

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology

Presently, Children's Behavioral Health Services (CBHS) is utilizing the follow Interactive Community Technology (ICT):

I. Project #1 Youth Outcome Questionnaire (Y-OQ)

The Youth Outcome Questionnaire (Y-OQ) is the most well developed and tested rapid clinical feedback system available. Outcome Measures, Inc, the developer of the Y-OQ, used a rigorous development process to select the questions with the greatest sensitivity to clinical change possible. The Y-OQ has been shown, in studies described in peer-reviewed articles, to be able to predict poor treatment outcome based on the trajectory of Y-OQ scores. This "early warning system" allows the clinical team (youth, parent, clinician, and supervisor) to reassess and reorient to maximize the possibility of a positive outcome.

The parent and the youth when s/he is over 11 years old complete the Y-OQ. The Y-OQ serves to amplify the youth and parent voice in Continuous Quality Improvement (CQI) efforts at all levels of the System of Care, which will become even more important as the Department moves toward full risk managed care.

Implementation of the Youth Outcome Questionnaire has been rolled out statewide in the Intensive Home and Community Treatment (HCT) program that provides services for @ 1,388 children (June 21/2011) and 4,050 children per year (July 10, 2011-June 21, 2011). The Y-OQ is being used in place of the Child and Adolescent Functional Assessment Scale (CAFAS). The move to the Y-OQ was made to access parent and youth feedback, (The CAFAS depends solely on input from the clinician). The purpose of this questionnaire is twofold:

- a. To function as an outcome measure than can detect change in the a child's clinical functioning, and
- b. To serve as a continuous quality improvement tool that gives the therapist "live feedback from the youth and parents on the effectiveness, or lack thereof, of therapeutic interventions. Thirty Provider organizations had 212 of clinicians trained and 954 of youth have been administered the tool August 1, 2011.
- c. The tool can be administered to the consumer in the "field" or office on a portable computer, net book, or PDA. The tool is synched with OQ measures using a web based link, and essentially instantaneously the provider is fed back a report which highlights the child or youths functional abilities as well as any concerning critical items (such as suicide or psychosis). There also is a client report available and both reports can be discussed with the clinician, child, and family.
- d. Regular Reports are provided to Children's Behavior Health Services:
 - i. The number of children receiving each scale
 - ii. The number of clinicians using each scale

- iii. The frequency of admission of each scale
- iv. Outcomes by agency
- v. Proportion of families with both youth and parent completing tool

Future Plans for the use of this ICT:

Maine spent two years preparing for the implementation of the Y-OQ in our intensive Home and Community Based Treatment. The next step will be to pilot implementation of the Y-OQ in Maine's outpatient services. This is planned for the beginning of 2012.

Incentives to encourage the use of this ICT:

The initial training was done face to face in two sites. The challenges of collecting 212 clinicians from across the state were significant and the challenge of fitting a day of training into a busy workweek was substantial. Currently OQ Measures and CBHS are developing a comprehensive web based training module that can be attended anywhere there is a computer, and in segments when the clinician, supervisor, or manager has an open hour

Support systems to encourage the use of this ICT:

The best support is continuous feedback. The state plans to distribute a series of reports that will allow reliable and valid feedback on consumer progress or lack thereof.

In addition, CBHS has contracted with OQ Measure to provide six consultation sessions with a child psychologist familiar with the Y-OQ and evidence based practices for children.

Barriers to the implementation of this ICT:

Barriers are the required training of clinicians, supervisors, and managers in use of technology and then overcoming inertia that is a challenge to all change in system functioning. There also is a need for ongoing monitoring and consultation, as a didactic training and a dime does not buy a cup of coffee. Systems change requires an ongoing sustainability effort.

How the State plans to work with organizations and other local service providers to identify ways ICTs can support the integration with primary care and emergency medicine:

CBHS has worked with a broad group of stakeholders (youth, parent representatives, providers, and DHHS staff) in implementation of the Y-OQ. We will continue this collaboration throughout the implementation and monitoring process (through the use regular meetings, phone interviews, and questionnaires)

Collecting data for program evaluation at both the client and provider levels for this ICT:

This will be one component of a continuous quality improvement effort by CBHS. Data will be shared with clinicians, supervisors, managers and CBHS staff, providing opportunities for monitoring and improvement at all levels.

The state is going to be tracking the percentage of children who are admitted to the Home and Community Treatment that receive one of the Y-OQ tools. The state also will follow changes in the child's functional assessment using the Y-OQ

In addition, CBHS will monitor the improvement in children's scores by provider, and sharing aggregate results

Measures and data collection for promoting and judging use and effectiveness of this ICT:

CBHS will determine what percentage of children/youth in HCT programs are being administered the Y-OQ, and how many clinicians/supervisors/managers are accessing the reports on these children/youth.

II. Future Plans for the use of ICT's

Project #1: CBHS Provider's of specified Maine Care services will be required to directly enter their service information into the Department's web based data system, The Enterprise Information System. This information will be used by CBHS to determine eligibility of service, to authorize amount and duration of treatment service, track wait time for service, calculate costs of service, track denial and appeal, and determine effectiveness of service. The EIS system will be used by both the provider and the CBHS staff for interactive communication for prior authorization, utilization review and outcome reporting for these identified services.

Incentives to encourage the use of this ICT:

Reduction in costs associated with mailing, copying, and faxing hardcopy required forms. The contracted provider's will be able to reduce personnel costs associated with the collection, collation and proof reading of hardcopy materials that are currently required to be mailed to the Regional offices. There will no longer be confusion on which forms to use or attempting to locate the most current, reducing returned forms. Decreased wait time for processing of material and for CBHS eligibility and treatment authorization decisions.

Support systems to encourage the use of this ICT:

Individual provider location trainings from regional CBHS staff, ongoing phone and contact support from the local CBHS Training Teams, an Instructional Manual available on the CBHS website with e-mail notifications of manual updates. Bi yearly refresher classes.

Barriers to the implementation of this ICT:

There are providers who may have to purchase additional computers. Personnel will require training on an additional data system.

How the State plans to work with organizations and other local service providers to identify ways ICTs can support the integration with primary care and emergency medicine:

Through the Hanely Behavioral Health IT Strategic Action Task Force. As a result of work with Maine behavioral health practitioners and stakeholders the task force will:

- A. Significantly increase awareness of the value of electronic information sharing and the most significant barriers to be overcome
- B. Plan and begin to implement activities to remove barriers and encourage acceleration of clinical information sharing
- C. Develop a strong, knowledgeable, and effective constituency for continuing to accelerate clinical information sharing
- D. Finalize a report with specific recommendations that will lay the groundwork for appropriately accelerating the sharing of information with primary care providers.

Office of Adult Mental Health Services

Maine believes that empowering consumer voice is necessary for system transformation. The Office of Adult Mental Health Services (OAMHS), a part of the Maine Department of Health and Human Services (DHHS), has a solid history of consumer involvement in designing, implementing, and evaluating mental health services as well as expanding peer services. Recovery language is part of many of our documents and our philosophy. The next step in system transformation is to bring recovery concepts truly to life.

OAMHS has completed an OQ pilot program, and is beginning statewide implementation of the OQ Measures Tool. Concurrently, OAMHS is in the planning stages of an OQ Measures Tool pilot program within the state psychiatric hospital system.

A component of this tool is the Recovery Assessment Scale (RAS) that will be used for a system assessment of recovery. Approximately 9,000 people are enrolled in community integration services, a case management and rehabilitation service, largely funded by Medicaid. Community integration was chosen as the focus because it is a core mental health service, is built on a common service model; the population meets the definition of persons with serious or severe and persistent mental illness, and represents a relatively long term service.

The Recovery Assessment Scale (RAS) was developed as an outcome measure for program evaluation to assess aspects of recovery and will be electronically self-administered annually. Consumers particularly like this tool because of its focus on hope and self-determination. OAMHS and the Office of Quality Improvement (another division of the DHHS) are working with the RAS developers to assure that the tool is valid at the statewide level.

The consumer uses a Web Based PDA, a netbook, or computer to answer questions at regular intervals. The OQ provides real time feedback on interpersonal relations, symptomatic distress, and functioning in daily activities. The scoring software applies algorithms to identify strengths and weakness with the consumer's recovery process. The software provides additional help for problem solving along with a decision tree and suggested interventions, thus providing the structure for the consumer to interact with the provider.

The funding for the implementation of the OQ and RAS tools, the training, and the technology is already a part of the OAMHS budget. Additional funding from the Block Grant will allow us to expand the community implementation statewide, and help to get the state psychiatric hospital pilot off the ground. Of course such an allocation would be based on our needs analysis in order to incorporate recovery training, materials, and strategies into an ongoing initiative.

Barriers to the statewide implementation of the OQ and RAS tools are principally technology and training based. Even with Air-Cards, there are locations in rural Maine where IT connectivity is not possible. Another technology related barrier is addressing

provider capacity and comfort level with sophisticated IT technologies. Full implementation of the OQ/RAS tools represents a recovery tool for consumers, a clinical tool for providers, as well as a quality management and outcome measurement tool for the state. The OQ Measures vendor has informed us that it is likely to take between 12-18 months for a reliable baseline to be built before we can fully take advantage of the analytic capabilities of this tool in making accurate assessments of various services and methodologies used by our provider network. The immediate benefit is to the consumer and clinician.

Another tool we have implemented in the last year targets persons living in Residential Treatment Facilities. In reviewing a number of well-known tools tested for their reliability and validity, a group consisting of providers, consumers, and OAMHS staff, have come to agreement that the Adult Needs and Strengths Assessment (ANSA) is an appropriate tool to use in supporting persons in residential settings moving towards more independent living situations in the community. The ANSA is a multi-purpose tool developed for adult behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. To date, every residential treatment provider has trained ANSA staff. OAMHS and our Office of Quality Improvement is currently collecting and analyzing data from this tool which is helping to inform us in the decision making process of moving persons to more independent settings in the community.

OAMHS will be examining the existing IT infrastructure with respect to our ability to meet current and future IT needs. . This IT review will not be limited to examination of existing systems, it will include a review of 3rd party IT vendors. Existing systems include Enterprise Information System (EIS), the Service Encounter Database, OQ Measures system, as well as SOAR, and ANSA data. Another database being used in Maine is the Homeless Management Information System (HMIS), using Bowman's Service Point Product. We will continue to work on interoperability by and between these and other state IT systems including: SSI, Medicaid, Food Stamps, etc.