Grants to Expand Care Coordination

Through the Use of Technology Assisted

Care in Targeted Areas of Need

(TCE-TAC)

RFA# TI-11-0023 808

CSAT BIANNUAL PROGRAMMATIC REPORT

Program Reporting Period:

October 1, 2013 to March 31, 2014

Instructions for Completing this Report

1. Save the report to your computer.

2. Click on the darkened box next to each item to fill in your response.

3. Save your completed survey BEFORE returning it.

4. Return the completed report by email to:
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TCE-Technology Assisted Care (TAC)
SAMHSA/CSAT
1 Choke Cherry Road, Room 5·1055
Rockville, MD 20850

Reporting Period:October 1, 2013 to March 31, 2014

6. RFA #: TI-11-0023 808

7. Grantee:Human Service Center

8. Provider Site(s): The site of Sinnissippi Centers Inc (SCI) was removed from the project in December, 2013 – this was a planned departure as the agency had not provided a referral to the program in the prior 18 months and was no longer interested in being involved in the project.

Provider Site Name	Address	Contact Person	Phone/Email
Human Service Center (HSC)	600 Fayette Street, Peoria, IL 61603	David Loveland	309 671-8090, dloveland@fayettecompanies.org
Sinnissippi Centers Inc. (SCI)	325 Illinois Route 2 Dixon, IL 61021	Kevin Buss	(815) 284-6611, kevinbuss@sinnissippi.com

9. Project Director:Corey Campbell

10. Evaluator:David Loveland

11. Evaluator Phone/Email: 309 671-8090, dloveland@fayettecompanies.org

12. Signature **Corey Campbell**

Project Director Signature Date April 25, 2014

13. List any changes in key staff contact information here:**no changes to personnel**

Staff Member	Add/Loss	Effective Date	Email	Phone

TABLE OF CONTENTS

BACKGROUND

Provide the abstract from your grant application. Specify all technologies being used in the project and any changes from the initial application.

Original Abstract

The MW&R project will allow individuals with a substance use disorder living in rural regions to access a range of e-therapy options, combined with community-based clinical services and access to medical care. The MW&R will provide cognitive behavioral therapy (CBT) and recovery-based resources through multiple forms of media, including smart phone applications, telephonic communication, and automated internet-based, computer programs.

The project is a collaboration of two comprehensive behavioral health organizations: Human Service Center and North Central Behavioral Health Services, and multiple primary care organizations nested within a 10-county region of central Illinois (total population of 598,493). The target population includes men and women above the age of 17 living in rural settings as classified by the U.S. Census Bureau (40% of total population). The population is approximately 96% White (3% Hispanic, 1% Black), 51% female, 8% unemployed, 12% living below the poverty level, and 29,498 have a dependence diagnosis to alcohol and other drugs and another 24,581 have a substance abuse diagnosis.

The MW&R will use two master level clinicians and one nurse to engage individuals in rural locations who are not willing to access, or wait to enter, an office-based addiction treatment program, but would be willing to receive evidence-based CBT through multi-media options. These options include telephonic contacts with a clinician; access to internet based CBT programs; access to smart phone applications that provide a range of real-time recovery supports, prompts and CBT skills training; and access to an extensive library of resources and community linkages stored in one website location. CBT skills training will include smoking cessation for tobacco addiction. The nurse will also assist individuals in connecting with a medical provider and learning how to store essential health information in a free, online personal health record (PHR) database. The project has three overlapping goals to increase and expand services: 1) Develop an expedited screening protocol to engage clients on the same day of self-request or through a referral from primary care clinics; 2) Implement a range of e-therapy options to deliver CBT to individuals, including phone, internet, interactive applications through smart phones or in-person as needed, 3) Develop a series of protocols that keeps individuals involved in CBT skills training, relapse prevention, and continuing care for at least six months through e-therapy interventions. The goal is to enroll 120 individuals in year 1 and 165 in years 2 & 3 for a total of 450. Measurable objectives include engaging individuals within 24 hours, initiating telephonic CBT within 1 to 2 days, keeping 80% of candidates engaged for at least six months, and assisting 75% in using e-therapy options. Other measurable outcomes include reducing alcohol and drug use over time (80% show decline), linking 75% to primary care and enrolling 60% in a PHR, increasing self-efficacy and access to social support.

Updated Technologies

Website is updated on a monthly basis

PROJECT IMPLEMENTATION

Project Goals and Objectives

Provide status reports of all current project goals and objectives,including lessons learned and best practices using the technologies.

Goal 1: Develop an expedited screening and referral protocol for rural clients
Status (minimal changes from last report): Screening and referral protocols have been developed and implemented at HSC as well as two additional sites, including a large FQHC in Peoria and a OSF's Home Health Care Program. We continue to engage medical providers in the area, but the process has been slow. We have established a contract with OSF to hire, train, and supervise one master-level clinician (LCSW) in one of the agency's large primary outpatient clinics. The hiring process was initiated in March, 2014 with a projected start date (hired and placed) in late June, 2014.The team also worked with the Institute of Physical Medicine and Rehabilitation (IPMR) to establish an integrated program within one or more of the agency's rehabilitation clinics. Negotiations are ongoing, but no plan has been established as of April 25, 2014. Our official partnership with SCI ended on December 31, 2013. This represents an early closer to the partnership that would have existed to the end of the grant; however, SCI has been unable to provide referrals to the program for nearly 18 months. **Lesson Learned**: We needed to expand our sites to include a mix of urban and rural clients. It will take time to develop referral bridges to rural communities; however, it appears that we will have more success recruiting directly from medical providers in large, urban primary care clinics. Medical providers also want assistance screening for other co-occurring conditions associated with substance use, such as anxiety, depression and chronic pain We are continually updating our marketing protocols to engage patients directly as well as engage new providers.

Goal 2: Implement web & phone-based technologies for addiction treatment interventions to deliver CBT skills training
Status (no change from last report): All objectives were achieved and additional technologies have been added, including a web-portal where individuals can submit screens and daily activity logs for cognitive behavioral therapy techniques (to support web and phone-based CBT interventions). **Lesson Learned (no change from last report)**: Over 60% of participants don't have access to the web; so we have had to develop paper copies of all our CBT protocols (see the next goal for a description of protocols) and less than 10% have had access to a smart phone for the A-CHESS application. We have also had to adapt our protocols for people who can't read, but can be engaged on the phone

Goal 3: Develop a series of protocols that keeps individuals engaged in CBT skills training and relapse

prevention for at least six months through the use of multiple e-therapy options

Status: The MW&R model has been implemented as planned, including developing a continuous care model that keeps individuals engaged for 6 to 12 months. Retention rates for 87 people (another 37 are still open) who have either graduated or withdrew from the program include:

- 48% graduate the primary skills training and continuing care protocol (10 to 25 modules completed)
- 40% completed an average of 4 skills training modules before being lost to contact
- 7% were transferred to a higher level of care
- 6% withdrew for other reasons

Lesson Learned: The most effective strategy for recruitment has been through ongoing and onsite contacts with medical providers and training of our assessment staff through HSC's central intake system. Rural providers, including our partner, SCI, have not been able to identify a sufficient number of referrals. Individuals who complete the GPRA survey are likely to stay engaged for a minimum of 4 skills training sessions and the overall average of everyone who completes at least one module is 6.5 modules.

Engaging techniques, such as providing motivational interviewing session prior to enrollment, has improved our retention rates, but has delayed the enrollment process. We are able to provide MI services within 24 hours of a referral; however, it now takes two to four weeks to complete the engagement process before individualsare asked to complete the baseline GPRA. A small group of participants require many weeks of MI before considering enrollment. Individuals who are involved in the criminal justice system are less likely to complete the continuum of care compared to participants without any involvement (reported) in the criminal justice system.

Status Toward Goals

If you are falling short in meeting any project objectives, please explain and provide your plan for catching up. Include anticipated date of resolution.

The primary challenge continues to be achieving the targeted recruitment rates. We have enrolled 124 individuals as of April 25, 2014, including 21 in the past two quarters of this review, which represents a 47% reduction from the prior six months and 23% of our projected target for every six months. We had gradually increased our enrollment numbers each quarter prior to the six months of this reporting period, but we have yet to enroll the average target of 45 in any quarter. The program received 204 referrals during the past six months, but nearly 66% of these individuals could not be reached (phone number was disconnected or never return calls) or decline the program when they were contacted (many of these individuals were patients at the FQHC who had not been asked to participate by their provider). Another 26% of referrals are individuals who are in the engagement process, but have yet to be enrolled. Approximately 6% of the 204 referrals (11 individuals) could be reached, were interested in the program, and enrolled during the reporting period. Our goal continues to include the target of 45 individuals every quarter; however, it is not likely that we will be able over recruit in the final six months to make up for the deficit.

We are submitting a proposal to our own agency, the Human Service Center (HSC), to provide staffing time at our central intake facility so that we may be able to engage potential clients in the MW&R program. The proposal is being considered as of April 30, 2014. If accepted, the MW&R program would provide team members at the intake facility to engage clients in the e-therapy program.

Our long-term plan continues to be expanding the program to other medical providers in the region. We hope to hire and place a MW&R team member onsite at a large, hospital-based healthcare provider in Peoria beginning in late June or early July, 2014. It has taken us nearly 18 months to develop a contract with the provider; i..e, OSF. We plan on enrolling patients in the MW&R from the new OSF primary care site in August or September.

We also hope to acquire a no-cost extension to use unspent grant dollars to recruit from the OSF site over the next 12 months. We will also continue working with our primary site, Heartland Community Health Clinics (a FQHC), with the hope that they will have achieved stability (e.g., recovery from significant turnover of physicians and other providers, switch over to a new electronic health record in August, 2014, and complete the takeover a large primary care clinic) by late summer; so we can provide training to medical staff and increase referrals to the MW&R.

If you changed any project goals or objectives (includingGPRA targets) during the reporting period, state the changes, the date changes were approved and how the approval was transmitted.

No changes have been made to the original goals, although additional interventions have been added to the program

If you intend to request approval of changes in any project goals or objectives during the next reporting period, state the changes and the reasons for wanting to make them. (Remember that you need prior approval from SAMHSA to make these changes.)

No changes are planned with the original goals or objectives, although we are expanding our recruitment protocol to include four to six medical clinics in central Illinois

ORGANIZATION AND MANAGEMENT

Personnel

List all positions supported by the grant, filled and vacant.

Position Title	Incumbent Name	Percent Time
Project evaluator	David Loveland	.20 FTE
Project Director &Clinical Supervisor	Corey Campbell	.8 FTE (reduced from 1.0 FTE)
Research Coordinator and part time clinician	Hilary Driscoll	.25 (reduced from .5 FTE)
MW&R clincian – master level	Krystyn Rutherford	1.0FTE

List staff additions or losses including contractors/consultants within the reporting period.

Staff/Contractor Position Title	FTE	Date Change Occurred	Addition or Loss

Discuss the impact of personnel changes on project progress and strategies forminimizing negative impact.

No change as contract staff were not recruiting clients for the project over the past 12 months

Discuss obstacles encountered in filling vacancies (if any); strategies forfilling vacancies and anticipated timeline for having positions filled.

No vacancies – project is fully staffed

Partnerships

List each of the partner organizations.

Partner
SCI was removed as a partner agency

Describe significant changes in relationships and/or working arrangements and summarizethe implications of the change**.**

SCI has been unable to identify candidates for the grant project over the past nine months (one referral has been provided in the past nine months). As a result of the low referral rate, HSC converted the contract to a per-diem/hourly rate for SCI staff if they provide a referral to the MW&R – funds that were initially allocated to SCI were moved to covering the salary of a second MW&R clinician who can work with local primary care clinics. The partnership with SCI ended on 12/31/13

Training and Technical Assistance (TA)

Describe staff development activities, including orientation and training for thisreporting period**.No training occurred during the reported period**

Staff Development Activity	Date	Number of Participants	Training Provider

If you received technical assistance from a SAMHSA TA provider, describe it**.**

None received during the six month period

If you plan any training or TA activities for the next reporting period,describe the topicand anticipatedaudience.

The MW&R team will provide multiple onsite trainings to primary care providers on the topics of screening and referring patients who have behavioral health disorders. The MW&R team will also provide a webinar to the Illinois Primary Health Care Association (the State organization for FQHCs) about the MW&R program (this occurred on April 24, 2014 and will be noted in the next biannual report)

PERFORMANCE INFORMATION

GPRA Performance

As close to the last day of the reporting period as possible, check your official GPRA statistics on the SAIS webpage.Complete the table below.Enter the cumulative numbers (from beginning of the grant) from the SAIS reports.

Date on which reporting quarter data was obtained: April 25, 2014

	Target	Actual	%	Target	Actual	%
Intakes (Baseline)	*41*	*10*	*24%*	*41*	*11*	*27%*
6-Month Follow			*59%*			*59%*

The SAIS system report does not display follow up data for the reporting period. For the entire grant project, the MW&R team has a follow up rate of 59% in the SAIS system = 63/107 (the only report that provided data was all years and all quarters)

If your intake or follow-up percentages are below 80 percent, please explain and state your plan forreaching your targets.

Our plan to increase our intake rate was described previously. Our follow up rate decreased over the past six months due to a loss of participants who were mostly involved in the criminal justice system. Modifications to the protocol include excluding GRPA survey assessments for individuals in the criminal justice system (they can receive the MW&R clinical services, but will not be enrolled in the evaluation). The actual number of participants lost to follow up is 7, but due to our low enrollment rates, the number had a significant impact on follow up rates.

If your count of the number of target or actual persons served (intakes) through your grant or your follow-up rates differ from those shown in your GPRA report, specify and account for the differences.Identify steps taken to seek assistance, if needed, to remedy the discrepancy.

Noted above

Evaluation

Describe evaluation activities, progress made/action steps, and changes during the reporting period.-

The evaluation team has created a quarterly management report (an updated copy is attached) that provides a summary of grant protocols, including referrals, enrollments, demographics, and services delivered (e.g., number of web-based modules completed). To improve referral rates, the evaluation team has also initiated monthly summary reports that are distributed to programs within HSC and agencies, such as Heartland Community Health Care (the FQHC noted previously). Copies of two of the reports are attached (one for an in-house program and one for Heartland with patient names removed

The management report has revealed that:

The MW&R team has received 796 referrals since the beginning of the project (26% or 204 occurred in the past six months)

Referrals have gradually decreased over the past six months compared to the prior six months. In addition, follow up rates have declined from near 80% to 59%

In the past six months, 21 individuals have been enrolled and another 54 are in the engagement phase (e.g., receiving MI phone calls to increase engagement and retention)

30% of referrals (83), either self or by agency, cannot be contacted (e.g., never answered the phone or the phone number had been disconnected)

27% of individuals (75, including 44 opened and 31 being engaged) were contacted by the MW&R team and have been engaged in the past six months (being engaged means that they are receiving phone-based MI sessions or have enrolled in the project and are participating in skills training)

the average person enrolled in the MW&R has 13 years of education (well above the average for our office-based programs)

a wide range of ages (mean 41 years old, range 19 to 70), near 42/58 split between females and males, 29% involved in criminal justice and mostly white participants have enrolled din the program

MW&R graduates remained actively engaged for 231 days and those who did not graduate or complete the program received 170 days of active participation. Specifically,

Average number of TES modules completed by graduates- 22.39 and non-graduates was 5.5

Average number of modules mailed to the participants' home (for those who did not have access to the web) completed by graduates was 9.57 and for non-graduates it was 5.44

Average number of Pain/Anxiety/Depression/Multi-modules completed by graduates was 9.83 and for non-graduates, it was 2.67

Data from the BAM and DTCQ screens indicate that MW&R participants are enhancing their skills to avoid alcohol and other drugs in the program

Note any changes to the evaluation plan for this period, and document that GPO approval was received prior to the implementation of the changes.

Our data collection plan has been implemented as proposed and we continue to use the additional outcome measures noted in the prior biannual report; e.g., The Behavioral Activation Scale (BAS for depression), the Chronic Pain Acceptance Questionnaire (CPAQ), a clinicalmeasure of depression (PHQ-9) and one measure of anxiety (GAD-7) in addition to collecting data on the Brief Addictions Monitor (BAM) and Drug Taking Confidence Questionnaire.

Provide as an attachment the most recent documentation of evaluation findings outside GPRA reporting.Indicate if there are no new evaluation findings from last reporting period.

A management report is included

Discuss any problems encountered in conducting the evaluation, the impact of these problems on the evaluation and on the overall project, and plans for resolving the problems.

No problems noted

Discuss how evaluation findings were used to improve the project.

Both the quarterly report and monthly update reports have been used to modify the project over time, including:

Developing new marketing ideas to reach people at the FQHC, such as developing posters and flyers that promote wellness (as opposed to addressing specific behavioral health disorders) – the goal is to increase engagement and self-referrals. The MW&R team posted new flyers about the program in all the clinical sites of the primary care agency where we are providing integrated services.

Process and outcome data from the project has been used in several workshops to promote the program, including conferences and webinars

Outcome scores from the BAM and drug taking confidence questionnaire are used in a graph to display the potential change in drinking or drug use behaviors for people who engage in the MW&R program – a copy of the updated graph is attached

A new weight loss CBT protocol was developed and implemented during the report period. CBT weight loss protocol is being marketed to healthcare providers that are interested in a menu of behavioral health services, in addition to substance abuse treatment

The MW&R team now provides monthly summaries to all programs to remind staff about the project and to provide feedback.

Attach any written evaluation reports received during the period. Indicate if there are no new evaluation reports from the last reporting period.

Attached are a management report summarizing a range of data collected in the project (e.g., referral and enrollment rates, number of modules completed, and graduation rates).

Interim Financial Status

Attach an updated program budget and any budget modifications.

Total Funding*: $279,517 for year 2 (Year 1 & 2 = $558,604)		
Expenditures		
Expense Category	Expenditures This Quarters	Cumulative Expenditures To Date
Staff salaries	$62,982	$190,312
Fringe	$23,907	$73,245
Contracts	$12,718	$150,251
Equipment	$605	$1,277
Supplies	$3,827	$10,118
Travel	$3,618	$8,918

Facilities		
Other	$1,328	$9,031
Total direct expenditures	$108,985	$443,152
Indirect costs	$16	$49,000
Total expenditures	$109,001	$492,152
	Remaining balance	$66,452
*Total funding should include supplemental awards if applicable, and supplement expenditures should be included in line item amounts.		

Other Significant Project Activities

Discuss any notable project activities, events, or other issues that occurred during the reporting period not previously described. Describe any problems that emerged, the effect it had on the projectand steps taken or planned to overcome the barrier.

All notable events and activities have been reviewed

Attach a copy of the project's policies and procedures.

MW&R Enrollment and Treatment Protocol - attached

Attach copies of any publications in professional journals or presentations about your project during the reporting period. Indicate if there have been no publications or presentations since the last reporting period.

No publications during the reporting period – multiple conference presentations occurred during the first quarter of the second grant year; however, most activities occurred through staffing booths (tables where MW&R staff provided conference attendees with flyers and information on the MW&R). Mobile Wellness staff did present on how e-therapy can be used for FQHC in expansion of integrated care and how Mobile Wellness uses e-therapy to provide treatment to those engaged at the FQHC. Illinois Primary Healthcare Association conference October 6th, 2013. Mobile Wellness was asked to do subsequent presentations to this organization that will be outlined in next report.

LIST OF ATTACHMENTS

List each attachment separately here and attach to the back of this report. (Attached to email)

Attachment 1: **MW&R management report 4-10-2014 (MS Excel file with three sheets)**

Attachment 2: **MW&R BAM & DTCQ scores 4-28-14 (MS Excel file with several sheets)**

Attachment 3:**MW&R Enrollment and Treatment Protocol (MS Word File)**

Attachment 4:

Attachment 5:

Attachment 6:

Attachment 7:

Attachment 8:

Attachment 9:

Attachment 10: