

**1. PROJECT IDENTIFICATION**

**Project Title:** GOALS

**Project Number:** H17MC04359

**Project Director:** Celia Neavel, M.D.

**Grantee Organization:** People's Community Clinic

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**Project Period:** March 1, 2005 to February 28, 2010

**Total Amount of Grant Awarded:** \$250,000

# PEOPLE'S COMMUNITY CLINIC

## GOALS Final Report

**1. PURPOSE OF THE PROJECT:** One of the oldest, continuously running independent primary care clinics in the country, People's Community Clinic (PCC) is a 40-year Austin tradition. PCC serves the uninsured and uninsured of Central Texas. Most patients are from working families earning too much to qualify for entitlements but unable to afford healthcare insurance premiums. Many of the pediatric and adolescent patients qualify for CHIP or Medicaid, but most Central providers do not accept these forms of insurance, and access is a problem. PCC's patient population includes homeless and at-risk adolescents, low-income pregnant women and teens, and older (55+) low-income adults. The Clinic is the medical home for 11,000 patients, providing the continuity of care that an Emergency Room simply is not designed to offer. PCC provides these health care services on a sliding scale basis according to the patients' income.

The GOALS Program is a behavioral developmental primary care program for youth ages 4-15 focusing on integrating behavioral and developmental health into a comprehensive primary care model. In 2002, the Indigent Care Collaboration (ICC) of Austin issued a report finding that, because of the pervasive lack of health insurance among the working poor of this area, 20 percent of the population needed mental health services, but less than 3 percent of children in the Austin-San Marcos SMSA received that care, and this is still true today. Many obstacles face these complex young patients.

Austin Travis County Integral Care facilities only accept the most severe patients with thought disorders or clear suicide risk. Medicaid and CHIP managed care

organizations do not always make pediatric-trained mental health providers easily accessible, and access to bilingual mental health providers is particularly problematic. When a family does go to Psychiatric Emergency Services, a child and adolescent psychiatrist may not be available. Mental health access remains a critical problem for Central Texas.

In addition, school districts are over-burdened in trying to identify and obtain help for students with delays and/or behavior problems. Economically and culturally disadvantaged families often do not understand how to advocate for and obtain appropriate services for their children, especially given the barriers above, and comprehensive intervention is needed when delays or behavioral issues impair a child's development and function. Intervention is needed both for the youth of low-income families already utilizing our Clinic, as well as for referred youth. Youth specifically referred to PCC for developmental/behavioral intervention are often in need of primary medical care and a medical home.

The GOALS Program was formalized in 2005 to address the need in the Austin/Central Texas area for the ongoing coordination of developmental, behavioral, and mental health as well as physical health needs in identified low-income youth. The program follows the American Academy of Pediatrics model of a medical home, delivering "primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective", something especially important for youth with special needs. The program includes screening, specific expertise in evaluation and management of more complex behavioral and developmental patients and their families, frequent interactions with area schools and youth-serving agencies, and

ongoing coordination of care. PCC screens about 1,500 patients ages 4-15 annually during their routine PCC medical visits, and between youth identified within our own clinic and youth specifically referred in from outside schools and agencies, GOALS follows approximately 250 patients with more intensive services.

By expanding the identification of children with special health care needs and providing a medical home to these patients, the GOALS program addresses the first three Healthy People 2010 objectives:

- (1). Related to Objective 16.23. Increase the proportion of Territories and States that have service systems for children with Special Health Care Needs to 100 percent.
- (2). Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.
- (3). Related to Objective 23.11 (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

Rating scales, school records, and other medical records are utilized to better define the diagnoses and needs of youth and families. Examples of diagnoses of GOALS patients include ADHD, Anxiety, Depression and other Mood Disorders, Language and other Academic Delays, Autism Spectrum Disorders, Sensory Integration and Coordination Disorders, and Parent-Child Problems that require a team-based approach. In addition, many of the children have co-occurring medical problems such as Asthma, Obstructive Sleep Apnea, complications of Obesity, and other disorders that need specific medical intervention.

GOALS team members include specialty-trained physicians, social workers, a psychologist, and a psychiatrist. Dr. Celia Neavel directs the GOALS program and has fellowship training in both adolescent and developmental medicine. She is faculty with the local pediatric residency program and lectures and supervises pediatric interns in developmental medicine and ensures the residents' exposure to an integrated behavioral health model. The Clinic's Chief Medical Officer and Director of Pediatrics, Dr. Louis Appel is a member of the GOALS team. He is an active member of the Texas Pediatric Society and serves as Co-Chair of TPS' Committee on Community Health Advocacy. He also serves as District CATCH Facilitator for District VII of the American Academy of Pediatrics. Social workers are vital in sustaining relationships through visits with families during routine medical visits, case management, telephone and in-office consultations, and general coordination of care. In addition, pediatric residents in training rotate through the Clinic, participating in evaluations and learning its interdisciplinary model of care, including the GOALS best practices.

Referrals are made to outside agencies such as Easter Seals Central Texas, Austin Child Guidance Center, LifeWorks, Austin Travis County Integral Care, and other physician specialists as needed. Collaboration also occurs through our GOALS Advisory Council which meets quarterly and is composed of community stakeholders. During these meetings, resources are shared and best practices are discussed. The program continues to evolve in determining best measures of effectiveness and ways to involve families and local agencies. Our experience has shown that collaborating with school districts has led to improved outcomes for our patients. We anticipate that future funding will enable us to further develop our program as a needed resource for our community with special

attention to increased school advocacy, implementation of staff in-services, and program evaluation tools.

The GOALS primary care team approach is highly effective, and over time the pediatric providers have learned to use the social workers and the consulting psychologist and psychiatrist as valuable resources. The GOALS program has been institutionalized into the People's Community Clinic model of care and paved the way for the Integrated Behavioral Health program pilot funded by the Hogg Foundation for Mental Health and the St. David's Foundation to serve PCC's adult patients. PCC now offers behavioral health services to patients of all ages, and the ease with which the Clinic integrated these services into the practice was due to the earlier successful adoption of the GOALS model.

We expect the program to continue to increase its impact on the community, both through its work with children and families and as a model of care. Project Director Dr. Celia Neavel is Associate Clinical Professor with University of Texas Southwestern Austin Pediatrics and is a strong advocate for the expansion of developmental/behavioral services for youth with special needs in a primary care setting. In 2007 Dr. Neavel received the *Ambassador Award* from St. Luke's Episcopal Health Charities in recognition of her leadership and vision in creating comprehensive health program for the underserved and uninsured adolescents in Central Texas.

In 2009 the GOALS Program received a grant from the St. Luke's Episcopal Health System and will receive funding from the St. David's Foundation in 2010. St. David's Foundation is also considering enlisting Dr. Toni Watt, Associate Professor in the Sociology Department at Texas State University to evaluate PCC's GOALS Program and the development/behavioral program at Lone Star Circle of Care.

**2. GOALS AND OBJECTIVES:** From the beginning the overarching goals of the GOALS Program have been to provide an improved permanent system of behavioral/mental health/developmental screening, assessment, and care coordination for pediatric and adolescent patients currently using the Clinic as their medical home; and to offer an improved, formalized resource to the larger Central Texas community by providing diagnostic assessments, case coordination, and a “medical home” to youth and families referred specifically to us by schools, youth-serving agencies, and individuals because of behavioral/developmental/mental health concerns.

Objective 1: PCC child/adolescent 4-15 year old patients (approximately 1,500 annually) will receive a behavioral/developmental screening at each well visit, or at acute visits at the discretion of the health care provider.

*Measurement:* 100 percent of 4-15 year old patients (approximately 1,500 annually) will receive developmental/ behavioral screening at their annual well child check.

Objective 2: Those patients with an identified need for behavioral/developmental/mental health assessments and services will receive them; more involved patients will be enrolled in the specialized GOALS program.

*Measurement:* 35 youth will receive full developmental assessments.

*Measurement:* 60 patient visits with a psychiatrist and psychologist will take place at the Clinic.

Objective 3: The Clinic will serve as the ongoing “medical home” for the children and adolescents referred from outside agencies, including primary health care, ongoing service coordination, medication management, follow-up, and referral as needed.

*Measurement:* 25 new PCC patients will be added through participation in the GOALS Program.

**3. METHODOLOGY:** The GOALS Program promotes optimal developmental functioning, wellness, and mental health. Diagnostic and treatment services are included as an essential part of child health. Basic elements include:

- Behavioral/developmental screenings and assessments of the pediatric and adolescent patients at PCC, and assessments of new patients referred by outside agencies;
- Psychiatric and psychological consultation/evaluation as indicated;
- Short-term, limited "bridging" of patients to specialized service providers in the community;
- A medical home for the ongoing coordination of physical, developmental, and mental health care, follow-up, and referral as needed;
- Medication management as appropriate;
- Serving as a resource for community agencies and school districts;
- Developing a reproducible model and serving as a teaching site for interdisciplinary and integrated health and
- Acting as a focal point for the development of family support systems.

For routine Well Child Check-ups for current PCC patients, a medical assistant (MA) gathers basic information, such as weight, height, etc. and inquires about current health. For Well-Child Checks in children ages 4 and up, the medical assistant gives age-specific handouts on child development. The MA also reviews with the family a few health and developmental issues (behavior issues, family stresses, type of child care, learning



problems, sleep problems, etc.) from the age-specific Well-Child exam form. For Well-Child Checks in adolescents (11 and older), the providers, health educators, or social workers review information with the youth and his/her accompanying adult. A structured interview following the H(home) E(eating) E(education) A (activities) D(drugs) D(depression) S(safety) S (strengths) S(sexuality) mnemonic is utilized. At all Well Check-ups and at provider discretion for patients 4-15 years of age, PCC additionally screens with the Pediatric Symptom Checklist (PSC) in English or Spanish. All accompanying adults receive the checklists, and youth 11-15 receive a version as well. This simple checklist is used to alert the medical staff to the possibility of a behavioral/developmental or mental health issue. After completing the checklist, the MA includes the checklist in the patient chart for the provider.

During the provider's visit with the patient and family, more information is gathered specifically following up on concerns raised by the PSC or in the course of the visit. The provider reviews further developmental questions outlined on the Well-Child Exam forms. If the provider finds that the patient/family is in crisis, the provider evaluates the situation and refers the patient to a PCC social worker. The provider or social worker may arrange for emergency services through the PCC consulting psychiatrist or in the community, for example through Safe Place, or Austin Travis County Integral Care Psychiatric Emergency Services. If the patient/family is not in crisis, but the patient has behavioral or developmental problems, the provider may then refer the patient to the GOALS program for more comprehensive evaluation. The social worker also may schedule the patient for a follow-up social work visit.

Patients and families with already identified problems who are specifically referred into PCC by an outside school or agency will be automatically enrolled in the GOALS Program and receive any needed primary health care, including a Well Child Check at the first visit, in addition to the comprehensive developmental/behavioral assessment.

Once referred to the GOALS program, the comprehensive developmental/behavioral/mental health assessment for both internal and external referrals typically entails a much longer provider visit utilizing a structured developmental assessment form, social work intake, and further self-report tools. Assessment tools used may include behavior checklists such as in the American Academy of Pediatrics' ADHD toolkit. The Achenbach series of behavior rating scales is utilized to gain information regarding the child's behavior and symptoms. These scales are completed by the child's parent and teacher; self-reports are completed by patients ages 11-18. In the case of suspected Autism Spectrum Disorder, the Social Responsiveness Scale is administered and interpreted and may be staffed with the GOALS program Psychologist. Other tests may be given or suggested by the provider or psychologist based on individual need. Referral for further diagnostic testing or specific evaluations will be coordinated as needed, and may include speech and language or occupational therapy assessments through the school or Easter Seals of Central Texas or another organization, or psycho-educational testing through the school, another agency, or consulting psychologist. The GOALS social worker works very closely with the family and other agencies to facilitate the appointment and to ensure the results of outside evaluations are integrated into the GOALS program treatment plan.

The Clinic psychologist may provide identified patients with formalized psychological or psycho-educational testing. The psychologist is consulted on patients presenting with particularly challenging learning disabilities and/or mental health concerns. When determined appropriate, the psychologist conducts brief assessments at PCC which may include IQ and specific learning disability testing, or Continuous Performance Testing for suspected attentional problems. When a more comprehensive evaluation is appropriate, the Clinic has contracted with several psychologists to conduct more in-depth mental health diagnostic testing. The sophisticated testing provided by psychologists is critical in helping with diagnosing learning problems, processing problems, pervasive developmental disorders, thought disorders, anxiety, and depression.

Records of any past developmental or psychological testing are reviewed during the evaluation process. After testing is completed, the psychologist's report is filed in the patient record and reviewed by the provider and social worker. If no specific diagnosed condition is identified, the provider or psychologist discusses the findings with the patient/family and continues to monitor the patient at return visits. If a developmental or mental health issue is identified, the provider or psychologist and appropriate PCC staff, such as the social worker, meet with the patient, family, and other concerned, involved individuals, to discuss testing results and possible intervention options that may be pursued to address the condition. The psychologist also may make specific recommendations to be shared with the patients' schools.

Through GOALS Program, a child and adolescent psychiatrist consults three hours once a month. The youth and his/her family meet with the consulting psychiatrist, PCC social workers, Dr. Neavel, and involved pediatric residents in a round table format to

review diagnostic, treatment, and medication issues. This group intervention has proved very successful in maintaining an integrated, holistic approach to mental health issues for those patients needing more intensive care. Team approach models such as these have proven to be very cost-effective and efficient. Recommendations are developed at this meeting, which may include treatment, medication, further evaluations, and/or referral. PCC staff then assists the family with implementing the recommendations, and performs regular follow-up with the family and outside agencies to facilitate their accomplishment. Progress is documented by PCC in the patient record. The child/adolescent continues to receive primary physical/mental health care, diagnostic re-evaluation, and ongoing needs assessment and support through People's Community Clinic. Observing patients with the consultant psychiatrist also allows GOALS team members to feel more comfortable assessing and treating mental health problems when the psychiatrist is not present.

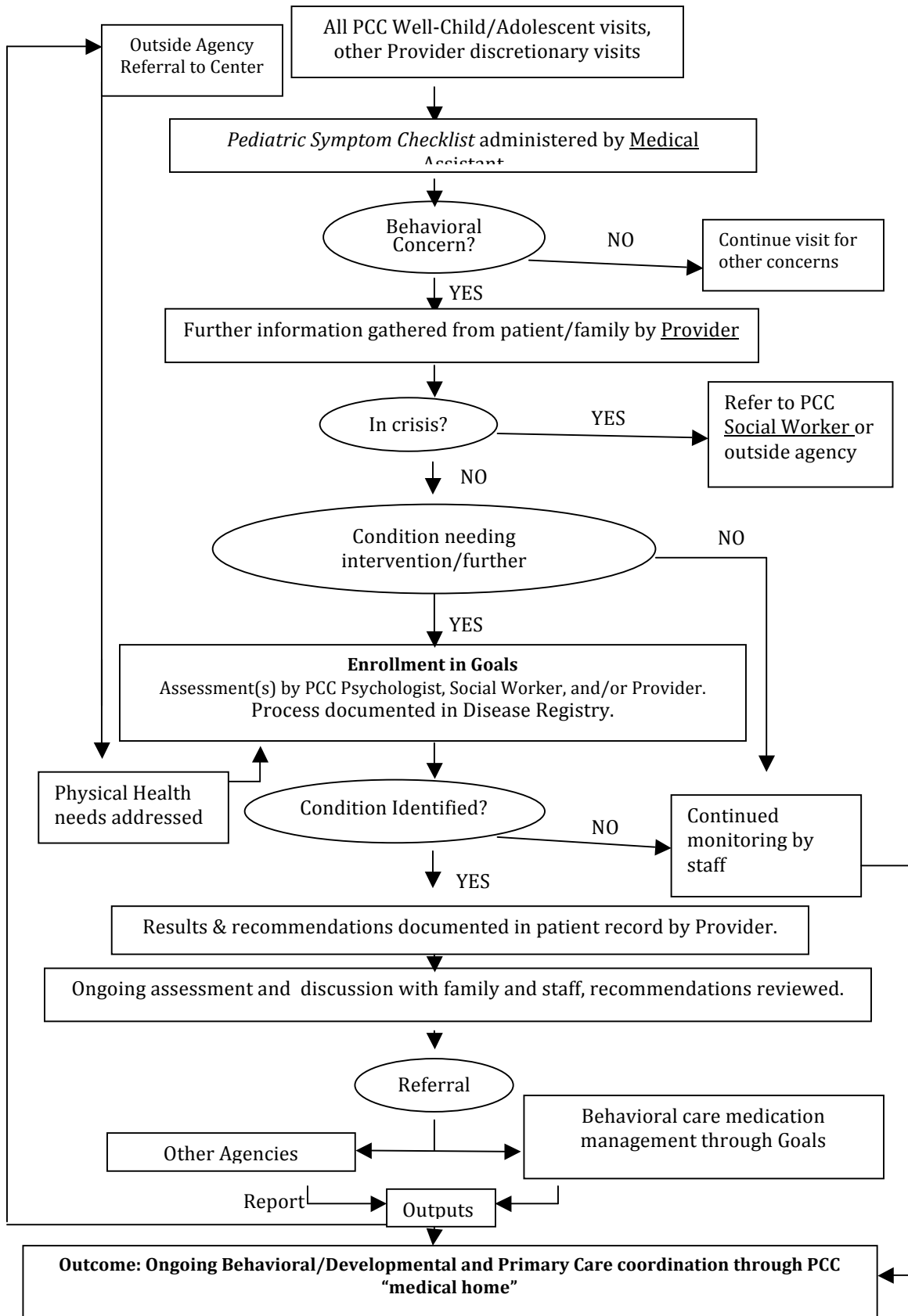
A specific benefit of the GOALS model is its continuity of care. Often behavioral/developmental assessments are done as a "snapshot." Patients at PCC are followed over time, allowing for a better understanding of each patient's unique issues. Families and patients become comfortable sharing more information and calling in times of crisis. For example, what looks like ADHD may in time be identified more clearly as Bipolar Disorder. Also, some patients and families may initially be reluctant to deal with developmental or behavioral/mental health issues but, since PCC is their medical home, these issues will be addressed as they come in for acute illnesses, smoothly integrating a total wellness model. Disorders such as receptive/expressive language delay or developmental coordination disorder can be monitored to ensure patients receive services through different grades and schools. Since some disorders are genetic, other siblings,

cousins, and even parents can be identified and offered evaluations or given referrals as appropriate.

PCC has established an Advisory Council for GOALS Program. (See Appendices 1-3 for Advisory Council Meeting Minutes.) Members are a diverse group and include school professionals from area school districts, physicians, a grandparent, local university faculty, and other non-profit professionals. The Advisory Council meets regularly and has become an important source for ongoing communication, networking, and learning about community resources. The Council also helps with referrals of appropriate youth to the program and with the program's visibility as a Central Texas resource. The ongoing work of the Council includes:

- Contributing to, reviewing and recommending approval of the organizational approach for assuring local determination and integration;
- Providing advice regarding program direction in light of community needs;
- Participating in discussion related to allocation and management of project resources;
- Putting in place conflict of interest policies governing all activities;
- Being aware of program management and activities such as data collection, monitoring, and evaluation, public education, and assuring continuity of care;
- Sharing responsibility for the identification and maximization of resources and community ownership to sustain project services beyond the project period;
- Reviewing cultural issues and needs of particular populations served by the project;
- Sharing information about community resources.

## PCC Goals Program



**4. EVALUATION:** Evaluation is conducted by staff using data from PCC's disease registry, social work records, practice management software, and chart audits to ensure that the program is meeting its objectives. The part-time psychologist on the GOALS team assists in program evaluation. This year People's Community Clinic adopted Next Gen practice management and electronic medical records software, and the developmental assessment information is now entered manually into the patient's Next Gen record. The GOALS team is assessing the feasibility of an interface between the disease registry and Next Gen, partially funded through a state grant.

Reports are run from the current disease registry system (DocSite) for the Project Director and Advisory Council to ensure that the program is conducted in a manner consistent with achieving program goals and objectives. The primary indicators tracked include numbers of: GOALS patients enrolled, developmental assessments conducted, psychiatry/psychology visits, external referrals, last Well-Child Check-up and changes in school services. The program utilizes a satisfaction survey to ensure feedback from all GOALS patients and families. Portions of the survey were modeled after the National Survey for Children with Special Health Care Needs to include an assessment of family-centered and culturally sensitive care. This year we began to gather pilot data on the Parent Stress Inventory-Short Form as a potential outcome measure for the program.

**5. RESULTS/OUTCOMES:** In 2009, the Clinic served almost 6,000 unduplicated patients; 1,944 were between the ages of 0 and 18. 73% were living at or below 100% of poverty and 93% of patients were living at or below 200% of poverty. 74% were Hispanic, 8% African-American, 17% White, and 1% other. Of the 263 GOALS patients 66% were Hispanic, 20% African-American, 13% White, and 1% Asian. Though some of

the GOALS patients are self or parent referred, many are referred by local schools, youth agencies, or the juvenile justice system.

From March 1, 2009 through February 28, 2010 PCC through its Well-Child Checks screened 1,500 children and adolescents for developmental or behavioral problems. During this period 253 patients were enrolled in the GOALS program and 66 full developmental assessments were provided (including 50 new patients from outside referrals). Over time the systems and practices of the GOALS program have become institutionalized at People's Community Clinic, and we expect this model to continue to serve us well.

**Program Goals:** to provide an improved permanent system of behavioral/mental health/developmental screening, assessment, and care coordination for pediatric and adolescent patients and to offer an improved, formalized resource to the Central Texas community by providing diagnostic assessments, case coordination, and a “medical home” to youth referred to us.

Objective 1: PCC child/adolescent 4-15 year old patients (approximately 1,500 annually) will receive a behavioral/developmental screening at each well visit, or at acute visits at the discretion of the health care provider.

*Measurement:* 100 percent of 4-15 year old patients (approximately 1,500 annually) will receive developmental/ behavioral screening at their annual well child check.

From March 1, 2009 to February 28, 2010, 100% of all 4-15 year olds received appropriate developmental/ behavioral screening such as the PDQ II Denver Assessment, Ages and Stages, specific developmental questions built into the



WCC forms, the Pediatric Symptom Checklist and the HEEADDSS structured interview for adolescents.

Objective 2: Those patients with an identified need for behavioral/developmental/mental health assessments and services will receive them; more involved patients will be enrolled in the specialized GOALS program.

*Measurement:* 35 youth will receive full developmental assessments.

*Measurement:* 60 patient visits with a psychiatrist and psychologist will take place at the Clinic.

From March 1, 2009 through February 28, 2010, 66 youth received full developmental assessments (188% of the goal) and 69 patient visits with a psychiatrist or psychologist took place at the Clinic (115% of the goal).

As PCC and GOALS staff and our consulting psychiatrist and psychologist have become more familiar with each others' approaches to various mental and behavioral health problems, we have been able to utilize these consultations more fully by increasing the number of staffing and chart reviews without the patients present. We staff between two and six patients per psychiatrist and psychologist meeting.

This past year the GOALS Social Worker and Psychologist introduced a parenting group with some of the established parents of GOALS children.

Effective parenting techniques were reviewed and discussed. Parents were given the opportunity to share concerns and meet other families with similar challenges.

A Spanish speaking parenting group followed and additional parenting groups are planned for the summer of 2010.

Objective 3: The Clinic will serve as the ongoing “medical home” for the children and adolescents referred from outside agencies, including primary health care, ongoing service coordination, medication management, follow-up, and referral as needed.

*Measurement*: 25 new PCC patients will be added through participation in the GOALS Program.

From March 1, 2009 through February 28, 2010, 50 new PCC patients were added through participation in the GOALS Program (200% of the goal).

GOALS Social Worker Anna Blomquist continues to attend outreach events to increase teacher and other youth-serving professional awareness of the program as a resource, most recently Austin’s Autism Expo held at Easter Seals Central Texas. An outreach letter including a GOALS referral form for teachers is mailed once a year to all AISD elementary, middle and high schools at the beginning of the school year. Outreach also happens on a less formal basis. Ms. Blomquist speaks frequently to school and agency personnel to advocate for specific Goals patients. As she develops these more personal relationships with schools and agencies, more new patients are appropriately referred. We also track the following measures to establish a baseline for future improvement:

*Measurement*: number of patients to have a change in school services to those more appropriate to patient needs, as indicated in the assessment.

From March 1, 2009 to February 28, 2010 33 patients were made eligible for special education services or had a change in their specific designations (e.g. Section 504, Learning Disabled, Otherwise Health Impaired, or other categories.)

*Measurement:* The Goals Program Survey was administered to obtain information about patient experiences with service delivery (medical care, social work services, appointments and reception), as well as overall satisfaction with the program. Another aim of the survey was to obtain information about experiences with family-centered and culturally sensitive care—central characteristics of a medical home that the GOALS program works to achieve. The survey data has been analyzed and a final report of the results is in preparation. The results were overwhelmingly positive with an overall satisfaction of service delivery of 95%. On question assessing family-centered care, the majority (88.3%-100%) of caregivers reported positively.

**6. PUBLICATIONS/PRODUCTS:** The GOALS Program designed a brochure (available upon request) that was available in early spring of 2007. We have been exploring possible publication about aspects of the program.

**7. DISSEMINATION/UTILIZATION OF RESULTS:** Project Director Dr. Celia Neavel was joined by Dr. Lynda Frost of the Hogg Foundation for Mental Health and Ms. Robin Rosell, Director of Social Services at PCC for a 3.5 hour Institute “Integrating Behavioral Health in Adolescent Primary Care: Making It Work in Your Practice” at the Society for Adolescent Health and Medicine Annual Meeting on Toronto on April 7, 2010.

**8. FUTURE PLANS/FOLLOW-UP:** HRSA’s support for the GOALS project over the last five years has institutionalized the program as part of People’s Community Clinic model of care. Its success paved the way for the pilot program in integrated behavioral health initially funded by the Hogg Foundation for Mental Health and the St. David’s

Foundation. PCC now offers behavioral health services to patients of all ages, and the ease with which the Clinic integrated these services into a primary care practice was due to the successful adoption of the GOALS model. The GOALS team and People's Community Clinic very much appreciate the support and technical assistance provided by Healthy Tomorrows. The support has helped the GOALS program to become firmly established and sustainable.

We continue to refine practices and evaluation tools. It seems likely that Dr. Toni Watt, Associate Professor in the Sociology Department at Texas State University will be evaluating the GOALS Program along with the development/behavioral program of another non-profit serving low-income families, Lone Star Circle of Care, and this will be an opportunity to consider where we are and where we want to go from here.

**9. SUSTAINABILITY EFFORTS:** The Clinic's budget for 2010 is approximately \$7.6 million. Financial oversight is provided by PCC's CFO and staff, with the annual audit performed by Montemayor, LLP. The GOALS program will receive funding from the St. David's Foundation in 2010, and we are seeking renewed funding from St. Luke's Episcopal Health System as well. People's Community Clinic continues to enjoy great support from foundation, corporate and private donors in the Central Texas area. In addition to great support provided by individual donors in our community, the Clinic enjoys the support of over thirty foundations and private companies, as well as federal, state, and city/county contracts.

## **Appendices**

- 1. GOALS Advisory Council Meeting Minutes May 2009—page 22**
- 2. GOALS Advisory Council Meeting Minutes September 2009—page 24**
- 3. GOALS Advisory Council Meeting Minutes April 2010—page 26**

## **Appendix 1**

### **GOALS Advisory Council Meeting Minutes 5/12/09**

#### **Present:**

JulieAnn Herrera, School Liaison, Manor ISD  
Jen Inman, Carousel Pediatrics Lead Therapist  
Melody Palmer-Arizola, MHMR  
Tamara Trager, Social Worker, Del Valle Children's Wellness Center  
Linda Duke, COPE Program Manager  
Ingrid Shows, Mental Health Liaison, MHMR  
Miriam Nisenbaum, Vice President Clinical Services, Easter Seals of Central Texas  
Gloria Young, AISD Special Education Instructional Coordinator  
Dr. Celia Neavel, GOALS Program Director  
Dr. Kellie Higgins-Strickland, GOALS Psychologist  
Anna Blomquist, GOALS Social Worker

Our guest speaker for this meeting was Linda Duke, COPE Program Manager. COPE stands for Collaborative Opportunities for Positive Experiences. COPE is the deferred prosecution program of the Travis County Juvenile Mental Health Court. The project serves 10-17 year olds with a mental health disorder or brain injury that has contributed to the commission of a juvenile offense. COPE diverts young offenders from court proceedings and criminal involvement by providing services and treatment. The COPE program has served 125 children with a goal of serving 140. The program provides in home family therapy, case management services, educational assistance and advocacy, mental health assessments, psychiatrics evaluations, and wrap-around services. The program has a 78% success rate. GOALS board members were invited to attend the COPE board meeting on June 12th from 11:30 to 12:30 at Gardner Betts.

We next discussed GOALS Program sustainability. Our HRSA grant expires in February 2010 so we are actively searching for new grant opportunities and partnerships. We are exploring partnering with AISD to provide psychological assessments on some of our patients.

We shared the Parenting Stress Inventory Tool that we recently purchased and have begun administering to parents of new patients. The form measures parental stress and is given on the family's third visit to the clinic and then every three months. We hope to see decreased stress levels as our interventions with families take effect.

#### **Community Updates:**

Jen Inman shared that she has started a new position with Carousel Pediatrics as their Lead Therapist. They are starting new school and home based therapy services.

Tamara Trager shared that the DVCWC will start accepting MAP in August. The clinic serves ages 0-21. They are using a Teen Screen with 11-19 year old patients. She also recommended a resource for teen suicide prevention called The Jason Foundation. They provide a toolkit, school resource videos and wallet sized cards for teens.

AISSD has done geomapping with Dr. Susan Malley. The Community Action Network has done a needs assessment. All agree there is a lack of support for families.

Council members discussed that the Lakeway/Lago Vista/Apache Shores areas are growing and have significant needs.

Dr. Higgins is to follow up with GOALS partnering with UT Social Work graduate students and working with Professor Pomeroy.

Our next meeting will be held in August. The specific date will be announced later.

Thank you for attending!

## Appendix 2

### GOALS Advisory Council Meeting Minutes 9/15/09

#### **Present:**

Dr. Jane Gray, Texas Child Study Center  
Melody Palmer-Arizola, ATC-MHMR  
Louise Lynch, ATC-MHMR  
Ingrid Shows, ATC-MHMR  
Julie Ann Herrera, Manor ISD  
Robin Rosell, PCC  
Anna Blomquist, PCC  
Dr. Celia Neavel, PCC  
Dr. Kellie Higgins-Strickland, PCC

Dr. Jane Gray was our featured speaker and spoke about her work with the Texas Child Study Center (TCSC). TCSC is a children's mental health clinic that works in collaboration with the University of Texas and Dell Children's Medical Center. They accept self-pay clients, Seton health plan, and anticipate accepting CHIP this fall. They do not see Medicaid patients. The team of psychiatrists, psychologists, and social workers at TCSC "offer evidence-based treatment for children with emotional and cognitive diagnoses and work with their families to provide understanding and guidance." They focus on the treatment of autism, anxiety disorders, OCD, depression, and PTSD.

Dr. Gray also told us about the Healthy Living, Happy Living Program starting at Dell Children's Hospital this fall. The program targets childhood obesity and lasts for nine weeks. Children and their parents meet with a team of professionals to focus on nutrition, mindful eating, and physical activity. The goal is to see changes in the patients' health behavior and self-esteem and to teach them coping strategies and positive self-talk skills. The program this fall will be for Spanish speaking families only. The patient's body mass index has to be in the 85th percentile for their age range. Referrals can be made to Megan Barron MS, RD at 512-324-9999 ext. 86337.

#### **Program Update:**

The GOALS team presented our current demographics for the program as follows:  
We have 295 active patients enrolled in GOALS.  
Of these, 57% are age 11-18, 35% are age 6-10, 5% are age 19-20, and 4% are age 0-5.  
63% of GOALS patients are male, 37% are female.  
63% of GOALS patients are Hispanic.  
18% are African-American.  
16% are Caucasian.  
2% are Other.  
1% are Asian.

#### **Parent Survey Update**



Dr. Higgins-Strickland reviewed the preliminary results of our PCC GOALS Program Survey that was conducted this year. 82 surveys were completed by GOALS parents. These surveys were done anonymously over a four month period. (A handout summary of data collected is included in this envelope.)

Council members suggested we keep a more accurate count of the response rate and possibly code the survey's to facilitate this.

The GOALS team has also been collecting data on the results of the Parent Stress Inventory (PSI). 78 PSI's have been completed by parents of GOALS patients. 13 parents have completed more than one survey at subsequent visits. The goal of using the PSI is to hopefully show a decrease in parental stress over time through their involvement in the GOALS program. A suggestion was made by a Council member that we use a cover sheet on the PSI giving patients further instructions on how to complete the form.

**Grant News:**

The GOALS team is pleased to announce we have been selected as recipients of an \$11,000 grant from the St. Luke's Foundation. Our current HRSA grant expires in February of 2010. We are currently seeking other grant opportunities as well.

**Community Updates:**

Louise Lynch announced that ATC-MHMR is currently seeking requests for proposals from 9/17/09 to 11/17/09. Texas law requires that MHMR contract out some of their adult psychiatric evaluations to providers in the community. They are hoping to move some of their stable patients to MAP providers. 900 people are on the wait list currently for MHMR services.

**Enclosures:**

TCSC brochure  
Program survey results  
GOALS demographics handout

**Next GOALS Advisory Council Meeting: Thursday, December 3, 2009, 11:30-1 pm.**

## Appendix 3

### Peoples' Community Clinic GOALS Advisory Council Meeting Minutes 4/22/10

#### **Present:**

Dr. Celia Neavel  
Dr. Kellie Higgins-Strickland  
Anna Blomquist  
Robin Rosell  
Debbie Wiederhold, Texas Parent to Parent  
Melody Palmer-Arizola, Integral Care  
Louise Lynch, Integral Care  
Gloria Young, AISD

New GOALS Advisory Council Member, Debbie Wiederhold, gave us a brief overview of the organization, Texas Parent to Parent. Their mission is to “provide support and information to families of children with disabilities, chronic illness, and other special health care needs.” Their services are offered free of charge. They make one on one parent matches statewide. They are holding an annual conference for parents on June 25th and 26th at the Embassy Suites in San Marcos. The Texas Parent to Parent website is: [www.txp2p.org](http://www.txp2p.org) or email: [info@txp2p.org](mailto:info@txp2p.org) or phone: 512-458-8600.

Dr. Neavel attended the Adolescent Medicine Conference in Toronto, Canada April 6-9th. She gave a presentation on Integrating Behavioral Health in Adolescent Primary Care that she presented with Robin Rosell and Lynda Frost from the Hogg Foundation. The PowerPoint presentation is attached for review.

Melody Palmer-Arizola gave an update on a new waiver called Youth Empowerment Services (YES). The program will serve 150 children ages 3-19. The program is currently in its pilot phase and serves only Travis and Bexar counties. Nontraditional services such as mentoring, respite and animal therapy will be offered to children with serious emotional disturbance. Intensive wraparound services and case management are also offered. To add a name to the interest list, please call 804-3191. Eligibility is based on the income of the child and application to Medicaid is required.

Anna gave a brief update on the Transitions to the Future Symposium that Easter Seals and Integral Care organized on April 16'th. Information on Medicaid waivers, employment, and legal guardianship was presented to community representatives and parents of children with developmental disabilities.

Louise Lynch announced Integral Care needs service providers for outsourcing.

PCC was granted a \$20,000 Medical Home Supports Grant through DSHS. We will facilitate the implementation of practice-level supports to improve the provision of a Medical Home for children and youth with special health care needs.

Our next meeting will be in September. Date to be announced.

**1. PROJECT IDENTIFICATION**

**Project Title:** GOALS

**Project Number:** H17MC04359

**Project Director:** Celia Neavel, M.D.

**Grantee Organization:** People's Community Clinic

**Address:** 2909 North IH-35, Austin, Texas 78722

**Phone Number:** (512) 708-3140

**E-mail Address:** IBAPPMD@aol.com

**Home Page:** austinpcc.org

**Project Period:** March 1, 2005 to February 28, 2010

**Total Amount of Grant Awarded:** \$250,000

# PEOPLE'S COMMUNITY CLINIC

## GOALS Abstract

### 1. PURPOSE OF THE PROJECT AND RELATIONSHIP TO SSA TITLE V

MATERNAL AND CHILDREN (MCH) PROGRAMS: The GOALS Program was established at People's Community Clinic in 2005 to address the need in the Austin/Central Texas area for the ongoing coordination of developmental, behavioral, and mental health as well as physical health needs in identified low-income youth. The program follows the American Academy of Pediatrics model of a medical home and includes screening, specific expertise in evaluation and management of more complex behavioral and developmental patients and their families, frequent interactions with area schools and youth-serving agencies, and ongoing coordination of care. By expanding the identification of children with special health care needs and providing a medical home to these patients, the GOALS program addresses the first three Healthy People 2010 objectives.

2. GOALS AND OBJECTIVES: To provide an improved permanent system of behavioral/mental health/developmental screening, assessment, and care coordination for pediatric and adolescent patients currently using PCC as their medical home; and to offer an improved, formalized resource to the larger Central Texas community by providing diagnostic assessments, case coordination, and a "medical home" to youth and families referred specifically to us by schools, youth-serving agencies, and individuals because of behavioral/ developmental/ mental health concerns.

3. METHODOLOGY: The GOALS Program promotes optimal developmental functioning, wellness, and mental health. Diagnostic and treatment services are included

as an essential part of child health. Operating within a primary care setting, basic elements include: behavioral/developmental screenings and assessments of the pediatric and adolescent patients at PCC, and assessments of new patients referred by outside agencies; psychiatric and psychological consultation/evaluation as indicated; medication management as appropriate; serving as a medical home for the ongoing coordination of physical, developmental, and mental health care with follow-up and referral as needed.

4. **EVALUATION:** Evaluation is conducted by staff using data from PCC's disease registry, social work records, practice management software, electronic medical records, and chart audits to ensure that the program is meeting its objectives.

5. **RESULTS/OUTCOMES:** From March 1, 2009 through February 28, 2010 the GOALS program screened 1,500 children and adolescents. 253 patients were enrolled in the program (including 50 new patients from outside referrals) and 66 full developmental assessments were provided.

**6. PUBLICATIONS/PRODUCTS:** The GOALS Program designed a brochure that was available in early spring of 2007. We have been exploring possible publication about aspects of the program.

**7. DISSEMINATION/UTILIZATION OF RESULTS:** Project Director Dr. Celia Neavel was joined by Dr. Lynda Frost of the Hogg Foundation for Mental Health and Ms. Robin Rosell, Director of Social Services at PCC for a 3.5 hour Institute "Integrating Behavioral Health in Adolescent Primary Care: Making It Work in Your Practice" at the Society for Adolescent Health and Medicine Annual Meeting on Toronto in April, 2010.

**8. FUTURE PLANS/FOLLOW-UP:** Over time the systems and practices of the GOALS program have become institutionalized at People's Community Clinic, and we

expect this model to continue to serve us well. Its success paved the way for the pilot program in integrated behavioral health and PCC now offers behavioral health services to patients of all ages.

**9. SUSTAINABILITY EFFORTS:** The GOALS program will receive funding from the St. David's Foundation in 2010, and we are seeking renewed funding from St. Luke's Episcopal Health System as well. People's Community Clinic continues to enjoy great support from foundation, corporate and private donors in the Central Texas area.

**Annotation**

The GOALS Program at People's Community Clinic is a behavioral/developmental primary care program for youth ages 4-15 focusing on integrating behavioral and developmental health into a comprehensive primary care model. The goals of the project are to provide an improved permanent system of behavioral/mental health/developmental screening, assessment, and care coordination for pediatric and adolescent patients currently using the Clinic as their medical home; and to offer an improved, formalized resource to the larger Central Texas community by providing diagnostic assessments, case coordination, and a "medical home" to youth and families referred specifically to us by schools, youth-serving agencies, and individuals because of behavioral/developmental mental health concerns. Patients receive a behavioral/developmental screening at well-child or acute visits or upon referral and those with an identified need receive behavioral/developmental/mental health assessments, and the family is offered appropriate information, counseling and follow-up regarding the assessments. Children and teens referred from outside agencies for behavioral/developmental/mental health assessments will be given primary physical health care as well and the Clinic will continue to serve as the medical home for the patient. The Goals program screens 1,500 patients annually and 250 receive more intensive services.

**Key Words:**

Adolescent Health Programs, Assessment Center, Behavioral Disorders, Continuity of Care, Developmental Delays, Developmental Disabilities, Developmental Screening, Case Management, Medical Home, Mental Health Services, Pediatric Health Programs, Primary Care, Wellness Programs.



