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Micro-Targeted Computerized Alcohol Misuse Intervention System for Health Care Study

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Micro-Targeted Computerized Alcohol Misuse Intervention System for Health Care Study

Table of Contents

List of Tables

Micro-Targeted Computerized Alcohol Misuse Intervention System for Health Care Study

Introduction

Alcohol misuse has been identified as a major public health problem in the United States. Nearly three out of ten American adults are affected, with behaviors ranging from occasional binge drinking to daily heavy drinking (American Public Health Association and Education Development Center, 2008). Alcohol screening and brief intervention (SBI), as defined by the American Public Health Association, consists of a structured set of questions designed to identify individuals at risk for alcohol misuse, followed by a brief discussion between an individual and a service provider, with referral to specialized treatment as required (American Public Health Association and Education Development Center, 2008). Alcohol SBI in the primary care setting has been shown to reduce problematic alcohol consumption (Friedmann, McCullough, Chin, & Saitz, 2000); however, this practice has not been widely adopted due to perceived barriers to implementation.

In order to facilitate SBI for alcohol misuse, Research Circle Associates (RCA), a Maryland-based research firm, obtained a Small Business Technology Transfer (STTR) grant to develop a computerized SBI for use in the primary care setting. The Interventionaire© is a software system used to create and administer patient-based behavioral screening questionnaires and provide normative feedback to patients immediately upon completion of the questionnaire. Following successful proof-of-concept work in Phase I of the STTR, RCA contracted with The Hilltop Institute to conduct a qualitative analysis to address one specific aim of a larger Phase II implementation study: identify staff-perceived barriers to implementing the Interventionaire© in the primary care setting.

RCA also partnered with Family Health Centers of Baltimore (FHCB), a federally qualified community health center that provides a range of services, including pediatric and adult primary care, women's health, dentistry, and behavioral health care. FHCB's Cherry Hill site, which provides both primary and behavioral health care, currently utilizes an established in-house screening and referral process from primary care to behavioral health care for patients with substance misuse issues. The Cherry Hill site provided an appropriate setting in which to investigate the feasibility of implementing the Interventionaire©.

For this study, Hilltop used a literature review, focus groups, and an online survey to identify staff-perceived barriers to implementing a computerized alcohol SBI tool in a primary care setting. While the principal focus of this analysis is the identification of barriers to implementation of the Interventionaire© at Cherry Hill, Hilltop also used this opportunity to identify potential facilitators, as well as to explore anticipated advantages and disadvantages to implementation.

Literature Review

Despite the growing body of evidence-based research supporting the effectiveness of alcohol SBI in primary care settings, this practice remains widely underutilized. Hilltop conducted a review of relevant peer-reviewed journal articles, research studies, and white papers to identify common perceived barriers to implementation of alcohol SBI in primary care. Given the novelty of the Interventionaire©, few published studies were found that specifically evaluated barriers to use of a computerized screening tool for alcohol misuse to be completed by the patient in the primary care setting. However, a number of related studies described challenges to the integration of behavioral health services with primary care more broadly (Samet, Friedmann, & Saitz, 2001; Urada, Teruya, Gelberg, & Rawson, 2014), as well as specific barriers to the use of: 1) technology-based therapeutic tools in the behavioral health setting (Ramsey, Lord, Torrey, Marsch, & Lardiere, 2016), 2) a computerized alcohol misuse screening administered in an emergency department (Bendtsen, Holmqvist, & Johansson, 2007), 3) non-computerized alcohol misuse screening in primary care (Broyles et al., 2012; Friedmann et al., 2000; Johnson, Jackson, Guillaume, Meier, & Goyder, 2010), 4) a computerized screening tool for alcohol misuse to be used by the primary care physician (Strayer et al., 2012), 5) computerized tools that screened for multiple health risk behaviors (Ahmad, Hogg-Johnson, & Skinner, 2008; Carlfjord et al., 2009; Shakeshaft & Frankish, 2003), and 6) Electronic Health Records (EHRs) in primary care (McGinn et al., 2011; 2012). Hilltop also consulted the National Ambulatory Medical Care Survey, Physician Workflow Supplement, to identify ways that use of a computerized tool could impact primary care clinicians. Identified barriers relevant to the Interventionaire© could be broadly categorized as either provider barriers, organizational barriers, or patient barriers.

Provider Barriers

Surveys of primary care providers (e.g., Friedmann et al., 2000) have identified a number of reasons for reluctance to address alcohol misuse with their patients. Primary care providers generally receive less training on dealing with substance abuse issues than their behavioral health counterparts; as a result, many report feeling unprepared to deal with alcohol misuse. According to Samet et al. (2001), some primary care providers are reluctant to address alcohol misuse because of the perception that patients with substance abuse problems are difficult and undesirable to treat. Many primary care providers appear to underestimate the prevalence of alcohol misuse in their patient population (Strayer et al., 2012). Some feel that patients do not want to discuss such issues with their primary care provider and fear that bringing up the subject of alcohol misuse could damage the doctor-patient relationship. In addition to these concerns, lack of time and the prospect of an increased workload were commonly cited by physicians as barriers to implementing alcohol misuse screening in primary care (Barry et al., 2004).

Organizational Barriers

Organizational barriers relevant to implementing a computer-based alcohol misuse screening tool mainly centered on costs of investing in and maintaining new technologies (e.g., McGinn et al.., 2011). Physicians and other health care professionals reported concerns about the adequacy of hardware, software, and network infrastructure. They recognized a need for staff training and IT support, both when the new technology was introduced and on an ongoing basis, to allow for successful functioning. Intraoperability, or whether a new type of technology could be integrated and capable of sharing information with any existing technology, was also raised as a concern. Finally, the ability of the organization to maintain patients' privacy and security of data was widely reported to be a barrier to the introduction and implementation of any new technology that would collect sensitive patient information.

Patient Barriers

While the current study focused on staff-perceived barriers, patient responses to a computerized alcohol screening tool can be expected to impact the overall success of implementation. Patients report generally positive responses to computerized screenings (Carlfjord et al., 2009; Johnson et al., 2010) and electronic medical record systems (McGinn et al., 2011), but their expressed concerns include fear that the provider-patient relationship would be depersonalized, fear of being singled out or stigmatized due to their responses to screening questions, and fear that the privacy of their data would not be maintained (Ahmad et al., 2008).

Methodology

Five preliminary research domains were derived from the literature review: 1) integration of behavioral health needs into primary care, 2) the potential impact of the Interventionaire© on clinic operations, 3) staff acceptance, 4) patient acceptance, and 5) advantages, disadvantages, and facilitators to implementation. These domains provided the framework for the focus group guides and the online staff survey.

Focus Groups

Hilltop conducted focus groups with selected Cherry Hill staff members to further refine the preliminary research domains and to identify additional domains for the online staff survey. While physicians were the primary focus of studies cited in the literature review, focus groups for this study acknowledged the importance of non-clinical as well as clinical staff to the successful operation of a health care facility, eliciting thoughts and opinions of staff from various job categories. Five focus groups were conducted at the Cherry Hill site: 1) administrators, 2) licensed clinical staff, 3) non-licensed clinic staff, 4) patient board members, and 5) non-patient board members. (The composition of each focus group is described in greater detail in the results section of this report.) Participants were provided with lunch and a stipend. Hilltop staff

demonstrated the Interventionaire© and then asked the participants a series of questions related to the five research domains. To eliminate potential survey bias, participants were asked not to share their focus group experience with staff who did not participate in the focus groups.

Each of the focus groups was recorded to facilitate data analysis. The recordings were transcribed by an off-site transcription firm, and the transcripts were returned to Hilltop using a secure process. Hilltop completed a systematic analysis of the focus group transcripts using NVivo to identify key themes and additional research domains and/or survey items for inclusion in the staff survey.

Staff Survey

Using the information obtained from the literature review and the focus groups, Hilltop developed an online survey (see Appendix C) to ascertain Cherry Hill staff opinions and attitudes regarding the five identified research domains (described above). The survey was created on the website www.SurveyMonkey.com and consisted of two demographic questions (i.e., job title and job location) and twenty-six statements. Respondents were asked to choose how strongly they disagreed or agreed with each statement (e.g., "Staff workload will increase if we use the Interventionaire©") on a five-point Likert scale of "strongly disagree," "disagree," "neither agree nor disagree," "agree," and "strongly agree." For purposes of presenting the results, responses of "strongly disagree" and "disagree" were combined into one response category, as were "strongly agree" and "agree."

Beta Test

While the online staff survey was designed to be conducted at Cherry Hill, Hilltop first conducted a beta test of the survey with staff from another FHCB clinic (Brooklyn) to identify potential survey design issues. The Brooklyn site provides primary care, but unlike Cherry Hill, Brooklyn does not provide behavioral health care onsite. The primary care staff members who served as beta test participants were each given an IPAD with internet links to both the Interventionaire© and the online staff survey. Participants were instructed to independently complete the Interventionaire© assessment and then complete the online staff survey. They were then asked a series of questions designed to elicit feedback about the online survey, including clarity of survey instructions and questions, as well as general ease of use. Lunch and a stipend were provided for the participants.

Deployment

The online staff survey was administered by RCA to Cherry Hill staff in January 2016. All staff took part in the survey; a stipend was provided for their participation. As in the beta test, each participant was given an IPAD with links to both the Interventionaire© and the online staff survey. Participants were asked to independently complete both the Interventionaire©

assessment and the online staff survey. Hilltop downloaded the resulting survey response data from the SurveyMonkey website for analysis.

Findings

Focus Groups

As shown in Table 1, Cherry Hill administrators and non-licensed clinic staff made up the largest percentage of the focus group participants. Licensed clinical staff, patient board members, and non-patient board members were equally represented in the groups.

Table 1. Number of Focus Groups Participants

Job Category	Position Types	Number of Participants	Percentage of Participants
Administrators	Chief operating, executive, financial, and medical officers; Human Resources Manager and Behavioral Health Program Director	3	23%
Licensed Clinical Staff	Medical director, physician assistant, nurse practitioner	2	15%
Non-Licensed Clinic Staff	Medical assistants, counselors, laboratory technicians, and front desk staff	4	30%
Patient Board Members	Cherry Hill board members who are also patients at this location	2	15%
Non-Patient Board Members	Cherry Hill board members who are not patients at this location	2	15%
Total Participants		**13**	**100%**

Focus group participants emphasized two potential barriers to implementation: 1) implementation and maintenance costs, and 2) patient literacy. Some participants expressed concerns that the added costs of purchasing and securing the iPads, as well as the potential cost of physical plant changes required to ensure the privacy of patients as they completed the tool, might be prohibitive. One participant's comments addressed both of these issues:

> My only concern with that [Interventionaire©] is two or three things. Number one [is the loss] of materials. Although ….. it is very much so a family-oriented setting, I feel like the patients very much know each other because it is a community-based clinic, but the "walkaway" with the tablet is a concern for me just because of having to replace. And…the other thing is what you mentioned earlier about people who had difficulty with reading. The language barrier I'm sure is an easy fix. Translation is probably not a big issue, but the inability to read, then at that point we'll have to consider microphones or earplugs of some sort to accommodate those individuals. For people who have difficulty seeing,

> what would be their accommodation? Will we have them go into a special room or? So, I'm just wondering what those logistical changes would have to be incorporated, and how much they would cost.

However, another participant appeared less concerned about the cost issue:

> From my perspective, I see there's—in the tools and in the pads and all that, it's simply the cost of doing business—a part of the cost of doing business. And healthcare has evolved. It's changing every day. The way healthcare services are delivered today is not the way that they were delivered ten years ago… So I'm not… you know, we don't want to give these things [iPads] away but some of them we're going to lose. But there are ways to protect ourselves and to turn them off so that they can't work. You know what I mean? There are things that can be done and we're moving in that direction.

Patient confidentially, while identified in the literature as a potential barrier, was also a key concern for participants. When asked to identify concerns patients may have about completing the Interventionaire©, patient confidentially was mentioned several times. Based on this feedback, Hilltop ensured that items related to costs, patient literacy, and patient confidentially were included in the online staff survey.

Beta Test

Two licensed clinical staff and two non-licensed clinic staff participated in a beta test of the staff survey. After independently completing the Interventionaire© and the online staff survey, the participants were immediately asked a series of questions related to the survey. All of the participants agreed that the instructions for completing the survey were clearly written and easy to follow. They also agreed that the survey items themselves were clearly written. When asked if there were additional items that should have been included in the survey, most agreed that the items were comprehensive and did not exclude any relevant topics. However, one participant suggested that an "other" field be added to the survey to capture concerns that did not seem to fit into any of the items provided. Based on this feedback, Hilltop added two "other," free-text fields to the sections of the survey that dealt with reasons that patients might either 1) need help to complete, or 2) refuse to complete the Interventionaire©, along with likert response scales to indicate how much the participant agreed or disagreed with the reason they entered.

While the usability of the Interventionaire© was not the primary focus of the beta test, participants suggested enlarging the size of the "next" button used to advance to the next screens and to improve the scrolling functionality. One participant also noted that one or more of the Interventionaire© questions were confusing and in need of clarification. This feedback was shared with RCA.

Staff Survey Results

Of the 56 survey participants, almost half were non-licensed clinic staff; the remaining half was almost evenly divided between administrators and licensed clinical staff. A similar pattern occurred with job location: almost half of the participants were located in primary care, followed by behavioral health and those whose jobs covered both locations. See Table 2. A small number of staff members did not self-identify by job category and/or job location. These individuals were included in frequency tabulations for overall staff but not in subgroup analyses for which they were missing the relevant response.

Table 2. Staff Survey Participants

Participants	Number	Percentage
All Staff	56	100%
Job Category		
Administrators	15	27%
Licensed Clinical	13	23%
Non-Licensed Clinic	26	46%
Unknown	2	4%
Job Location		
Primary Care	26	46%
Behavioral Health	15	27%
Both Locations	11	20%
Unknown	4	7%

Domain 1: Appropriateness of Integrating Behavioral Health Concerns into Primary Care

The first domain assessed was the appropriateness of integrating behavioral health concerns into the primary care visit. Given that the Interventionaire© is designed to assess alcohol misuse (i.e., a behavioral health issue) in a primary care setting, staff opinions on addressing behavioral health issues in primary care would likely impact whether or not they would support use of the Interventionaire© in the clinic. Specifically, two survey items addressed staff opinions about whether behavioral health and primary care concerns should be dealt with 1) in the same location and 2) by the same person. Table 3 shows these results.

Table 3. Integration of Behavioral Health Needs into Primary Care

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
Patients should have their primary care and behavioral health needs treated in the same location.				
All Staff		8%	11%	82%
by job category	Administrators	13%	20%	67%
	Licensed Clinical Staff	8%	0%	92%
	Non-licensed Clinic Staff	4%	12%	85%
by job location	Primary Care	12%	12%	77%
	Behavioral Health	7%	7%	87%
	Both Locations	0%	18%	82%
Patients should have their primary care and behavioral health needs treated by the same person.				
All Staff		38%	39%	23%
by job category	Administrators	33%	47%	20%
	Licensed Clinical Staff	31%	31%	39%
	Non-licensed Clinic Staff	42%	39%	19%
by job location	Primary Care	46%	35%	19%
	Behavioral Health	33%	33%	33%
	Both Locations	27%	46%	27%

Overall, most staff (82 percent) chose to "agree" or "strongly agree" that "Patients should have their primary care and behavioral health needs treated in the same location." By job category, licensed clinical staff were most likely to choose "agree" or "strongly agree" (92 percent), followed by non-licensed clinic staff (85 percent) and administrators (67 percent). By location, behavioral health staff were most likely to choose "agree" or "strongly agree" (87 percent), followed by staff in both locations (82 percent) and primary care staff (77 percent).

There was considerably less consensus with the statement that "Patients should have their primary care and behavioral health needs treated by the same person." Overall, less than one quarter of staff (23 percent) chose to "agree" or "strongly agree." Licensed clinical staff were twice as likely (39 percent) to choose "agree" or "strongly agree," compared to administrators (20 percent) and non-licensed clinic staff (19 percent). Behavioral health staff were most likely to choose "agree" or "strongly agree" (33 percent), followed by staff in both locations (27 percent) and primary care staff (19 percent).

Domain 2: Potential Impact of Interventionaire on Clinic Operations

The second domain assessed staff perceptions of the potential impact of the Interventionaire© on clinic operations. Three items addressed perceptions of current clinic operations, including screening and referral protocols. Additional items addressed perceptions of how the Interventionaire© might impact future operations, including the quality of the information that

the Interventionaire© would collect and how it would be used, staff training that would be needed, and the level of assistance that would be needed in order for patients to successfully complete the Interventionaire©.

Current Clinic Operations

In order to determine whether there might be room for the Interventionaire© to streamline and/or improve certain aspects of clinic operations, Hilltop presented statements related to current screening and referral protocols between Primary Care and Behavioral Health, and the quality of communication between the two areas of the clinic about patient care. Table 4 shows the results.

Table 4. Current Clinic Operations

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
The way our clinic now screens for alcohol misuse in primary care works well.				
All Staff		6%	26%	69%
by job category	Administrators	0%	33%	67%
	Licensed Clinical Staff	0%	25%	75%
	Non-licensed Clinic Staff	12%	20%	68%
by job location	Primary Care	12%	20%	68%
	Behavioral Health	0%	29%	71%
	Both Locations	0%	27%	73%
The way our clinic now refers patients with alcohol misuse for treatment works well.				
All Staff		9%	20%	71%
by job category	Administrators	0%	20%	80%
	Licensed Clinical Staff	17%	25%	58%
	Non-licensed Clinic Staff	12%	15%	73%
by job location	Primary Care	15%	27%	58%
	Behavioral Health	0%	7%	93%
	Both Locations	9%	9%	82%
At Family Health Centers, primary care and behavioral health staff communicate well with each other about patient care.				
All Staff		12%	11%	77%
by job category	Administrators	7%	7%	87%
	Licensed Clinical Staff	8%	8%	85%
	Non-licensed Clinic Staff	19%	15%	65%
by job location	Primary Care	19%	8%	73%
	Behavioral Health	0%	13%	87%
	Both Locations	9%	9%	82%

Overall, most staff (69 percent) chose to “agree” or “strongly agree” that “The way our clinic now screens for alcohol misuse in primary care works well.” Licensed clinical staff (75 percent) were slightly more likely to choose “agree” or “strongly agree” than non-licensed clinic staff (68 percent) and administrators (67 percent). Frequencies of “agree” or “strongly agree” were similar across job locations, ranging from 68 to 73 percent.

Staff also reported high levels of agreement that “The way our clinic now refers patients with alcohol misuse for treatment works well.” Overall, most staff (71 percent) chose to “agree” or “strongly agree.” However, differences between subgroups were more pronounced for the current system of referral than they were for the current system of screening. While most administrators (80 percent) chose to “agree” or “strongly agree,” fewer licensed clinical staff (58 percent) made that choice. Similarly, although nearly all behavioral health staff (93 percent) chose to “agree” or “strongly agree,” just over half of primary care staff (58 percent) made that choice.

Regarding communication between the primary care and behavioral health sections of the clinic, more than three quarters of all staff (77 percent) chose to “agree” or “strongly agree” with “At Family Health Centers, primary care and behavioral health staff communicate well with each other about patient care.” Non-licensed clinic staff (65 percent) were less likely than administrators (87 percent) and licensed clinical staff (85 percent) to choose “agree” or “strongly agree.” Similarly, primary care staff (73 percent) were less likely than behavioral health (87 percent) and staff from both locations (82 percent) to choose “agree” or “strongly agree.”

Future Clinic Operations: Information and Training

After asking about current clinic operations as a baseline, Hilltop asked staff about their perceptions of specific impacts that use of the Interventionaire© could have on future clinic operations. Hilltop was particularly interested in the perceived value of the information collected by the Interventionaire©, how it might be integrated into patient care, and the training that would be necessary to use the Interventionaire©. Results are shown in Table 5.

Table 5. Future Clinic Operations: Information and Training

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
The Interventionaire© will give us more useful information than we now get on alcohol misuse.				
All Staff		5%	13%	82%
by job category	Administrators	7%	20%	73%
	Licensed Clinical Staff	8%	15%	77%
	Non-licensed Clinic Staff	0%	8%	92%
by job location	Primary Care	0%	12%	89%
	Behavioral Health	7%	13%	80%
	Both Locations	18%	9%	73%
Information from the Interventionaire© needs to become part of the patient's electronic medical record.				
All Staff		11%	18%	71%
by job category	Administrators	13%	7%	80%
	Licensed Clinical Staff	23%	23%	54%
	Non-licensed Clinic Staff	4%	24%	72%
by job location	Primary Care	12%	27%	62%
	Behavioral Health	13%	13%	73%
	Both Locations	10%	10%	80%
All staff will need to know something about the Interventionaire©.				
All Staff		7%	4%	89%
by job category	Administrators	7%	7%	87%
	Licensed Clinical Staff	8%	8%	83%
	Non-licensed Clinic Staff	8%	0%	92%
by job location	Primary Care	8%	4%	88%
	Behavioral Health	13%	7%	80%
	Both Locations	0%	0%	100%
All staff will need updates from time to time on the Interventionaire©.				
All Staff		11%	6%	83%
by job category	Administrators	0%	7%	93%
	Licensed Clinical Staff	42%	8%	50%
	Non-licensed Clinic Staff	4%	4%	92%
by job location	Primary Care	12%	8%	80%
	Behavioral Health	20%	7%	73%
	Both Locations	0%	0%	100%

Overall, most staff (82 percent) chose to "agree" or "strongly agree" that "The Interventionaire© will give us more useful information than we now get on alcohol misuse." Non-licensed clinic staff were most likely to choose "agree" or "strongly agree" (92 percent), followed by licensed clinical staff (77 percent) and administrators (73 percent). Similarly, 89 percent of primary care staff chose "agree" or "strongly agree," followed by behavioral health staff (80 percent) and staff in both locations (73 percent).

Overall, almost three-quarters of staff (71 percent) chose to "agree" or "strongly agree" that "Information from the Interventionaire© needs to become part of the patient's electronic medical record." Most administrators (80 percent) and non-licensed clinic staff (72 percent) chose to "agree" or "strongly agree," while licensed clinical staff (54 percent) were least likely to choose "agree" or "strongly agree."

There were high levels of agreement with the following statement: "All staff will need to know something about the Interventionaire©." Overall, 89 percent of staff chose "agree" or "strongly agree," and the range was from 80 to 100 percent for all subgroups. There were similarly high levels of agreement that "All staff will need updates from time to time on the Interventionaire©." The exception was licensed clinical staff, of which only 50 percent chose to "agree" or "strongly agree," while 42 percent chose to "disagree" or "strongly disagree."

Future Clinic Operations: Patient-Related Impacts

Another factor that could moderate the impact of the Interventionaire© on clinic operations is the ability of patients to use it relatively quickly and with minimal assistance. To address this factor, Hilltop asked staff to rate their agreement with items related to patient flow, time it would take patients to complete the Interventionaire©, and reasons that patients might need help to complete it. See Table 6 for the results of these questions.

Table 6. Future Clinic Operations: Patient-Related Impacts

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
Patient flow will be better if we use the Interventionaire©.				
All Staff		4%	36%	61%
by job category	Administrators	7%	40%	53%
	Licensed Clinical Staff	0%	39%	62%
	Non-licensed Clinic Staff	4%	31%	65%
by job location	Primary Care	4%	35%	62%
	Behavioral Health	0%	53%	47%
	Both Locations	9%	18%	73%
Most patients (80% or more) will be able to finish the Interventionaire© within 10 to 20 minutes.				
All Staff		7%	35%	58%
by job category	Administrators	13%	47%	40%
	Licensed Clinical Staff	8%	8%	85%

	Non-licensed Clinic Staff	4%	40%	56%
by job location	Primary Care	8%	31%	62%
	Behavioral Health	7%	40%	53%
	Both Locations	9%	18%	73%
Most patients (80% or more) will need a lot of help to use the Interventionaire© because they cannot read some of the questions.				
All Staff		28%	9%	63%
by job category	Administrators	47%	7%	47%
	Licensed Clinical Staff	15%	23%	62%
	Non-licensed Clinic Staff	25%	0%	75%
by job location	Primary Care	23%	4%	73%
	Behavioral Health	36%	14%	50%
	Both Locations	30%	10%	60%
Most patients (80% or more) will need a lot of help to use the Interventionaire© because they do not know English well.				
All Staff		30%	28%	43%
by job category	Administrators	40%	33%	27%
	Licensed Clinical Staff	39%	31%	31%
	Non-licensed Clinic Staff	21%	21%	58%
by job location	Primary Care	23%	23%	54%
	Behavioral Health	43%	29%	29%
	Both Locations	40%	20%	40%
Most patients (80% or more) will need a lot of help to use the Interventionaire© because they are not able to use a computer on their own.				
All Staff		26%	17%	57%
by job category	Administrators	47%	7%	47%
	Licensed Clinical Staff	31%	23%	46%
	Non-licensed Clinic Staff	13%	17%	71%
by job location	Primary Care	27%	8%	65%
	Behavioral Health	21%	29%	50%
	Both Locations	40%	20%	40%

More than half of all staff (61 percent) chose to “agree” or “strongly agree” with the following statement: “Patient flow will be better if we use the Interventionaire©.” Non-licensed clinic staff were most likely to choose “agree” or “strongly agree” (65 percent), followed by licensed clinical staff (62 percent) and administrators (53 percent). Staff who work in both locations were most likely to choose “agree” or “strongly agree” (73 percent), followed by primary care (62 percent) and behavioral health (47 percent) staff.

Overall, more than half of participants (58 percent) chose to “agree” or “strongly agree” with the statement that “Most patients (80 percent or more) will be able to finish the Interventionaire© within 10 to 20 minutes.” Licensed clinical staff were most likely to choose “agree” or “strongly

agree" (85 percent), compared to 40 percent of administrators and 56 percent of non-licensed clinic staff.

When presented with potential reasons "most patients (80 percent or more) will need a lot of help to use the Interventionaire©," overall, 63 percent of staff chose to "agree" or "strongly agree" with "Cannot read some of the questions," 43 percent chose to "agree" or "strongly agree" with "Do not know English well," and 57 percent chose to "agree" or "strongly agree" with "Are not able to use a computer on their own."

For each reason patients would need help, non-licensed clinic staff were most likely to choose "agree" or "strongly agree." Compared to just fewer than half of administrators (47 percent), three-quarters of non-licensed clinic staff agreed or strongly agreed that most patients would need help because they cannot read some of the questions. Non-licensed clinic staff were twice as likely (58 percent) as licensed clinical staff (31 percent) and administrators (27 percent) to agree or strongly agree that patients would need help because they would not know English well, and more likely (71 percent) than administrators (47 percent) and licensed clinical staff (46 percent) to agree or strongly agree that patients would need help because they would not be able to use a computer on their own.

In terms of job location, primary care staff were the most likely to choose to "agree" or "strongly agree" to each of the possible reasons most patients would need help using the Interventionaire©. Primary care staff reported the highest agreement with patients needing help to read (73 percent), help with English (54 percent), and help to use the computer (65 percent). Half of behavioral health staff agreed or strongly agreed that most patients would need help with reading and using the computer, but only 29 percent agreed or strongly agreed that most patients would need help with English. Responses of "agree" or "strongly agree" for each reason ranged from 40 to 60 percent for staff in both locations.

Based on feedback from the beta test, Hilltop included a free-text field for staff to indicate any other reason they felt that patients might need help to complete the Interventionaire©. Few reasons were reported that could not be encompassed by a reason previously offered in the survey, and these responses generally did not contradict any previous responses. For instance, one respondent entered, "Can not [sic] comprehend," and chose "agree." This individual had already chosen to "agree" with previous reasons related to patient comprehension (i.e., patient cannot read and patient does not understand English well). Similarly, another staff member responded, "Elderly patients need more help" and chose to "agree." However, this respondent had also chosen to "agree" with the suggested reason that patients might need help because they are unable to use a computer on their own, which would seem to encompass elderly patients needing help. Because there were no responses to the free-text item that contradicted responses to earlier items, no earlier responses were changed.

Other reasons entered in the free-text field seemed more appropriately classified as reasons patients would refuse to use the Interventionaire© (as will be discussed) rather than reasons they

would need help. Such reasons included, "Patient will not want to be honest," "Patient doesn't think they have a problem," and "Fear information could be shared." The latter reason, related to confidentiality of the information collected, was offered elsewhere in the survey as a potential reason patients might refuse to use the Interventionaire©.

Domain 3: Staff Acceptance

The third domain assessed related to anticipated staff acceptance of the Interventionaire©. As emphasized in the literature and Hilltop's focus groups with staff, the degree to which staff accept any new policy or procedure has a tremendous impact on its implementation success. Staff acceptance of a given policy or procedure may in turn be strongly influenced by the perception of how it will affect their workload. Hilltop posed two statements to assess staff perceptions of how the Interventionaire© would affect their workload and whether or not staff would want to integrate the Interventionaire© into the patient visit. Table 7 shows these results.

Table 7. Staff Acceptance

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
Staff workloads will increase if we use the Interventionaire©.				
All Staff		23%	32%	45%
by job category	Administrators	13%	33%	53%
	Licensed Clinical Staff	31%	39%	31%
	Non-licensed Clinic Staff	27%	31%	42%
by job location	Primary Care	27%	31%	42%
	Behavioral Health	13%	47%	40%
	Both Locations	27%	18%	55%
The staff will want to make the Interventionaire© part of the patient visit.				
All Staff		7%	16%	77%
by job category	Administrators	13%	7%	80%
	Licensed Clinical Staff	8%	39%	54%
	Non-licensed Clinic Staff	0%	12%	88%
by job location	Primary Care	0%	23%	77%
	Behavioral Health	7%	13%	80%
	Both Locations	27%	9%	64%

Slightly less than half of all survey participants (45 percent) chose to "agree" or "strongly agree" with "Staff workloads will increase if we use the Interventionaire©." Administrators were most likely to choose "agree" or "strongly agree" (53 percent), followed by non-licensed clinic staff (42 percent) and licensed clinical staff (31 percent). Similarly, staff from both locations (55

percent) were more likely than primary care (42 percent) and behavioral health (40 percent) staff to choose "agree" or "strongly agree."

Overall, most staff (77 percent) chose to "agree" or "strongly agree" with the following: "The staff will want to make the Interventionaire© part of the patient visit." Non-licensed clinic staff (88 percent) and administrators (80 percent) were more likely than licensed clinical staff (54 percent) to choose "agree" or "strongly agree." Behavioral health staff were most likely to choose "agree" or "strongly agree" (80 percent), followed by primary care staff (77 percent) and staff from both locations (64 percent).

Domain 4: Patient Acceptance

The fourth domain assessed was staff perceptions of the degree to which patients would accept the Interventionaire©. Although staff perceptions of the Interventionaire© were the focus of the survey, patients' willingness to use the Interventionaire© would be an important determinant of its impact on clinic operations. Hilltop asked staff how they thought patients would perceive the Interventionaire©'s impact on the quality of their care, and presented potential reasons patients might refuse to use it. See Table 8 for the results.

Table 8. Patient Acceptance

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
Most patients (80% or more) will feel that using the Interventionaire© will help them get better care.				
All Staff		7%	24%	69%
by job category	Administrators	13%	33%	53%
	Licensed Clinical Staff	8%	33%	58%
	Non-licensed Clinic Staff	0%	15%	85%
by job location	Primary Care	4%	23%	73%
	Behavioral Health	7%	29%	64%
	Both Locations	9%	18%	73%
Most patients (80% or more) will not want to use the Interventionaire© because they do not want to take the time to answer the questions.				
All Staff		27%	20%	54%
by job category	Administrators	13%	33%	53%
	Licensed Clinical Staff	23%	15%	62%
	Non-licensed Clinic Staff	39%	15%	46%
by job location	Primary Care	23%	15%	62%
	Behavioral Health	40%	20%	40%
	Both Locations	27%	27%	46%
Most patients (80% or more) will not want to use the Interventionaire© because they cannot read some or all of the questions.				

All Staff		20%	25%	55%
by job category	Administrators	27%	33%	40%
	Licensed Clinical Staff	8%	31%	62%
	Non-licensed Clinic Staff	23%	15%	62%
by job location	Primary Care	8%	35%	58%
	Behavioral Health	27%	13%	60%
	Both Locations	36%	18%	46%
Most patients (80% or more) will not want to use the Interventionaire© because they are not able to use a computer on their own.				
All Staff		18%	25%	57%
by job category	Administrators	27%	20%	53%
	Licensed Clinical Staff	8%	39%	54%
	Non-licensed Clinic Staff	19%	19%	62%
by job location	Primary Care	12%	19%	69%
	Behavioral Health	20%	33%	47%
	Both Locations	36%	18%	46%
Most patients (80% or more) will not want to use the Interventionaire© because they think their answers will be shared.				
All Staff		20%	18%	62%
by job category	Administrators	7%	27%	67%
	Licensed Clinical Staff	17%	25%	58%
	Non-licensed Clinic Staff	31%	12%	58%
by job location	Primary Care	20%	20%	60%
	Behavioral Health	27%	27%	47%
	Both Locations	18%	0%	82%
Most patients (80% or more) will not want to use the Interventionaire© because they fear that people will think badly of them because of their responses.				
All Staff		26%	26%	48%
by job category	Administrators	20%	40%	40%
	Licensed Clinical Staff	23%	23%	54%
	Non-licensed Clinic Staff	29%	21%	50%
by job location	Primary Care	28%	24%	48%
	Behavioral Health	27%	40%	33%
	Both Locations	20%	20%	60%

About two thirds of all staff (69 percent) chose to “agree” or “strongly agree” with “Most patients (80 percent or more) will feel that using the Interventionaire© will help them get better care.” Non-licensed clinic staff were the most likely (85 percent) to choose “agree” or “strongly

agree," whereas just over half of licensed clinical staff (58 percent) and administrators (53 percent) chose to "agree" or "strongly agree." Differences in response patterns based on job location were not as pronounced as those based on job category.

Overall, around half of participants chose to "agree" or "strongly agree" with "Most patients (80 percent or more) will not want to use the Interventionaire© for the following reasons:" 1) do not want to take the time to answer the questions (54 percent), 2) cannot read some or all of the questions (55 percent), 3) not able to use a computer on their own (57 percent), 4) think their answers will be shared (62 percent), and 5) fear that people will think badly of them because of their responses (48 percent).

In contrast to the previous item regarding patients' perceptions of overall care, responses to reasons for refusing the Interventionaire© differed more by job location than by job category. In particular, behavioral health staff were less likely to "agree" or "strongly agree" with a number of reasons patients might refuse to use the Interventionaire©; e.g., not able to use a computer on their own (69 percent of primary care staff vs. 47 percent of behavioral health staff), think their answers will be shared (82 percent of staff from both locations vs. 47 percent of behavioral health staff), and fear that people will think badly of them (60 percent of staff from both locations vs. 33 percent of behavioral health staff).

As was the case when assessing staff opinions on reasons patients might need help using the Interventionaire©, Hilltop also included a free-text field for staff to indicate reasons patients might refuse to use the Interventionaire© that were not offered in the survey. Some reasons entered were related to reasons already offered in the survey. For instance, two free-text responses were related to concerns that patients' answers would be shared, and two were related to the idea of the patient fearing being judged by others or viewed differently due to their answers. In most cases, the response choice associated with the free-text reason (i.e., "agree" or "disagree") matched the corresponding response choice associated with the related survey item. However, in two cases, the response to the free-text item contradicted the response to the related survey item. In those cases, the response to the related survey item was removed from analysis, as it was deemed unreliable. Finally, one free-text response that the survey did not cover was "no incentives," and the respondent opted to "strongly agree" that this is a reason patients might refuse to use the Interventionaire©.

Domain 5: Advantages and Disadvantages

The fifth domain assessed was broadly defined as potential advantages or disadvantages to using the Interventionaire©. We asked staff whether they thought patient care overall would be better, and to what degree they anticipated infrastructure changes or other significant expenses associated with using the Interventionaire©. See Table 9 for the results.

Table 9. Advantages and Disadvantages

		Disagree or Strongly Disagree	Neither Agree nor Disagree	Agree or Strongly Agree
Patient care overall will be better if we use the Interventionaire©.				
All Staff		4%	16%	82%
by job category	Administrators	7%	13%	80%
	Licensed Clinical Staff	0%	15%	85%
	Non-licensed Clinic Staff	4%	16%	80%
by job location	Primary Care	4%	12%	84%
	Behavioral Health	7%	13%	80%
	Both Locations	0%	18%	82%
The clinic will need to make changes like moving chairs in the waiting area or building a new space to use the Interventionaire©.				
All Staff		29%	35%	36%
by job category	Administrators	27%	20%	53%
	Licensed Clinical Staff	46%	31%	23%
	Non-licensed Clinic Staff	24%	44%	32%
by job location	Primary Care	35%	31%	35%
	Behavioral Health	20%	53%	27%
	Both Locations	40%	10%	50%
The Interventionaire© will cost too much money to set up in our clinic.				
All Staff		32%	55%	13%
by job category	Administrators	20%	53%	27%
	Licensed Clinical Staff	23%	54%	23%
	Non-licensed Clinic Staff	42%	56%	0%
by job location	Primary Care	34%	54%	12%
	Behavioral Health	27%	67%	7%
	Both Locations	46%	27%	27%
The Interventionaire© will cost too much money to keep up over time.				
All Staff		25%	58%	16%
by job category	Administrators	13%	67%	20%
	Licensed Clinical Staff	23%	46%	31%
	Non-licensed Clinic Staff	32%	60%	8%
by job location	Primary Care	23%	54%	23%
	Behavioral Health	27%	73%	0%
	Both Locations	40%	40%	20%

Overall, most staff (82 percent) chose to "agree" or "strongly agree" that "Patient care overall will be better if we use the Interventionaire©." Frequencies of "agree" or "strongly agree" ranged from 80 percent to 85 percent for all subgroups. Very few staff chose to "disagree" or "strongly disagree" (by job category, only 7 percent of administrators and 4 percent of non-licensed clinic staff; by job location, only 7 percent of behavioral health staff and 4 percent of primary care staff).

About one-third of all staff (36 percent) chose to "agree" or "strongly agree" that "The clinic will need to make changes like moving chairs in the waiting area or building a new space to use the Interventionaire©." Administrators were most likely to choose "agree" or "strongly agree" (53 percent), while licensed clinical staff were least likely to choose "agree" or "strongly agree" (23 percent). By location, staff from both locations were the most likely to choose "agree" or "strongly agree" (50 percent), but they were also the most likely to choose "disagree" or "strongly disagree" (40 percent) than staff in primary care or behavioral health. In other words, staff from both locations were the least likely to choose the neutral option of "neither agree nor disagree" (10 percent).

Overall, few staff (13 percent) chose to "agree" or "strongly agree" with "The Interventionaire© will cost too much money to set up in our clinic." About one quarter of administrators (27 percent) and licensed clinical staff (23 percent) chose to "agree" or "strongly agree," while no non-licensed clinic staff made that choice. About one quarter of staff who work in both locations (27 percent) chose to "agree" or "strongly agree," followed by primary care staff (12 percent) and behavioral health staff (7 percent).

Similarly, few staff (16 percent) chose to "agree" or "strongly agree" with "The Interventionaire© will cost too much money to keep up over time." Slightly less than one-third of licensed clinical staff (31 percent) chose to "agree" or "strongly agree," followed by administrators (20 percent) and non-licensed clinic staff (8 percent). Less than one-quarter of primary care staff (23 percent) and staff from both locations (20 percent) chose to "agree" or "strongly agree," while no behavioral health staff made that choice. These items relating to the costs of setting up and maintaining the Interventionaire© were the most likely of all of the survey items to receive the response of "neither agree nor disagree," suggesting that staff might be either unsure as to what costs would be involved or do not know how these costs would fit into the center's budget.

Conclusion

Overall, results from Hilltop's survey of staff at Cherry Hill suggest that the Interventionaire© is perceived as a potentially useful tool that would improve patient care and be well-received by both staff and patients. Responses suggest strong support for addressing behavioral health needs—which would include alcohol misuse—in primary care. Although most staff agreed that screening, referral, and communication currently work well, primary care staff and non-licensed clinic staff were somewhat *less* likely than other categories of staff to agree. At the same time,

primary care staff were *most* likely to agree that the Interventionaire© would provide more information than is currently collected, and that it would improve patient care overall. Taken together, these response patterns suggest that primary care staff might particularly appreciate a formalized alcohol misuse screening and referral protocol that includes the Interventionaire©, which is important because primary care staff would be administering the Interventionaire© and acting on the results.

No particular item appeared to present a significant barrier to implementation of the Interventionaire©. Although around half of all staff agreed that the Interventionaire© would increase staff workload and that patients would need considerable assistance using the Interventionaire©, slightly more than half of all staff agreed that use of the Interventionaire© would improve patient flow. Responses to items addressing potential costs to set up and maintain the Interventionaire© suggested that most staff do not have enough information about the costs involved to have an opinion as to whether or not they would fit into the center's budget. Nevertheless, given the generally positive views of the Interventionaire©, it is likely that most potential barriers to implementation could be surmounted.

Of particular note were the responses of non-licensed clinic staff. This group's responses indicated the most concern about patients' ability to complete the Interventionaire© due to a variety of challenges (literacy, English-proficiency, and ability to use a computerized tool), but they also suggested strong support for the Interventionaire©'s use. Non-licensed clinic staff were most likely to agree that 1) the Interventionaire© would provide more information than is currently collected, 2) patient flow would improve, 3) staff will want to make it a part of the patient visit, and 4) patients will feel they are getting better care. Since non-licensed clinic staff in primary care would likely be the group of staff charged with administering the Interventionaire© to patients (e.g., providing instruction and assistance as needed so that the patient can complete the computerized tool), their approval of the Interventionaire© could greatly facilitate efforts to incorporate the Interventionaire© into the patient visit.

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Appendix A. Sample Focus Group Discussion Guide

Focus Group Guide for Micro-targeted Computerized Alcohol Misuse Intervention System for Health Care

Focus Group Participants: Leadership/Administration Hello and thank you for agreeing to take part in this focus group. You are one of five groups at the Family Health Centers that have been asked to participate in a focus group regarding the implementation of computerized alcohol screening in the primary care setting. As the leadership team of the Family Health Centers we recognize your importance in determining major changes in the center's operations and the implementation of those changes as they impact patient care, staffing functions, and daily operations. Your perspective regarding how the implementation of computerized alcohol screening will impact your managerial operations, staff perceptions and functions, as well as any thoughts you may have on how patients may or may not accept this change are of extreme importance. At the end of the study, we will provide you with feedback on the feasibility of disseminating this technology to primary care settings as well as on stakeholder perception of the benefits and harm that may come from the implementation of computerized alcohol screening at the Family Health Centers.

Introduction: Let us begin with introductions. My name is _____and this is _____. We are from The Hilltop Institute at UMBC. We will be conducting the focus group today. The purpose of the focus group discussion is to learn your current thoughts and feelings about screening for alcohol use using a computerized screening tool. Patients will answer questions about their alcohol intake using a hand-held computer. While they are answering these questions on the computer, they will be provided information by the computer that tells them how their use of alcohol compares to alcohol use by other people of the same age group, sex, and race as them. This is called "normative feedback"; because it gives the patient an idea of what is the normal range of alcohol use for people like themselves. They will see whether they usually have fewer drinks, an average number of drinks, or more drinks than most people like themselves. To help you prepare to answer our questions, we will show you how the computerized alcohol screening tool works before we begin our discussion.

Our task today is to understand how you think this method of alcohol screening will impact how the center runs and how staff and patients may respond to this method. We will ask questions about any changes you think may have to be made if this computer screening becomes a regular part of the patient visit. We will also ask your thoughts about the advantages or disadvantages of using this method of computerized alcohol screening.

Anonymity: Because we want to capture all the information you tell us, we will be taping our discussion. However, we want to assure you that the discussion will be anonymous as well as confidential. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow any of you to be linked to specific statements. None of the notes taken will be given to anyone at the clinic. Please answer the questions as honestly as you can. While we need and want your full participation, please know that you are free to abstain from answering any question. You are also

free to stop your participation in the focus group at any time. Because of our guarantee of confidentiality and anonymity, we will not discuss your specific comments with anyone from the Family Health Centers. To help ensure your confidentiality and anonymity, we ask that you not discuss the comments of other focus group participants outside this session.

Ground rules

- Please allow one person at a time to speak. If you have a different opinion, please wait until the speaker is finished and then let us hear your view.
- There are no right or wrong answers.
- You do not have to speak in any particular order.
- When you do have something to say, please do so. Even if you are in agreement with something that has been said, it is helpful that we know you agree.
- You do not have to agree with the views of other people in the group.
- We will not offer opinions; however, we may ask you to explain your answer more fully in order to make certain we are interpreting your response correctly.

Questions about Ground Rules:

Are there any questions or clarifications before we get started?

Icebreaker:

As we go around the table, please introduce yourself, your role, your tenure at the Family Health Centers, one thing you enjoy about your leadership role.

Before we begin our questions, we will show you (screen shots or video demonstration) of the alcohol screening tool so that you can see how it works and the type of questions patients will be asked.

Now that you are briefly familiar with the tool, please put on your "FHC-Cherry Hill hat" when thinking about how to respond to an interview question.

Interview questions:

Domain: Perception of the integration of BH services into the primary care setting

1. As leadership team members, how do you feel about having behavioral health issues such as alcohol use addressed in the primary care setting?
2. As the leadership team, what type of investment (e.g. training, technology, systems) if any, do you think will be required to help the clinicians address patients' alcohol use and assess and initiate the appropriate level of intervention as assessed by the computer screening tool?

   2a. Do you think training will be required for other staff? If so, what kind of training?

3. If you were to rate staff readiness to work with patients regarding the use of the computerized alcohol screening tool, which category of staff do you think will be most ready and why?
4. If you were to rate staff willingness to work with patients regarding the use of the computerized alcohol screening tool, which category of staff do you think will be most willing and why?
5. Have any of you ever worked in a place where primary care and behavioral health screening were done by the same staff?

    5a. If so, what did you perceive as the advantages and disadvantages about this model of care?

    Advantages:

    Disadvantages:

    5b. Do you foresee an issue with reimbursement for this service?
6. How do you think the primary care staff will view computerized alcohol screening done by the primary care staff?
7. How do you think the behavioral health staff will view computerized alcohol screening done by primary care staff?
8. How well do you think the primary care and behavioral health staff can work as a team to address problematic alcohol use?

We will now move to a different set of questions that focus on your experience and thoughts regarding the impact of computerized alcohol screening on patients.

Domain: Impact of computerized alcohol screening on managerial and clinical operations

1. When the Family Health Centers implements new clinical programs, who has responsibility for the following activities:
    a. Who has responsibility for planning and development of new program affecting primary care?
    b. Who has responsibility for planning and development of new programs affecting behavioral health?
    c. Who has responsibility for implementation of new programs in primary care?
    d. Who has responsibility for implementation of new programs in behavioral health?
    e. Who is responsible for determining whether the intended goal of a program in primary care has been met?
    f. Who is responsible for determining whether the intended goal of a program in behavioral health has been met?
    g. Who is responsible for monitoring new processes in primary care?
    h. Who is responsible for monitoring new processes in behavioral health?
    i. Who is available to primary care staff for questions, orientation to the new procedure, or other additional areas of need related to the process?
    j. Who is available to behavioral health staff for questions, orientation to the new procedure, or other additional areas of need related to the process?

k. Who is responsible for review and approval of primary care related policies and procedures?
l. Who is responsible for review and approval of behavioral health care related policies and procedures?

2. From your experience in implementing clinical programs at the Family Health Centers, Cherry Hill what factors have facilitated the implementation?
3. From your experience in implementing clinical programs at the Family Health Centers, Cherry Hill, what are the challenges you faced with the implementation?
4. If you had to physically rearrange areas in the clinic to accommodate computerized alcohol screening in primary care, which areas would you rearrange and why?
5. How do you think patient flow for primary care visits will change due to the implementation of the computerized alcohol screening?
6. How do you think patient flow for behavioral health visits will change due to the implementation of the computerized alcohol screening?
7. How much latitude does the staff have to change the way the clinic operates prior to seeking management approval?
8. What potential benefits and challenges do you anticipate in implementing the computerized alcohol screening?

8a. Benefits to leadership

8b. Challenges to leadership

8c. Benefits to clinical and non-clinical staff

8d. Challenges to clinical and non-clinical staff

8e. Benefits to patients

8f. Challenges to patients

9. What percentage of your adult patients do you think will be able to:
   a. Adapt quickly, be able to use the computerized alcohol screening tool without a problem ☐
   b. Adapt slowly, willing to use but will need staff help to use the computerized alcohol screening tool ☐
   c. Refuse to use the tool ☐

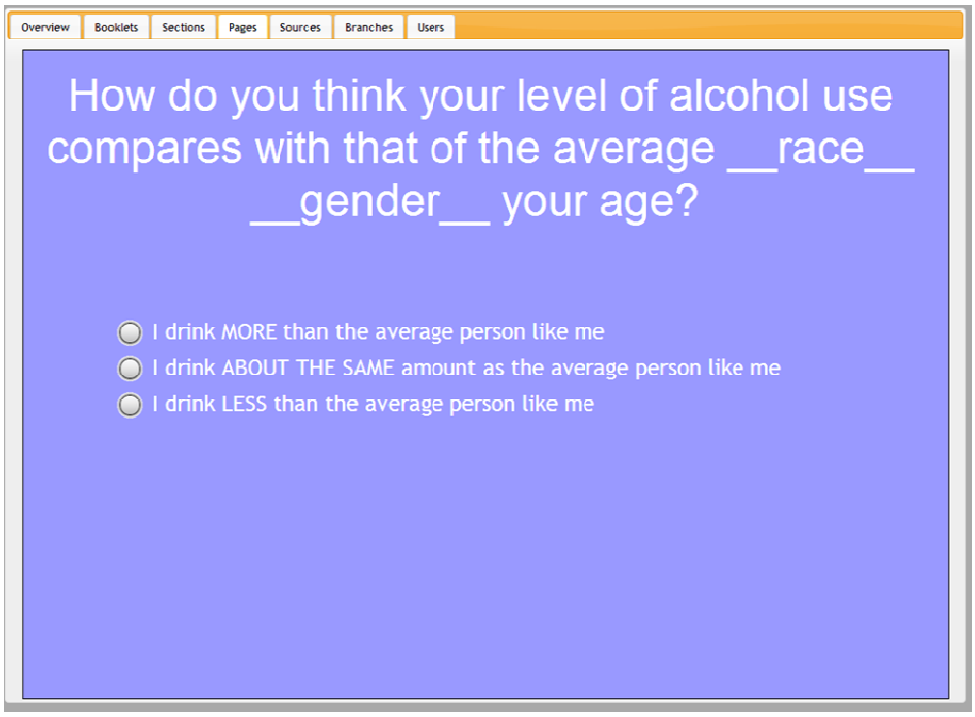
Concluding questions

- Of all the things we've discussed today, what would you say are the most important issues for consideration in implementing the computerized alcohol screening tool?
- Would you like to add any thoughts that we did not discuss?

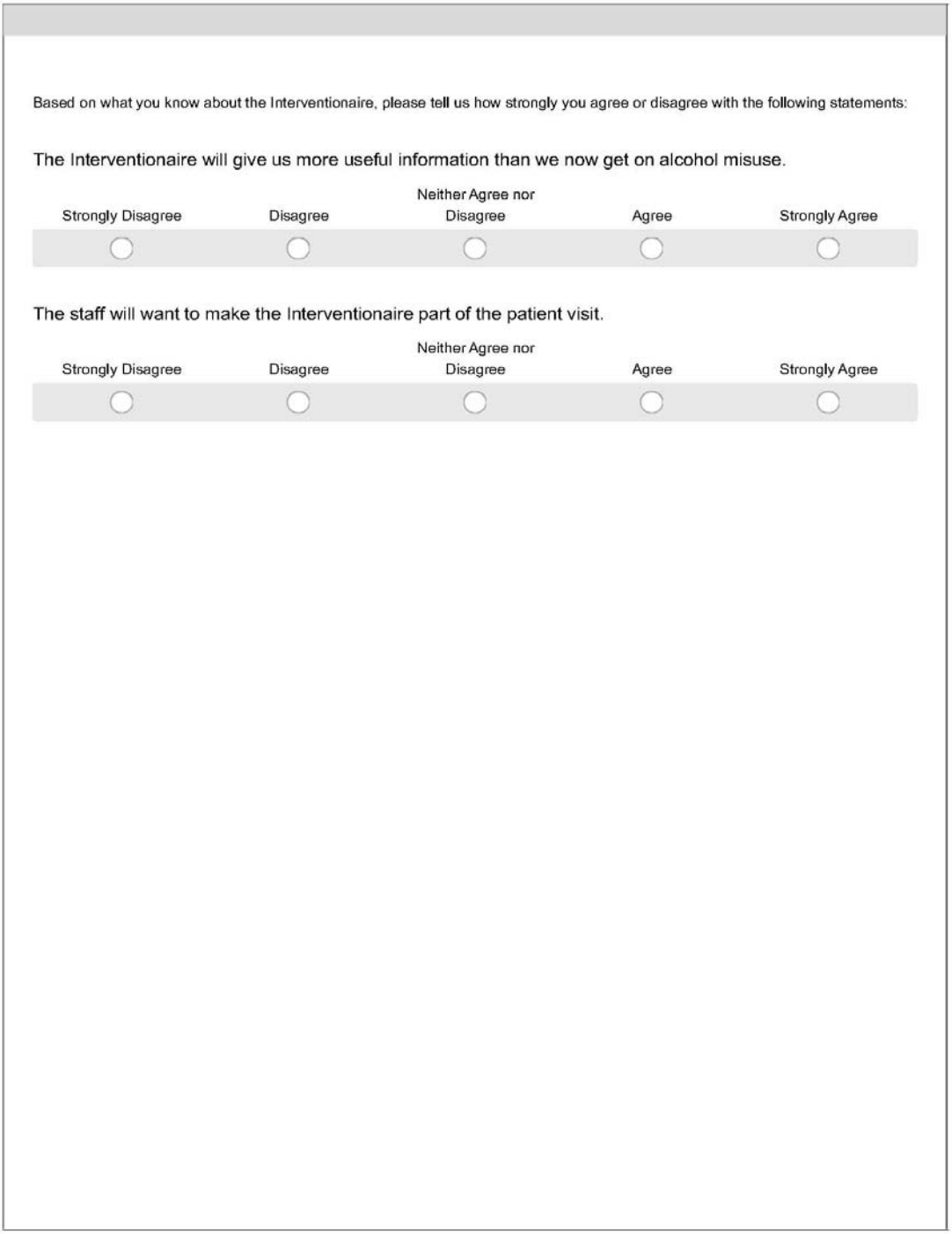
Conclusion

- Thank you for participating. The discussions have been very informative.
- Your opinions will be a valuable asset to the study
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or have any concerns, please let us know and we can put you in contact with the Principal Investigator for the project.
- I would like to remind you that any comments in the final report will be anonymous and your confidentiality will be maintained.
- Would the Leadership Team want a brief presentation of the research team findings at the conclusion of the study? Is there any particular group of staff you would like the research team to prepare a brief of the findings?

Appendix B. Sample Interventionaire© Question with Targeted Feedback



Appendix C. Sample Screenshot of Staff Survey on SurveyMonkey



Based on what you know about the Interventionaire, please tell us how strongly you agree or disagree with the following statements:

The Interventionaire will give us more useful information than we now get on alcohol misuse.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

The staff will want to make the Interventionaire part of the patient visit.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

Appendix D. Complete List of Staff Survey Items

Thank you for participating in our survey. We want to know what you think about using the Interventionaire as part of the primary care visit at Family Health Centers. The survey will take about 15 minutes. Your answers will be kept private.

Where do you work in the clinic?

- Primary Care
- Behavioral Health
- Both

What is your job at the clinic?

- Non-licensed clinic staff
- Licensed clinical staff
- Leadership/Administration

Based on what you know about how the clinic works, please tell us how strongly you agree or disagree with the following statements:

Patients should have their primary care and behavioral health needs treated in the same location.

Patients should have their primary care and behavioral health needs treated by the same person.

The way our clinic now screens for alcohol misuse in primary care works well.

The way our clinic now refers patients with alcohol misuse for treatment works well.

At Family Health Centers, primary care and behavioral health staff communicate well with each other about patient care.

Based on what you know about the Interventionaire, please tell us how strongly you agree or disagree with the following statements:

The Interventionaire will give us more useful information than we now get on alcohol misuse.

The staff will want to make the Interventionaire part of the patient visit.

Staff workloads will increase if we use the Interventionaire.

Patient flow will be better if we use the Interventionaire.

Patient care overall will be better if we use the Interventionaire.

The Interventionaire will cost too much money to set up in our clinic.

The Interventionaire will cost too much money to keep up over time.

Information from the Interventionaire needs to become part of the patient's electronic medical record.

The clinic will need to make changes like moving chairs in the waiting area or building a new space to use the Interventionaire.

All staff will need to know something about the Interventionaire.

All staff will need updates from time to time on the Interventionaire.

Most patients (80% or more) will be able to finish the Interventionaire within 10 to 20 minutes.

Most patients (80% or more) will not want to use the Interventionaire for the following reasons:

Do not want to take the time to answer the questions

Cannot read some or all of the questions

Not able to use a computer on their own

Think their answers will be shared

Fear that people will think badly of them because of their responses

Other reason (choose how strongly you agree or disagree with the reason, then type the reason in the box below)

Most patients (80% or more) will need a lot of help to use the Interventionaire because they:

Cannot read some of the questions

Do not know English well

Are not able to use a computer on their own

Other reason (choose how strongly you agree or disagree with the reason, then type the reason in the box below)

Most patients (80% or more) will feel that using the Interventionaire will help them get better care.

Thank you for completing this survey!

The Hilltop Institute

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org