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

1st Cohort Implementation Site Visit

Central Oklahoma Family Medical Center

[November 1–2, 2012]

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	Central Oklahoma Family Medical Center
Grantee Project Name	Central Oklahoma Family Medical Center
Address	527 West 3rd Street, Konawa, OK
Grant TI Number	TI1023797-01
Date of Site Visit	November 1–2, 2012
Grantee Contact Person	Jon Brandon
Grantee Agency Director	Jon Brandon
Government Project Officer	Wilson Washington
Site Visit Team Members	Wilson Washington, SAMHSA Dave Wanser, Ph.D., and Alaysia Phillips, JBS International

Grantee Project Team Member Participants
Jon Brandon, Project Director Brenda Ware, Chief Executive Officer Sallie Clark, Coordinator Roger Groff, Counselor Katie Jones, Counselor

Overview and Summary of Findings

Site Visit Overview

Central Oklahoma Family Medical Center (COFMC) is a Federally Qualified Health Center (FQHC) and has a variety of programs, some of which are housed in three separate buildings on the main site in Konawa, Oklahoma. COFMC provides the following services: primary health care, dental, mental health, and substance abuse. COFMC's Technology Integration for Rural Substance Abuse Treatment Provision is in a separate building 500 feet away from the FQHC. COFMC's FQHC receives funds from Medicaid and the Department of Mental Health and Substance Abuse Services for the State of Oklahoma.

The concept of the substance abuse program derived from the current Project Director, Jon Brandon, and the former Development Director and Grant Writer for COFMC. The plan, as initially conceived, was to provide substance abuse treatment through a combination of evidence-based practices (EBPs) including web-based assessment and self-reporting tools. COFMC intended to integrate substance abuse treatment within its existing electronic health record (EHR) system, NextGen, to facilitate primary care treatment services in conjunction with substance abuse treatment.

JBS' Health Information Technology (HIT) Team conducted a site visit at COFMC on November 1, 2012. The purpose of the site visit was to evaluate the Technology Integration for Rural Substance Abuse Treatment Provision program's effectiveness. JBS' goal of the site visit was to accomplish the following:

1) Discuss strengths, barriers to implementation, and lessons learned with senior program staff.

2) Review of evaluation plan and data collection methodologies (related to the collection of GPRA [Government Performance and Results Act]).

3) Discuss current marketing/recruitment plan for clients in rural communities.

4) Discuss future direction of program and the development of an action plan that address Technical Assistance (TA) needs.

The site visit took place at the Technology Integration for Rural Substance Abuse Treatment Provision building. All HIT grantee program staff were present. Government Project Officer (GPO) Wilson Washington attended and began the day's discussions by explaining the purpose for the site visit.

Program Design and Vision

The Technology Integration for Rural Substance Abuse Treatment program was slated to serve the following rural counties of south central Oklahoma: Seminole, Hughes,

Okfuskee, Northeastern Pontotoc, Pottawatomie, and Southern Cleveland. To date, the program is currently only serving clients in Shawnee (Pottawatomie County), Ada (Northeaster Pontotoc), and Konawa (Seminole County).

COFMC's FQHC utilizes an EHR (NextGen) to collect intake and assessment data; for progress notes; for laboratory and pharmacy; and for third-party billing. There have been a number of difficulties in integrating the substance abuse program into the existing platform of the EHR. Some of the challenges included concerns of the FQHC's Chief Operating Officer regarding how to address substance abuse patient privacy requirements (42 CFR, Part2), at least as they understood them; the information technology lead for COFMC not being sure of how to ensure compatibility with the ambulatory system; and the NextGen Account Manager quoting an unaffordable price of $100,000 to create needed functionality for the substance abuse staff. These barriers led to the substance abuse program purchasing their own cloud-based her—Milan Medical. According to the substance abuse staff that has only recently begun to utilize this application, Milan Medical is more user-friendly than NextGen. However, it presents additional problems: information is not transferrable to and from NextGen; it is not being implemented in such a way as to make the patient data easily accessible (staff are scanning forms instead of entering patient's information); it is not capable of being part of an integrated health care data system; and it is not a certified EHR. The Government Project Officer (GPO), Wilson Washington, suggested reviewing Substance Abuse and Mental Health Service Administration's (SAMHSA's) FAQs on how addressing the concerns regarding compliance with 42 CFR, Part 2. The HIT Site Visit Team suggested that COFMC seek to use NextGen as their one and only EHR for all of their programs and to reach out to other FQHCs that use NextGen regarding their experiences with integrating behavioral health functionality into the primary care EHR. Another suggestion, with regard to privacy concerns was to create a Qualified Service Agreement for Health Information Exchange within the FQHC and for referral agencies that might need to share patient information.

COFMC currently receives clients via walk-ins, the judicial system (driving under the influence [DUI] and drug court), and pain management. Recently, the pain management physician that was referring a bulk of the clients over to the program suffered a stroke and is no longer practicing. Therefore, that source of referrals is no longer available and his position has not been filled. The clients being seen in the program tend to be below the Federal poverty level; are frequently transient (move from home to home); have no contract cell phones with limited minutes and texting (and they often switch numbers); lack transportation; and multiple family members may be experiencing substance abuse or mental illnesses. COFMC recently began providing transportation and is able to pick up clients and bring them to their sessions. However, the HIT Site Visit Team suggested using technology as stated in the grant, such as tele-health to see the patients. This would eliminate the need to pick up patients and also comply with the grant requirements to utilize HIT to provide or support treatment services.

Administrative Observations:

Workflow

Currently, COFMC is using two separate EHRs that are unable to transfer information between the two systems. Clients are referred to the substance abuse program, whenever the physician believes that the client may have a substance abuse problem. There is not an expectation for universal screening at COFMC for mental health and

substance abuse, although such expectations are increasingly considered best practice and will be a part of the required quality measurement expectation of the Federal HIT Meaningful Use program. The HIT Site Visit Team suggested efforts should be increased to increase the level of integration and use of team-based models for health care provision and to train medical and other FQHC staff in the Systems of Care model or a Screening, Brief Intervention and Referral to Treatment (SBIRT) model. Implementing such an approach would improve patient outcomes and would increase the number of referrals to the mental health and substance abuse programs.

COFMC projected that they would see 500 substance abuse clients per year using the web-based assessments, self-reporting tools, and the EHR. Currently, the program is seeing 65 patients and not using any of the technologies in the delivery of care. The HIT Site Visit team suggested developing strategies for providing either group or individual sessions by using web-based curriculum modules and then phone or tele-health based sessions that would focus on the patient's learning experience form the assigned modules. Web-based or smartphone-based interventions require streamlining the process and the use of shorter, more targeted interventions based on the clients' need. This approach also provides for more flexible scheduling and a wider range of options for clients seeking to interact via the technology interface.

Staffing

COFMC's Technology Integration for Rural Substance Abuse Treatment's current program staff consists of the Project Director, two counselors, one front desk intern, and two coordinators. COFMC has a history of a high turnover rate and difficulty recruiting, which is a typical challenge for rural providers. In order to combat the turnover and recruitment issues, the Project Director increased the salary base with the hopes of improving recruitment, although this has resulted in a traditional office-based treatment program. The HIT Site Visit Team suggested that in order to utilize the technology and to increase the numbers of clients accessing the program, that COFMC focus on contracting any additional staff besides two counselors that can deliver the interventions. In addition, the purpose and advantage of the use of tele-health is that it obviates the need to recruit local staff and can provide for much more clinical specialization.

Demonstration of Technology

There is currently no technology being utilized to provide substance abuse treatment services in the Technology Integration for Rural Substance Abuse Treatment program. There is a website for the program, but not one for the entire agency. The agency does have the ability to have patients fill out surveys and exchange communication over e-mail via the website. However, the website is text heavy and does not provide linkage to patient health records (PHRs), patient education materials, potential other resources and opportunities for electronically scheduling appointments. The HIT Site Visit Team suggested that the agency create one website, with the substance abuse program easily accessible from the home page. The page should be interactive allowing for patient engagement and educational with videos focusing on topics including anxiety, stress and depression, and how these issues are frequently linked to substance abuse.

Community Partners, Client Outreach, and Implementation Plan

COFMC's originally planned to create partnerships with Seminole, Hughes, Okfuskee, Northeastern Pontotoc, Pottawatomie, and Southern Cleveland Counties. As to date, the program is currently only serving clients in Shawnee (Pottawatomie County), Ada (Northeastern Pontotoc), and Konawa (Seminole County). Due to a lack of technology, COFMC is unable to provide services remotely. In addition, the lack of a marketing strategy focusing on a segment of the population that would not be seeking services already available in these counties has led to some provider resistance to the program encroaching on what they consider their territory.

COFMC's substance abuse program receives referrals from the onsite FQHC (co-occurring disorders and pain management), the Chickasaw area health clinic, and judicial system (typically drug offenses, DUI, probation and parole, and law enforcement). The Technology Integration for Rural Substance Abuse Treatment program does not have a marketing plan, outside of visiting surrounding towns and posting signs/banners. The staff has been successful at creating flyers, brochures, and business cards to use to approach criminal attorneys and the area drug prevention coalition. However, the HIT Site Visit Team suggested creating targeted marketing plans that focus on addressing health problems in the area for outreach to local regional planning bodies and chambers of commerce. These entities can act as community referral sources.

Data Collection and Evaluation

COFMC's substance abuse program currently uses the Addiction Severity Index (ASI) and collects information on GPRA. There is no external evaluator for the program and no incentives are being used in the program to increase follow-up rates. The clients that are referred through the FQHC are required to fill out FQHC intake information, patient demographic information, and several other documents required for funding source compliance. Once the client is referred to the substance abuse program, they are also required to fill out additional documents that collect frequently duplicate information. This can be overwhelming and burdensome for the client and reduce engagement and treatment completion. The program staff was open to assistance in exploring strategies to decrease the amount of information collected. The HIT Site Visit Team suggested streamlining the data by eliminating redundancies and designing the work flow so that data collection can occur throughout the pre-visit to treatment initiation processes, including identifying web portal or other electronic means for the client to fill out much of the needed information before their visit. The goal should be to never collect the information more than once and with careful design this can be realized. The program would benefit from adding use of technology questions to the process to determine what type of technology clients have access to, the types of internet access and phone access, and where they most often access information.

The staffing design contemplates hiring additional coordinators, which is largely in order to collect GPRA required data. The current coordinator is also the evaluator. This is not the best use of resources and consideration should be given to developing a written

evaluation plan that utilizes an external evaluator. There should be no need for additional coordinators if the data collection progress is designed to be more efficient and automated.

Sustainability

The HIT Site Visit Team was able to meet with the COFMC Chief Executive Officer (CEO), Brenda Ware. She mentioned that the FQHC just completed the fiber optic cable and Wi-Fi set up. The FQHC is also getting ready to roll out iPads for the physicians to use during office visits, web portals, and a website, all under the entire umbrella of the organization. While, the COFMC does not currently have a sustainability plan in place for the HIT grant-funded services, the FQHC has the ability to bill for substance abuse treatment services under its third-party billing system. However, due to the FQHC and the substance abuse program being siloed, there have been some difficulties merging the substance abuse portion to the FQHC's EHR-based billing system. The substance abuse program has been billing staff time and treatment services under the current health center billing practices. The substance abuse program should be billing all current work under the grant at the present time, which can streamline the intake process and facilitate the use of tele-health and web-based services without needing to figure out how billing can occur.

Technical Assistance Recommendations:

Site Visit Debriefing with Wilson Washington and TA Recommendations

1) Integrate the behavioral health program into NextGen. Milan Medical is not a certified EHR and duplicate systems will not facilitate good continuity of care.

    - The agency should consider looking to the Meaningful Use stage 2 and 3 requirements for quality data collection which should guide the development of an integrated approach for conducting screenings and interventions for substance use along with measures of smoking and depression.

2) Initiate a process to redesign approaches to recruiting clients, utilizing outsourced staff, and utilizing technology.

    - Identify what technology would work best. While COFMC needs to stay within what the cohort of grantees is implementing, there are many options that can be implemented within the existing grant framework.

3) Create an organization-wide website that is more interactive and portrays the range of health and behavioral health services available. Include self-screening tools on the website.

- The substance abuse program should have an easily accessible link to its homepage and include education modules, videos, and allow for client's access to PHRs

4) Use the tele-health equipment (previous utilized for the Veteran Administration tele-health grant) to provide tele-health services remotely.

    - This will enable the substance abuse program to recruit clinicians in other communities to deliver service, such as Norman and Oklahoma City, and to serve clients being seen by regional social, justice, and health services agencies.

5) Determine best billing method for client

    - Those being served under the grant should be billed towards the grant.

    - Integrating substance abuse into NextGen third-party billing. This will provide sustainability for the program once the grant ends.

6) Initiate a design process for how COFMC can utilize technology in ways that support Meaningful Use and improve the level of service integration and patient engagement. Emphasis should be on making the web portal more interactive, the inclusion of screening and education modules, videos, and access to PHRs.

    - Using iPads, kiosks, and a portal for clients to fill out paperwork prior to and between appointments will enable clinicians to begin client engagement sooner, and remain in contact with clients between appointments.

7) Integrate behavioral health portion into the ambulatory EHR (NextGen).

    - Review SAMHSA's FAQs 1 and 2 for assistance in troubleshooting Federal confidentiality requirements. The HIT Site Visit Team will provide contact information with fellow NextGen user, Lonestar Circle of Care, regarding behavioral health module integration.

8) Consider the SBIRT model in delivery of care. This will make the interventions more targeted and free clinician time to see more clients.

    - Staff is interested in SBIRT training modules and videos.

9) Use incentives in 6-month follow-up to increase GPRA follow-up rate.

    - The agency will need to put in a request with their GPO, Wilson Washington, for the approval of using incentives.

10) Develop a targeted marketing plan and create partnerships with other substance abuse providers in the other rural counties

    - Connect outreach about the technology-enhanced services to Alcohol Anonymous chapters.

    - Outreach with marketing materials to Chambers of Commerce, health providers, justice and social service agencies, and community coalitions

11) Rethink current staffing model. There will be a need for additional clinical staff to handle an increase in clientele.

    - Contract out additional clinicians in other counties (Norman, Tulsa, and Oklahoma City). Tele-health technology will enable clinicians outside of Konawa to provide substance abuse treatment remotely.

    - Determine how to utilize an external evaluator.

    - Streamline data collection in order to eliminate the need for additional coordinators.

12) Redo workflow and streamline documentation process.

    - Reduce the amount of paperwork collected at intake and points of contacts.

    - Automate data collection and increase the ability of patients to provide information electronically.

13) Add additional technology questions to evaluation forms.

    - Ask questions such as, what types of technology do clients have access to, means of internet access and smartphone access.

COFMC needs to address all of the aforementioned TA over the next 6-month period in order to be able to see the numbers of required clients. There will need to be significant changes in the current process in order to utilize HIT effectively. The substance abuse team will need to identify their client's needs and access to technology in order to best select the technologies to implement for services delivery. The JBS HIT team will assist COFMC in submitting TA requests for the most urgent TA needs, which are: developing a marketing plan to the other counties, creating an evaluation plan, streamlining data collection and enhancing the use of clinical guidelines, and increasing staffing options by contracting out clinical work. The JBS HIT team will create a more detailed action plan for completion of each TA once the requests have been submitted and approved by SAMHSA.