TCHATT School Staff Survey

The FY 2025 TCHATT School Staff Survey examined school staff experiences with program use, implementation supports, training, and satisfaction among schools that had used TCHATT in the past year. A total of 137 school staff participated, with most respondents serving in

student support roles—primarily counselors—and reporting high levels of involvement in TCHATT implementation. Almost all (98%) had been implementing TCHATT for at least six months.

Key findings include:

- **Perceived student outcomes:** School staff most often reported stable or improved student outcomes following TCHATT services. Improvements were most commonly noted for behavioral incidents (45% reported decreases) and grades (38% reported better grades). Fewer than 2% of respondents reported negative outcomes.
- **Perceived impact on school capacity:** School staff reported that TCHATT expands access to mental health services not otherwise available through school counselors and supports schools in addressing high levels of student need. About half of respondents reported that over one-quarter of students required counseling or other non-academic supports, underscoring the program's role in filling critical service gaps.
- **Program satisfaction and continued use:** Satisfaction with TCHATT was high across program components, with 85% of school staff satisfied with service quality and 84% satisfied with student referral processing time. Nearly all respondents indicated strong program endorsement, with 92% reporting they would recommend TCHATT to other schools and 97% intending to continue use.
- **Program prioritization and leadership support:** TCHATT was viewed as a priority at multiple levels, with 79% reporting it as a personal priority, 71% as a priority for their school, and 69% as a priority for their district. In addition, 91% indicated that school leadership supports TCHATT implementation.
- **Program champions:** Most respondents (81%) reported having a TCHATT champion at their school; however, fewer (67%) identified an influential individual who actively and consistently promotes TCHATT.
- **Implementation experiences:** School staff reported high participation in core referral and service delivery activities, including identifying students for TCHATT, coordinating referrals, and supporting on-campus service delivery. Participation in training and engagement activities—such as receiving ongoing information from HRIs and discussing TCHATT during staff meetings—was less consistent.
- **Barriers and challenges:** School staff cited limitations of the telehealth model for some students, mental health stigma, and challenges with family access and engagement, including limited internet access and lack of parental interest. School-based logistical constraints—such as students missing class, limited space, and insufficient staff capacity to support participation—were also reported by many respondents.
- **Communication and implementation support opportunities:** Although satisfaction with communication, training, and engagement with HRIs was generally high (approximately three-quarters satisfied), some school staff expressed a need for clearer and more consistent information related to referral status, student progress, and next steps for continued care and family engagement.

TCHATT HRI Staff Interviews

The FY 2025 evaluation included 24 interviews with TCHATT implementation staff across all HRIs to understand operational practices, district engagement strategies, and experiences delivering services within schools. Findings highlight common themes across HRIs, as well as challenges and facilitators shaping implementation.

Key findings include:

- **Staffing and internal communication:** HRIs described broad, multi-functional staff roles spanning outreach, intake, coordination, and clinical care, supported by strong internal communication through regular team meetings and real-time collaboration across clinical and administrative staff.
- **District recruitment:** HRIs emphasized that relationship-driven outreach—through partnerships with the Texas Education Agency (TEA) and Education Service Centers (ESCs), in-person meetings, and community-centered engagement—was most effective for recruiting schools and districts. At the same time, limited school capacity, staff turnover, non-responsiveness, and community mistrust (particularly in rural areas) created persistent recruitment challenges.
- **Onboarding and training:** Successful onboarding was driven by strong relationship-building, clear communication, flexibility in adapting to district needs, and the presence of school staff who could champion the program. Key challenges included limited school capacity, frequent staff turnover requiring retraining, lengthy MOU processes, competing demands on counselors, and variability in district processes.
- **School engagement:** School engagement was essential for sustaining TCHATT implementation. Strong relationships, regular check-ins, tailored communication, and in-person presence at school and community events supported ongoing participation. Challenges such as limited school capacity, staff turnover, and competing priorities highlighted the need for flexible, low-burden engagement strategies and sustained communication.
- **Parental consent and family engagement:** Strong caregiver participation was described as essential to successful treatment and continuity of care. Effective engagement was supported by timely outreach, dedicated enrollment staff, clear communication about confidentiality, flexible digital consent options, and multiple communication channels. Challenges—including difficulty reaching caregivers, lengthy paperwork, technology barriers, stigma, and inconsistent follow-through—highlight the need for streamlined consent workflows and ongoing support to maintain family engagement.
- **Service delivery and quality of care:** Strong staffing models, supportive workplace culture with regular supervision, parental involvement in intake appointments, and flexible scheduling (including extended hours) supported quality care delivery. Strong Local Mental Health Authority (LMHA) relationships facilitated warm handoffs to additional services. Challenges included varying family readiness to engage, referral mismatches when student needs exceeded TCHATT's scope, and high communication demands for coordinating across multiple partners.

- **Data utilization:** Data has become central to guiding TCHATT operations, supporting referral tracking, parental engagement monitoring, workflow refinement, and strategic outreach. Many HRIs supplement Trayt with additional systems to enable real-time monitoring and quality improvement. Continued investment in improving and simplifying data systems, strengthening analytic support, and clarifying metric definitions will be essential to fully leverage data for quality improvement and accountability.
- **Cross-HRI collaboration:** Strong collaboration among HRIs was described as a defining strength of TCHATT, supported by engaged leadership, active peer networks, and regular opportunities for shared problem-solving. While geographic, staffing, and institutional differences limit full standardization, HRIs emphasized that continued investment in collaborative structures, onboarding support, and system improvements is essential to sustaining program quality statewide.

TCHATT Conclusions

Findings from the FY 2025 evaluation indicate that TCHATT is viewed by school staff and implementation partners as a valuable program for expanding access to student mental health services. School staff reported high satisfaction with services and generally perceived student outcomes as stable or improved. Implementation experiences across regions highlight that program effectiveness is shaped less by program design than by school capacity, family engagement, and perceptions related to telehealth and mental health stigma. These findings underscore the importance of supporting schools' implementation capacity, reducing family-level access barriers, and clearly communicating the benefits and fit of TCHATT for students and families.

TCHATT Priority Recommendations

To strengthen access to services and effective use of TCHATT across schools, the following priorities are recommended:

- **Support schools in addressing capacity and logistical constraints that affect service delivery**, including space availability, scheduling, and coordination processes, to reduce implementation burden and improve referral flow.
- **Reduce family-level access barriers by strengthening navigation and support for required forms and consent processes**, including targeted assistance for families facing language, technology, or time constraints.
- **Increase visibility of TCHATT's benefits and relative advantages for students, families, and school staff**, with clear messaging that address concerns about telehealth effectiveness, mental health stigma, and perceived disruption to the school day.

CPAN Program Findings

CPAN Provider Survey

The FY 2025 CPAN Provider Survey examined provider experiences with program use, implementation supports, training, and satisfaction among primary care providers who had used CPAN in the past year. A total of 109 providers participated, representing a range of clinical settings and experience levels across the 12 HRIs.

Key findings include:

- **CPAN use:** Providers with 20 or more years in practice were more likely to report calling CPAN occasionally, whereas providers with less than 10 years in practice were more likely to be regular CPAN users.
- **CPAN organizational factors affecting implementation:** Most organizational motivation factors for using CPAN were rated highly by respondents, especially those related to: Compatibility (how well CPAN fits with clinic needs); Observability (visibility of positive outcomes from using CPAN); and low complexity (ease of use).
- **CPAN as a priority resource:** Most respondents personally considered CPAN a priority for themselves. However, fewer respondents viewed CPAN as a priority for their clinic as a whole.
- **Program champion:** Half (52%) of clinics report having a CPAN "champion" who serves as an influential staff member actively promoting CPAN. Less than 30% have someone within clinics who takes a lead role in ensuring CPAN is used.
- **Implementation climate:** Most clinics (~73%) have the infrastructure needed to support CPAN (e.g., time, space, privacy, staffing). Leadership endorsement is strong (75% agreed their clinic leadership supports CPAN implementation).
- **Interorganizational relationships:** Fewer than half of respondents feel they can reliably get support from their CPAN HRI when needed. Only 48% agree they can problem-solve with the CPAN HRI, and 57% feel supported by colleagues within their clinic, indicating potential for improvements through strategies to boost organizational support for the program
- **Enrollment and training activities:** Most providers received basic information about CPAN during enrollment (85% received instructions on calling in; 83% received service info). Just 26% attended CPAN training, but among those, 75% found it "very" or "extremely" helpful.
- **Implementation support, consultation, and child assessment & ongoing care:** Most providers received brochures or other information (71%) and an introduction to CPAN services (78%). Over 70% received educational materials from CPAN on mental health conditions. Almost half (44%) have participated in CME activities, and 34% have attended CPAN discussions in clinic meetings. The majority (80–90%) use CPAN for psychiatric consults and referrals, and most (90%) follow recommendations provided by the psychiatrist. Almost 90% of providers reported using recommendations and education material from prior consultations to inform care for subsequent patients.

CPAN Direct Patient Consultation Survey

The FY 2025 External Evaluation assessed provider experiences with the CPAN Direct Consultation service to understand satisfaction, usability, perceived clinical impact, and opportunities to strengthen service delivery. A total of 73 providers who had completed at least one direct patient consultation participated in the survey. Respondents represented a range of clinical settings and HRIs, with most respondents (68.6%) experienced pediatricians who had been in practice for over a decade (median = 13 years).

Key findings include:

- **Use of the Direct Consultation service:** Providers most often used the service for medication management (96%), diagnostic clarification (78%), and support with complex clinical presentations.
- **Satisfaction and acceptability:** Providers reported very high satisfaction with the Direct Consultation service. Nearly all (over 95%) agreed that it meets a clinical need, is easy to use, and that they intend to use it again. Communication with consulting psychiatrists was consistently described as timely, clear, and responsive to their needs, with over 95% expressing satisfaction.
- **Perceived impact on clinical care:** Over 95% of providers reported that direct patient consultations improved diagnostic clarity, helped clarify next steps for treatment, and increased their confidence in managing pediatric mental health concerns. Most (86%) also indicated that the Direct Consultation reduced the need for immediate specialty referrals.
- **Provider knowledge, skills, and confidence:** Nearly all providers (99%) reported increases in their mental health knowledge, skills, and confidence following direct patient consultations. Roughly half noted substantial gains across these areas, and most others reported moderate improvement.
- **Perceived patient and family experience:** Providers perceived patients and families as generally satisfied with the Direct Consultation experience, with over 85% reporting they were very or somewhat satisfied.
- **Follow-up consultation:** Most respondents received a follow-up consultation, and nearly all who did reported it to be very or somewhat helpful (98%) for reinforcing recommendations and ensuring clarity on next steps.
- **Barriers and challenges:** Providers noted coordination and scheduling difficulties, including finding time for the consult (44%), caregiver non-response (39%), and delays in HRI scheduling (22%). Some also reported uncertainty about how the direct consultation process works (19%).
- **Benefits:** Providers emphasized improved access to psychiatric expertise, timeliness of support, increased confidence in managing complex cases, and meaningful assistance in clinics lacking on-site behavioral health resources.
- **Opportunities for improvement:** Providers recommended clearer and more consistent post-consult documentation, streamlined scheduling processes, clearer communication

and follow-up procedures, and stronger linkage to community-based resources to support continuity of care.

CPAN HRI Staff Interviews

The FY 2025 evaluation included interviews with CPAN implementation staff (n=21) across all 12 HRIs to understand operational practices, provider recruitment and engagement strategies, and experiences delivering consultation and referral services. Findings highlight common themes across HRIs, as well as challenges and facilitators shaping implementation.

Key findings include:

- **Staffing and internal communication:** HRIs described multi-functional staff roles spanning recruitment, consultation delivery, referral coordination, and provider support, led by medical directors who balanced strategic oversight with direct clinical involvement. Strong internal communication through daily huddles, regular team meetings, and shared digital platforms supported seamless operations and consistent provider experiences across diverse regions.
- **Provider recruitment and enrollment:** HRIs emphasized that relationship-driven outreach—through in-person clinic visits, partnerships with TCHATT, targeted engagement in high-need areas, and physician-to-physician connection—was most effective for recruiting providers. Cold calls, faxes, and impersonal communications consistently yielded minimal results. Key barriers included gatekeeping by front-desk staff, scheduling constraints, provider misconceptions about CPAN's consultative role, and limited local resources in rural areas.
- **Onboarding and training:** Successful onboarding was driven by clear initial orientations co-led by program staff and psychiatrists, welcome packets with concise reference materials, and early-call coaching that modeled CPAN's consultation process. Training was continuous, reinforced through in-person provider meetings, residency orientations, data-informed follow-up with inactive clinics, and brief refreshers. Challenges included information overload at sign-up, scheduling constraints, enrolled-but-inactive providers, and role misunderstandings about CPAN's scope.
- **Sustaining provider engagement:** Provider engagement required ongoing relationship management through structured follow-up triggered by utilization data, educational activities including CME sessions and residency orientations, cultivation of super-users who championed the program, and tailored communication matched to clinic and provider preferences. The first consultation experience was consistently identified as the "make-or-break moment" for sustained engagement, with timely, supportive, clinically useful responses driving repeat use and peer referrals.
- **Service delivery and quality of care:** Strong triage by behavioral health specialists, warm handoffs to psychiatrists, and carefully vetted referrals supported quality care delivery. Consultations served a dual role of addressing immediate clinical needs and building long-term provider capacity through education and coaching. Challenges included incomplete patient information limiting consultation quality, geographic gaps

and insurance restrictions affecting referral options, and provider resistance to psychiatric input when seeking only resource lists.

- **Data utilization:** Trayt was essential for tracking call volumes, response times, and provider engagement, supporting quality improvement through proactive outreach to inactive providers and recognition of super-users. While valued for accountability and operational monitoring, staff described limitations including cumbersome filtering, manual workarounds, fragmented data for patients with multiple visits, and inadequate fields for key details. Enhanced reporting functionality and better integration with clinical workflows would strengthen data-driven improvements.
- **Cross-HRI collaboration:** Strong collaboration among HRIs was described as a defining strength of CPAN, supported by engaged leadership, statewide coordinator and psychiatry peer group meetings, and a culture of open knowledge sharing. Best practices spread organically through peer exchanges, including strategies for proactive direct consults, creative engagement approaches, and streamlined onboarding materials. While some felt statewide convenings could be more substantive and include more candid problem-solving, the collaborative spirit has reinforced CPAN's identity as a unified network rather than isolated programs.

CPAN Conclusions

Findings from the FY 2025 evaluation indicate that CPAN continues to play a critical role in supporting pediatric primary care providers' capacity to address child and adolescent mental health needs. Providers reported high satisfaction with CPAN services, strong perceived value of both provider-to-provider consultation and direct patient consultations, and widespread intent to continue using and recommending the program. Direct patient consultations were viewed as timely and clinically useful, particularly for patients with complex needs, reinforcing CPAN's role in expanding access to specialty mental health expertise.

At the same time, implementation experiences across data sources suggest that CPAN's reach and consistent use are influenced by variation in provider awareness, onboarding experiences, and patterns of engagement over time. Specific challenges noted in the provider survey findings include a lack of program champions across all sites, limited interorganizational collaboration, and gaps in training/materials. HRI interviews highlighted the importance of relationship-driven outreach and the challenges of sustaining engagement among lower-utilization or newer providers, particularly amid competing demands and administrative burden. Together, these findings suggest that sustaining CPAN's impact will depend on continued efforts to strengthen provider onboarding and training, reinforce CPAN's relative advantages, and support consistent integration of CPAN services into routine clinical workflows.

CPAN Priority Recommendations

To support sustained provider engagement and effective use of CPAN services, the following priorities are recommended:

- **Strengthen and standardize provider onboarding and ongoing training**, with targeted strategies for newer providers and lower-utilization clinics to ensure awareness, confidence, and appropriate use of CPAN consultation pathways.

- **Leverage CPAN's demonstrated value and high provider satisfaction to reinforce its relative advantages**, including timely access to psychiatric expertise and support for complex cases, through peer champions and relationship-based outreach.
- **Reduce administrative and workflow-related barriers to engagement by supporting integration of CPAN services into routine clinical practice**, such as clarifying consultation pathways, aligning CPAN use with existing clinical workflows, and identifying clinic-level champions who can reinforce use and normalize CPAN as part of standard care.

Limitations

The findings in this report should be interpreted with several limitations. Survey response rates were modest, and although each HRI was represented, participation levels varied, which may limit generalizability. Participation bias may also have influenced who chose to participate, with individuals who held stronger opinions or more direct experience with the programs potentially more likely to respond. All data were self-reported, which may introduce recall challenges, differences in interpretation, or social desirability bias. In addition, not all respondents completed every item, resulting in variable sample sizes across analyses.

Qualitative findings from TCHATT and CPAN HRI interviews represent the experiences of selected staff and may reflect local context rather than statewide consensus. Although analyses were conducted using structured coding frameworks and dual-analyst review to promote consistency, interpretation remains inherently subjective. Despite these limitations, the multi-method approach combining quantitative surveys with qualitative interviews across multiple stakeholder groups provides valuable insights into program implementation and experiences. Consistent themes across data sources and HRIs strengthen confidence in the overall patterns identified.