Target Capacity Expansion-Health Information Technology (TCE-HIT)

1st Cohort Implementation Site Visit

Human Service Center

Peoria, IL

Prepared by JBS International, Inc. for the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment

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TCE-HIT Service Design Visit

Grantee Name	Human Service Center
Grantee Project Name	Mobile Wellness and Recovery
Address	600 Fayette St.
Grant TI Number	TI023808-01
Date of Site Visit	September 27–28, 2012
Grantee Contact Person	David Loveland, Ph.D.
Grantee Agency Director	Fred Nirde
Government Project Officer	Wilson Washington
Site Visit Team Members	Dave Wanser; Ph.D. and Afriika McKinnon

Grantee Project Team Member Participants
Fred Nirde – Chief Executive Officer David Loveland, Ph.D. – Project Director Corey Campbell – Team Mental Health Specialist Hilary Driscoll – Lead Research Analyst

Overview and Summary of Findings

Site Visit Overview

The Human Service Center's (HSC) "Mobile Wellness and Recovery" project goals are to allow individuals with substance use disorders living in rural regions access to a range of e-therapy options. Additionally, the goal is to combine treatment with community-based clinical services and access to medical care based on cognitive behavioral therapy (CBT) and recovery-based resources. Currently, HSC's intake rates of substance use disorder persons living in rural areas are less than predicted. JBS's goal of the site visit was to accomplish the following:

1. Meet with key stakeholders, including staff and clients, to observe program operations and gain a full understanding of the program's history and current operations.

2. Review the grant implementation and service delivery process to support programmatic strengths while suggesting technical assistance (TA) opportunities to effectively meet challenges.

3. Provide the Substance Abuse and Mental Health Services Administration (SAMHSA) with data on the following factors that will aid in determining opportunities to support grantee efforts to achieve success:

    a. Program Vision and Design
    b. Program Leadership
    c. Data Collection and Evaluation
    d. Community Partners, Client Outreach, and Implementation Plan
    e. Sustainability and Scalability Plan

The meetings were primarily held at the HSC main headquarters on Fayette St. in Peoria, Illinois and at its sister site at the Hamilton Building (also on Fayette St.). Four staff members were present, including the Chief Executive Officer and the Project Director. The Project Director, Dr. David Loveland, began the day with an overview of the history of the Mobile Wellness and Recovery program and its services. The rest of the morning and early afternoon was spent meeting with staff members in the residential intake office. HSC's strengths are strong community linkages, a comprehensive service array, extensive data collection and analysis capabilities, and its attention to recovery-based care.

Program Vision and Design

In the Health Information Technology grant proposal, HSC planned to partner with the North Central Behavioral Health Services Center—a rural behavioral health care organization serving 10 rural counties—as their major recruitment tool. This plan was conceived at a time the two organizations were contemplating a merger. Unfortunately, efforts to reach an agreement were unsuccessful and the merger plans were abandoned. Given the need for another rurally based partner, HSC negotiated a partnership with a treatment center of which they already had a strong established relationship, Sinnissippi Centers. Sinnissippi Centers is a recovery-oriented behavioral health system of care program that should aid HSC in meeting their rural population intake numbers. In addition, HSC aims to work with probation officers, churches, and local hospitals to also expand the variety of referral sources.

HSC uses a master-level clinician to engage individuals unwilling to access or wait to enter an office-based addiction treatment program but are willing to receive evidence-based CBT through multi-media options. These options include telephonic contacts with the clinician; access to internet-based CBT programs; and access to the University of Wisconsin developed ACHESS smartphone applications that provide a range of real-time recovery support. Although all three treatment options are active, the telephone clinician engagement and the internet-based CBT training have been the most successful strategies to date.

The average educational age of the clients receiving treatment is around15 years of schooling (substantially above the typical educational level of other center clients and the national average rate of about 8 years of schooling). Most of the clients interviewed reported that the benefits of the mobile wellness program are: 1) constant connection to recovery support opportunities; 2) anonymity; and 3) convenience of use. Unfortunately, the ACHESS mobile applications developed to aid in recovery are found to be less convenient in use, in part because HSC are unable to provide constant connection in many rural areas. Therefore, the focus on expanding the use of the mobile application has been reduced, while the internet-based online curriculum and the telephone access to the clinician have been the primary intervention. It will be useful for SAMHSA to support increased dialogue between the users of the ACHESS application and the University of Wisconsin developers, and to encourage identification of strategies that have proven most effective in optimizing the application's effectiveness. Issues that were identified with the application include: problems with making the Alcoholics Anonymous meeting locator work; discussion boards were not well utilized—particularly if users did not already know each other; slow loading of content; the "other events" portion of the application was not utilized; and the panic features were not well developed.

Lessons learned thus far include the realization that providing same-day access is often best for engaging clients as early as possible, and having the project clinician introduce the program to potential utilizers yields better results since some center staff members were not as effective in advocating its use. It is also suggested in response to the program's efforts thus far, that consideration be given to providing for other interventions through the Therapeutic Education System (TES) and CBT interventions that would target smoking and depression. The program will also need a plan to adapt to increased volume as referrals increase.

Community Partners, Client Outreach, and Implementation Plan

Since needing to recruit and develop a partnership agreement with an alternative rural provider had delayed the expected start date and resulted in a smaller number of individuals accessing the mobile interventions, HSC has increased marketing efforts using radio Public Service Announcements to recruit new clients. In addition, they are seeking partnerships with the local hospitals as a possible referral to treatment. Additionally, HSC is partnered with Sinnissippi Centers which currently provides 25 percent of their referral sources and may be able to increase the referrals as they introduce a part-time primary care physician to their staffing pattern. It is hoped that this will allow more outreach to rurally based physicians who could serve as an excellent referral source. Most of HSC's current referral sources come from their residential treatment center. HSC has found that the rate of intake through the residential treatment center could potentially be increased if the project's clinician was able to speak directly to clients at first encounter, rather than depending on residential program staff to introduce the program. It was suggested that developing a video for posting on the agency's website and on YouTube may help with marketing their services. HSC could benefit from TA that can aid this endeavor.

Although mobile devices are not provided, each client receives access to the ACHESS mobile application, 24-hour access to the TES program (an online training and skill enhancement curriculum), and access to the staff clinician. The mobile wellness website, which currently hosts the TES program, also hosts a recovery blog, a Facebook social media page, online chat sessions, self-help phone applications on IPhone, Android, and Window's 7 platforms, and free treatment screening tools. Upon completion of each series of skill training modules, clients are automatically contacted by the staff clinician. Site visit team members interviewed three current clients who all agreed that the online modules are very useful for a recovery tool. They also noted that the online clinician is extremely skilled and able to provide valuable input in a short amount of time and that the flexibility of the program made it easy to remain engaged in treatment.

HSC noted that the clinician is trained extensively in providing valuable CBT treatment in less than 20 minutes, and fidelity to the CBT model is rigorously tracked and feedback provided on a regular basis to ensure consistency in the approach. Ample research supports this EBP and has proven to be the strongest component of efforts to foster and sustain client engagement.

Although HSC has increased intake rates through the PSR initiative, they realize that there are also growth possibilities in several areas including more focused marketing and expanding the opportunities with health care providers by leveraging change in care delivery models necessitated by the Affordable Care Act (ACA)—such as increased use of Accountable Care Organizations, health homes, managed care, and other payment reform strategies. Marketing is a new activity for HSC staff since they have historically had no need to advertise the availability of their services, nor are they all that familiar with how to approach hospitals about entering into collaborative partnerships. HSC suggested that they could benefit from TA to aid them in marketing strategy development, as well as best practices for recruiting potential partners and clients through their mobile wellness website. It is recommended that the TA include assistance in the developing of a targeted marketing plan to be implemented over the next 90 days.

Data Collection and Evaluation Summary

The Project Director and Research Analyst have a respectable track record in developing successful grant-funded projects and in utilizing existing research on evidence-based practices (EBPs) to inform the program design, data collection process, and evaluation questions. The research team has years of experience in protocol development and served as one of the initial pilot sites for the ACHESS application. HSC is also a recipient of the SAMHSA Primary Care Behavioral Health Integration Grant. Consequently, the evaluation practices in use are much more inclusive than what is required to meet GPRA requirements. HSC utilizes proven strategies to ensure effective follow up with program participants such as providing gift card incentives for clients who complete the survey questions, which include GPRA data and other data required by their evaluation plan. Current rates of follow up are 96 percent. Hilary Driscoll, the Lead Evaluator, meets with the clinical and outreach team once a month to provide feedback and discuss the data collection efforts and share findings. HSC's Mobile Wellness and Recovery has the following evaluation objectives:

- Decrease substance use disorders in rural Illinois.
- Keep consumers involved in CBT skills training, relapse prevention, and continuing care for 6–9 months.
- Decrease risky substance use behavior in rural communities.

Mobile Wellness and Recovery's goals are to enroll 120 persons into the program before June 2013.

The HSC Evaluators have also collaborated with the other two funded TCE-HIT grantees in Illinois—TASC, Inc. and NICASA

Sustainability and Scalability Plan

HSC foresees an opportunity for the program to sustain itself eventually; however, much work remains due to the increased sensitivity to stigma in rural areas, and the need to increase training for referral sources. There are also challenges in engaging with individuals who have been mandated to participate in treatment since adhering to the TES protocol, and focused clinician contact is in many ways more onerous than coming to office-based counseling. In addition, due to required training and supervision that is critical to maintaining fidelity to the e-therapy CBT model, the cost of the service currently surpasses that of group-based intensive outpatient services. As ACA plays more of a role in local health care provision through the expansion of the Medicaid program and with requirements for parity for behavioral health treatment, the ability to bill for the services provided may increase, so long as Illinois Medicaid and other insurers provide for telephonic-based services. HSC may benefit from TA that facilitates collaboration between programs with similar outreach and service delivery strategies to seek innovative ways to develop a return on an investment model that is sustainable over time. This strategy may include adding additional interventions to the TES program, such as treatment for depression, anxiety, tobacco cessation, and pain management.

Additionally, HSC has found the program to be most successful among higher educated, middle-aged, employed clients who prefer this approach to accessing care due to sensitivity about retaining their anonymity. HSC predicts there could be opportunities for scalability within this demographic. It is interesting that there has been less interest among existing center clients, something that was unanticipated.

There is also an interest in determining a sustainability business model for the use of the ACHESS application since it is difficult to envision any mechanism for reimbursement for the services available through the application.

Considerations for Grantee Actions: Recommended Technical Assistance

Site Visit Debriefing and TA Recommendations

1) HSC could benefit from ensuring best practice implementation of their newly selected electronic health record (EHR) system

    a. Possible TA would include the following: Review implementation plans and governance processes and protocols to see if possible improvement can be made in planning, implementation strategies, and ongoing governance and training. The agency would benefit from a data strategic plan so that efforts to utilize the EHR, personal health record (PHR), portal, Therapeutic Education System (TES) modules, and ACHESS or other smartphone applications are well integrated.

2) HSC could benefit from ensuring grantee project is using best practices for e-therapy and e-learning modules

    a. Possible TA would include the following: Partner with grantees with similar e-learning modules to ensure grantees are reaching optimum best practice intake rates.

3) HSC could benefit from ensuring best practice for marketing/recruiting consumers

    a. Possible TA would include the following: Develop and implement a marketing plan over the next 90 days that will result in increased referrals.

    b. Possible TA would include the following: Partner with JBS marketing team to create concepts for reaching consumers through: podcasting; fliers; marketing slogans; community outreach; and broadcast and social media.

        i. Determine the best outreach approaches

        ii. Develop an intervention package for pre-contemplators who may not be ready to engage in treatment but might be able to be engaged in learning more about the consequences of substance use.

4) HSC could benefit from ensuring best practices for referrals to treatment

    a. Possible TA would include the following: Conduct a work flow analyses to expedite the assessment and treatment initiation process for new clients.

5) HSC could benefit from ensuring best practices for maintaining and creating partnerships with local hospitals and health care providers.

    a. Possible TA would include the following: Review current business model for recruiting new partners in the health care community and provide technical assistance (TA) in understanding how policy and practice changes in health care delivery can support their efforts.

    b. Possible TA would include the following: Develop partnership agreements in order to work with trauma centers in mining data for potential areas where prevention and intervention initiatives could be launched.

        i. HSC would like to see SAMHSA support cross site data sharing, initially with the other Illinois-based sites, but eventually across more of the grantees. This would allow for better data upon which to model program innovations such as risk adjusting groups of clients utilizing various technologies.

        ii. HSC has an interest in developing intent to treat designs so that specified protocols for engagement could be developed for use with different client groups based on their familiarity with technology and their level of need for interventions. The goal would be to become as effective as possible with engagement.

    c. Possible TA would include the following: Change management for HSC staff so that adaptions required increasing access, client engagement address population health issues, and facilitate staff adoption of health information technologies.