YEAR 2 REPORT | 2022

External Evaluation of the Texas Child Mental Health Care Consortium

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CONTENTS

EXECUTIVE SUMMARY

CPAN Survey with Enrolled Providers

- Year 2 implementation surveys were obtained from a diverse cross-sectional sample of providers (n=97), comprising those who used CPAN services (n=74) and those who did not use CPAN services (n=23).

- 40% of providers were pediatricians, while 12% were family physicians. Pediatricians were more likely than family physicians to use CPAN services (56% vs. 11.9%).

- Of the 24 providers who had not utilized CPAN services, 19 (80%) reported that they planned to use CPAN services sometime in the future.

- More than half (58.3%) of the providers who did not utilize CPAN reported that they had sufficient in-house resources or capacity to provide mental health services.

- We compared providers who were regular users of CPAN services to providers who were occasional users of CPAN services on a variety of clinic-related readiness factors.

    - Regular CPAN users consistently reported more favorable scores among motivation subcomponents (e.g., relative advantage, priority) compared to occasional CPAN users.

    - Regular users of CPAN also had higher scores than occasional users on two other factors related to organizational capacity, including innovation-specific knowledge and skills (degree to which there is enough knowledge and skills in the organization to use CPAN), and presence of program champions (if there as an important person(s) in the organization that supports CPAN).

- The most common reason for calling CPAN is medication management (82.2%), followed by requests for referral assistance (61.6%).

- There is high buy-in for CPAN services among those that have used CPAN services. More than 70% of providers that utilized CPAN reported that their knowledge, skills, and confidence to provide mental health care increased moderately or very much due to CPAN. A majority (>90%) reported an intention to use CPAN again in the next six months and would recommend CPAN to other providers.

- Majority of providers reported that accessibility of consultation services, information, and resources to help address the pediatric mental health needs of their patients was the greatest benefit of CPAN.

- The most frequently mentioned areas for improvement include improved outreach and awareness of CPAN, more implementation support and training on the program, and improved connections to community resources and referrals.

TCHATT Survey with School Staff

- Year 2 implementation surveys were obtained from a diverse cross-sectional sample of school staff who implemented TCHATT (n=197)

- 84% of survey respondents were counselors; 75% of survey respondents reported that they were the person who implemented TCHATT at their school campus or district.
- Approximately 60% of respondents reported that more than 1 in 4 students in their campus population had a need for non-educational supports (e.g., meals, clothing) and needs related to counseling or behavioral therapy.
- 70% of campuses reported that at least half of parents/guardians had consented to obtain TCHATT services for their child when TCHATT services were offered.
- We compared campus characteristics and factors associated with TCHATT implementation among school staff who reported full and systematic implementation of TCHATT and school staff who reported inconsistent implementation of TCHATT.
    - Compared to campuses with inconsistent implementation, campuses with full implementation have:
        - a higher percentage of students with needs for non-educational supports (e.g., meals, clothing) and counseling or behavioral therapy;
        - another school/district MOU to provide mental health services to students (besides TCHATT);
        - a higher percentage of parental consent to receive TCHATT services for their child.
    - Compared to school staff who reported inconsistent implementation, school staff who reported full implementation had higher scores in all motivation subcomponents (e.g., relative advantage, priority) of program readiness.
- We compared campus characteristics among school staff who reported high (≥50%) parental consent for TCHATT services for their child and school staff who reported low (<50%) parental consent for TCHATT services for their child (when child was referred to TCHATT).
    - Lower (<50%) perceived parental consent for TCHATT services was reported among school staff from:
        - smaller campuses (less than 500 students);
        - campuses located in metro areas;
        - campuses with a higher percentage of economically disadvantaged students;
        - campuses with a higher percentage of students with needs for counseling and more staff time spent addressing behavioral problems.
    - In general, school staff perception of student needs for non-educational supports (e.g., meals, clothing) and school staff time spent addressing non-educational needs was not differential by parental consent.
- When parents refuse TCHATT services (when offered), only 50% of respondents reported that their staff often or sometimes asked parents if they are willing to talk to someone at the HRI or consider TCHATT in the future.

- 70% of respondents reported that their school often or sometimes received training to implement TCHATT, while 80% reported ongoing information from the HRI to support TCHATT implementation.

- 48-64% of respondents indicated that because of TCHATT, students had decreased behavioral incidents, and better attendance and grades at school.

- 79% of respondents reported accessibility of care for underserved students in need was the greatest benefit of the TCHATT program.

- The most frequently mentioned areas of improvement included the desire for an enhanced implementation process, better communication and follow-up, more training on campus, more flexibility in scheduling students, and additional sessions for students.

CPWE Qualitative Interviews with Fellows

- 11 CPWE trainees (6 residents and 5 fellows) representing 10 different HRIs were interviewed.

- Residents and fellows reported different experiences during their CPWE training; particularly with their time spent at their CPWE placement sites and in-person vs. virtual treatment of patients.

- The CPWE training did not impact trainees' future career plans directly, but generally contributed positively to reaffirming career decisions or expanding their thinking about career options.

- The CPWE program offered exposure to diverse patient populations that helped build trainees' capacity and prepare them for cross-cultural interactions and culturally responsive mental health care.

- Overall, the majority of trainees were highly satisfied with their CPWE training experience. Exposure to diverse patients in community settings and effective supervision were identified as the greatest strengths of the CPWE training program.

- Complexity in treating patients, limited resources, and telehealth were seen as the biggest challenges experienced by residents, while time constraints was the biggest challenge among fellows.

- Areas for quality improvements recommended by trainees included: stronger support and resources, more in-person patient visits, more learning opportunities to enhance understanding of the larger system of care, provide an orientation to the CPWE program, and increase time at rotations (for fellows).

INTRODUCTION

This Year 2 (September 2021-August 2022) Part 1 External Evaluation report presents implementation evaluation results for the Texas Child Mental Health Care Consortium (TCMHCC) funded by the 86th Texas Legislature in Senate Bill 11 to increase youth access to mental health services throughout Texas. TCMHCC comprises five initiatives, including three – the Child Psychiatry Access Network (CPAN), Texas Child Access through Telemedicine (TCHATT), and the Child Psychiatry Workforce Expansion (CPWE) – which are the focus of this external evaluation. The external evaluation was requested as part of this comprehensive effort and funded by the Texas Legislature.

TCMHCC leverages the expertise and capacity of the psychiatry departments affiliated with the health-related institutions (HRIs) of higher education to address the urgent mental health challenges and improve the mental health care system for children and adolescents in the state of Texas. Twelve HRIs act as hub teams and provide mental health consultation and referral services to clinics and providers enrolled in CPAN and provide direct mental health services (e.g., assessment and triage, brief interventions, and connection to community-based providers) to at-risk youth in schools enrolled in TCHATT across the state of Texas. This report focuses on statewide, as well as HRI-specific, CPAN and TCHATT program implementation questions (e.g., clinic and school user perceived benefits, barriers and facilitators to program engagement, and satisfaction with the program). Because Year 2 continued to represent an early phase of program implementation, in which HRI activities focused on delivering services as well as expanding their reach, these evaluation results are preliminary. In Year 2, program planners continued to refine processes for enrolling clinics and school districts, to provide training and identify best practices, and improve data management systems to facilitate implementation efficiencies and evaluation activities.

The Year 2 external evaluation report includes two parts**. Part 1** focuses on CPAN, TCHATT and CPWE program implementation and process evaluation results. **Part 2** focuses on CPAN and TCHATT program reach and service delivery (based on Trayt data), implementation costs, and preliminary cost-effectiveness results.

This **Year 2, Part 1 Report** presents the CPAN, TCHATT and CPWE implementation and process evaluation findings, including the following:

1) Ongoing CPAN and TCHATT implementation evaluation to:

    a. Examine contextual factors influencing the implementation of CPAN and TCHATT at the clinic and school level. Method: Self-administered surveys of providers and school staff enrolled in the programs;

    b. Examine CPAN and TCHATT users' perceived benefits, facilitators, challenges, and satisfaction with program implementation. Method: Self-administered surveys of providers and school staff enrolled in the programs.

2) CPWE qualitative evaluation to:

    a. Examine CPWE residents' and fellows' perceptions of their training experience, including satisfaction, perceived benefits and challenges, and impact on future career plans. Method: In-depth qualitative interviews with current CPWE residents and fellows.

Key Terms

This section provides definitions for tables and figures included in the report.

Metric Definitions for Tables and Figures:

- **HRI:** Health-related institution (HRI) responsible for providing CPAN and TCHATT services. The following acronyms are used in this report to reference the health-related institutions:
    - BCM: Baylor College of Medicine
    - TAMUHSC: Texas A&M University / Baylor Scott and White
    - TTUHSC: Texas Tech University Health Science Center
    - TTUHCSEP: Texas Tech University Health Science Center at El Paso
    - UNTHSC: University of North Texas Health Science Center at Fort Worth
    - UTDell: Dell Medical School at the University of Texas at Austin
    - UTHSCH: University of Texas Health Science Center at Houston
    - UTHSCSA: University of Texas Health Science Center at San Antonio
    - UTHSCT: University of Texas Health Science Center at Tyler
    - UTMB: University of Texas Medical Branch at Galveston
    - UTRGV: University of Texas Rio Grande Valley
    - UTSW: University of Texas Southwestern Medical Center

- **Childhood Opportunity Index 2.0 (COI):** This measure comprises 29 childhood indicators of health and economic outcomes across three domains (education, health and environment, social and economic). Detailed description of the COI 2.0 methodology is provided in the Child Opportunity Index 2.0: Technical Documentation. January 15, 2020. By Clemens Noelke, Nancy McArdle, Mikyung Baek, Nick Huntington, Rebecca Huber, Erin Hardy, Dolores Acevedo-Garcia Accessed at ddk_coi2.0_technical_documentation_20200212.pdf (diversitydatakids.org).

- **Rural-Urban Continuum Code (RUCC):** The Rural-Urban Continuum Codes are a classification schema developed by U.S. Department of Agriculture that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area. The codes provided in this report are based on 2013 RUCC codes, the most-recent version available. Counties are classified as follows: urban (RUCC 1-3), nonmetropolitan (RUCC 4-7), and non-metropolitan rural (RUCC 8-9).

CPAN-Specific Definitions for Tables and Figures:

- **Enrolled Clinic**: Any unique clinic identified in the Trayt Clinic Directory database with an “Active” account status and a “Signed” agreement status.

- **Enrolled Clinic Staff (Providers)**: Any provider or clinic staff with an “Active” or “Active-No clinic” clinic staff account status in the Trayt Clinic Directory database.

TCHATT-Specific Definitions for Tables and Figures:

- **Enrolled Campus:** Any campus in the internal evaluation team’s list of TEA campuses whose district has an “MOU in Place” status.

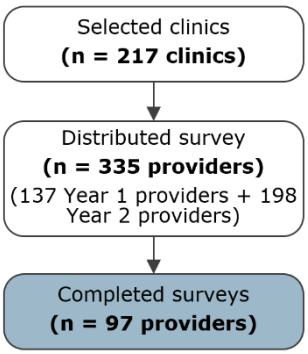
- **Student Referral:** Referral made by school TCHATT liaison to HRI.

CPAN PROVIDER SURVEY

Methods

Sample

Figure 1. CPAN Provider Survey Completion



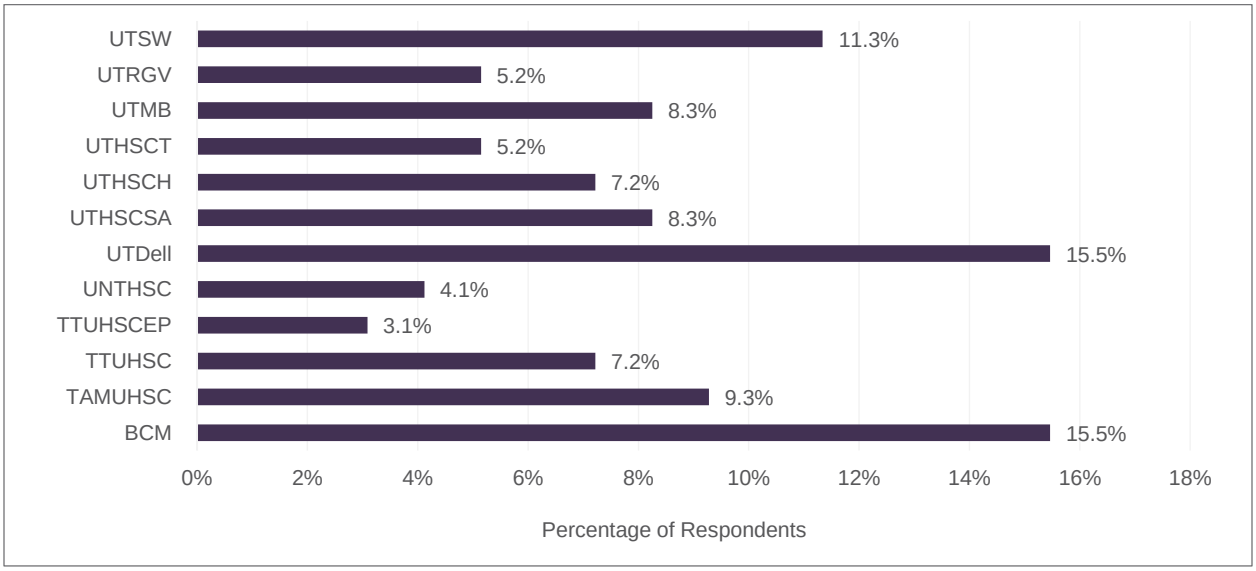
The Year 2 survey sampling was split between two stages: first, re-sampling clinics who completed the Year 1 survey; second, identifying a new sample of clinics enrolled in CPAN. Overall, our goal was to survey 100 clinics from the Year 1 pool and 100 new clinics. We identified a diverse sample of clinics across all 12 HRIs based on geographic (population density) and sociodemographic (social vulnerability) characteristics. Within selected clinics, we randomly selected up to two providers in order to include a cross-section of providers comprising those who used CPAN services and those who had not used CPAN services. The final sample for survey distribution included 137 providers from clinics who completed the Year 1 survey and 198 providers from new clinics (Figure 1).

Survey & Data Collection

The development of the CPAN provider survey was guided by the external evaluation logic models (updated at the beginning of Year 2), measures table, and Year 1 process mapping findings. The purpose of the survey was to assess provider-related factors influencing provider use of CPAN services, as well as organizational factors and processes affecting program adoption and implementation from clinic stakeholder perspectives. Surveys included closed-ended and open-ended questions.

In September 2022, we invited 335 providers to complete the Year 2 CPAN Provider Implementation Survey. After multiple outreach attempts, 97 providers across 88 clinics completed electronic surveys, for a survey response rate of 29%. All HRIs were represented among survey participants, but response rates varied widely across HRIs. The distribution of survey HRIs is provided in Figure 2 below.

Figure 2. Distribution of Survey Respondents Across HRI (n=97)



(a) Data Source: 2022 External Evaluation CPAN Provider Survey.

Quantitative Results

Descriptive Characteristics of Surveyed Providers

Table 1 presents demographic characteristics of providers who completed the survey. The majority of providers were female. About half (52%) identified as non-Hispanic White and approximately 17% Hispanic. More than half of the sample reported completing their professional training within the last 12 years. Physicians comprised three-fourths of the sample; slightly more than 40% reported their primary role as pediatrician. As described in the methods section above, we sampled to include both a distribution of CPAN users and non-users and a distribution of Year 1 survey respondents and new providers. In the surveyed sample, 75% of providers reported making at least one call to CPAN and slightly more than 25% completed the Year 1 survey.

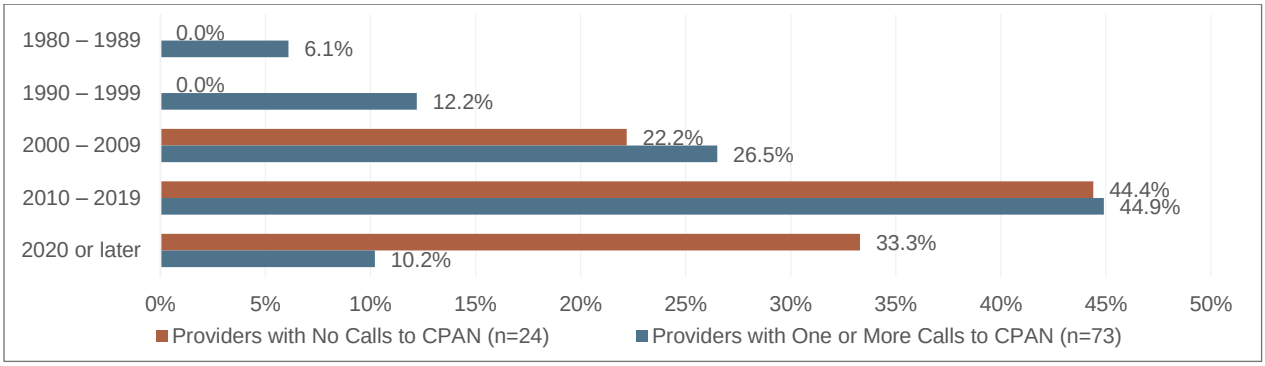
Table 1. Characteristics of Surveyed Providers

	Total Providers[a] (n=97) n (%)
Provider Gender	
Male	14 (18.4%)
Female	62 (81.6%)
Other	0 (0.0%)
Provider Race/Ethnicity	
White, Non-Hispanic	39 (52.0%)
Black, Non-Hispanic	5 (6.7%)
Hispanic	13 (17.3%)
American Indian/Alaska Native	13 (17.3%)
Other	5 (6.7%)
Year Provider Completed Professional Training	
Before 1980	0 (0.0%)
1980 – 1989	3 (5.2%)
1990 – 1999	6 (10.3%)
2000 – 2009	15 (25.9%)
2010 – 2019	26 (44.8%)
2020 or later	8 (13.8%)
Provider Role[b]	
Physician Assistant	2 (2.1%)
Nurse Practitioner	12 (12.4%)
Pediatrician	40 (41.2%)
Family Physician	12 (12.4%)
Other Physician besides Pediatrician or Family Physician	1 (1%)
Medical Director	5 (5.2%)
Resident	3 (3.1%)
Other	6 (6.2%)
Years Worked at this clinic	
Median [Min, Max]	5 [0, 23]
Hours Worked at this clinic per week	
Median [Min, Max]	40 [4, 80]
Year 1 Survey CPAN Respondent?	
Yes	27 (27.8%)
No	70 (72.2%)

(a) Data source: 2022 External Evaluation CPAN Survey. 97 providers completed the survey; however, sample sizes vary due to missing data. (b) Respondents could choose more than one role; therefore, responses are not mutually exclusive.

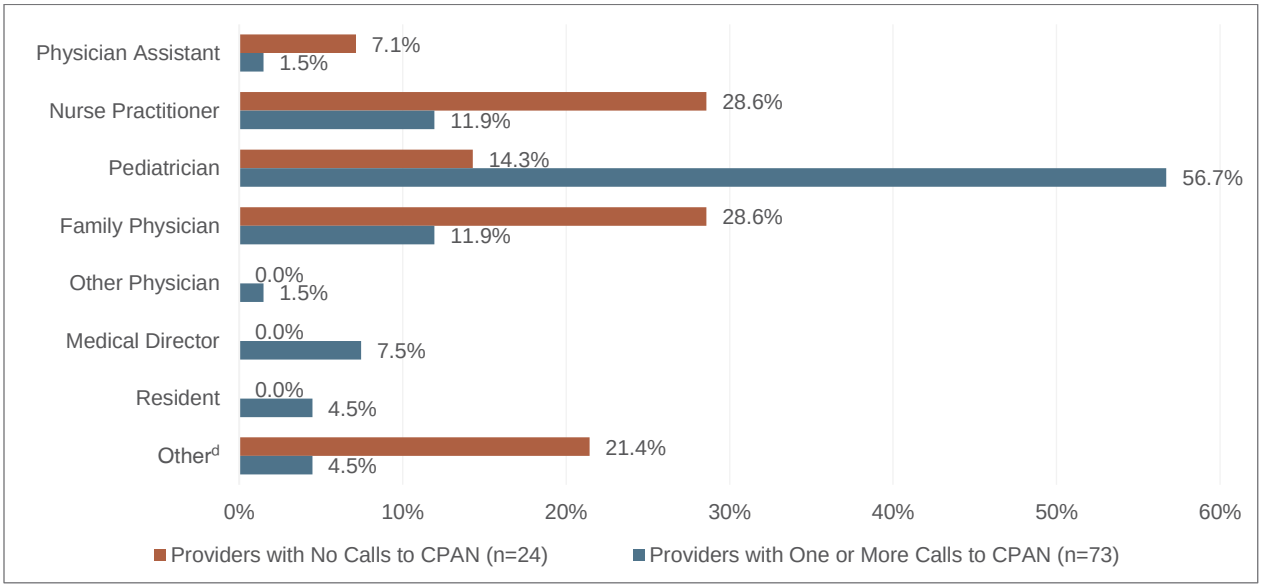
Figure 3-Figure 4 present provider characteristics (i.e., length of time since training and specialty type) by CPAN use (i.e., provider with at least one call to CPAN versus no reported calls to CPAN). Overall, results show that providers who completed their professional training prior to 2020 were more likely to report making at least one call to CPAN compared with providers who completed professional training more recently (i.e., 2020 or later) (Figure 3). In addition, pediatricians were most likely to call CPAN compared to other reported provider roles (Figure 4).

Figure 3. Year Provider Completed Professional Training and CPAN Utilization[a]



(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported being aware of the CPAN program. Year provider completed professional training missing for 39 respondents (15 who reported no calls to CPAN and 24 who reported one or more calls to CPAN).

Figure 4. Provider Role and CPAN Utilization[a]



(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported being aware of the CPAN program. Provider role missing for 21 respondents. Respondents could choose more than one option; thus, the responses are not mutually exclusive.

Descriptive Characteristics of Clinics

Table 2 compares geographic and population-level vulnerability indicators for clinics enrolled in Trayt (through 8/31/22) and clinics that completed the survey. Rural-Urban Continuum Codes (RUCC) is a classification schema developed by U.S. Department of Agriculture that distinguishes metropolitan (metro) counties by the population size of their metro area, and non-metropolitan (non-metro) counties by degree of urbanization and adjacency to a metro area. Overall, the distribution of RUCC scores were similar between clinics enrolled in Trayt (as of 8/31/22) and clinics that completed the survey. However, clinics in metro areas are slightly over-represented in the survey when compared to the total enrolled population. To examine inclusion of clinics serving geographic areas characterized by vulnerability, we examined the distribution of clinics geographically, characterized by community-level Child Opportunity Index 2.0 (COI 2.0) scores. The COI is a validated tool that quantifies neighborhood conditions in the United States for children, ranking them from lowest to highest opportunity. This index includes 29 indicators in three domains: (1) education, (2) health and environment and (3) social and economic. Childhood opportunity levels were similar between enrolled and surveyed clinics, although clinics in “low opportunity” areas were slightly under-represented in the survey sample.

Table 2. Comparison of Clinics Enrolled in CPAN and Surveyed Clinics by Geographic and Population-Level Vulnerability Indicators

	Enrolled Clinics[a] (n=1798) n (%)	Surveyed Clinics[b] (n=97) n (%)
Rural-Urban Continuum Code[c]		
Metro	1497 (83.4%)	82 (89.1%)
Non-metro (Urban)	270 (15.1%)	8 (8.7%)
Non-metro (Rural)	27 (1.5%)	2 (2.2%)
COI Level[d]		
Very Low	374 (20.8%)	24 (24.7%)
Low	319 (17.8%)	8 (8.2%)
Moderate	350 (19.5%)	21 (21.6%)
High	369 (20.6%)	25 (25.8%)
Very High	382 (21.3%)	19 (19.6%)

(a) Data source: Trayt CPAN Clinic Staff Directory; enrolled refers to clinics with a signed agreement as of 8/31/22. (b) Data source: 2022 External Evaluation CPAN Survey. (d) Data Source: 2013 Rural-Urban (RUCC) Continuum Codes, USDA Economic Research Service, U.S. Department of Agriculture. Metro comprises: counties in metro areas of 1 million population or more; counties in metro areas of 250,000 to 1 million population; and counties in metro areas of fewer than 250,000 population. Nonmetro (Urban) comprises urban population of 20,000 or more, adjacent to a metro area; urban population of 20,000 or more, not adjacent to a metro area; urban population of 2,500 to 19,999, adjacent to a metro area; and urban population of 2,500 to 19,999, not adjacent to a metro area. Nonmetro (Rural) comprises: completely rural or less than 2,500 urban population, adjacent to a metro area; and completely rural or less than 2,500 urban population, not adjacent to a metro area. RUCC classification missing for 5 enrolled clinics (USDA could not calculate the RUCC code). (e) Data source: 2022 Child Opportunity Index 2.0 database (https://www.diversitydatakids.org/). COI classification missing for 4 enrolled clinics.

Table 3 presents the clinic characteristics of surveyed providers, including type of clinic practice, clinic region, clinic size, and percentage of patients economically disadvantaged. The majority of surveyed providers were employed at private practices, followed by federally-qualified health centers (FQHCs) and hospital-based clinics. Approximately half of surveyed providers were from urban regions and employed at small clinics of two to five providers. On average, surveyed providers reported that slightly more than half of their patients are economically disadvantaged.

Table 3. Clinic Characteristics of Surveyed Providers

	Surveyed Providers[a] (n=97) n (%)
Type of Clinic Practice[b]	
Private practice	31 (42.5%)
FQHC	22 (30.1%)
Hospital-based clinic	20 (27.4%)
Clinic Region[c]	
Urban	32 (45.1%)
Suburban	24 (33.8%)
Rural	15 (21.1%)
Clinic Size[d]	
Solo (1 provider)	5 (7.7%)
Small (2-5 providers)	36 (55.4%)
Medium (6-20 providers	20 (30.8%)
Large (20+ providers)	4 (6.2%)
Percentage Patients Economically Disadvantaged[e]	
Mean [Min, Max]	57 [5, 100]

(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported being slightly, somewhat, or very aware of CPAN. (b) Clinic type missing for 24 respondents. Private practice includes solo or group practice, or HMO. Federally Qualified Health Centers (FQHCs) include community, migrant, rural, or Indian health centers. Hospital-based clinics include university clinic or residency teaching practices. (c) Clinic region missing for 26 respondents. (d) Clinic size missing from 32 respondents. (e) Percentage of patients economically disadvantaged missing from 26 respondents.

CPAN Implementation among Surveyed Providers

We examined providers' implementation of CPAN (i.e., making calls). The majority of surveyed providers reported calling CPAN on occasion (61%) or regularly (14%) (Table 4). Among providers who had not called CPAN, a majority (79%) reported that they plan to call CPAN in the future.

Table 4. Implementation of CPAN among Surveyed Providers

	Total Providers[a] (n=97) n (%)
CPAN Implementation	
Have not called CPAN and do not plan to in the future	5 (5.2%)
Have not called CPAN but plan to in the future	19 (19.6%)
Called CPAN on occasion	59 (60.8%)
Called CPAN regularly	14 (14.4%)
Called CPAN but do not call anymore	0 (0%)

(a) Data source: 2022 External Evaluation CPAN Survey. Participants responded to the question "Did you call CPAN during the past 12 months when there was a need?"

Clinic Factors Associated CPAN with Implementation

We also examined clinic-related factors associated with readiness to implement CPAN among all surveyed providers reporting some level of CPAN implementation. We evaluated two major components (or factors) of program readiness derived from the R=MC2 framework in the CPAN provider implementation survey[1-4]: (1) motivation and (2) innovation-specific capacity. Due to survey length and the high burden on survey participants during the Year 1 survey, as well as lack of variability in responses to the general capacity questions, we did not include general organization capacity items in the Year 2 survey. Motivation is the degree to which the organization wants the innovation to happen. Innovation-specific capacity is what is needed to implement the innovation.

Table 5 provides the definitions of the different sub-components of each factor. According to the R=MC2 framework, organizations with high levels of motivation and innovation-specific capacity will be more likely to adopt and implement an effective program, practice, or policy. Subcomponents of these constructs were measured on a five-point Likert scale (1 = strongly disagree; 5 = strongly agree) with lower scores indicating lower levels of readiness and higher scores indicating higher readiness – with the exception of complexity, which is reverse coded.

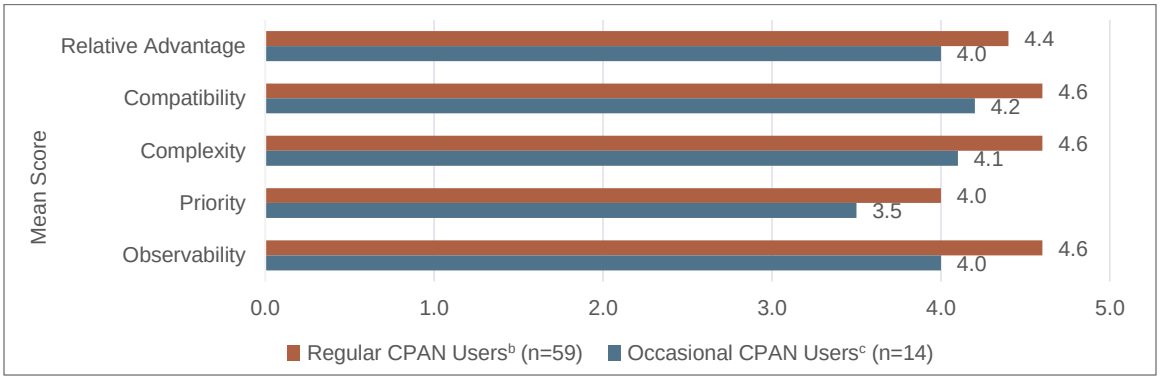
Table 5. Definitions of Organizational Factors Associated with Implementation[5,6]

Factor	Definition
Motivation	Degree to which the organization wants TCHATT to happen.
Relative Advantage	If TCHATT seems more useful than what the organization is currently doing.
Compatibility	Whether TCHATT fits with how the organization does things.
Complexity	How complex TCHATT seems.
Priority	How important TCHATT is compared to other priorities.
Observability	How easy it is to see that TCHATT is producing outcomes.
Innovation-Specific Capacity	What organizations need to implement TCHATT.
Innovation-Specific Knowledge and Skills	Degree to which there is enough knowledge and skills within the organization to use TCHATT.
Program Champion	If there is an important person(s) that supports TCHATT.
Inter-Organizational Relationships	The connections beyond the organization (people, organizations, and other communities) to help with TCHATT.
Intra-Organizational Relationships	The relationships within the organization that support the use of TCHATT.
Implementation Climate	Necessary supports, processes, and resources to enable the use of TCHATT.

Consistently, regular CPAN users reported more favorable scores among motivation subcomponents compared to occasional CPAN users (see Figure 5). The subcomponents with the highest scores are compatibility, complexity, and observability, while the largest gap between regular and occasional CPAN users was in the observability component.

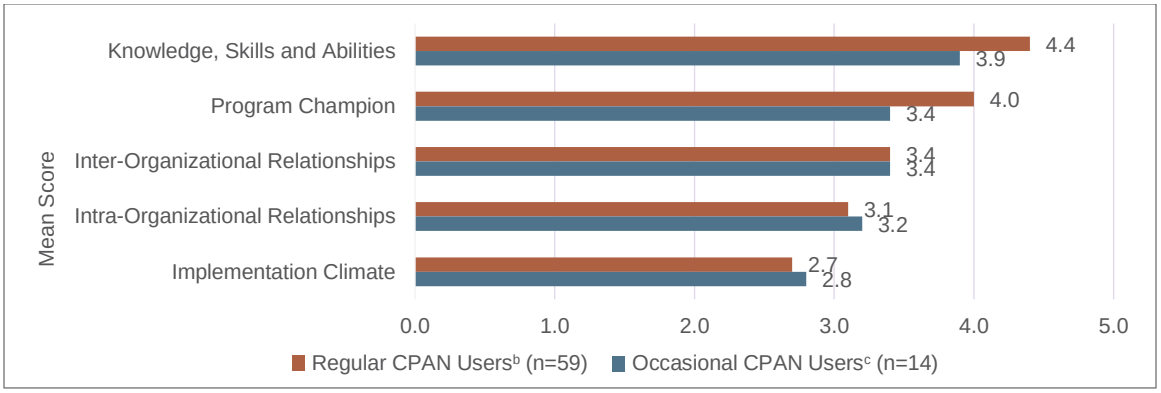
A similar pattern was found for innovation-specific capacity subcomponent scores for knowledge, skills and abilities and program champion (Figure 6). The lowest innovation-specific capacity subcomponent score was for implementation climate.

Figure 5. Organizational Factors Associated with CPAN Implementation: Motivation[a]



(a) Data source: 2022 External Evaluation CPAN Survey. (b) Includes individuals who reported calling CPAN regularly. (c) Includes individuals who reported calling CPAN on occasion.

Figure 6. Organizational Factors Associated with CPAN Implementation: Innovation-Specific Capacity



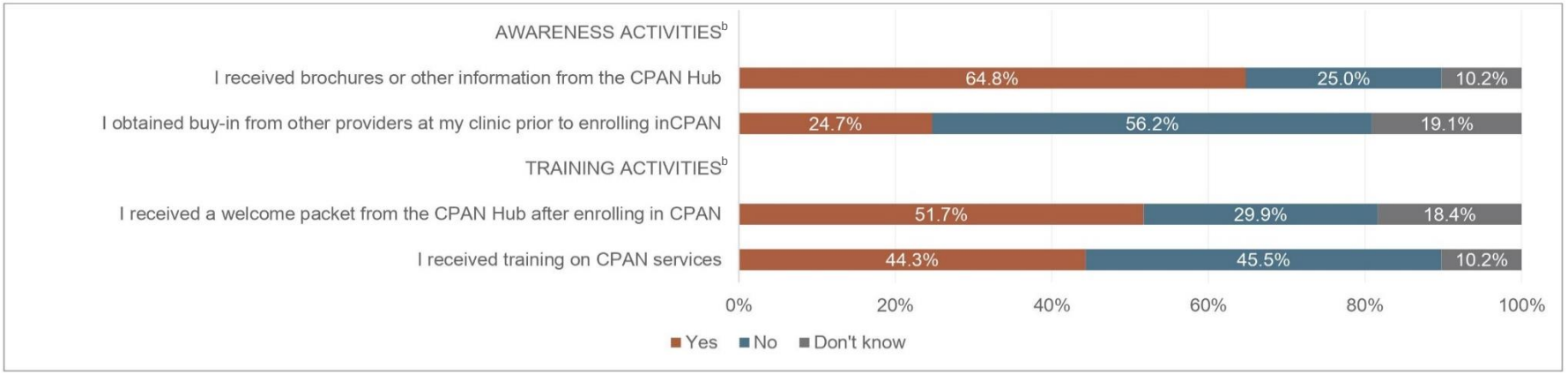
(a) Data source: 2022 External Evaluation CPAN Survey. (b) Includes individuals who reported calling CPAN on occasion.
(c) Includes individuals who reported calling CPAN regularly.

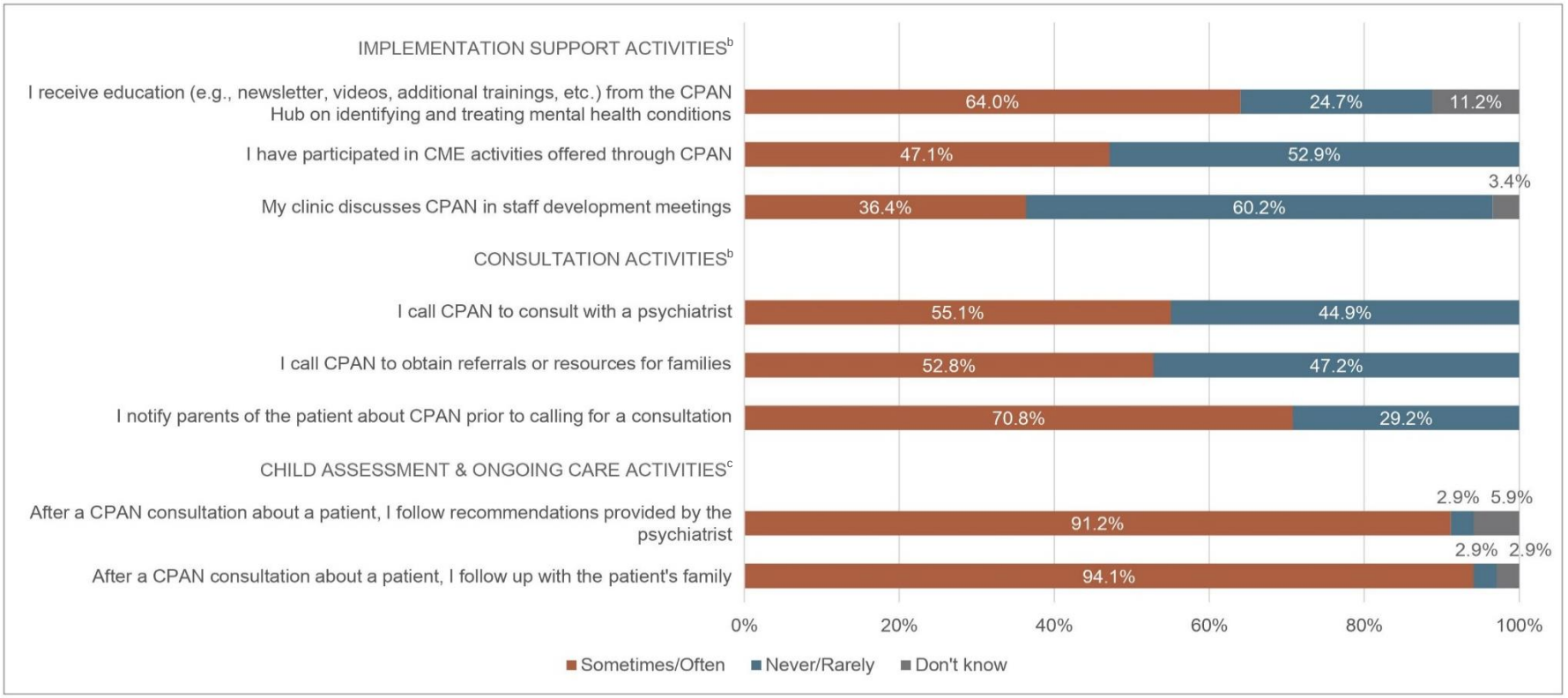
Participation in CPAN Activities

We also queried respondents' participation in various activities that comprise CPAN. These questions were designed to assess implementation fidelity to the CPAN program steps based on the process maps developed with CPAN stakeholders in Year 1. Activities were divided into Awareness, Training, Implementation Support, Consultation, and Child Assessment and Ongoing Care activities (Figure 7).

The majority of providers reported receiving brochures or other information from the CPAN hub. Approximately one-fourth reported obtaining buy-in from other providers at the clinic before enrolling in CPAN. Almost 20% of surveyed providers did not know if they received a welcome packet. The vast majority also participate in child assessment and ongoing care activities related to following the psychiatrist's recommendations and follow up with the patient's family (Figure 7).

Figure 7. CPAN Activity Checklist[a] (n=97)





(a) Data source: 2022 External Evaluation CPAN Survey. (b) 97 providers completed the survey; however, sample sizes vary due to missing data. (c) Only includes providers who reported calling CPAN on occasion or regularly (n=73; however, sample sizes vary due to missing data).

Reasons for Calling and Not Calling CPAN

Among the 97 providers who responded to the survey, 75% were CPAN users (i.e., they reported making at least one call to CPAN).

The most common reasons that providers reported for not calling CPAN included not knowing how to call in and not encountering mental health issues that could not be address on their own (Table 6). More than a quarter of providers that did not call CPAN (29%) reported that they did not know how to do so. The majority of providers (58%) reported that they did not need the additional resources that CPAN offers.

Table 6. Reasons Reported for Not Calling CPAN among Providers that Reported Not Ever Calling CPAN

Reasons for Not Calling[b]	Total Providers[a] (n=24) n (%)
I did not know how to call in	7 (29.2%)
I have not come across any mental health issues that I could not address on my own	7 (29.2%)
I am already trained in treating mental health conditions	2 (8.3%)
I am able to meet the needs of children with mental health issues using existing resources	5 (7.1%)
I am in the process of enrolling in CPAN	0 (0.0%)
Other[c]	4 (1.7%)

(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported not calling CPAN in the past 12 months. (b) Respondents can choose more than one option; therefore, results are not mutually exclusive. Reason(s) for not calling in not reported by 5 individuals. (c) Other reasons include: "I have not found it user friendly; "I am an LVN and the doctor instructs me who to refer to"; and "I am not comfortable prescribing medications that a psychiatrist prescribes. Too risky."

The external evaluation survey included questions related to the reasons for calling CPAN. The most commonly reported reason for calling CPAN was for medication management followed by referral assistance, behavioral management, and general resources (Table 7). Approximately one-fourth of clinics or clinic systems reported reasons for calling related to each of the following areas: assessment, diagnosis, advice for parents, and crisis. Note that respondents could choose more than one option for reasons and outcomes. These top reasons for calling are consistent with those reported in Year 1.

Table 7. Reasons for Calling CPAN

Reason for Call[b]	Total Providers[a] (n=73) n (%)
Medication management	60 (82.2%)
Referral assistance	45 (61.6%)
Behavioral management	25 (34.2%)
General resources	21 (28.8%)
Diagnosis	18 (24.7%)
Assessment	15 (20.5%)
Crisis	14 (19.2%)
Advice for parents	13 (17.8%)
Second opinion[c]	10 (13.7%)
School issues	9 (12.3%)

(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported calling into CPAN in the past 12 months. (b) Respondents can choose more than one option; therefore, results are not mutually exclusive. (c) Second opinion refers to questions or concerns about care provided by a community mental health provider.

Call outcomes reported by survey respondents that occurred at least once as a result of a CPAN consultation are presented in Table 8. Commonly reported outcomes included initiation or adjustment of medication, recommendation or referral to therapy, and referral to a psychiatrist.

Table 8. Outcomes that Occurred at Least Once as a Result of a CPAN Call

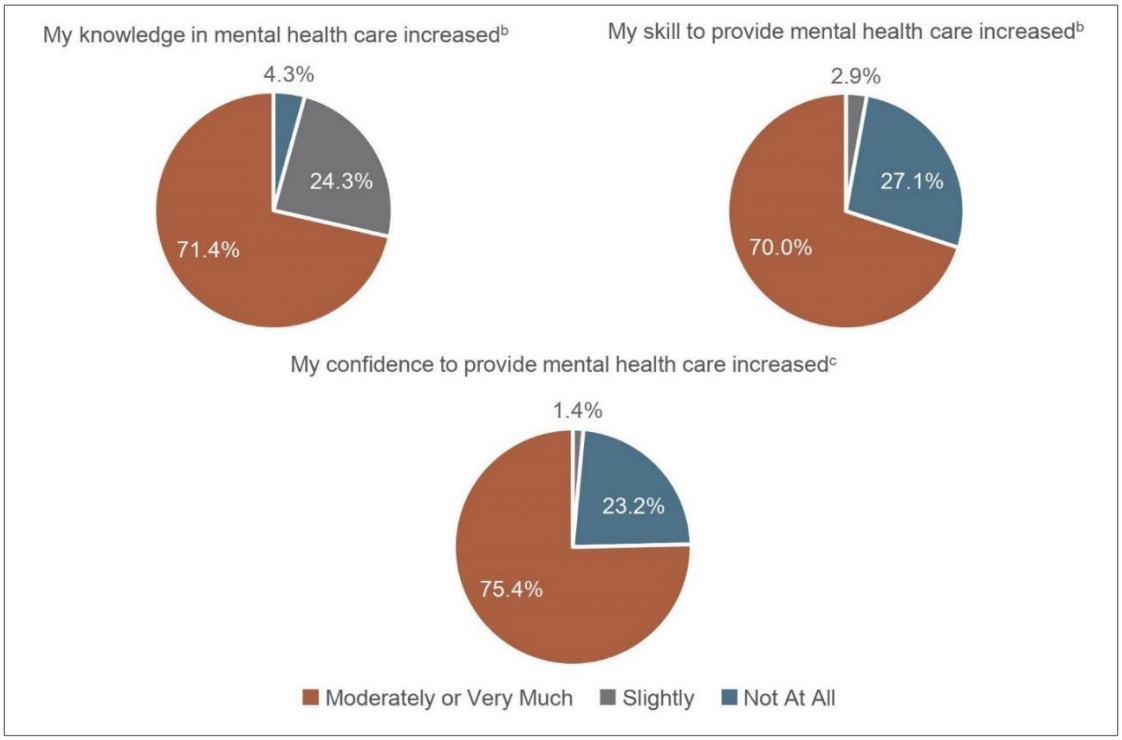
Outcome of CPAN Consultation[b]	Total Providers (n=73)[a] n (%)
Recommendation of therapy	39 (18.5%)
Referral to a child and adolescent psychiatrist	38 (18%)
Initiation of new medication	34 (16.1%)
Adjustment of current medication	33 (15.6%)
Referral to other mental health professional (e.g. LP, LPC, LCSW, LMFT) in the community	33 (15.6%)
Continuation of PCP management	26 (12.3%)
Other needs of patient met	8 (3.8%)

(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported calling into CPAN in the past 12 months.
(b) Respondents can choose more than one option; therefore, results are not mutually exclusive.

Reported Perceived Outcomes and Future Recommendations for CPAN

More than 70% of providers reported their knowledge, skills, and confidence to provide mental health care increased moderately or very much due to CPAN (Figure 8).

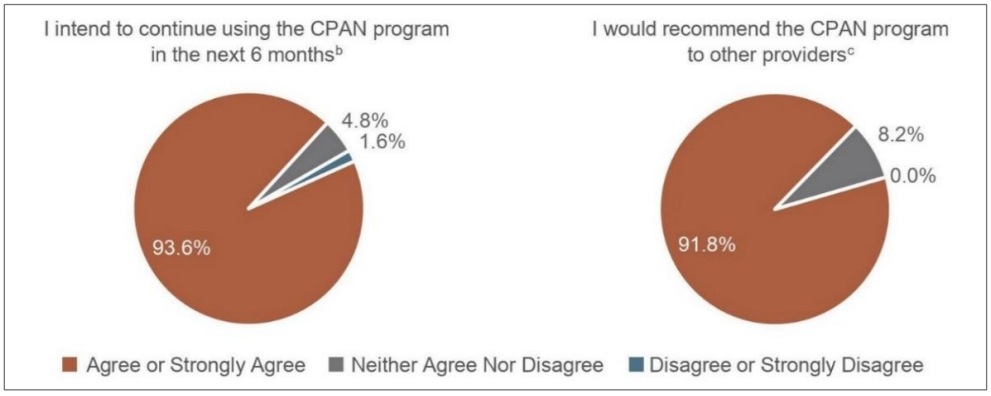
Figure 8. Survey Providers' Perceived Outcomes of CPAN[a] (n=73)



(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN in the past 12 months.
(b) Missing response from 3 individuals. (c) Missing response from 4 individuals.

Almost all providers reported that they agree or strongly agree with recommending CPAN to other providers (Figure 9). A similar percentage reported an intention to continue using CPAN in the next 6 months.

Figure 9. Survey Providers' Recommendations and Future Use of CPAN[a] (n=73)



(a) Data source: 2022 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN in the past 12 months. (b) Missing response from 11 individuals. (c) Missing response from 12 individuals.

Qualitative Results

The University of Texas Health Science Center at Houston (UTHealth Houston) External Evaluation team partnered with the Decision Information Resources, Inc (DIR) qualitative analysis team to conduct a content analysis of open-ended survey responses. The findings in this section discuss CPAN survey respondents' perceptions of the benefits of the program, barriers to utilization, and areas for improvement.

Benefits of the CPAN Program

Overall, 64 CPAN providers (52 who reported calling CPAN at least once; 12 who reported never calling CPAN) provided open-ended responses asking about the greatest benefits of the CPAN program. Out of the 64 respondents, 61 (95% of total respondents) indicated that **accessibility was the greatest benefit** of the CPAN program. Respondents specified that the accessibility of consultation services, information, and resources by the CPAN program helped them to better address the pediatric mental health needs of their patients. They reported that immediate access to mental health professionals, particularly psychiatrists, is beneficial to serving patients as wait times for direct mental health care services can be long and resources limited. Some reported that direct access to psychiatrists through CPAN can avert mental health crisis situations. Providers appreciated quick consultations with psychiatrists to get the immediate needs of their patients met, whether it was advice on medication management or referrals to community resources.

"A resource that helps patients get the psychiatric care they need immediately instead of waiting. CPAN can help avoid a crisis if used with patients."

"Almost immediate advice, recommendations, and resources. It has been immensely helpful, especially when psych and counseling waitlists are currently over a year out. Please thank everyone at CPAN for their hard work!"

"I am a family doctor and patients expect me to help them with their children's psych issues - it is hard for them to get help - so I can immediately get them some help and get treatment started or good referral sources."

"Helpful to have this as a resource when questions arise regarding a patient's ADHD management. This allows me to have direct access to a psychiatrist regarding next steps rather than delaying a patient's treatment plan."

"A way to provide primary care providers with a timely and accessible means to get support for the mental health needs of our patients, including direct consultation and community and counseling resources."

About 17% of respondents (n=11) mentioned that CPAN **increased their confidence in treating pediatric patients with mental health needs without a full referral**. Specifically, providers indicated that they felt more comfortable prescribing and managing the medication needs of patients with psychiatric conditions through their consultations with CPAN psychiatrists.

"I have received information about medication management that has allowed me to make adjustments to patients medicine that I wouldn't have made otherwise."

"Able to confirm answers to child psych management questions without needing to make a full referral."

"Specific advice for clinicians regarding medication use, dosing, titration, etc."

Overall, most respondents agreed that quick and direct access to consultation services with psychiatrists to obtain information and resources to support patient needs was the biggest benefit to enrolling in and using CPAN services. Additionally, CPAN has increased primary care providers' confidence in treating patients with mental health needs more efficiently and effectively. This is especially important given the long wait times for patients to be seen by psychiatrists for their mental health needs. One respondent indicated that they had not seen a benefit of the program so far and two respondents had not yet used the service.

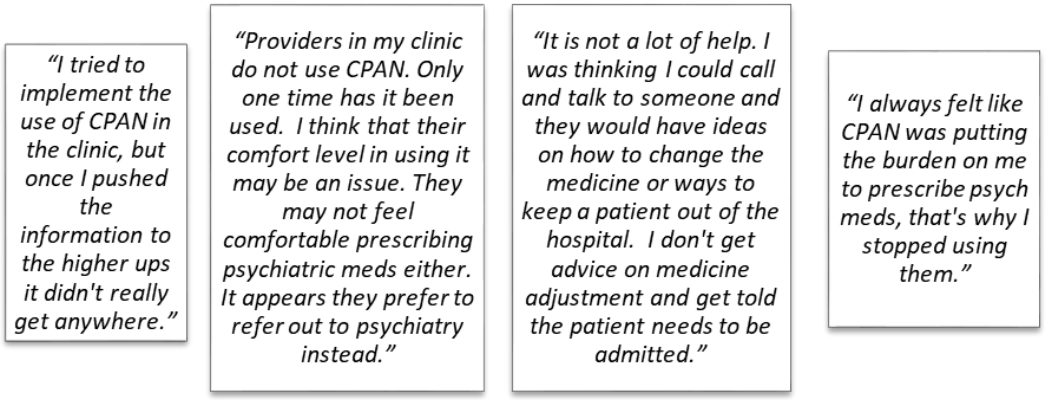
Barriers and Improvements to the CPAN Program

Overall, 62 CPAN providers (50 who reported calling CPAN at least once; 12 who reported never calling CPAN) provided open-ended responses asking about barriers and improvements to the CPAN program. The greatest barrier to utilizing CPAN services identified was **time constraints** (13%; n=8). As busy care providers, making calls to CPAN can disrupt workflow and requires additional time built into schedules to allow for consultations despite the benefits of the program. Other barriers discussed, though to a lesser extent, were **buy-in and support at their clinics** (10%; n=6) and the **program not meeting their needs** (e.g., burden to prescribe psychiatric medications and would rather refer, lack of information about medications and keeping patients out of the hospital, and referrals to patient resources outdated) (8%; n=5).

"It takes additional time I do not have built into my schedule to address these concerns. It is also unnerving prescribing medications I have never prescribed and making psychiatric diagnoses, even with a psychiatrist."

"Time constraints on making a call, flow disruption."

"The biggest barrier would be lack of time. Appointments are not any longer for patients with psych problems."

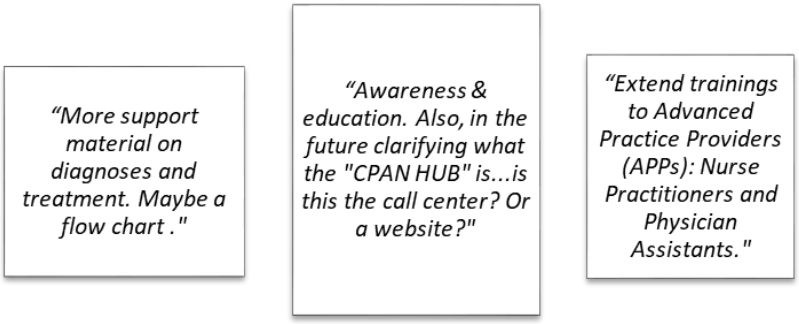


CPAN providers varied in their responses to areas for program improvement. The most frequently mentioned areas for improvement include:

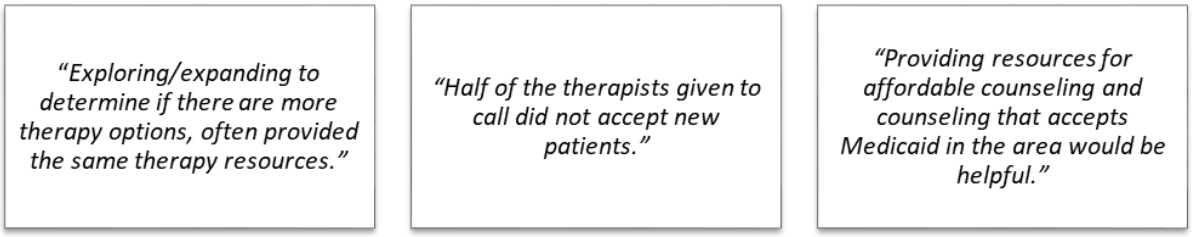
- **improved outreach and awareness** of CPAN (31%; n=19);
- **more implementation support and training** on the program (31%; n=19); and
- **improved connections to community resources and referrals** (18%; n=11).

Respondents felt that CPAN could improve their community outreach and general awareness of the program. This would help remedy the barrier of buy-in and support at clinics. Outreach and awareness were discussed both in terms of primary care providers' own clinics and community institutions at large. They indicated that providers within their own clinics were not always aware of CPAN services and having more of a presence in clinics could be beneficial to enrollment in the program. It would also help enrolled providers understand the resources available to them better. Similarly, the program could benefit from increasing outreach and awareness in the larger community to enroll more providers and inform other institutions about the role CPAN is playing in mental health care. This latter part is particularly useful when making community referrals.

Similar to the need to build providers' and clinics' awareness to enhance utilization, respondents indicated that direct CPAN program training, as well as providing implementation support would benefit stakeholders, especially given the time constraints of primary care providers. Training would allow providers who enroll to better understand the benefits of the program and how to use it most effectively. Some lacked clarity on the steps to take once enrolled and how to best utilize the program. It would also help providers who lack buy-in to better understand the program benefits and how it can support patient care. A few respondents indicated that there was a level of discomfort managing patients with psychiatric needs and medications given their own lack of training. One respondent suggested expanding provider training to include nurse practitioners and physicians assistants.



Finally, respondents would like to see improved connections to community resources through CPAN such as updated referral lists offering more affordable and viable resources for their patients. As identified earlier, some providers have found that referrals to community resources have been a barrier. They indicated that some resources (e.g. therapists) they are referred to are not always available, or able or willing, to see their patients (e.g. long wait times, not accepting new patients, or insurance issues). Of particular concern was obtaining resources for their patients on Medicaid.



Other suggestions for improvement were identified by respondents but were less widespread. They include things like providing follow-up with patients to ensure their needs were met and offering virtual options such as the ability to text or virtually chat with CPAN providers. About 19% of respondents noted that they had no barriers or recommendations for improvement. This was generally due to great experiences with the CPAN program or limited utilization at the time of the survey.

In summary, the barriers and recommendations for improvement to CPAN were varied. In terms of barriers, time constraints, internal buy-in and support, and the program not meeting the needs of primary care providers were the biggest barriers to utilizing CPAN services. While not all respondents proposed solutions to these barriers, the most identified areas of improvement included outreach and awareness among clinics and providers in the community, enhanced implementation support and training, and improved connections to resources and referrals in the community.

Summary

By far, the greatest benefit of the CPAN program identified by respondents was accessibility of consultation services, information, and resources to help address the pediatric mental health needs of their patients. Some providers found that this access enhanced their confidence in treating pediatric patients with immediate mental health needs until they were able to be seen by a psychiatrist. The greatest barriers to utilization identified by respondents included time constraints, internal buy-in and support, and the program not meeting the needs of primary care providers. Areas of improvement included outreach and awareness among clinics and providers in the community, enhanced implementation support and training, and improved connections to resources and referrals in the community. Figure 10 provides a visualization of the content discussed across both open-ended

questions in the survey, with the size of words depicting the frequency in which they were mentioned (highest frequency words larger; lower frequency words smaller).

Figure 10. Word Cloud depicting CPAN qualitative survey responses

There were some notable similarities and differences when comparing Year 2 findings to Year 1 findings for CPAN. In terms of benefits, accessibility was consistently identified as the greatest benefit of the program but to a greater extent in Year 2 (95%) than Year 1 (83%). The same was true for increased confidence in treating young patients with immediate mental health needs (17% in Year 2; 11% in Year 1). In Year 1, respondents were not specifically asked about barriers though they were asked about improvements to the program. Consistent with Year 1 was a desire for more awareness and outreach about CPAN, more training and support, and improved connections to community resources for patients. A desire for more communication options with CPAN providers was more prevalent in Year 1 than Year 2, though it was mentioned by a few respondents in terms of addressing the barrier of time constraints. Overall, those utilizing the CPAN program noted positive experiences though there are some areas of improvement that could help make the program even stronger.

Recommendations

1) **Increase outreach and awareness of CPAN in the larger community.** This could help improve buy-in and support at clinics, enroll more providers across the state, and better inform other institutions about the role CPAN is playing in mental health care.

2) **Provide more direct training on the CPAN program**, including:
    a. implementation support to clinics to help them build CPAN into their current workflow;
    b. training providers on how to call in to CPAN;
    c. the benefits of the program and how it can be used to support patient care;
    d. targeted training for younger providers, family physicians, and advanced practice providers (i.e., PAs and NPs), who have lower rates of program utilization.

3) **Improve connections to community resources and referrals through CPAN** by:
    a. updating referral lists;
    b. offering more affordable and viable resources for patients, particularly those on Medicaid.

Limitations

There are some limitations of the Year 2 provider survey. First, there was a low response rate, even after multiple outreach attempts. Due to the voluntary nature of participation, providers who agreed to complete the survey may be more likely to provide more favorable responses. Additionally, the sample was drawn from a list of providers covered by a signed agreement as of June 2022, so it may not represent providers enrolled in CPAN after this time. These factors limit the conclusions that can be drawn from the results. Care should be taken when generalizing to groups that are substantially different from the respondents.

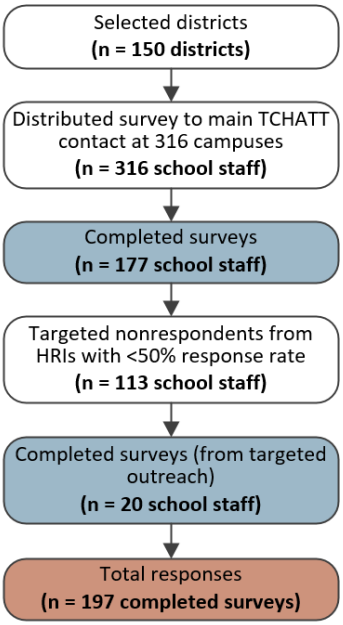
TCHATT SCHOOL STAFF SURVEY

Methods

Sample

The Year 2 survey sampling was split between two stages: first, re-sampling campuses who completed the Year 1 survey and were still active; second, selecting a new sample of campuses enrolled in TCHATT. Overall, our goal was to survey 100 campuses from the Year 1 pool and 100 new campuses. We identified a diverse sample of campuses participating in TCHATT across all 12 HRIs based on geographic (rural/suburban/urban) and economic disadvantage characteristics. The sample included 153 campuses that completed the Year 1 survey and 163 new campuses. We then reached out to districts to compile a distribution list of program implementers at participating schools. One main TCHATT contact (i.e., the person identified by either the HRI or district as the main TCHATT contact) was selected at each of the 316 campuses (Figure 11).

Figure 11. TCHATT School Campus Survey Completion

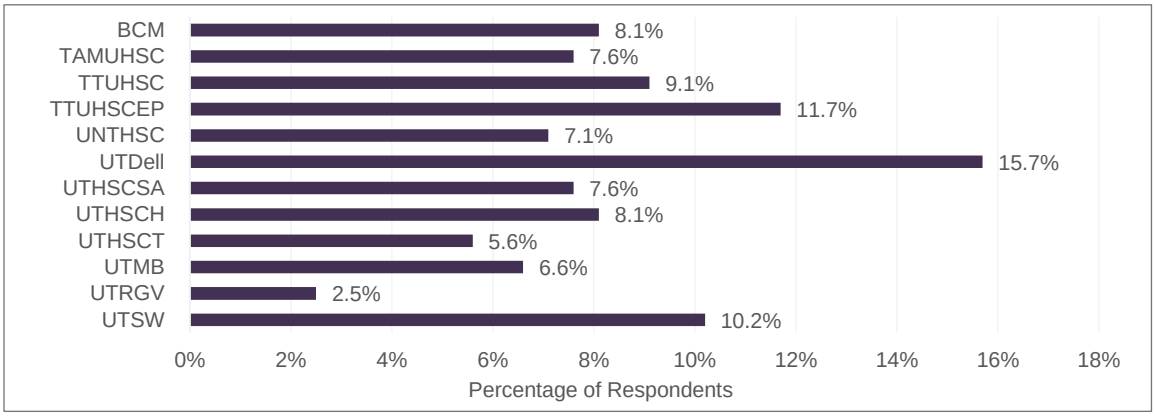


Survey & Data Collection

The development of TCHATT school staff surveys was guided by the external evaluation logic models (updated at the beginning of Year 2), measures table, and Year 1 process mapping findings. The survey purpose was to assess factors influencing school staff participation in the program, student referrals and participation, as well as to assess organizational factors and processes affecting program adoption and implementation from school stakeholder perspectives. Surveys included closed-ended and open-ended questions.

In June 2022, we invited 316 school staff to complete the *Year 2 TCHATT School Staff Survey*. Many staff were out of office due to the summer break, so we paused survey reminders at the end of June, and then resumed them as staff returned in late August 2022. We continued data collection through mid-September 2022. After multiple outreach attempts, 197 school staff completed the electronic survey, for a response rate of 62%. The distribution of survey respondents across HRIs is provided in Figure 12.

Figure 12. Survey Response Distribution Across HRIs (n=197)[a]



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know.

Quantitative Results

Descriptive Characteristics of Surveyed School Staff

Table 9 presents the demographic characteristics of TCHATT survey respondents. Almost 90% of respondents were female. Slightly more than 50% of respondents were non-Hispanic White, 13% were Black, and almost one-third were Hispanic. The majority reported having a master's degree or higher. Approximately 84% were counselors. Nearly 75% of survey respondents reported that they were the person who implemented TCHATT at their school campus or district.

Table 9. Demographic Characteristics of Survey Participants

	Total School Staff[a] n=197 n (%)
Gender[b]	
Male	17 (10.6%)
Female	144 (89.4%)
Race/Ethnicity[b]	
White, not of Hispanic origin	84 (52.2%)
Black, not of Hispanic origin	21 (13%)
Hispanic	50 (31.1%)
Other	6 (3.7%)
Primary Role[b]	
Principal/Assistant Principal/School Administrator	5 (3.1%)
Counselor	135 (83.9%)
Social worker	10 (6.2%)
School psychologist	5 (3.1%)
Nurse	1 (0.6%)
Other	5 (3.1%)
Highest Education[b]	
High School	4 (2.5%)
Associate's degree	1 (0.6%)
Bachelor of Arts/Bachelor of Science	2 (1.2%)
Master of Arts/Master of Science	81 (50.3%)
Master's degree plus 15 or more additional course hours	64 (39.8%)
EdD/PhD	3 (1.9%)
Other professional degree	6 (3.7%)
Are you the person who coordinates TCHATT at your school?[c]	
Yes	143 (74.1%)
No	42 (21.8%)
Don't know	8 (4.2%)

(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know and who reported being somewhat or very involved in the implementation of TCHATT at their school. (b) Demographic data missing for 36 participants. (c) Involvement in the coordination of TCHATT missing for 4 participants.

TCHATT Implementation among Surveyed School Staff

Almost all surveyed school staff (98%) reported that their school implemented TCHATT at some level (early stage, inconsistent implementation, or fully and systematic implementation) (data not shown). Among these TCHATT implementers, almost 70% reported being very involved with TCHATT implementation at their campus or district (Table 10). Approximately 30% reported being somewhat involved. Slightly more than half of survey respondents reported implementing TCHATT more than 12 months. 80% of participants also reported attending TCHATT trainings or receiving TCHATT materials and/or resources.

Table 10. Survey Participant Involvement in TCHATT and TCHATT Trainings

	School Staff[a] n=197 n (%)
Involvement with the implementation of TCHATT at school	
Not at all involved	3 (1.5%)
Somewhat involved	60 (30.5%)
Very involved	134 (68.0%)
Months implemented TCHATT[b]	
Less than 6 months	21 (11.4%)
6 - 12 months	65 (35.3%)
More than 12 months	98 (53.3%)
School personnel attended TCHATT trainings[c]	
Yes	154 (80.2%)
No	33 (17.2%)
Don't know	5 (2.6%)

(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (b) Months implementing TCHATT missing for 13 individuals. (c) Involvement in TCHATT trainings missing for 5 individuals.

Descriptive Characteristics of School Campuses

Table 11 presents a comparison of three groups: all Texas campuses per the Texas Education Agency (TEA), all Texas campuses enrolled in TCHATT as of 8/31/22 per TRAYT, and all surveyed campuses. Across the three groups, the table provides a description of school characteristics in regards to indicators of vulnerability, including TEA district type, National School Lunch Program eligibility, and campus size.

Overall, surveyed campuses are comparable to Texas campuses and campuses enrolled in TCHATT with respect to TEA district type and percentage of students considered economically disadvantaged. However, charter schools are slightly underrepresented among campuses enrolled in TCHATT (as of 8/31/22) and campuses surveyed; and the percentage of economically disadvantaged students is slightly lower among surveyed campuses. School size distribution was comparable between all Texas campuses and campuses enrolled in TCHATT. When compared to both Texas campuses and TCHATT-enrolled campuses, campuses with less than 500 students were under-represented in the surveyed sample.

Table 11. Comparison of Texas Campuses, Enrolled TCHATT Campuses, and Surveyed Campuses by Geographic and Population-level Indicators

	Texas Campuses[a] n=8,973[a] n (%)	Enrolled TCHATT Campuses[b] n=5,364 n (%)	Surveyed Campuses[c] n=197 n (%)
TEA District Type[d]			
Metro	3360 (37.5%)	2270 (42.3%)	78 (39.6%)
Non-Metro	2852 (31.8%)	1892 (35.3%)	72 (36.6%)
Rural	1888 (21.1%)	1057 (19.7%)	42 (21.3%)
Charter School	869 (9.7%)	143 (2.7%)	5 (2.5%)
% Students Economically Disadvantaged[a]			
< 70%	4247 (48.7%)	2652 (49.5%)	106 (53.8%)
≥ 70%	4478 (51.3%)	2710 (50.5%)	91 (46.2%)
Campus Census[a]			
<500	4259 (48.7%)	2311 (45%)	64 (32.8%)
500 - 1000	3473 (39.7%)	2100 (40.9%)	84 (43.1%)
1000 -1500	520 (6%)	355 (6.9%)	20 (10.3%)
1500 +	492 (5.6%)	365 (7.1%)	27 (13.9%)

(a) Data Source: Texas Education Agency PEIMS Data 2021-2022. There are 8,973 Texas school campuses, but sample sizes vary due to missing data. (b) Data Source: TCHATT Campus List (through August 31, 2022). There are 5,364 Texas school campuses enrolled in TCHATT, but sample sizes vary due to missing data. (c) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (d) Data Source: Texas Education Agency 2020-2021 District Type Data; Metro: major urban, major suburban; Non-Metro: other central city, other central city suburban, independent town; Rural: non-metropolitan fast growing, non-metropolitan stable, rural.

Characteristics of Campuses Implementing TCHATT

The next set of tables and figures present respondents' perceptions of campus-level student needs and staff involvement in addressing these by level of TCHATT implementation (inconsistent vs. full and systematic implementation). School staff who reported that their campus was in an early stage of TCHATT implementation were not included in these analyses.

Approximately 60% of respondents reported that more than 1 in 4 students in their campus population had a need for non-educational support (e.g., meals, clothing) and needs related to counseling or behavioral therapy; overall, campuses with full implementation reported higher levels of these student needs vs. campuses with inconsistent implementation (Table 12). Slightly more than half of respondents reported that they spend six or more hours per week addressing needs for non-educational support; again, this proportion was higher among schools with full TCHATT implementation. However, time spent each week addressing counseling or behavioral problems was slightly lower for campuses implementing TCHATT fully and systematically versus campuses implementing TCHATT inconsistently.

Table 12 also presents measures of perceived need for and awareness of campus mental health resources. Overall, awareness of school level initiatives and resources to address mental health needs is low, with 42% of respondents in campuses with inconsistent TCHATT implementation and 55% in campuses with full implementation reporting that they did not know whether or not there was a school / district MOU for providing mental health services. A smaller proportion of campuses with full implementation compared to campuses with inconsistent implementation (26% vs 39%) reported having another school/district MOU to provide mental health services to students (besides TCHATT). Among those campuses, over half reported that students had access to mental health services through a local mental health center and about a quarter reported access to these services through a community health center or social services organization (data not shown).

We also examined the proportion of parents/guardians who consented to obtain TCHATT services for their child (if their child was referred to TCHATT). Overall, about 70% of campuses reported that at least half of parents/guardians had consented to obtain TCHATT services for their child. **Campuses implementing TCHATT fully and systematically were more likely to report a higher percentage of parental consent compared to campuses implementing TCHATT inconsistently (73% vs. 66%, respectively).**

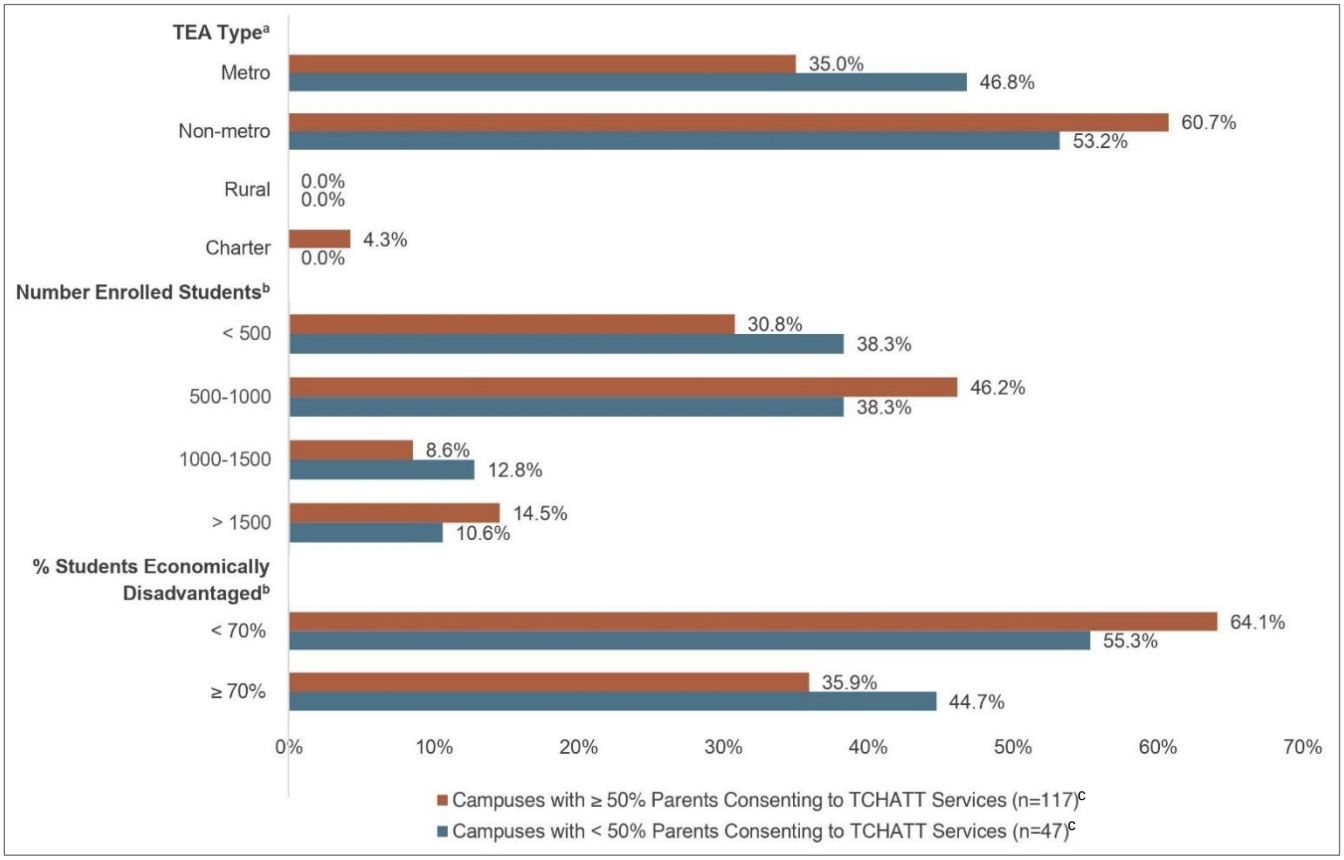
Table 12. Characteristics of School Campuses Implementing TCHATT as Reported by School Staff: Student Needs, Other Mental Health Services, and Parental Consent to TCHATT Services

	All Campuses Implementing TCHATT[a] n=197 n (Column %)	Campuses Implementing TCHATT Inconsistently[b] n=46 n (Column %)	Campuses Implementing TCHATT Fully and Systematically[c] n=124 n (Column %)
Presence of school/district MOU to provide mental health services to students (besides TCHATT)[d]			
Yes	47 (29.4%)	13 (39.4%)	28 (26.4%)
No	28 (17.5%)	6 (18.2%)	20 (18.9%)
Don't Know	85 (53.1%)	14 (42.4%)	58 (54.7%)
% student population has need of non-educational supports (e.g., sleep deprivation, meals, school supplies, and/or clothing)[e]			
Less than 26%	68 (39.3%)	18 (48.6%)	41 (36.6%)
Greater than 26%	105 (60.7%)	19 (51.4%)	71 (63.4%)
Time school staff spends addressing non-educational needs (e.g., sleep deprivation, meals, school supplies, and/or clothing)[f]			
Less 11 hrs/wk	122 (73.1%)	28 (80.0%)	75 (68.8%)
More than 11 hrs/wk	45 (26.9%)	7 (20.0%)	34 (31.2%)
% student population has need for counseling or behavioral therapy[g]			
Less than 26%	66 (38.8%)	15 (42.9%)	40 (36%)
Greater than 26%	104 (61.2%)	20 (57.1%)	71 (64%)
Time school staff spends addressing counseling or behavioral problems[h]			
Less than 15 hrs/wk	64 (37.2%)	12 (33.3%)	40 (35.4%)
More than 15 hrs/wk	108 (62.8%)	24 (66.7%)	73 (64.6%)
% parents/guardians who have consented to obtain TCHATT services for their child (if child was referred to TCHATT)[i]			
Less than 25%	31 (18.9%)	8 (22.9%)	19 (17%)
26 - 49%	16 (9.8%)	4 (11.4%)	11 (9.8%)
50 - 75%	32 (19.5%)	6 (17.1%)	19 (17%)
More than 75%	85 (51.8%)	17 (48.6%)	63 (56.3%)

(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes 197 individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know and who reported being somewhat or very involved in the implementation of TCHATT at their school; however, sample sizes vary due to missing data. (b) Includes 46 individuals who indicated that their school was implementing TCHATT inconsistently; however, sample sizes vary due to missing data. (c) Includes 124 individuals who indicated that their school was implementing TCHATT fully and systematically; however, sample sizes vary due to missing data.

Because parent consent to TCHATT services is an important pre-requisite for TCHATT implementation, we further examined characteristics of campuses by percentage of parents consenting to TCHATT services (≥50% vs <50%). Respondents from metro campuses and those with a higher percentage of economically disadvantaged students reported lower parental consent in TCHATT compared to non-metro campuses and campuses with fewer economically disadvantaged students (Figure 13). With respect to school size, greater parental interest is more likely among campuses with 500 students or more (Figure 13).

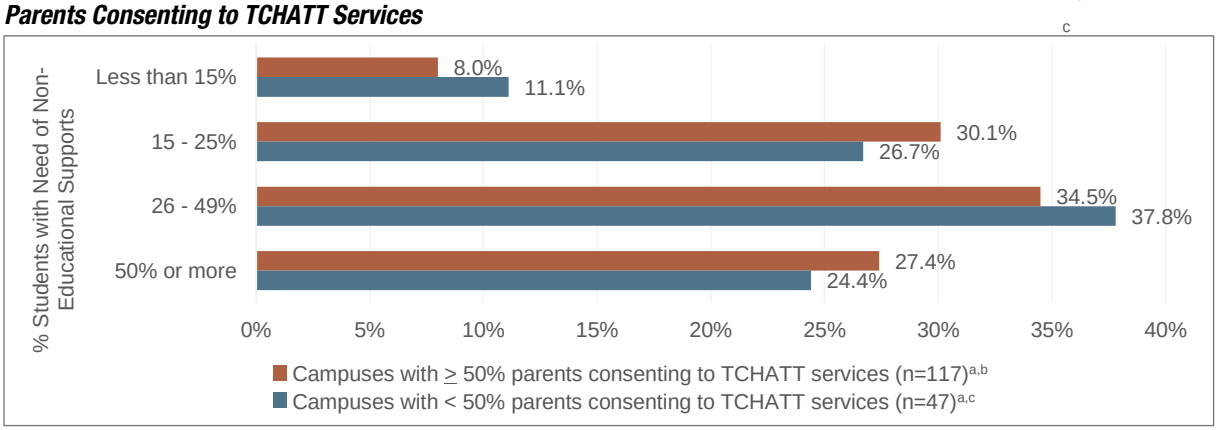
Figure 13. School District Type, Economic Disadvantage, and Percentage of Parents Consenting to TCHATT Services



(a) Data Source: Texas Education Agency 2020-2021 District Type Data. Metro: major urban, major suburban; Non-Metro: other central city, other central city suburban, independent town; Rural: fast growing, non-metropolitan: stable. (b) Texas Education Agency 2019-2020 District Snapshot. (c) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know.

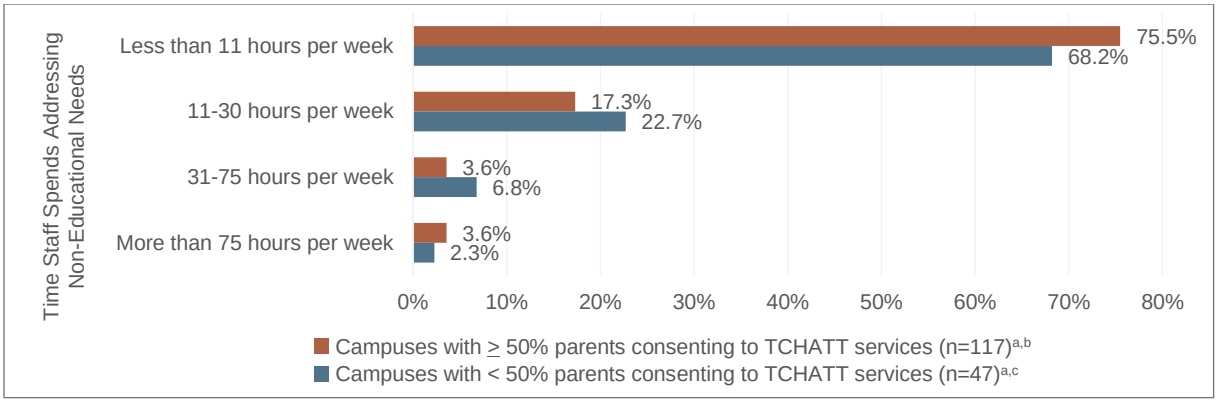
In general, school staff perception of student needs for non-educational supports (e.g., meals, clothing) and school staff time spent addressing non-educational needs was not differential by parent interest (Figure 14-Figure 15). **However, in schools with <50% parental consent, school staff reported greater student needs for counseling and more staff time spent addressing behavioral problems compared to schools with ≥50% parental consent** (Figure 16-Figure 17).

Figure 14. Student Population Need of Non-Educational Supports (as Perceived by School Staff) and Percentage of Parents Consenting to TCHATT Services



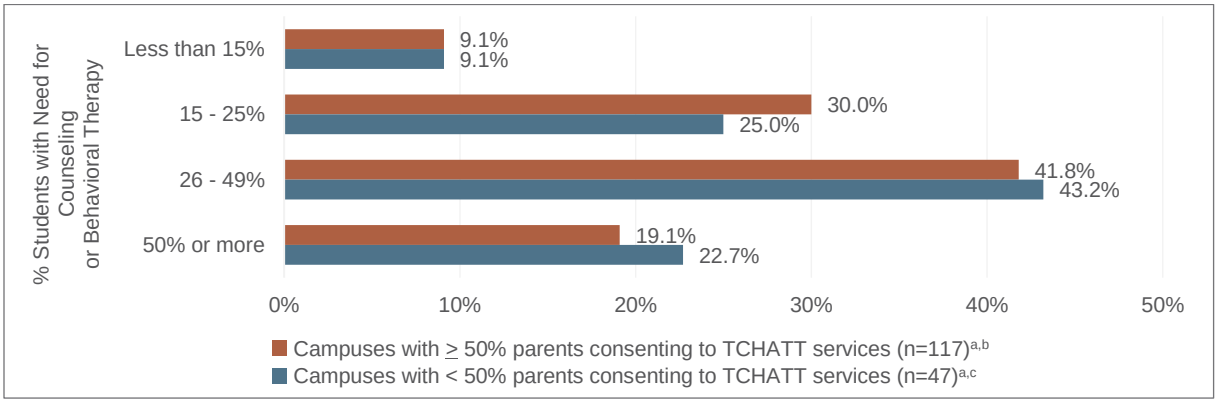
(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (b) Data missing from 4 campuses with 50% or more of parents consenting to TCHATT services. (c) Data missing from 2 campuses with less than 50% of parents consenting to TCHATT services.

Figure 15. Time School Staff Spends Addressing Non-Educational Needs (as Perceived by School Staff) and Percentage of Parents Consenting to TCHATT Services



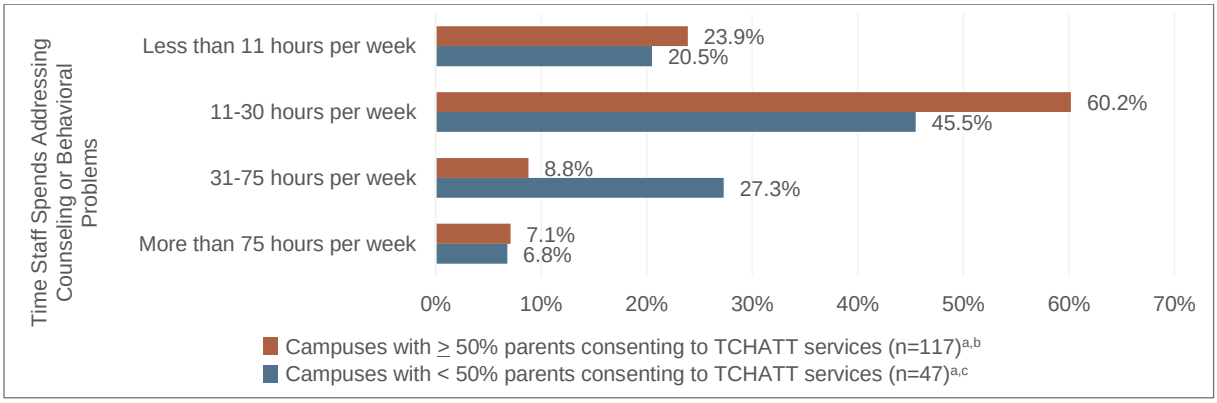
(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. (b) Data missing from 7 campuses with 50% or more of parents consenting to TCHATT services. (c) Data missing from 3 campuses with less than 50% of parents consenting to TCHATT services.

Figure 16. Student Population Need for Counseling or Behavioral Therapy (as Perceived by School Staff) and Percentage of Parents Consenting to TCHATT Services



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. (b) Data missing from 7 campuses with 50% or more of parents consenting to TCHATT services. (c) Data missing from 3 campuses with less than 50% of parents consenting to TCHATT services.

Figure 17. Time School Staff Spends Addressing Counseling or Behavioral Problems (as Perceived by School Staff) and Percentage of Parents Consenting to TCHATT Services



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. (b) Data missing from 4 campuses with 50% or more of parents consenting to TCHATT services. (c) Data missing from 3 campuses with less than 50% of parents consenting to TCHATT services.

School Campus Factors Associated with TCHATT Implementation

We also examined factors associated with readiness to implement TCHATT among all surveyed providers reporting some level of TCHATT implementation. We evaluated two major components (or factors) of program readiness derived from the R=MC2 framework in the TCHATT school staff implementation survey[1-4]: (1) motivation and (2) innovation-specific capacity. Due to survey length and the high burden on survey participants during the Year 1 survey, as well as lack of variability in responses to the general capacity questions, we did not include general organization capacity items in the CPAN external evaluation survey in Year 2. Motivation is the degree to which the organization wants the innovation to happen. Innovation-specific capacity is what is needed to implement the innovation. Both were assessed among campuses indicating awareness and implementation of TCHATT.

Table 13 provides the definitions of the different sub-components of each factor. According to the R=MC2 framework, organizations with high levels of motivation and innovation-specific capacity will be more likely to adopt and implement an effective program, practice, or policy. Subcomponents of these constructs were measured on a five-point Likert scale (1 = strongly disagree; 5 = strongly agree) with lower scores indicating lower levels of readiness and higher scores indicating higher readiness – with the exception of complexity, which is reverse coded. Individual scores were formed by averaging the responses for each scale for each individual that responded to at least 2/3 of the items for the scale.

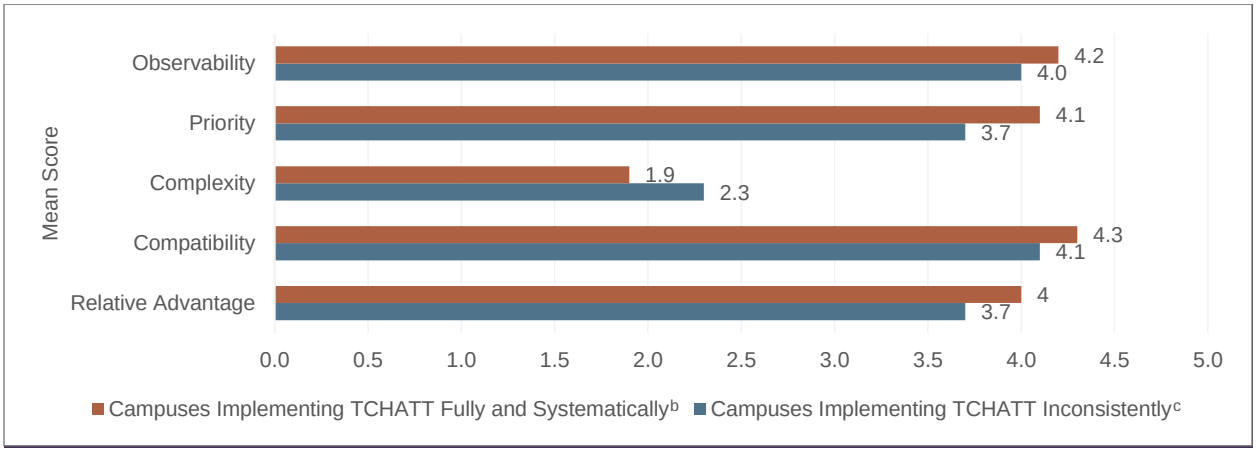
Table 13. Definitions of Organizational Factors Associated with Implementation[5,6]

Factor	Definition
Motivation	Degree to which the organization wants TCHATT to happen.
Relative Advantage	If TCHATT seems more useful than what the organization is currently doing.
Compatibility	Whether TCHATT fits with how the organization does things.
Complexity	How complex TCHATT seems.
Priority	How important TCHATT is compared to other priorities.
Observability	How easy it is to see that TCHATT is producing outcomes.
Innovation-Specific Capacity	What organizations need to implement TCHATT.
Innovation-Specific Knowledge and Skills	Degree to which there is enough knowledge and skills within the organization to use TCHATT.
Program Champion	If there is an important person(s) that supports TCHATT.
Inter-Organizational Relationships	The connections beyond the organization (people, organizations, and other communities) to help with TCHATT.
Intra-Organizational Relationships	The relationships within the organization that support the use of TCHATT.
Implementation Climate	Necessary supports, processes, and resources to enable the use of TCHATT.

Consistently, school staff who implemented TCHATT fully and systematically reported more favorable scores among motivation subcomponents compared to school staff who implemented TCHATT inconsistently (Figure 18). The largest gap between full and inconsistent TCHATT implementation was in the observability and priority components.

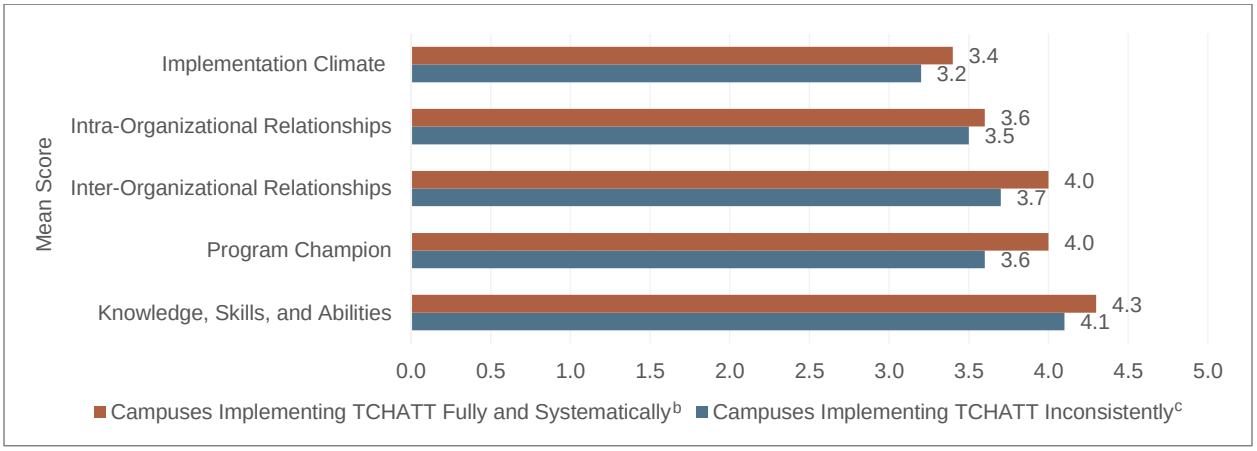
A similar pattern was found for all innovation-specific capacity subcomponent (Figure 19). The lowest innovation-specific capacity subcomponent score was for implementation climate.

Figure 18. Organizational Factors Associated with TCHATT Implementation: Motivation[a]



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. (b) Includes individuals who indicated that their school was implementing TCHATT fully and systematically. (c) Includes individuals who indicated that their school was implementing TCHATT inconsistently.

Figure 19. Organizational Factors Associated with TCHATT Implementation: Innovation-Specific Capacity[a]



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. (b) Includes individuals who indicated that their school was implementing TCHATT fully and systematically. (c) Includes individuals who indicated that their school was implementing TCHATT inconsistently.

Participation in TCHATT Activities

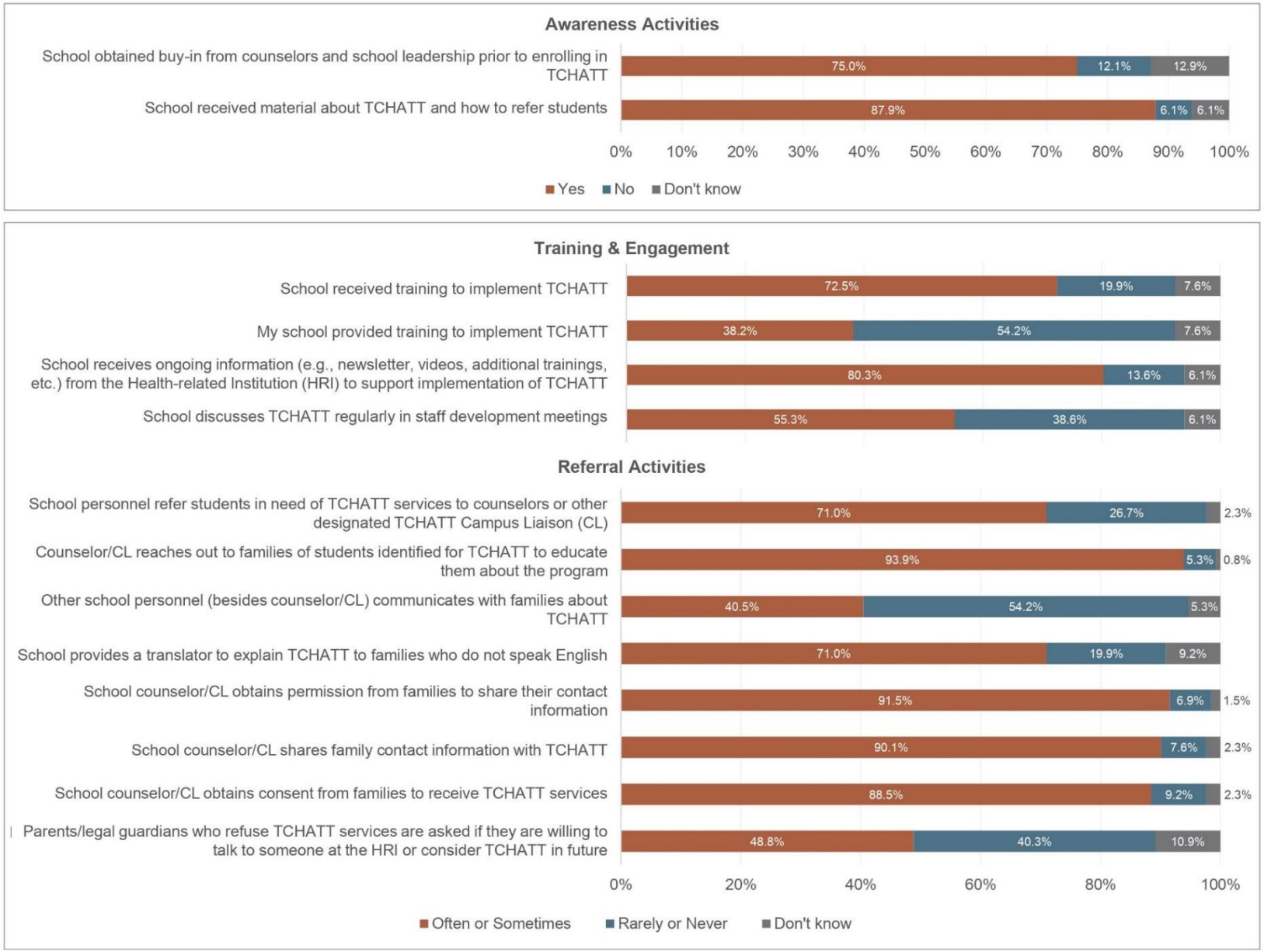
Among 143 school staff who reported being the person who coordinates TCHATT at their school, we queried respondents' participation in various activities that comprise the TCHATT program in schools. These questions were designed to assess implementation fidelity based on the TCHATT process maps developed with TCHATT stakeholders in Year 1 of the external evaluation. Activities were divided into the following categories: Awareness, Training & Engagement, Referral Activities, Service Delivery, and Ongoing Care activities.

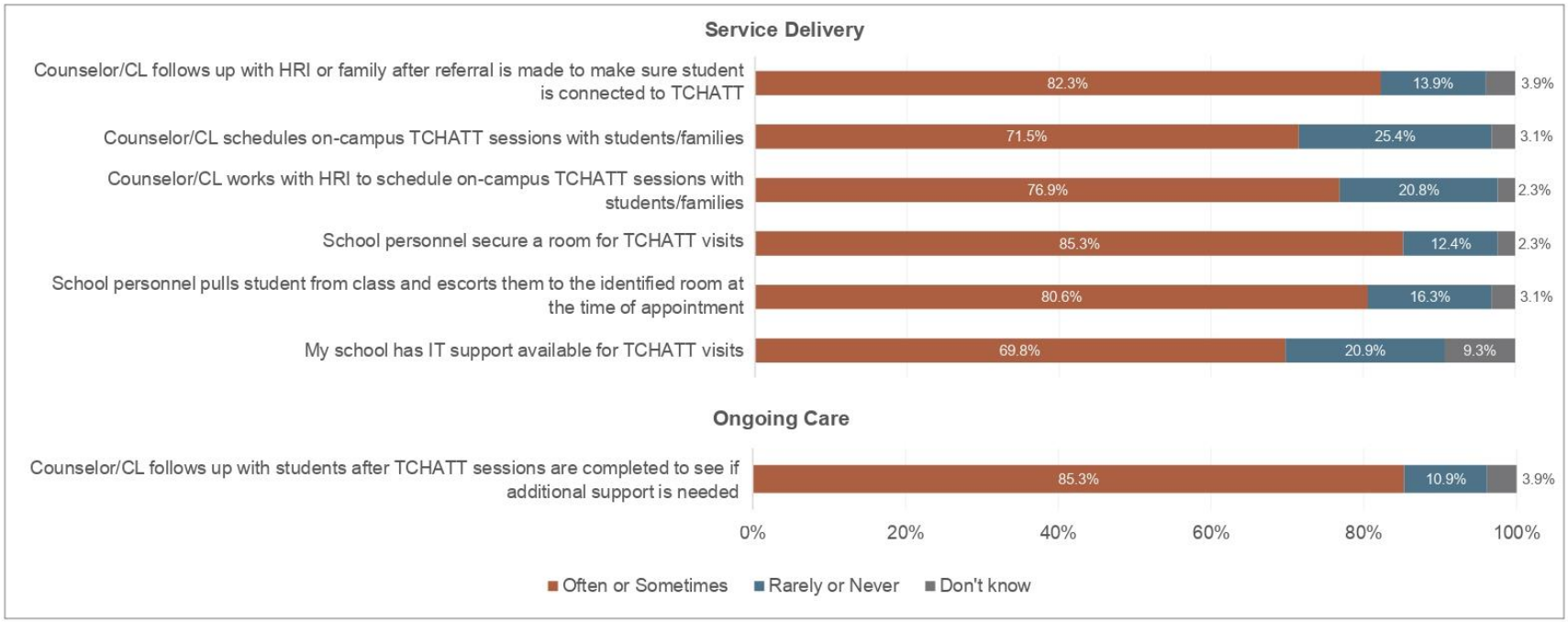
Levels of awareness and receipt of training were high. Over three quarters of respondents reported that their campus obtained buy-in from school leadership prior to TCHATT enrollment, or received material about TCHATT (Figure 20). Over 70% of respondents reported that their school often or sometimes received training to implement TCHATT, while 80% reported ongoing information from the HRI to support implementation of TCHATT. On the other hand, less than 40% reported that their school often or sometimes provided training, and only a little over 50% of participants reported sometimes or often discussing TCHATT regularly in staff development meetings.

With respect to TCHATT referral activities, 70% of survey respondents reported that school personnel often or sometimes refer students in need to TCHATT, and over 90% of survey respondents reported that the counselor often or always reached out to educate families of students identified for TCHATT. However, fewer than 40% reported that other school personnel often or sometimes communicate with families about TCHATT. Additionally, when parents refuse TCHATT services, only 50% of respondents reported that their staff often or sometimes asked parents if they are willing to talk to someone at the HRI or consider TCHATT in the future.

All service delivery activities occur at high levels (70% or more reporting that the activity occurs often or sometimes), including post-referral follow up with HRI or family, scheduling of on-campus TCHATT sessions with students/ families, IT support for TCHATT visits, and escorting students to appointments at the scheduled time. Finally, 85% of respondents reported that counselors often or sometimes follow up with students after TCHATT sessions to check on additional support needs.

Figure 20. TCHATT Activity Checklist (n=143)[a]



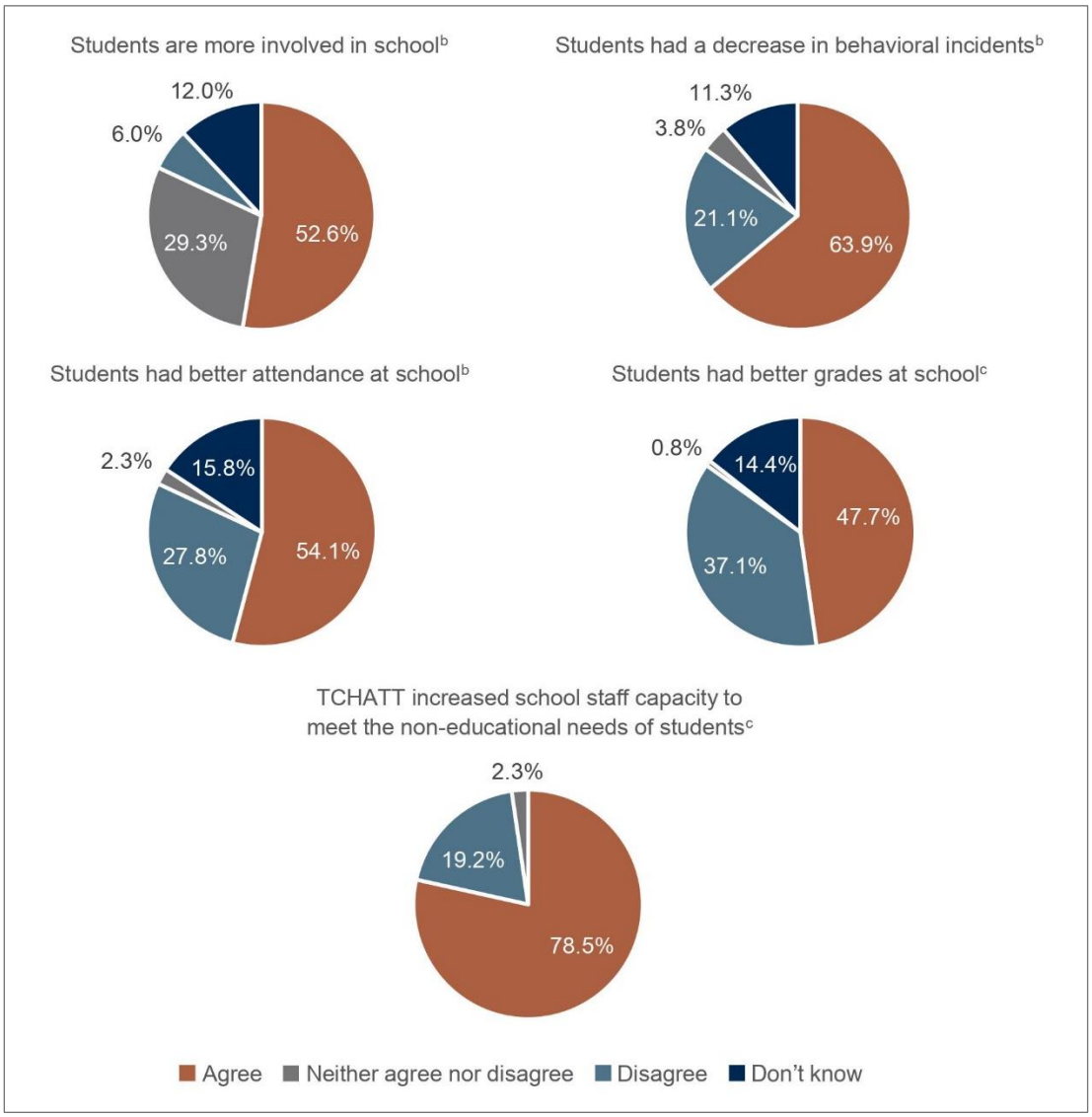


(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who reported being the person who coordinates TCHATT at their school and reported that either their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. Some individuals are excluded due to missing data. "Often" was combined with "sometimes" and "rarely" was combined with "never" for reporting purposes.

Participants' Perceived Outcomes and Future Recommendations for TCHATT

Perceptions of TCHATT effects on student outcomes and staff capacity are favorable among school staff who reported being the person who coordinates TCHATT at their school (n=143). Between 48-64% of respondents indicated that, because of TCHATT, students had decreased behavioral incidents and better attendance and grades at school (Figure 21), and close to 80% of respondents reported that students were more involved in school. Almost 80% reported that TCHATT increased school staff capacity to meet the non-educational needs of students. Between 11-16% of respondent reported that they did know whether TCHATT had an impact on behavioral incidents, attendance, and grades at school.

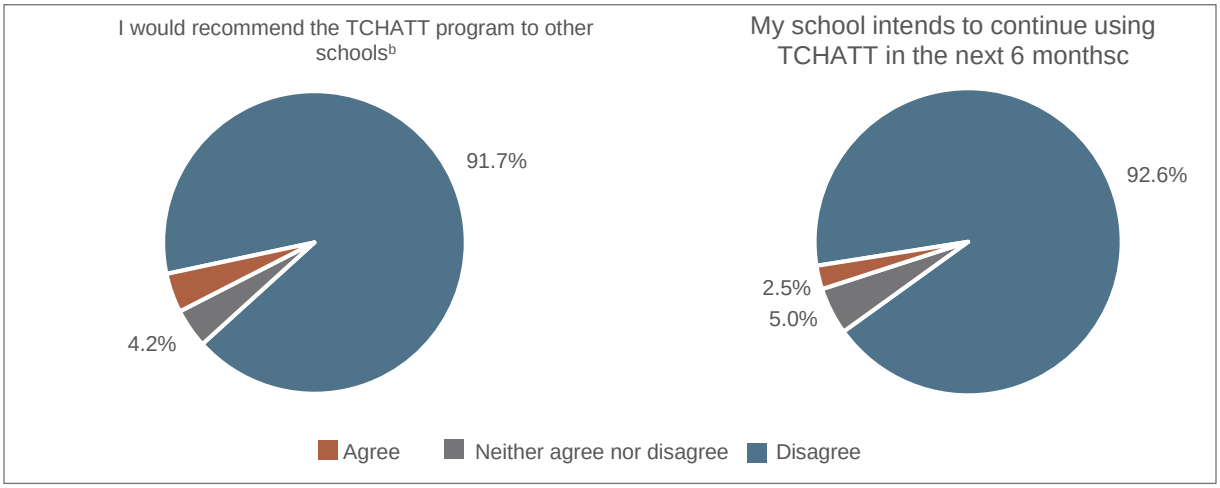
Figure 21. Survey Participants' Perceived Outcomes of TCHATT (n=143)[a]



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who reported being the person who coordinates TCHATT at their school and that either their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or they didn't know. Strongly agree was combined with agree and strongly disagree was combined with disagree for reporting purposes. (b) Response missing from 10 providers. (c) Response missing from 11 providers. (c) Response missing from 13 providers.

Approximately 90% of respondents reported that they agree or strongly agree with recommending TCHATT to other schools (Figure 22). A similar percentage reported an intention to continue using TCHATT in the next 6 months.

Figure 22. Participants' Recommendations and Future Use of TCHATT (n=143)[a]



(a) Data Source: 2022 External Evaluation TCHATT School Staff Survey. Includes individuals who reported being the person who coordinates TCHATT at their school and that either their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or they didn't know. Strongly agree was combined with agree and strongly disagree was combined with disagree for reporting purposes. (b) Response missing from 23 providers. (c) Response missing from 22 providers.

Qualitative Results

The University of Texas Health Science Center at Houston (UTHealth Houston) External Evaluation team partnered with the Decision Information Resources, Inc. (DIR) qualitative analysis team to conduct a content analysis of open-ended survey responses. The findings in this section discuss TCHATT survey respondents' perceptions of the benefits of the program, areas for improvement, and additional comments about the activities conducted as part of the program.

Benefits of the TCHATT Program

Overall, 127 TCHATT respondents provided open-ended responses asking about the greatest benefits of having the TCHATT program available in their schools. Of the 127 respondents, or 79% (n=100), indicated that **accessibility of care for underserved students in need was the greatest benefit** of the TCHATT program. Respondents indicated that TCHATT provides immediate and flexible mental health services to vulnerable children who may not have access to the same level of care without the program. The program is seen as a convenient external resource that can support school staff and parents in getting children the mental health care that they need when alternative resources are extremely limited. Respondents indicated that their students tend to come from underserved and underinsured communities, making the cost-free services of TCHATT valuable. Since the visits are virtual and conducted while children are in school, it also removes the barrier of transportation for parents as well as minimizes time spent away from the classroom for students.

"TCHATT has allowed access to counseling resources that students would not have had otherwise, due to time constraints, financial constraints, or just availability."

"We are in a remote area and resources are difficult to reach. TCHATT is easily accessible for our students who cannot travel to the nearest city for services."

"Removal of barriers to services, limited off-campus/out of instruction time, collaborative support with school."

"On campus virtual sessions has made it easy for families to receive support. The amount of time between the referral and first session is minimal which makes it easy for families to receive services quick."

About 15% of respondents (n=19) mentioned that TCHATT **provides a level of mental health care that cannot be provided by school counselors alone**. Respondents discussed how school counselors may not have the level of expertise some students require and often have time constraints caring for large student populations. TCHATT provides school counselors with additional support to serve their students' mental health needs more effectively and provides students and families with a trusted outside provider that will help address mental health needs directly and through referrals. TCHATT provides feedback to both parents and school counselors as permitted, creating a collaborative environment to help children get their needs met.

"Students are able to receive support with mental health or behavioral support that is beyond the scope of what I, the school counselor, am able to support. TCHATT has streamlined the referral services that I would have only been able to haphazardly offer to parents through a printed-out brochure. TCHATT has helped our students so much!"

"The additional support for your high needs campus allows us a little more time to address more of the student population in need."

"The biggest benefit of having TCHATT available in our school is the ability to make sure our higher needs students get additional support outside of what we can give them, due to all the roles we play on our campus. We don't always get to just council students, and they need more support at time, than what we can give them."

Three respondents indicated that the program has not yet been fully implemented in their schools; therefore, they could not speak to benefits.

Improvements to the TCHATT Program

Overall, 78% of respondents (n=99) provided open-ended responses asking about improvements to the TCHATT program. TCHATT respondents varied in their responses to areas for program improvement. The most frequently mentioned areas for improvement include:

- the desire for an **enhanced implementation process** (30%; n=30)
- **Better communication and follow-up** (20%; n=20)
- **more training on campus** (12%; n=12)

- **more flexibility in scheduling students** (11%; n=11)
- **additional sessions for students** (8%; n=8)

Respondents believe that the TCHATT program could be improved by enhancing the implementation of the program. Respondents indicated that they would like to see a more efficient and streamlined paperwork system that works better for both the counselors as well as the families they refer. Paperwork was described as lengthy, often confusing, and overwhelming to parents. Parents do not always have access to internet, email, or printers, which hinders the consent process further. Accessibility of forms has been an issue for families. Paperwork is generally a barrier to care for students. The referral process for school staff is burdensome and they request that there be an option for online intake as well as a paper option to accommodate parents.

"The procedures on how to refer students to TCHATT needs to be improved. The extra steps and extra documentation that's required is rather stressful. And just knowing ahead of time as a counselor that a student may need services that extend longer than 4 or 5 weeks, makes me want to refer them elsewhere where kids are set up automatically with their therapist and there is not a need for a change later. Students need stability with a therapist. it takes time to build that relationship."

"Provide parent forms to the counselor responsible for implementing the program. I may secure "buy in" or agreement, but by the time a parent leaves my office they don't respond to the emails or phone calls from TCHATT. This creates a void in services and is not helpful to the child. Our population needs more support in the initial phases of referral to follow through."

"The referral forms and process has changed several times since implementation. Many staff members have been confused and have missed steps in process. Some of my colleagues have also expressed frustration for being held accountable for parents and situations outside of school environment."

Respondents would like better communication and follow-up while students are involved in the TCHATT program. Specifically, respondents indicated that they would like to receive more communication after student sessions and be informed about the plan for follow-up care after all sessions are completed. They expressed a desire to help students and families follow-up with appropriate referrals after their TCHATT sessions, or check in to make sure the treatment plan was being followed, but a lack of communication did not always allow them to do so. Respondents indicated that there was not always a way for school counselors to track who was being serviced, and communication from TCHATT regarding student visits would be beneficial in this regard. Further, respondents expressed a need for more bilingual TCHATT counselors to address the needs of those students.

"Scheduling with TCHATT is very time consuming for school counselors (current liaison with TCHATT). The sessions with the TCHATT interventionists and students are private and there is no information for the school counselor or other staff about the case or how we can be supportive of the progress the student/family has made. There are no recommendations. In some sense it seems like the TCHATT counselors conduct their sessions and then are through. School counselor or other staff have no other information. In addition, school people are not consulted in seeking to know if the students are making progress and what observations or other data could be collected and shared."

"It would be nice if we can have a system that allows counselors to see who we referred already, who is receiving services, and who has completed services. That way we are kept in the loop."

"A quick outtake session with campus counselor at conclusion of TCHATT services."

Respondents expressed a desire to receive more training, especially as it relates to implementation of the TCHATT program. Respondents expressed a desire for more training sessions including refresher trainings throughout the school year. In-person trainings on campus were preferred by 7 of the 12 respondents. Five out of the 12 or 5% respondents expressed that they would like to see more counselors on the TCHATT staff hired and trained to keep up with the needs at their schools.

"Better training, more explanation about implementation and expectations. Make referral process smoother."

"Overall, the program has been great! Would love to receive additional trainings and education to have the skills to help the small issues for students in house."

"Provide more literature for staff and community"

"The only thing I can think is getting more staff so we can have more appointments!"

"There is more need for the service, so they need more therapists."

While respondents were grateful for the TCHATT sessions their students received, several expressed a desire for more sessions. Respondents suggested increasing the number of sessions to ensure students were stable and additional follow-up care was in place. Sometimes there can be a long wait period for children to receive follow-up care after their TCHATT sessions are over, resulting in a gap of care. Some respondents also mentioned having a hard time convincing parents to sign up due to the limited number of sessions.

"The procedures on how to refer students to TCHATT needs to be improved. The extra steps and extra documentation that's required is rather stressful. And just knowing ahead of time as a counselor that a student may need services that extend longer than 4 or 5 weeks, makes me want to refer them elsewhere where kids are set up automatically with their therapist and there is not a need for a change later. Students need stability with a therapist. it takes time to build that relationship."

"Additional sessions with students if they can't be referred due to lack of insurance, money, access, etc.

"I need help with how to convince parents to go with a program that is only available for 4 sessions."

Respondents would like to see TCHATT have more flexibility when scheduling students. They indicated that finding space at the school can be difficult as well as that there is concern with how long students are taken out of class to complete their sessions.

"It needs to be more flexible - sessions are scheduled with little regard to the student's schedule (scheduled during math rather than during an elective). TCHATT counselors need to communicate with the school counselor regarding school protocols rather than making assumptions and communicating false information to parents without first clarifying."

"Length of time away from class, shorten to 45 min"

"Scheduling is sometimes hard and finding space at school."

Other suggestions for improvement were identified by respondents but were less widespread. They include things like improving the timeliness of scheduling the first visit, offering an in-person visit as an option, and decreasing the burden on school staff. About 20% of respondents did not have any recommendations for improvement. This was generally due to great experiences with the TCHATT program or limited utilization at the time of the survey.

In summary, recommendations for TCHATT improvement varied. However, the most common were the need for an improved implementation process, better communication and follow-up, additional student sessions, more training on campus, hiring more TCHATT staff, and shortening the length of time until the first visit.

Additional Comments Related to the TCHATT Program

Overall, 46% of respondents (N=58) provided open-ended responses asking for additional comments related to the activities conducted as part of TCHATT. Out those respondents, 31% (n=18) provided **positive remarks regarding the program in terms of support offered to students and school staff**.

"TCHATT has been an excellent support and very diligent in their efforts to ensure continuity of services. Always available and supportive of our district needs. Well informed and pleasantly responsive. We are very grateful and excited that their services are available to our students and their families. We will continue to collaborate!"

"I am so grateful to TCHATT! This program has helped me to feel like I finally have a resource to help my students. While every student hasn't been a success, the successes dramatically outweigh the loss."

"I appreciate the support TCHATT provides for our families. The dashboard is user friendly and communication between school, family and TCHATT is effective."

"This was my first year as the campus liaison for TCHATT. There are some areas I will work to improve on including contacting parents who have not submitted consent paperwork and checking in with students/families once students have completed their sessions. The new step in which TCHATT sends documents to families directly was very helpful. Brochures in English and Spanish would be beneficial. Attending intake sessions is beneficial. Attending additional sessions is not always feasible considering the other commitments and responsibilities a counselor has. The TCHATT staff and personnel are friendly, professional and extremely helpful. Very appreciative for the service and all the staff and personnel do to help serve our students."

While some of the comments provided were similar to the open-ended responses related to benefits and areas for improvement, there were some noteworthy comments regarding the desire for more training. Some respondents indicated that they **would like more training to better implement the TCHATT program at their schools** (9% or n=5). Some respondents indicated that the program is new to them, and they would like more information about TCHATT. Others mentioned the desire for more training materials, more brochures for both staff use as well as to pass out to parents, and training offered more than once a year. Several respondents requested training on filling out the consent forms due to it being the barrier it creates for students to receive services.

"This was my first year, I would like a brochure on TCHATT to be able to use it appropriately next year."

"Information about TCHATT is on our webpage. I think it would be worthwhile to provide a brief video and training to all personnel at the beginning of the schoolyear. The most challenging aspect is getting parents to complete the process of completing the parent forms."

"There seems to be a disconnect between our school referral and parents responsiveness to services once a TCHATT representative calls. I'm wondering if we should begin scheduling in-person meetings with parent to call TCHATT coordinator together and set them up with apps and consents."

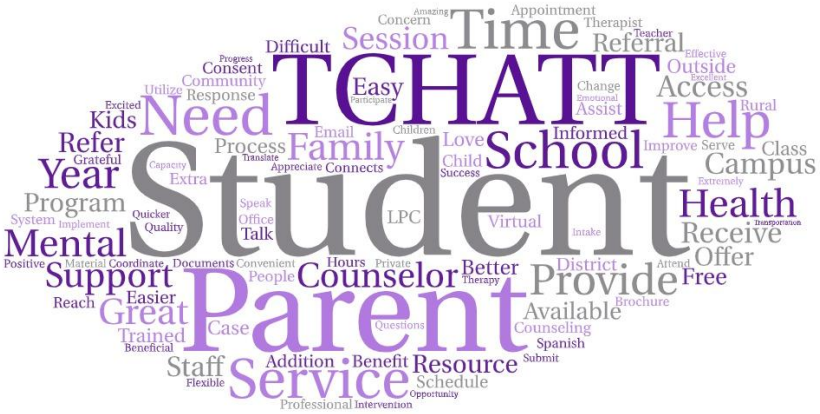
In summary, respondents provided positive feedback about their experiences with TCHATT generally and discussed reasons why implementation was lacking this past year. There were a few comments specific to Spanish-speaking parents and the intake process. While some respondents indicated that information was translated into Spanish for parents by TCHATT staff but would like materials like brochures to be translated into Spanish as well. Other comments reiterated the benefits such as the accessibility to students as well as areas of improvement already described previously such as cumbersome paperwork, a desire for more communication from TCHATT providers, more involvement with parents in the process, and a request for more student sessions, among others.

Summary

Respondents indicated that the biggest benefits of the program included accessibility of care for underserved students in need and that TCHATT provided a level of mental health care that cannot be provided by school counselors alone. Areas of improvement included the desire for an enhanced implementation process, better communication and follow-up, more training on campus, more flexibility in scheduling students, and additional sessions for students. Additional comments provided by TCHATT stakeholders included positive remarks about the TCHATT program, the desire for more training and more bilingual materials.

Figure 23 provides a visualization of the content discussed across open-ended questions in the survey, with the size of words depicting the frequency in which they were mentioned (highest frequency words larger; lower frequency words smaller).

Figure 23. Visual Content Analysis of TCHATT Qualitative Survey Data



In contrast with year one findings for TCHATT, less respondents reported that they did not implement the program. Respondents still believe that the top benefits of the TCHATT program are the accessibility of care for students as well as providing mental health services beyond the school counselors. Respondents also still requested very similar improvements to year 1 such as enhance implementation, more training for staff, better communication between school staff and TCHATT, more marketing materials and additional student sessions.

Recommendations

1) **Institute an enhanced implementation process**, including a more efficient and streamlined paperwork system that works better for both the counselors as well as the families they refer;

2) **Consider ways to improve communication and follow-up while students are involved in the TCHATT program**, including:

    a. a system to track students referred and those currently receiving services;

    b. better communication after student sessions and the plan for follow-up care after all sessions are completed;

3) **Increase access to bilingual TCHATT counselors** to address the needs of those students.

4) **Offer more training to campuses**, including:
    a. training on program implementation and expectations;
    b. refresher trainings throughout the school year;
    c. educational session to provide school counselors with the skills to help meet the needs of their students.

5) **Consider options for allowing more flexibility in scheduling students.**

Limitations

There are some limitations of the Year 2 school staff survey. Sampling for the external evaluation surveys prioritized ensuring that a diversity of segments was given the opportunity to respond, rather than focusing on rigorous, statistically representative estimates. Due to the voluntary nature of participation, providers who agreed to complete the survey may be more likely to provide more favorable responses. Further, the sample was drawn from the list of enrolled campuses as of March 11, 2022 and, therefore, may not represent school staff from campuses that enrolled after this time. These factors limit the conclusions that can be drawn from the results. Care should be taken when generalizing to groups that are substantially different from the respondents.

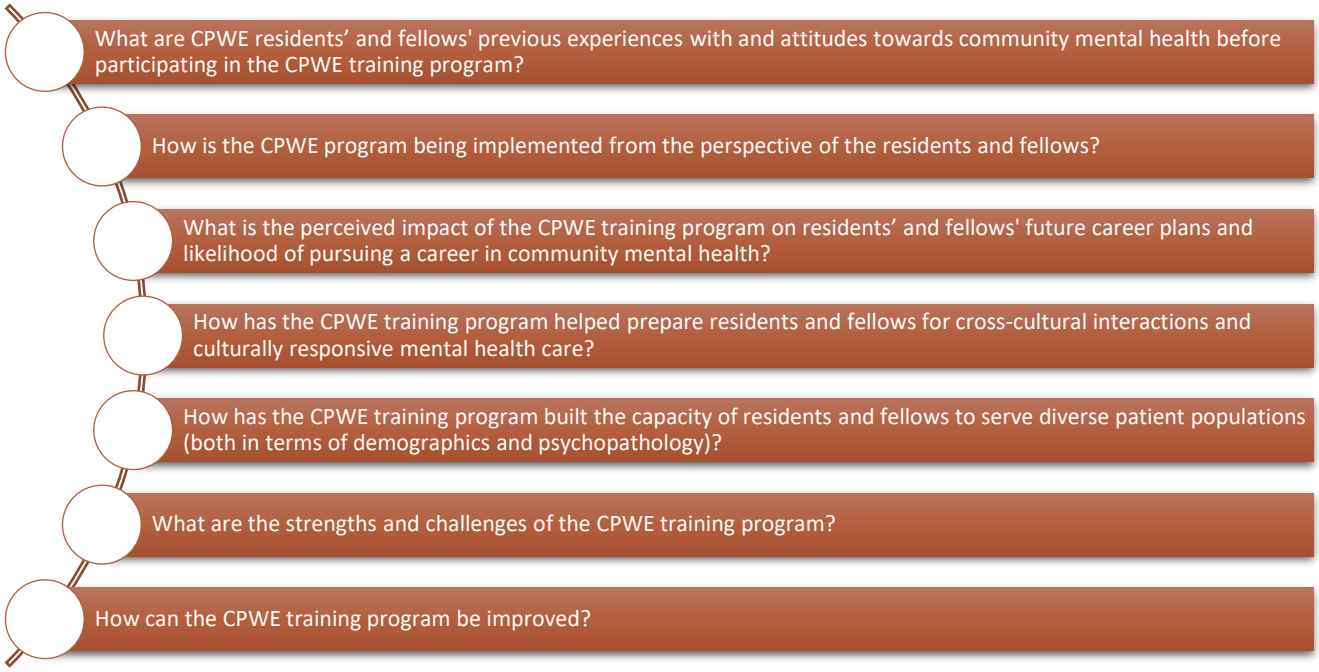
In addition, these findings are descriptive in nature and, therefore, should be interpreted carefully. Several variables (e.g., parental consent and participant outcomes) are from the perception of school staff and unable to be measured objectively.

CPWE QUALITATIVE INTERVIEWS

The UTHealth Houston External Evaluation team partnered with Decision Information Resources, Inc. (DIR) to conduct and analyze in-depth interviews with residents and fellows of the CPWE program as part of the external evaluation of TCMHCC's initiatives. Understanding the impacts of the CPWE program is an important component of determining whether TCHMHCC's goals for this initiative are being met. **The goals of the CPWE qualitative program evaluation are to understand trainees' (residents and fellows) (1) experiences during the CPWE program, (2) perceived impact of the program, (3) satisfaction with the program, and (4) recommendations for quality improvement.** A summary of the evaluation questions this qualitative program evaluation seeks to answer are provided in Figure 24. Qualitatively analyzing trainees' experiences, particularly as they relate to the strengths, challenges, and impacts of the CPWE program, can provide valuable information to the TCMHCC and CPWE program directors about what can be done to further support their goals of providing improved mental health care to underserved youth and support the development of future community mental health practitioners.

In the sections that follow, we discuss the methods used, highlight key findings, and offer recommendations as they pertain to program implementation.

Figure 24. Guiding Qualitative Program Evaluation Questions for CPWE: From the Perspective of the Residents and Fellows



Methods

Sample

We sought to engage a sample of trainees across HRIs, to understand their range of experiences as participants in the CPWE program. DIR invited CPWE trainees to take part in the interviews by email after receiving a list of eligible trainees by UTHealth Houston, who worked with directors of the HRIs to identify the sample. In essence, a purposive sampling method was used. The only eligibility requirement

was that residents and fellows were participating in the CPWE program. In total, 11 CPWE trainees (6 residents and 5 fellows) representing 10 different HRIs were interviewed as part of this Year 2 evaluation. Two of the participating HRIs did not have current or recent residents or fellows in the CPWE program; therefore, they could not be represented in the data collection and analysis. Table 14 provides an overview of interview participant characteristics and demographics.

In-depth Interviews

A semi-structured interview guide was developed with questions centered on understanding trainees' experiences during their training, perceived impact of the program, satisfaction, and recommendations for the program. Questions about trainees' experiences prior to participating in the CPWE program were included to gain a better understanding of trainees' experiences with and attitudes towards community mental health prior to participating in CPWE. This provided context and background information for each trainee, which helped further explain trainees' perceptions of the CPWE program.

Each in-depth interview was conducted by a lead interviewer and supported by a note taker. All 11 interviews were conducted via Zoom between June 27 and August 11, 2022. Residents and fellows were informed of their rights as participants in the evaluation, including confidentiality. Verbal consent and a request to audio record was requested of each participant ahead of their interview. Each participant was offered a $50 gift card as a thank you for their time.

Table 14. Year 2 Interview Participant Characteristics and Demographics[a]

	Total Trainees (n=11) n (%)
Participant Type	
Resident	6 (55%)
Fellow	5 (45%)
Graduating Class	
2014	1 (9%)
2015	1 (9%)
2017	2 (18%)
2018	2 (18%)
2019	4 (36%)
2020	1 (9%)
Ethnicity	
Hispanic/Latino	2 (18%)
Not Hispanic/Latino	8 (73%)
Unknown[b]	1 (9%)
Race[b]	
Asian	2 (18%)
Black/African American	2 (18%)
White/Caucasian	4 (36%)
Mixed	1 (9%)
Other	1 (9%)
Unknown[b]	1 (9%)
Gender	
Male	5 (45%)
Female	5 (45%)
Gender Fluid	1 (9%)

(a) Participants were asked basic open-ended demographic questions ahead of their interviews, without specific response options. The responses shown in the table are self-reported. (b) One participant did not provide information regarding their ethnicity or race as shown above; thus, reported as "Unknown".

Data Analysis

A team of three researchers trained in qualitative methods conducted a thematic analysis[7] to identify patterns and themes within the qualitative data collected. This iterative process included transcribing the audio files from each interview, reading through the transcripts for deeper understanding, and analyzing and interpreting the data using both deductive and inductive coding processes. We developed a qualitative codebook to guide the initial coding process, which was refined as the analysis continued. It included codes, definitions, and examples to ensure uniformity and reliability in applying codes. Inter-rater reliability was conducted to ensure consistency across coders. Second cycle coding was used to refine and categorize the data, as well as identify emerging themes. Data management and coding was conducted in NVivo, a computer-assisted qualitative data analysis software (CAQDAS) tool.

In the section that follows, we present the key learnings that emerged from the data as they relate to the goals of the qualitative program evaluation.

Results

Experience with Community Mental Health Prior to CPWE

Trainees varied in their experiences with community mental health prior to their CPWE training.

When trainees were asked about their understanding of community mental health (CMH) prior to entering the CPWE training program, their responses varied widely. Differences were particularly pronounced when looking at the experiences and attitudes of residents versus fellows. Overall, **residents generally went into their training optimistically, but with little understanding of CMH, working with children, and the goals of the CPWE program**. Residents often described their CPWE residency as a natural progression of their medical training in psychiatry, not a program they specifically sought out due to interest. Their CMH knowledge and experience were limited prior to their CPWE training. Aside from one resident, the majority also went into the CPWE program with no formal child psychiatry training other than school lectures and singular clinical experiences. They described working in other clinical settings such as acute, inpatient units and sometimes outpatient clinics, often focused on treating adult patients. Some indicated that they worked in other capacities within their LMHAs previously, providing a level of familiarity working in settings serving underserved patient populations.

Fellows generally reported having more CMH or child psychiatry experience than residents going into their CPWE training sites and had more of an understanding of what the CPWE program goals were when compared to residents. The majority of fellows reported that they were familiar with CMH settings, going into their CPWE rotations with prior knowledge or experience working in comparable settings or with similar patient populations. Fellows indicated that they purposefully sought out their fellowships because of a strong desire to pursue child and adolescent psychiatry as a career and experience working in diverse CMH settings. Often, their prior clinical rotations and residencies exposed them to child psychiatry and CMH, prompting them to seek specialization in these areas. Therefore, their attitudes were very favorable going into their CPWE training.

*"I'm not familiar with the [CPWE] prog*ram in general. I think it was built into our rotations. The first time I heard about it was *whenever I was emailed by you guys. That's the extent of knowing the name of the program and the goals of the program."* -PGY4 Resident

*"I had Harris Health outpat*ient experience in medicine and in some specialty care, but not necessarily mental health care. Most of my mental health exposure prior to this residency was acute care, so emergency room visits, inpatient consult *service. Not really any outpatient care."* -PGY3 Resident

"It's actually one of the things which brought me to the fellowship - having those multiple options, community reach options, which many programs still don't have across the country. Having that wide exposure to populations and settings wa*s one reason that I chose this fellowship."* -Fellow

"I heard about it through our residency and fellowship program. They had informed us about SB-11 and the expansions. My understanding was that it [CPWE] was funded through the Bill SB-11 which is trying to expand mental health access in Texas. That was where the funding for this rotation was coming from and that we would have two-month rotations to have *exposure to outpatient community health."* -Fellow

Experience During the CPWE Program

CPWE implementation focused on treating youth patients within community outpatient settings, but residents and fellows experienced their training differently.

When asked how the CPWE training is structured and implemented, there were commonalities and differences in the experiences of trainees. The biggest commonality was that residents and fellows alike **focused on child and adolescent psychiatry in a community mental health setting** as part of their CPWE training. They also equally discussed the importance of **regular supervision** by attending psychiatrists as part of their training, though fellows expressed having more autonomy in their training than residents. Both residents and fellows were provided important **clinical exposure** as well as an **educational experience** working alongside attendings and within interdisciplinary teams. For example, attendings provided guidance and a deeper understanding of psychological or behavioral presentations, treatment plans, medications, and other aspects of working with diverse patient populations in community settings. Interestingly, both residents and fellows reported taking part in **other SB-11 programs** (i.e., CPAN and TCHATT) as practitioners while participating in their CPWE training.

Despite commonalities, residents and fellows discussed several differences in the structure of their CPWE training**.** Perhaps the largest **difference is in the time spent at their CPWE placement sites** as a result of the way residencies versus fellowships are organized. Residents reported spending an entire year at their CPWE site, whereas fellows only spent approximately two months at their CPWE sites. This difference is important as time spent within the CPWE program can have an impact on trainees' overall experience. Residents spent consistent time in the same place with the same clinical staff (and often, patients) compared to fellows who did not get longer-term exposure to staff and patients in any one setting during their fellowships. Fellows rotated through multiple sites within the year focusing on different child patient presentations (e.g., eating disorders, neurological disorders, trauma, ADHD, etc.) and clinical settings (e.g., juvenile justice, schools, inpatient, outpatient, residential treatment centers, etc.). Only one of their rotations was at a CPWE training site, restricting their ability to build rapport with staff and patients, go beyond surface-level training and exposure, and fully understand how the clinics operate. Yet, they received a valuable, holistic experience of child psychiatry across all sites. Another **difference was in-person versus virtual treatment of patients**. All fellows engaged in in-person patient

visits as part of their training, whereas only half of residents reported seeing patients in person. On the other hand, all residents reported engaging in telehealth visits, as opposed to 60 percent of fellows. This, too, impacted the experience of CPWE trainees and how they assess and treat patients. Some residents shared how telehealth visits, while beneficial to patients who have limited access to resources, can affect how they assess and treat patients that they cannot observe and interact with face-to-face.

> *"One day in*-person visits and one day telehealth visits. We saw patients that were 4-18 years old, most of which are *Medicaid patients. They were often referred for various issues at school. The term used is 'at risk,' but basically, they're patients with either difficult social situations, poor performance or difficulties with school."* –PGY3 Resident
>
> *"I had one afternoon a week with one attending for the whole year. I don't think I had any other attending I was assigned to for the whole year. It was mostly telemedicine."* –PGY2 Resident
>
> *"You're traveling* to different places. You're introduced to multiple settings, multiple health systems in general. It's hectic. Sometimes you are transitioning all over the place, but at the same time, you're introduced to all the things that you need to know about psychia*try practice in Texas."* -Fellow
>
> *"I think in fellowship, you get more responsibility. There is more expectation that you're going to be the lead on* patient encounters and formulate the plans. There's an attending that supervises us, makes sure we run the plans by them, but the expectation is that you're going to come up with a plan to present to them and make sure that they *agree."* -Fellow

Perceived Impact of the CPWE Program

***The CPWE training did not impact trainees' future* career plans directly, but generally contributed positively to reaffirming career decisions or expanding their thinking about career options.**

When trainees were asked how the CPWE program has influenced their decisions about future career plans, the majority indicated that the **program did not directly impact their decision-making** but did provide a valuable learning experience. Trainees generally viewed the CPWE program as **one component of a larger integrated training experience** working across mental health systems and with diverse patient populations to build their skills and knowledge as psychiatrists. Forty-five percent of trainees shared that they are still undecided about the career path they will take, but more than half are considering CMH as an option. Fellows were more likely to consider working in CMH as a future career; however, this is not necessarily attributed to their CPWE training experience. During the interviews, fellows reported that their exposure to either working with children or working in a CMH environment prior to their rotation in the CPWE program led them to seek out this type of fellowship and **re-affirmed their decision to pursue a career working with youth in a CMH setting**. Not necessarily attributed solely to CPWE, some fellows also discussed how rotating through different settings as part of their fellowship and working with diverse populations opened their eyes to additional career possibilities. During the interviews, residents often indicated that the CPWE training program **broadened their understanding of the field of psychiatry and expanded their thinking about CMH as a future career option**. One resident shared that the CPWE program experience had a negative impact on their desire to pursue CMH due to workflow and resource challenges. Overall, the CPWE program offered exposure to CMH in a way that contributed positively to participants' training in psychiatry but did not directly impact their decision-making about future career paths.

"I have no set plans. I mean, I've thought of a few things. I thought about working for the VA [Veterans Affairs]. I've thought about working for the local AIDS Council here - I know that they're trying to expand psychiatric services and I think that would be very similar to the work at [CPWE clinic]. I've thought about applying to work at [CPWE clinic] too, or just doing *private practice. I'm still considering community stuff."* –PGY2 Resident

"The diversity of the population that I saw definitely changed my perspective on what I really wanted to work on and do. Not just the outpatient or inpatient settings, but even the population that I want to work with. A program that I can do for some of the kids, the immigrant population, with underprivileged services. I'm rethinking what I would want to do from that realm because I think that's more meaningful at this point, which I didn't know about. It's definitely going *to make a big impact on my career choice in the future… At this point, still deciding, but I'm leaning more towards*

CPWE program offers exposure to diverse patient populations that has helped prepare trainees for cross-cultural interactions and culturally responsive mental health care.

When discussing how the CPWE program has prepared trainees for working with culturally diverse patients, the general consensus was that sheer **exposure to diverse patients** has helped prepare them for providing individualized mental health care that is responsive to the needs and beliefs of their patients. Direct exposure to patients of different cultures and socioeconomic backgrounds, who exhibit a variety of symptoms and diagnoses, for example, provides **opportunities to learn** how patients express themselves, cope, and think about mental health care. CPWE trainees felt they were learning how to provide a level of care that meets the needs of patients. Both residents and fellows shared how direct exposure helped them **better understand the challenges of their patients** and how they impact treatment plans, how patients' cultural backgrounds and norms can influence treatment options, and how navigating nuances is important to delivering effective care.

Further, working in CMH settings allowed trainees to see how important **accessibility to mental health services** is to their patients, **contributing to their understanding of the need to reduce disparities**. While formal trainings on cultural competency and culturally responsive mental health care did not appear to be part of the CPWE training experience, experiential learning through direct exposure was a significant part of trainees' preparation for working with diverse patient populations and providing culturally responsive care. While not mentioned widely, other factors that prepared some trainees were opportunities for patient advocacy and prior clinical experiences.

*"I think just listening to patients' stories, to parents, and the*ir perspectives on discipline. I think it's opened my eyes *to, I guess, different cultural concepts on how to raise children and what people think is best."* –PGY3 Resident

*"I just feel they're [patients] so deserving with the services and support, and th*ey're receptive. You feel like you're part of the solution and you feel like progress is being made. You learn so much about people and their cultures and their perspectives and their motivations. That definitely is rooted in a community mental health experience more than *any other psychiatric rotation experience."* -Fellow

The CPWE program has built the capacity of trainees to serve diverse patient populations through exposure and enhancing knowledge of resources.

There was also discussion about how the CPWE program expanded trainees' capacity to serve diverse patient populations (i.e., both in terms of demographics and psychopathologies). Trainees indicated that **exposure to demographically diverse patients experiencing a variety of mental health conditions**

and **understanding community resources** to make referrals have been most impactful. Exposure and knowledge (e.g., understanding of patient socioeconomic and resource challenges; wide range of mental health conditions) acquired during the CPWE program has allowed trainees to consider the best and most cost-effective treatment options. During interviews, trainees shared how their exposure to patients experiencing different symptoms, diagnoses, and psychosocial stressors have also exposed them to a **variety of assessment strategies and treatment modalities** that have built their capacity as providers. Further, all trainees indicated that working with disadvantaged and underserved patients has **increased their flexibility in care**. Trainees shared how they have become acutely aware of the socioeconomic barriers their patients face seeking mental health services, whether it is transportation to and from visits, the cost of treatment and medications, long wait times for appointments, or other systemic issues that create gaps in care. Several residents shared how telehealth visits have been beneficial to their patients and allows them to maintain flexibility in the way they provide care. These factors were important to consider when providing treatment and making referrals. Sixty-seven percent of trainees explained how their knowledge of community resources has increased through their CPWE training, making them more confident in their ability to make patient referrals to counseling or social services, for example.

"The pathologies, the diagnoses I see in these individuals are very wide-ranging. It's rarely the same thing twice. I see a lot of individuals with different diagnoses, have different assessments, and because of that I've used a lot of *different treatment modalities. That has helped me learn more about the future."* –PGY2 Resident

"I think it made me much more aware of community resources, particularly for pediatric patients. For example, understanding the process of neurocognitive testing for autism, who you can refer for other public programs either *through the school system or otherwise. There were a lot of resources that I was not aware of."* –PGY3 Resident

"I would say that resource-wise, I'm more knowledgeable at this point for my patients - to make recommendations on the services they can have, what options we have in the community. I think that it makes me a little more *confident in providing service to these patients."* –Fellow

"I feel I really have a better understanding of when patients need certain levels of care, like inpatient versus long-term treatment versus outpatient. And I definitely have more experience working with care coordinators and therapists and knowing what res*ources are out there that patients might qualify for."* -Fellow

Satisfaction with the CPWE Program

Exposure to diverse patients in community settings and effective supervision were identified as the greatest strengths of the CPWE training program.

During the interviews, trainees indicated that **exposure to diverse patients** and **strong supervision** were the two greatest strengths of the CPWE program. All trainees believed that their exposure to diverse patients in community settings increased their capacity to provide quality care in the future. As discussed previously, exposure has enhanced the awareness, knowledge, and skills necessary to understand the needs of diverse patients and provide treatment in an individualized and culturally responsive way. Working within CMH settings also opened trainees' eyes to future career options, especially residents who had little prior experience working in such environments. Fellows, while not exclusive to their CPWE rotation, found exposure through working in multiple settings during their fellowship impactful. In terms of supervision, 60 percent of trainees identified it as a strength of the overall program. Specifically, they expressed that the time, attention, and feedback received from attendings and other mentors was helpful to their growth.

*"I think my clinic experience here was fantastic. I got an attending that was extremely attentive and provided high-*quality services to her patients, whom were on Medicaid and from a lower socioeconomic status. She provided awesome services, and really was able to connect well. Throughout that process, I really enjoyed learning from her, getting to work with these kids and our community. Because of that, since it was a positive experience, I think it benefited me as I start looking for jobs in community mental health. That was an area that I didn't have a ton of *exposure to throughout prior years of residency."* –PGY4 Resident

*"I think the biggest piece is that exposure and being open. Then co*mes knowledge gain and awareness, and that's such a big piece of the work we have *to do as a human race."* -Fellow

Other strengths were mentioned, too, though less widely across trainees. For residents, 67 percent indicated that **telehealth** was an asset to their training. No fellows shared the same sentiment, though they were less involved in virtual care than residents**. Inter-professional collaboration** and self-determination, or **autonomy**, over their work were also mentioned by some as strengths.

Complexity in treating patients, limited resources, and telehealth were seen as the biggest challenges experienced by residents, while time constraints was the biggest challenge among fellows.

There was a stark difference in the challenges experienced by residents and fellows in their CPWE training. Sixty-seven percent of residents identified **telehealth** as a challenge, and half of residents indicated that **complexity in treating patients** and dealing with **limited resources** were challenges. Interestingly, telehealth came up as both a strength and challenge of the program. Whereas telehealth was viewed favorably from a patient-access perspective, it was also seen as limiting residents' overall experience in evaluating and treating patients that they could not interact with face-to-face. Residents shared that children do not always have access to a quiet space, may experience unstable Wi-Fi connections, or may not have privacy to speak freely and honestly. Overall, residents saw telehealth as a necessary and useful tool, but would like to experience more in-person visits with patients. In terms of complexity in treating patients, residents shared their experiences working with children who have needs beyond mental health services making treatment tricky. For example, socioeconomic struggles that lead to unstable housing or food insecurity, lack of family involvement in treatment, or abusive home environments. They spoke of the difficulties treating child patients' mental health just to send them back to an environment that contributes to their struggles. This often goes hand-in-hand with the limited resources residents identified as a challenge. Even though the community-focused, systems-based care offered through their LMHAs is intended to provide holistic services to patients, residents described difficulties making referrals for things like therapy within their systems because of a lack of providers or other resources. This often resulted in long wait times for patients, affecting their treatment plans. While residents indicated that their knowledge of community-based resources increased, there was still difficulty connecting patients to them. Sometimes this was due to a lack of awareness of resources in their patients' communities or providers not accepting the insurance they have.

Fellows' biggest challenge was the **limited time spent at each rotation**, including their CPWE site. As mentioned previously, fellows described rotating through clinical placements every two months. While the breadth of their overall fellowship experience provided valuable exposure to many patient populations and clinical settings, the depth of their experience at each placement was limited. The transition from one

clinical setting to another was also difficult as it takes time to acclimate to new patients, colleagues, and system of care, and there was little time to do so.

Other challenges mentioned by trainees, though to a lesser extent, were **difficulty navigating work relationships** (e.g., with clinic staff), **program implementation challenges** (e.g., clashes between academic and community-based cultures; lack of awareness about program, expectations, and goals), **poor supervision** (e.g. difficulty contacting supervisors when they are not on-site), **workflow and logistical issues** (e.g. inefficient electronic medical records (EMR) system impacting patient care), and feelings of **lost learning opportunities** (e.g. not receiving comprehensive training on the larger system of care or resources available; restrictions due to the COVID-19 pandemic).

> *"Trying to talk to a kid over the phone is tricky. Trying to make sure that a kid is alone to talk to them. It's been hard* to ensure that the parent isn't actually listening in. I try, for the most part, with kids to get as accurate information as possible and also do due diligence of screening for any concerns, whether it'd be something like food insecurities of the kids or concerns of abuse happening in the home. That's always tricky over the phone because it's like, "Hey, do *you feel safe at home?" and you don't know who is listening."* –PGY3 Resident
>
> *"Psychiatric issues that arise are not in a vacuum and so there's a lot of psychosocial asp*ects to it, some of which you can try to address with parents and families, but a lot of which are really difficult to address. Sometimes you feel *hopeless, like, 'Oh, we're treating them and then sending them back into this really difficult environment.'* I guess not *being able to fix everything for patients, that's been very difficult."* -Fellow

Recommendations for Quality Improvement

Areas of improvement to the CPWE program identified by trainees largely reflected the challenges experienced.

When discussing areas of improvement to the CPWE program, residents and fellows primarily reflected on the challenges they experienced. However, it is important to note that participants were highly satisfied overall with their CPWE training experiences, rating it an average of 8 (range of 2 to 10) on a scale from 1 to 10. For residents, improvements around **stronger supports and resources** to effectively treat patients experiencing complex psychosocial and socioeconomic issues is an area of improvement. Support can be in the form of individual supervision or patient supports within the larger system of care (e.g., care coordinators and social service supports). They also expressed a desire to have **more in-person patient visits** in additional to telehealth to enhance their learning and ability to provide effective care. Additionally, **learning opportunities** to enhance understanding of the larger system of care, how to navigate it, and what resources are available would be a beneficial improvement. Some also mentioned that an **orientation and introduction to the CPWE program**, as well as goals and expectations, would be useful before the placement begins. For fellows, they suggested considering **how time limitations at rotations could be addressed** to the extent possible. They acknowledged that the structure of their fellowships provides excellent exposure to multi-faceted areas of child psychiatry but time constraints impact their ability to dive deeper into the experience (e.g., patients; systems) and can affect patient care (e.g., building rapport; turnover in care).

"I'd like for all the patients to have to come in person but, I don't think that that's unique to the CPWE program." – PGY3 Resident

*"We hate to have to change e*very two months. Then patients lose hope because every time they get there-- it affects rapport, *it affects compliance."* -Fellow

Summary

The Year 2 qualitative program evaluation of the CPWE program focused on exploring trainees' (1) experiences during the CPW program, (2) perceived impact of the program, (3) satisfaction with the program, and (4) recommendations for quality improvement. Through in-depth interviews conducted with trainees of the program across participating HRIs, there continues to be emerging evidence of the CPWE initiative preparing trainees to serve the diverse needs of patients of the public mental health system in the long term while building the capacity of LMHAs to serve medically underserved youth in the short term.

The key learnings from the in-depth interviews support some of the learnings in the Year 1 qualitative evaluation report—the CPWE program is **building the capacity of trainees to effectively serve diverse patient populations** in public mental health settings and is **contributing positively to their overall training in psychiatry**. The program itself is **not directly impacting decision making about future career plans** but is **expanding trainees' thinking about community mental health as an option**.

This year, we learned that **implementation of the CPWE program varies widely** across participating HRIs and those entering as residents versus fellows. This variation makes it difficult to generalize the experiences across all sites and trainees; however, there were important insights gleaned that could help program directors understand the strengths, challenges, and areas of improvement. The greatest strength of the CPWE program was exposure. **Exposure to diverse patients and community-based clinical settings** was found to build the capacity of trainees to provide individualized and culturally responsive patient care. It helped them understand the challenges faced by their patients and offer **flexibility in care**. Enhanced **resource knowledge** was also seen as a strength of the program, equipping trainees with the ability to make meaningful patient referrals. Finally, **strong supervision and mentorship** was seen as a strength of the CPWE program, particularly as it relates to the time, attention, and feedback provided throughout the training experience.

Challenges of the CPWE training program were perceived differently by residents versus fellows. Residents found the **complexity in patient presentations and care to be challenging**, especially as it relates to addressing child needs beyond mental health care with limited resources. Although patients tended to favor **telehealth**, residents found it to be a major challenge when evaluating and treating children that they cannot observe in person and who may not have access to quiet, safe, and private spaces with reliable Wi-Fi. Fellows' biggest challenge was **limited time in clinical rotations**, including their CPWE placement. This impacted their acclimation to new patients, staff, and systems as well as interrupted patient care due to turnover in providers. The challenges experienced by trainees were reflected in their suggested program improvements. For example, residents would like to see **improvements to supports and resources** to help address treatment of complex cases and make appropriate referrals, enhanced **learning opportunities** to better understand systems of care and

community resources, and **more in-person visits** with patients to improve their overall training experience and provide more effective care to patients. Fellows would like the CPWE program to **consider the time limitations** of their training experience and how their placements can be improved from individual learning and patient care perspectives.

The implementation of the CPWE program is still in the early stages of implementation; therefore, it will take time to see the full impact of the program on trainees and communities. Year 2 of the CPWE program has shown promising indicators of progress toward accomplishing its goals, as indicated in the qualitative findings above. The learnings so far also highlight areas of opportunity as implementation of the CPWE program continues and expands and the evaluation progresses.

Recommendations

1) **Offer a formal orientation to the CPWE program** to ensure that all trainees understand the goals and expectations of the CPWE program, especially for trainees with little prior experience in CMH and with children and adolescents.

2) **Consider extending fellows' time at CPWE training sites** to provide an opportunity to gain a deeper-level training experience and build rapport with staff and patients.

3) **Continue to provide strong supervision to trainees**, which was perceived as a strength to the program.

4) Although telehealth was perceived as an asset, many residents identified it as a challenge. Therefore, **providing further guidance and best practices related to telehealth to residents may be beneficial**.

5) Although CPWE contributed positively to trainee's experience in psychiatry, it did not directly impact their decisions regarding their future career paths, particularly for residents; this was partly due to residents' perceived complexity in treating patients and limited resources. Therefore, **focusing on mitigating these challenges (e.g., providing individual supervision and more in-patient visits) may help increase trainees' future decisions to continue in CMH**.

Limitations

There is much more to learn in the third year evaluation as it explores the implementation of the CPWE initiative across HRIs and longer-term impacts. Documentation of CPWE initiative implementation, and how uniform or varied it is across HRIs, was limited. In contrast to Year 1, we did randomly select residents from each HRI; however, our sample was still one of convenience since many residents did not respond to our outreach attempts and, in some cases, some HRIs only had a handful of residents to choose from. Limitations of this method include the potential of a non-representative sample and introducing respondent bias since residents who agreed to be interviewed may be more likely to provide more favorable responses. Additionally, triangulating resident interview data with other data sources such as surveys or interviews with other key stakeholders (e.g., HRI staff responsible for implementation) would be advantageous to evaluating the CPWE program. In the next year, it will be important to continue embarking on a learning and discovery journey to better understand the CPWE initiative from the resident selection and onboarding process, to the ways HRIs are structuring and implementing the residencies.

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