Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Access to Recovery (ATR) Grants (TI 04-009)
(Initial Announcement)

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

Authority: Sections 501(d)(5) and 509 of the Public Health Service Act (42 U.S.C. Sections 290aa(d)(5) and 290bb-2)

Key Date
Application Deadline: June 4, 2004

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I. FUNDING OPPORTUNITY DESCRIPTION

The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2004 grants to implement voucher programs for substance abuse clinical treatment and recovery support services pursuant to sections 501 (d)(5) and 509 of the Public Health Service Act (42 U.S.C. sections 290aa(d)(5) and 290bb-2). This new program, called Access to Recovery (ATR), is part of a Presidential initiative to provide client choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. Monitoring outcomes, tracking costs, and preventing waste, fraud and abuse to ensure accountability and effectiveness in the use of Federal funds are also important elements of the ATR program. Through the ATR grants, States, Territories, the District of Columbia and Tribal Organizations (hereinafter collectively referred to as "States") will have flexibility in designing and implementing voucher programs to meet the needs of clients in the State. The key to successful implementation of the voucher programs supported by the ATR grants will be the relationship between the States and clients receiving services, to ensure that clients have a genuine, free, and independent choice among eligible providers. States are encouraged to support any mixture of clinical treatment and recovery support services that can be expected to achieve the program's goal of achieving cost-effective, successful outcomes for the largest number of people.

In addition, States should propose innovative strategies for their ATR projects to accomplish the following:

- Ensure genuine, free, and independent client choice for substance abuse clinical treatment and recovery support services appropriate to the level of care needed by the client. For the purposes of this grant program, choice is defined as a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection.

- Require all substance abuse assessment, clinical treatment, and recovery support services under this program be provided pursuant to a voucher or vouchers given to a client by a State or its designee. No funding shall be given directly to a provider through a grant or contract to provide any services under this program, including assessment.[1]

[1] Indirect funding means that individual, private choice, rather than the Government, determines which substance abuse service provider eventually receives the funds. With indirect funding, the individual in need of the service is given a voucher, coupon, certificate, or other means of free agency, such that he or she has the power to select for himself or herself from among eligible substance abuse service providers, whereupon the voucher (or other method of payment) may be "redeemed" for the service rendered. Under "direct" funding, the Government or an intermediate organization with the same duties as a governmental entity purchases the needed services directly from the substance abuse service provider. Under this scenario, there are no intervening steps in which the client's choice comes into play. The government or intermediate organization selects the provider from which the client will receive services.

- Ensure each client receives an assessment for the appropriate level of services and is then provided a genuine, free, and independent choice among eligible providers, among them at least one provider to which the client has no religious objection.

- Use the grant funds to implement a system to provide vouchers to eligible clients to pay for assessment and other clinical treatment and recovery support services from a broad network of eligible providers, including organizations that have not previously received public funding. Eligible service providers for the voucher program may include the following: public and private, nonprofit, proprietary, as well as faith-based and community organizations, as approved by the State.

- Ensure that faith-based organizations otherwise eligible to participate in this program are not discriminated against on the basis of their religious character or affiliation.

- Maintain accountability by creating an incentive system for positive outcomes and taking active steps to prevent waste, fraud and abuse. (See Section VI-3 and Appendix C for reporting expectations under this program).

- Expand clinical treatment and recovery support services by leveraging use of all Federal funds, preventing cost shifting, and ensuring that these funds are used to supplement and not supplant current funding for substance abuse clinical treatment and recovery support services in the State.

SAMHSA is interested in supporting a range of models to implement substance abuse voucher programs, including:

- Full implementation of the program through a designated lead State or sub-State agency.

- Implementation of the program through public/private partnerships (i.e., a contract between the State and a lead private entity to implement all or part of the program).

States may implement the program statewide or may target geographic areas of greatest need, specific populations in need, or areas/populations with a high degree of readiness to implement a voucher program. States may propose alternate models for consideration, as long as they conform to the expectations articulated above.

States are encouraged to minimize the funds used to cover both the direct and indirect costs of administration of the program, to develop a system to manage the program on the basis of reasonable costs, to develop a system to provide incentives to eligible providers with superior outcomes, and to include a broad range of stakeholders in planning and designing their proposal.

Appendix E provides a hypothetical example of a program that conforms to these expectations. States may wish to consult this appendix as a starting point for developing their ATR Grant applications.

Due to the unique nature of this grant program, SAMHSA recognizes that applicants may wish to entertain an array of program and administrative options. To respond, SAMHSA will make available both pre-application and post-award technical assistance to applicants and current and future providers of substance abuse clinical treatment and recovery support services under this program. Examples of topics for which technical assistance may be provided include, but are not limited to:

- Eligibility determinations for clinical treatment and recovery support services providers and for which service in the continuum of recovery will be included in the voucher reimbursement system.
- Eligibility determinations for clients, including management of a system for assessment and service determinations.
- Identifying and determining eligibility of new clinical treatment and recovery support service providers.
- Fiscal/cost accounting mechanisms that can track voucher implementation.
- Management of information systems to track performance and outcomes.
- Development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support service providers.
- Oversight of standards and fraud and abuse.
- Outreach to entities unknown to the State.

II. AWARD INFORMATION

1. AWARD AMOUNT

It is expected that approximately $100 million will be available in fiscal year 2004 to fund up to approximately 15 awards in the Access to Recovery (ATR) program. No more than one grant award will be made to any State or Tribal Organization. Individual awards are expected to be up to $15,000,000 in total costs (direct and indirect) per year. Grants will be awarded for a period of 3 years. The actual award amount in any one year will depend on the availability of funds. Awards may be adjusted based on the number of individuals proposed to be treated successfully per year.[2]

Proposed budgets cannot exceed $15,000,000 in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and a determination that continued funding of the award is in the best interest of the Government.

[2] For purposes of this program, successful completion of an episode of paid treatment/recovery support is defined, at a minimum, as an individual having completed the major goals of his/her treatment plan and having submitted a minimum of four consecutive, randomly collected samples that are free from illegal drugs and alcohol. (This requirement does not apply to brief treatment interventions).

2. FUNDING MECHANISM

The ATR awards will be made as grants to States that, in turn, must distribute funds to clients through vouchers.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligibility for Access to Recovery (ATR) grants is limited to the immediate office of the Chief Executive (e.g., Governor) in the States, Territories, District of Columbia; or the head of a Tribal Organization. (A "Tribal Organization" means the recognized governing body of any Indian tribe or any legally established organization of Indians, including urban Indian health boards, inter-tribal councils, or regional Indian health boards, which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such an organization.) **The Chief Executive of the State, Territory, or District of Columbia, or the head of the Tribal Organization must sign the application.**

Eligibility is limited to the immediate office of these Chief Executives because only they have the authority to leverage funding across the State, implement the necessary policy changes, manage the fiscal responsibilities, and coordinate the range of programs necessary for successful implementation of the voucher programs to be funded through these grants.

No more than one application from any one Chief Executive or head of a Tribal Organization will be funded.

2. COST SHARING

Cost sharing is not required in this program. However, grantees must use these funds to supplement, and not supplant, current funding for substance abuse clinical treatment and recovery support services within States.

3. OTHER

Applications must comply with the following requirements, or they will be screened out and will not be reviewed:

- Use of the PHS 5161-1 application;
- Application submission requirements in Section IV-3 of this document; and
- Formatting requirements provided in Section IV-2.4 of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

(To ensure that all submission requirements are met, a checklist is provided in Appendix F of this document.)

1. ADDRESS TO REQUEST APPLICATION PACKAGE

Applicants may request a complete application kit by calling SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686.

Applicants also may download the required documents from the SAMHSA Web site at www.samhsa.gov. Click on "grant opportunities."

Additional materials available on this web site include:

- A technical assistance manual for potential applicants
- Standard terms and conditions for SAMHSA grants
- Guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, client and family participation, and evaluation)
- Enhanced instructions for completing the Public Health Service (PHS) 5161-1 application.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1 Required Documents

SAMHSA application kits include the following:

- PHS 5161-1 (revised July 2000) – Includes the face page, budget forms, assurances, certification, and checklist. Applicants must use the PHS 5161-1. **Applications not submitted on the PHS 5161-1 will be screened out and will not be reviewed.**

- Request for Applications (RFA) – Includes instructions for the grant application. This document is the RFA.

Applicants must use both of the above documents in completing an application.

2.2 Required Application Components

To ensure equitable treatment, applications must be complete. For an application to be complete, it must include the required 10 application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Appendices, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page –** Use Standard Form (SF) 424, which is part of the PHS 5161-1. [Note: Beginning October 1, 2003, applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet web site at www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, Dun and Bradstreet should be informed that the applicant is a public/private nonprofit organization preparing to submit a Federal grant application.]

- **Abstract** – The total abstract should not be longer than 35 lines. In the first five lines or less of the abstract, write a summary of the project that can be used in publications, reporting to Congress, or press releases if the project is funded.

- **Table of Contents** – Include page numbers for each of the major sections of the application and for each appendix.

- **Budget Form** – Use SF 424A, which is part of the PHS 5161-1. Complete Sections B, C, and E of the SF 424A.

- **Project Narrative and Supporting Documentation** - The Project Narrative describes the project. It consists of Sections A through D. **Sections A through D together may not exceed 35 pages in length.** More detailed instructions for completing each section of the Project Narrative are found in Section 2.3 below.

  The Supporting Documentation provides additional information needed for review of the application. This supporting documentation should be included immediately following the Project Narrative in Sections E through G. There are no page limits for these sections, with the exception of Section F (Biographical Sketches/Job Descriptions).

  - *Section E* **-** Budget Justification, Existing Resources, Other Support. Applicants must provide a narrative justification of the items included in the proposed budget, as well as a description of existing resources and other support expected for the proposed project. **Proposed budgets cannot exceed $15 million per year**.

  - *Section F* **-** Biographical Sketches and Job Descriptions.
    - Include biographical sketches for the Project Director and other key positions. Each sketch should be two pages or less. If a key staff person has not been hired yet, include a letter of commitment from the individual with a current biographical sketch.
    - Include job descriptions for all key personnel. Each job descriptions should be no longer than one page in length.
    - Sample biographical sketches and job descriptions are listed on page 22, Item 6 in the Program Narrative section of the PHS 5161-1.

- *Section G* - Confidentiality and SAMHSA Participant Protection/Human Subjects. Instructions for completing Section G of the application are provided in Section VIII-1 of this document.

- **Appendices 1 through 7** – Use only the appendices listed below. **Do not submit more than 50 pages in total (excluding any data collection instruments and interview protocols) for all of the appendices combined.** Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them.

  - *Appendix 1*: *Letters of Commitment/Support*
  - *Appendix 2: Data Collection Instruments/Interview Protocols*
  - *Appendix 3: Sample Consent Forms*
  - *Appendix 4: Non-Supplantation Letter*
  - *Appendix 5: Three-year Capacity Building Plan*
  - *Appendix 6: Three-year Data Collection and Implementation Plan*
  - *Appendix 7*: *Literature Citations*

- **Assurances** – Non-Construction Programs. Use SF 424B found in PHS 5161-1. Sign and date the form.

- **Certifications** – Use the "Certifications" forms found in PHS 5161-1. Sign and date the forms.

- **Disclosure of Lobbying Activities** – Use SF LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes, or for the preparation, distribution, or use of information designed to support or defeat legislation pending before the Congress, State legislatures, or Tribal Councils. This includes "grass roots" lobbying, described as appeals to members of the public suggesting they contact their elected representatives to express support for or opposition to pending legislation or to urge those representatives to vote in a particular way.

2.3. Project Narrative – Sections A through D

Sections A through D are the Project Narrative of the application. These sections describe the project itself. **Sections A through D together may not exceed 35 pages in length**.

Use the instructions below that have been tailored to this program to develop the project narrative. **Do not use** the "Program Narrative" instructions found on page 21 of the PHS 5161.

Be sure to provide references for any literature cited in the application; include those references in Appendix 7 of the application.

- ***Section A: Need for Voucher Program***

  Describe the current substance abuse clinical treatment and recovery support system in the State (or sub-State target area, if appropriate), including the number of providers currently funded by the State, gaps in service delivery, and barriers to service access.

  Describe the nature and prevalence of substance abuse problems in the State (or sub-State target area), and quantify the need for services, capacity of the service system to provide services, and the difference between the two.

  Describe how a voucher program would help the State (or sub-State target area) address the difference between system capacity and service need, including how and by how much capacity would be increased for each year of the grant. Clearly state the number of clients who would be treated under the proposed program in each year of the grant.

  In Appendix 4 of the application, provide a letter certifying the State will supplement, and not supplant, current funding for substance abuse clinical treatment and recovery support services.

- ***Section B: Proposed Approach***

  Describe the approach that will be used to develop or implement (depending on applicant level of readiness) the program in the State, including the following:

  - Implementation model (e.g., State, sub-State agency, public/private partnership or other model).

  - Eligibility criteria for clients to receive vouchers for clinical treatment and recovery support services.

  - Procedures/policies for screening, assessment, and level of care determinations to identify appropriate clinical treatment and recovery support services options and to place clients with the eligible provider of their choice. Describe the process to ensure that clients receive a comprehensive assessment, using an instrument that assesses need for clinical treatment and recovery support services (See Appendix A for a discussion of clinical treatment and recovery support services, and Appendix D for information on screening, assessment, and level of care determination). Describe the process to ensure that clients receive vouchers for the most appropriate services and are transitioned between services based on established criteria. (See Appendices D and E for more information and resources about criteria.) Describe steps to ensure that clients successfully enter clinical treatment and/or recovery support services following receipt of a voucher, regardless of where the client is seen for screening, assessment, and referral. Clearly state the number of clients who would be successfully treated under the proposed program.

- Eligibility criteria for provider organizations, including: (1) standards for all eligible provider organizations and/or processes to ensure individuals receive appropriate services in safe settings from appropriate individuals, including plans to enforce those standards and processes; and (2) reporting requirements. (See Appendix C for SAMHSA's expectations regarding standards for States.)

- Method/process for designating providers as eligible participants in the voucher program and for maintaining an up-to-date, client friendly information service to ensure client choice is always available and clients are aware of their choices (e.g. a website or 24-hour staffed help line).

- Method/process for measuring client satisfaction in management of the voucher program.

- Process to enable providers previously unable to compete effectively for Federal funds to participate in the Access to Recovery program (including some faith-based and community providers). Clearly state how many of such providers are expected to be designated under this program and the timeframe in which this will occur. Affirm that faith-based organizations that otherwise satisfy program requirements will not be discriminated against on the basis of religious character or affiliation.

- Unbundling of services, if the State intends to use this strategy to achieve the best outcomes at the lowest cost.

Describe how the proposed approach will increase capacity over the period of the voucher program, particularly capacity for recovery support services.

Provide a three-year plan for increasing capacity in Appendix 5 of the application. The plan must include specific milestones with target dates for their achievement and must identify the party(ies) responsible for achieving milestones.

Describe how the State will ensure that voucher recipients have genuine, free and independent choice among eligible clinical treatment and/or recovery service providers.

- ***Section C: Readiness to Implement a Voucher Program***

Describe the timeframe by which the proposed voucher program would be fully operational.

Document which of the following capabilities the State **currently possesses** to implement the voucher program:

- Ability to make eligibility determinations for clients and providers.
- Ability to manage and monitor a voucher program.

- Ability to collect and report data (either through an existing or planned system).
- Ability to implement quality improvement activities including technical assistance and training.
- Ability to establish and implement standards for clinical treatment and/or recovery support service providers.
- Capability to conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.
- Capability to provide a list of eligible providers for anyone to whom a voucher is issued.

Describe other organizations/entities partnering in the project, including their roles in implementing the voucher program. In Appendix 1 of the application, provide letters of commitment showing that identified partner organizations are ready and able to fulfill their roles.

Describe anticipated potential operational problems, if any, and propose feasible solutions to them. Examples include:

- Ensuring clients genuine, free, and independent choice of clinical treatment and/or recovery support providers in situations in which the range and number of providers are limited.
- Handling significant numbers of clients eligible for vouchers who may exceed the State's ability to fund vouchers, and ensuring that resources are appropriately allocated during the course of the year.
- Preventing potential conflict-of-interest among those conducting screening, assessment, level of care determination, and service provision.

Section D: Management, Staffing and Controlling Costs

Describe how the lead agency will manage the voucher program, including steps the State will take to ensure quality of care; prevent waste, fraud and abuse; and prevent supplantation of funds. Document how resources will be appropriately allocated throughout the project period to ensure against funding shortfalls.

Describe how the State will address provider performance issues through both the process of determining provider eligibility and monitoring/oversight.

Describe how the lead agency will work with other agencies with roles and responsibilities related to implementing and administering the voucher program.

Describe the State's and other participating entities' experience managing other voucher-type programs (e.g., Temporary Assistance for Needy Families (TANF), HUD/housing, daycare), if any, and discuss how these experiences will be applied to the proposed voucher program.

Describe qualifications of the key staff to effectively implement and manage the voucher program.

Document the ability or present a plan for developing the ability of the State to collect and report all necessary data on costs and outcomes to SAMHSA (see Appendix C for more information about data collection and reporting to monitor costs and outcomes).

Provide a detailed three-year data collection and implementation plan identifying key tasks/milestones, target dates, role and responsibilities, in Appendix 6 of the application.

Describe the process the State will use to regularly monitor implementation of the voucher program (including costs and outcomes) and make adjustments to the program (including the introduction of evidence-based practices) in order to achieve the intended outcomes in the most cost-effective manner. Specify how the State will create incentives for positive outcomes (e.g., adjusting provider eligibility reimbursement based on such outcomes). The extent to which evidence supports abstinence from substance use is of the utmost importance in assessing provider performance.

Describe how the State will maintain direct and indirect costs of administration of the program to as low of a percentage of total expenditures as possible, preferably no more than 15% of total expenditures. Include a specific percentage of the total grant award that is intended to cover administrative costs, as defined in Appendix B.

Describe how the State will manage the program on the basis of reasonable costs. Include a justification if the applicant proposes to deviate from the cost ranges outlined in Appendix G.

2.4. Application Formatting Requirements

Applicants also must comply with the following basic application requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

- Information provided must be sufficient for review.
- Text must be legible.
    - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
    - Text in the Project Narrative cannot exceed six (6) lines per vertical inch.
- Paper must be white paper, 8.5 by 11.0 inches in size.

- To ensure equity among applications, the amount of space allowed for the Project Narrative (Sections A-D) cannot be exceeded.

    - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and by adhering to the page limit of 35 pages for the Project Narrative (Sections A-D).
    - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs, and footnotes) cannot exceed 58.5 square inches, multiplied by the page limit of 35 pages. This number represents the full page, less margins, multiplied by the total number of allowable pages.
    - Space will be measured on the physical page. In determining compliance, space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative.

- The page limit for Appendices 1 through 7 cannot exceed 50 total pages (excluding data collection instruments and interview protocols).

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, following these guidelines will help reviewers to consider your application.

- Pages should be typed single-spaced with one column per page.

- Pages should not be printed on both sides.

- Please use black ink and number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- Send the original application and two copies to the mailing address in the funding announcement. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

3. SUBMISSION DATES AND TIMES

The application must be received by **June 4, 2004.** Applications received after this date must have a proof-of-mailing date from the carrier dated at least one (1) week prior to the due date. Private metered postmarks are not acceptable as proof of timely mailing.

Applicants will be notified by postal mail that the application has been received.

Applications not received by the application deadline or postmarked by a week prior to the application deadline will be screened out and will not be reviewed.

4. INTERGOVERNMENTAL REVIEW

Because eligibility for the ATR Grants is limited to the Chief Executive of the States, applicants for the ATR Grants Program are not required to comply with the requirements of Executive Order (EO) 12372.

5. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents:

- Institutions of Higher Education: Office of Management and Budget (OMB) Circular A-21
- State, Local Governments and Indian Tribal Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Appendix E Hospitals: 45 Code of Federal Regulations (CFR) Part 74

6. OTHER SUBMISSION REQUIREMENTS

6.1 Where to Send Applications

Send applications to the following address:

Office of Program Services, Review Branch
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 17-89
Rockville, Maryland, 20857

Be sure to include the title of this program (Access to Recovery – Grants) and funding announcement number (TI 04-009) on the face page of the application. If a phone number is needed for delivery, use (301) 443-4266.

6.2 How to Send Applications

Mail an original application and two copies (including appendices) to the mailing address provided above. The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Use a recognized commercial or governmental carrier. Hand-carried applications will not be accepted. Fax or e-mail applications will not be accepted.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

Applications will be reviewed and scored using specific evaluation criteria.

The Project Narrative (Sections A-D), Supporting Documentation (Sections E-G), and Appendices 1-7 will be considered by reviewers in assessing the application.

A Peer Review Committee will assign a point value to the application for each evaluation criterion.

The number following each heading in the listing of evaluation criteria is the maximum number of points a review committee may assign to that section of the Project Narrative. Statements within each criterion are provided to invite the attention of applicants and reviewers to important areas within the criterion and are not individually scored.

Reviewers also will look for evidence of cultural competence in each section of the Project Narrative. The score receive for each evaluation criterion will be based in part on how well cultural competence is addressed in the relevant sections of the Project Narrative.

The following evaluation criteria will be used by the Peer Review Committee:

- ***Evaluation Criterion 1: Extent to Which Proposed Project Meets ATR Goals (30 points)***

  Has the applicant provided feasible and timely plans to:

  - Ensure voucher recipients have a genuine, free and independent choice among eligible clinical treatment and recovery support service options?
  - Enable providers previously unable to compete effectively for Federal funds to participate in the Access to Recovery program (including some faith-based and community providers) and ensuring that faith-based organizations otherwise eligible to participate in the program are not discriminated against on the basis of religious character or affiliation?

- Increase capacity over the period of the voucher program, particularly for recovery support services?
- Monitor the operation and the effectiveness of the voucher program in their jurisdiction through the timely reporting of data?

- ***Evaluation Criterion 2: Proposed Approach (20 points)***

  - Has the applicant proposed a feasible, effective approach to developing a substance abuse voucher program that meets all Federal requirements described in Section 1 and addresses all instructions provided for completing the Project Narrative?

- ***Evaluation Criterion 3: Management, Staffing and Controlling Costs (25 points)***

  - Has the applicant proposed effective plans to manage the voucher program?
  - Has the applicant proposed a method for managing provider performance through both its process of determining provider eligibility and its monitoring/oversight process?
  - Have key staff been designated? Do they have the necessary skills, qualifications and experience to administer and manage the program?
  - Has the applicant proposed a feasible, effective plan that minimizes the amount of funds used to cover both direct and indirect costs of administering the program?
  - Has the applicant proposed a feasible, effective plan for managing the program on the basis of reasonable costs?
  - Has the applicant proposed a feasible, effective plan for providing incentives to eligible providers with superior outcomes, particularly abstinence?
  - Has the applicant proposed an effective strategy to adjust the program to achieve intended outcomes?
  - Has the applicant proposed abstinence from substance use as the critically most important outcome to assess provider performance?
  - Has the applicant demonstrated that resources will be appropriately allocated throughout the year and that the State will take effective steps to ensure quality of care; prevent waste, fraud and abuse; and prevent supplantation of funds?

- ***Evaluation Criterion 4: Readiness to Implement Voucher Program (15 points)***

  - Has the applicant demonstrated that the proposed voucher program can be fully operational in an appropriate timeframe?
  - Are all participating organizations at the administrative and services levels ready and/or able to fulfill their roles in this program?
  - Has the applicant adequately anticipated potential operational problems and proposed feasible solutions to them?
  - Has the applicant demonstrated that an operational information management system is in place?
  - Is the information management system capable of tracking outcomes and costs as described in Appendices C and G?

- ***Evaluation Criterion 5: Need for a Voucher Program (10 points)***

    - Has the applicant clearly documented the need for a voucher program and described the current substance clinical treatment and recovery support services system, using the instructions provided for Section A of the Project Narrative?

NOTE: Although the budget for the proposed project is not a review criterion, the Peer Review Committee will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

2. REVIEW, SELECTION, AND AWARD PROCESS AND CRITERIA

SAMHSA applications for this program are peer-reviewed according to the review criteria listed above. For those programs with an individual award of over $100,000, the Center for Substance Abuse Treatment National Advisory Council also must review applications.

Decisions to fund a grant are based on:

- Strengths and weaknesses of the application as identified by the Peer Review Committee and approved by the Center for Substance Abuse Treatment National Advisory Council.

- Availability of funds.

- Balance among the geographic regions of the United States, different models for implementing the voucher programs (see Program Requirements, in Section I.), and the use of effective approaches to address those with special needs (e.g., homeless populations, people with co-occurring disorders, people living in rural areas, etc.).

- Evidence that funds will be distributed through a voucher mechanism that guarantees clients genuine, free, and independent choice among eligible clinical treatment and recovery support providers, among them at least one provider to which the client has no religious objection.

- Evidence that the applicant has addressed the standards for grantees outlined in Appendix C.

- Evidence the applicant will increase capacity for recovery support services.

In the event of a tie among applicant scores, the following method will be used to break the tie: Scores on the criterion with the highest possible point value will be compared (Extent to Which Proposed Project Meets ATR Goals – 30 points). Should a tie still exist, the evaluation criterion with the next highest possible point value will be compared, continuing sequentially to the evaluation criterion with the lowest possible point value, should that be necessary to break all

ties. If an evaluation criterion to be used for this purpose has the same number of possible points as another evaluation criterion, the criterion listed first in Section V-1 will be used first.

VI. AWARD ADMINISTRATION INFORMATION

1. AWARD NOTICES

After the application has been reviewed, applicants will receive a letter from SAMHSA through the postal mail that describes the general results of the review, including the score the application received.

If approved for funding, an applicant will receive an **additional** notice, the Notice of Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant Award is the sole obligating document that allows the grantee to receive Federal funding for work on the grant project. It is sent by postal mail and is addressed to the contact person listed on the face page of the application.

If not funded, applicants may re-apply if there is another receipt date for the program.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- Applicants must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA web site. For the SAMHSA web page, please use the following: www.samhsa.gov/grants/2004/useful_info.aps.

- Depending on the nature of the specific funding opportunity and/or the review of the proposed project itself, additional terms and conditions may be negotiated with the grantee prior to grant award. These may include, for example:

    - Actions required to be in compliance with human subjects requirements;
    - Requirements relating to participation in a cross-site evaluation; or
    - Requirements to address problems identified in review of the application.

- Applicants will be held accountable for the information provided in the application relating to the capacity expansion proposed in the application. SAMHSA program officials will consider progress in meeting goals and objectives, as well as failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

3. REPORTING REQUIREMENTS

3.1 Progress and Financial Reports

On a quarterly basis, ATR Grantees must report financial and outcome data to SAMHSA. Financial data will monitor costs and ensure that funds are being used for appropriate and intended purposes. Outcome data will measure the success of clinical treatment and recovery support services and ultimately measure the success of the voucher program. SAMHSA will obtain OMB approval for the various reporting requirements and final requirements will be available only upon receipt of OMB approval.

By design, outcome data are consistent with performance domains that SAMHSA will implement to assess the accountability and performance of its discretionary and formula grant programs. In addition, these same will be used by SAMHSA to meet the reporting requirements of the Government Performance and Results Act (GPRA).

GPRA mandates accountability and performance-based management by Federal agencies, focusing on results or outcomes in evaluating the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives. All SAMHSA grantees must comply with GPRA data collection and reporting requirements.

ATR Grantees will be required to report data in seven specific domains, as follows:

- Abstinence from Drug/Alcohol Use
- Employment/Education
- Crime and Criminal Justice
- Family and Living Conditions
- Social Support
- Service Access/Capacity
- Retention in Clinical Treatment and/or Recover Support Services

Data expectations for each domain are provided in Appendix C. The grantee's ability to demonstrate improvement in the domains listed above, particularly abstinence, will be a factor in determining grantee funding levels in years occurring after year one of the grant.

Applicants should be aware that SAMHSA may conduct a cross-site evaluation of the ATR program. If SAMHSA does conduct a cross-site evaluation, grantees will be required to provide performance data to the evaluator as well as to SAMHSA. In addition, it is possible the evaluation design may necessitate changes in the required data elements and/or timing of data collection or reporting. Grantees will be required to comply with any changes in data collection requirements.

3.2 Publications

If funded under this program, an applicant is required to notify the Government Project Officer (GPO) and SAMHSA's Publications Clearance Officer (301-443-8596) of any materials based on the SAMHSA-funded grant project that are accepted for publication.

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.

- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.

- Include a disclaimer stating the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

For questions on program issues, contact:

Andrea Kopstein, Ph.D., M.P.H.
SAMHSA/CSAT
5600 Fishers Lane
Rockwall II, Suite 7-40
Rockville, MD 20857
Phone: (301) 443-3491
Fax: (301) 443-3543
E-Mail: akopstei@samhsa.gov

For questions on grants management issues, contact:

Kathleen Sample
Division of Grants Management
Substance Abuse and Mental Health Services Administration/OPS
5600 Fishers Lane
Rockwall II 6th Floor
Rockville, MD 20857
Phone :(301) 443-9667
Fax : (301) 443-6468
E-mail: ksample@samhsa.gov

VIII. OTHER INFORMATION

1. SAMHSA CONFIDENTIALITY AND PARTICIPANT PROTECTION REQUIREMENTS AND PROTECTION OF HUMAN SUBJECTS REGULATIONS

Applicants must describe their procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section H of the application, using the guidelines provided below. Problems with confidentiality, participant protection, and protection of human subjects identified during peer review of the application may result in the delay of funding.

Confidentiality and Participant Protection:

All applicants must address each of the following elements relating to confidentiality and participant protection. The application must document how these requirements will be addressed or why they are not applicable.

Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse affects.

- Discuss risks that are due either to participation in the project itself or to the evaluation activities.

- Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

- Identify plans to provide help if there are adverse effects to participants.

- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If other, alternative beneficial treatments will not be used, provide the reasons for not using them.

Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, or others who are likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how participants will be recruited and selected. Identify who will select participants.

Absence of Coercion

- Explain if client participation in the project is voluntary or required. Identify possible reasons why it may be required, for example, if court orders may require people to participate in this program.

- If the project plans to pay clients, state how clients will be awarded money or gifts.

- State how volunteer participants will be told that they may receive services even if they do not participate in the project.

- Explain how the project will ensure that a client receives a genuine and independent choice among eligible clinical treatment and recovery support services providers, even if required to participate in the program, for example, through a court order.

- Explain how the project will ensure that a client will be guaranteed the choice of an alternative service provider to which the client has no religious objection.

Data Collection

- Identify from whom data will be collected (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- **Provide in Appendix 2, "Data Collection Instruments/Interview Protocols," copies of <u>all</u> available data collection instruments and interview protocols that the project plans to use.**

<u>Privacy and Confidentiality:</u>

- Explain how privacy and confidentiality will be ensured. Include who will collect data and how it will be collected.

- Describe:

    - How data collection instruments will be used.
    - Where data will be stored.
    - Who will or will not have access to information.
    - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

<u>Adequate Consent Procedures:</u>

- List what information will be given to clients who participate in the project, particularly information regarding the genuine and independent choice clients have among eligible providers. Include the type and purpose of their participation. Notice given to clients must, at a minimum, include:

- The client's right to a genuine, free, and independent choice among eligible providers, that includes the client's right to an alternative provider to which the client has no religious objection.

- A description of the data to be collected, how the data will be used, and how the data will be kept private.

- The client's right to leave the project at any time.

- Possible risks from participation in the project.

- Plans to protect clients from these risks.

- Explain how, if the client's participation in the voucher program is not voluntary (e.g., is by court order), the client will still be provided genuine, free, and independent choice among eligible providers.

- Explain how consent will be elicited for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, written informed consent is necessary.

- Indicate if informed consent will be requested from participants or, in the case of minor children, from their parents or legal guardians. Describe how the consent will be documented. For example: Will consent forms be read? Will prospective participants be questioned to be sure they understand the forms? Will they be given copies of what they sign?

- Include sample consent forms in **Appendix 3, "Sample Consent Forms."** If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases the project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data.

- Additionally, if other consents will be used in the project (e.g., consents to release information to others or gather information from others), provide a description of these consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

Risk/Benefit Discussion:

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

Applicants for the ATR Grants are not required to address Protection of Human Subjects Regulations (45 CFR 46). However, SAMHSA may choose in the future to conduct a cross-site evaluation of the ATR Grants. Such an evaluation could require grantees to comply with the Protection of Human Subjects Regulations, depending on the evaluation design. If SAMHSA

does conduct a study that requires grantee compliance with the Protection of Human Subjects Regulations, SAMHSA will assist grantees in obtaining Institutional Review Board (IRB) approval for their projects.

Additional information about Protection of Human Subjects Regulations can be obtained on the web at http://ohrp.osophs.dhhs.gov. Applicants may also contact OHRP by e-mail (ohrp@osophs.dhhs.gov) or by phone (301-496-7005).

Appendix A: Comprehensive Array of Clinical Treatment and Recovery Support Services

Overview:

Research has established that there are many paths to recovery from alcohol and drug problems. Indeed, many resolve their alcohol and drug problems naturally, without any outside intervention. Others recover with the support of self-help groups such as Alcoholics Anonymous, and/or the faith community. Still others have found recovery through formal clinical treatment interventions. A variety of factors can influence which of these paths is taken successfully. For example, individuals with moderate problems and social support/stability are more apt to recover naturally or with minimal interventions. In contrast, people who seek treatment tend to have more serious problems.

To achieve the best outcomes at the lowest cost, SAMHSA encourages States to provide access to a comprehensive array of clinical treatment and recovery support services as described below. Both components – clinical treatment services and recovery support services–are appropriate for many, if not all, individuals who meet the DSM-IV diagnostic criteria for substance dependence. However, not all services and/or interventions are needed by every individual in treatment for or in recovery from substance dependence. Those who meet the diagnostic criteria for substance abuse may require a less comprehensive range of services. In addition, the array of services described below need not be provided by a single entity but can be provided by a consortium of addiction treatment, health, and human service providers.

This array is not specific to any particular philosophy of clinical treatment and recovery, modality, or setting. It is a generic framework within which potential applicants can conceptualize service arrays, service capabilities, and appropriate managerial and administrative processes, including evaluation.

Methods of implementing the components of this array, the staff who deliver each service, the manner and setting in which different services are delivered, etc., should be based on individual assessment and level of care determination that considers 1) the needs of the individual; 2) the extent to which there are clinical treatment services, recovery support services, health, human services, housing, criminal justice supervision, and labor training alternatives in the jurisdiction of authority; and 3) the extent of available resources and agencies linked through coordinated case management.

In many cases, it will be desirable to provide various components of the array simultaneously, with the emphasis changing throughout the clinical treatment and recovery process. For example, in the earlier, acute phase of clinical treatment, heavier emphasis may be placed on clinical treatment services; the emphasis may switch toward recovery support as individuals move through rehabilitation and enter a maintenance phase of clinical treatment and recovery. In some cases, recovery support services alone will suffice.

Examples of Clinical Treatment and Recovery Support Services:

Clinical treatment services are provided by individuals who are licensed, certified, or otherwise credentialed to provide clinical treatment services in the State, often in settings that address specific treatment needs.

Recovery support services are typically provided by paid staff or volunteers familiar with how their communities can support people seeking to live free of alcohol and drugs, and are often peers of those seeking recovery.

Such services can include:

- Screening/assessment
- Brief intervention
- Treatment planning
- Detoxification
- Medical care
- Substance abuse education
- Individual counseling
- Group counseling
- Residential services
- Pharmacological interventions
- Co-occurring treatment services
- Family/marital counseling
- Family services, including marriage education, and parenting and child development services
- Pre-employment counseling
- Case management
- Relapse prevention
- Continuing care (including face-to-face and telephone-based continuing care counseling)
- Alcohol/drug testing
- Outreach
- Individual services coordination, providing linkages with other services (legal services, TANF, social services, food stamps, etc.)
- Recovery coaching (including stage-appropriate recovery education, assistance in recovery management, telephone monitoring, etc.)
- Family support and child care
- Transportation to and from treatment, recovery support activities, employment, etc.
- Supportive transitional drug-free housing services
- Self-help and support groups, such as 12-step groups, SMART Recovery, Women for Sobriety, etc.
- Spiritual support
- Employment coaching

Appendix B: Services Included as Administrative Expenses

- Eligibility determinations for clinical treatment and recovery services providers and for which services in the comprehensive array of clinical treatment and recovery support services will be included in the voucher reimbursement system
- Management of a system for client eligibility determination and assessment for appropriate level of care
- Identifying, screening, and determining eligibility for clinical treatment and recovery support services providers
- Fiscal/cost accounting mechanisms that can track voucher implementation
- Management of information systems for tracking outcomes and costs, including the costs of data collection and reporting
- Development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support providers
- Marketing of vouchers to client and provider organizations
- Oversight of standards and fraud and abuse issues

Appendix C: Standards For The Access To Recovery Program

States will be expected to administer the Access to Recovery (ATR) program in a manner consistent with good management practices. States will have flexibility in establishing standards appropriate and feasible for their service delivery system and target population. However, once States and Tribes have established standards for participating provider organizations, they are expected to enforce such standards.

In its application, the State should demonstrate how it intends to:

1. Ensure that clients receive a genuine, free, and independent choice among assessment, placement, clinical treatment, and recovery support services.

a. For purposes of this program, choice is defined as a client being able to select among at least two providers which are qualified to provide the services needed by the client, among them at least one provider to which the client has no religious objection.

2. Ensure that clients receive a clinical assessment and a level of care determination from a qualified person and/or provider organization.

a. States should describe the qualifications they require of individuals and/or providers that perform assessments and level of care determinations.

b. States should describe steps they will take to prevent potential conflicts of interest among practitioners and/or provider organizations conducting screening, assessment and referral to clinical treatment and/or recovery support services.

3. Ensure that clients receive appropriate services from clinical treatment and recovery support programs.

a. To be eligible for voucher reimbursement, clinical treatment and recovery support programs should meet standards that are required by the State for other providers that provide the same type of services (e.g. residential, outpatient, family support services, etc.).

b. Each State should document the eligibility requirements and program standards the State intends to use for each of the services proposed to be reimbursed under the voucher program. Eligibility requirements and standards should be documented for services across the entire array of recovery, as described in Appendix A, including eligibility requirements and standards for clinical treatment services and recovery support services. (For example, the State should document its eligibility requirements and standards for specific types of providers such as residential, outpatient, methadone, recovery support services, etc.) In the case of services for which no standards currently exist, the State must describe the process to be used to ensure that

individuals receive appropriate services in safe settings from appropriate individuals. States must also describe how they intend to monitor compliance with these standards and/or processes.

4. Expand the range of clinical treatment and recovery support services providers that meet appropriate standards.

a. States should describe how they intend to provide technical assistance and training to providers of clinical treatment and recovery services as described in Appendix A in order for them to meet State standards.

5. Ensure that outcome and financial data is reported in a timely manner.

a. States should describe how they intend to ensure that outcome data are reported in the following seven domains:

1. Abstinence From Drug and Alcohol Use

1.1 During the past 30 days, how many days has the client used the following:

		Number of Days
a.	Any alcohol	
b1.	Alcohol to intoxication (5+ drinks in one setting)	
b2.	Alcohol to intoxication (4 or fewer drinks and felt high)	
c.	Illegal drugs	

1.2 During the past 30 days, how many days has the client used any of the following:

		Number of Days
a.	Cocaine/crack	
b.	Marijuana/Hashish	
c.	Heroin or other opiates	
d.	Hallucinogens/psychedelics	
e.	Methamphetamine or other amphetamines	
f.	Benzodiazepines	
g.	Barbiturates	
h.	Ecstasy and other club drugs	
i.	Ketamine	
j.	Inhalents	

2. Employment/Education

2.1 Is the client currently employed?

- Full time – Working 35 hours or more each week; includes members of the uniformed services
- Part time – Working fewer than 35 hours each week
- Unemployed, looking for work during the past 30 days, or on lay off from a job
- Not in labor force – Not looking for work during the past 30 days or a homemaker, student, disables, retired, or an inmate of an institution

2.2 For those not in the labor force, what is their status?

- Student enrolled in a school or job training program
- Homemaker
- Retired
- Disabled
- Inmate of an institution that restrains a person, otherwise able, from the workforce

2.3 Is the client currently enrolled in school or a job training program?

- Not enrolled
- Enrolled, full time
- Enrolled, part time
- Other (specify) _____

3. Crime and Criminal Justice

3.1 In the past 30 days, how many times has the client been arrested?

If no arrests, go to item 4 |____|____| *times*

3.2 In the past 30 days, how many times has the client been arrested for alcohol or illicit drug offenses?

|____|____| *times*

3.3 In the past 30 days, how many nights has the client spent in jail/prison?

|____|____| *times*

4. Family and Living Conditions

4.1 In the past 30 days, where has the client been living most of the time?

- Homeless – No fixed address; includes shelters
- Dependent living – Dependent children and adults living in a supervised setting such as a halfway house or group home
- Independent living (including on own, self-supported, and non-supervised group homes)

4.2 Does the client have children? ○ No (go to section 5) ○Yes

2.a How many children does the client have? |____|____|

2.b Are the client's children living with someone else due to a child protection court order?

○ No (go to section 5) ○Yes

2.c If yes, how many of the client's children are living with someone else due to a child protection court order?

|____|____|

2.d For how many children has the client lost parental rights? (The client's parental rights were terminated.)

|____|____|

5. Social Support of Recovery

5.1 In the past 30 days, did the client attend any voluntary self-help groups? (i.e., did the client participate in a non-professional, peer-operated organization devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, Women for Sobriety, etc.)

○ No ○Yes

5.2 In the past 30 days, did the client attend any religious/faith affiliated recovery or self-help groups?

○ No ○Yes

5.3 In the past 30 days, did the client attend meetings of organizations that support recovery other than the organizations described above?

○ No ○Yes

5.4 In the past 30 days, did the client have interaction with family and/or friends that are supportive of recovery?

○ No ○Yes

6. Access/Capacity

6.1 How many people received vouchers for clinical treatment and recovery support services?

|____|____|____|____|

6.2 What is the total number of vouchers issued for clinical treatment and recovery support services?

|____|____|____|____|

6.3 How many providers of clinical treatment and recovery support service providers were designated as participating providers in the ATR program?

|____|____|____|____|

7. Retention

7.1 Identify the number of service sessions/days provided to each client during the past 30 days.

Field	*Sessions/Days*
Clinical Treatment and Recovery Support Services:	
7.1.1. Screening/assessment	
7.1.2. Brief Intervention	
7.1.3. Treatment planning	
7.1.4. Detoxification	
7.1.5. Medical care	
7.1.6. Substance abuse education	
7.1.7. Individual counseling	
7.1.8. Group counseling	
7.1.9. Family/marriage counseling	
7.1.10. Pharmacological interventions	
7.1.11. Co-occurring treatment services	
7.1.12. Family services, including marriage education, and parenting and child development services	
7.1.13. Pre-employment counseling	
7.1.14. Case management	
7.1.15. Relapse prevention	

7.1.16. Continuing care (including face-to-face and telephone-based continuing care counseling)
7.1.17. Alcohol/Drug testing
7.1.18. Outreach
7.1.19. Individual services coordination, providing linkages with other services (legal services, TANF, social services, food stamps, etc.)
7.1.20. Recovery coaching (including stage-appropriate recovery education, assistance in recovery management, telephone monitoring, etc.)
7.1.21. Family support and childcare
7.1.22. Transportation to and from clinical treatment, recovery support activities, employment, etc.
7.1.23. Supportive transitional drug-free housing services
7.1.24. Self-help and support groups, such as 12-step groups, SMART Recovery, Women for Sobriety, etc.
7.1.25. Spiritual support
7.1.26. Employment coaching
7.1.27 Other

7.2 Length of stay (described by date of first individual or group addiction counseling service to date of last contact for addiction service)

2.a What is the date (month, day, and year) that the client last received clinical treatment or paid recovery support services?

2.b What is the date of discharge? (Specify the month, day, and year the client was formally discharged from the treatment provider, service, or program. This date may be the same as the date of last contact.)

2.c What is the reason for discharge?

- Treatment completed
- Transferred to another provider
- Administrative discharge
- Incarcerated
- Death
- Lost contact (dropped out)

Notes regarding outcome data in the 7 domains:

(1) Data on drug/alcohol use, employment/education, crime and criminal justice involvement, family and living conditions, and social support shall be collected at the time of entry to, exit from, and at least every two months during an episode of care. This data will be collected by the providers and given to the States. In

the case of brief interventions, only drug/alcohol use should be reported. Please note that the substance use domain is framed in terms of rates of frequency of use; however, the primary outcome measure for this program is abstinence from substance use, and successful completion of an episode of care should be established by randomly collected samples that are free of these substances.

(2) It will be necessary for States to uniquely identify clients through the course of a clinical treatment/recovery support episode of care and provide basic demographic information. Client IDs should be client specific and should also allow for clients to be tracked though multiple episodes of care.

(3) For the purposes of the voucher program, an episode of care means the period of time from entry to exit from a paid service, whether it be a clinical treatment service or a recovery support service.

(4) Providers will collect data on access/capacity and retention at entry to, exit from, and at least every two months during an episode of care. This data will be given to the States. The retention domain does not apply in the case of brief interventions; however, for brief interventions the client should report completion.

(5) The grantee's ability to demonstrate improvement in the above domains will be a factor in determining funding levels in years after year 1 of the grant.

(6) States should propose a plan for collecting 6-month post-exit data from a paid service on a sample basis by the third year of the grant.

b. States should describe how they intend to ensure financial data is reported as follows:

1. Information should be provided on the type of service, date of service, and the days, partial days, or hour(s) of service provided.

2. Each State should submit data on reimbursement rate per service (clinical treatment or recovery support service) per day, partial day, or hour (s) for the voucher program.

c. States should describe how they intend to ensure data is reported to SAMHSA within the following time frames:

1. Outcome measures and financial data will be reported to SAMHSA quarterly, within 30 days from the end of the quarter.

2. States will take action necessary to ensure that data are valid and reliable, and are submitted in a timely manner.

Appendix D: Screening, Assessment, and Level of Care Determination

Screening

The purpose of screening is to quickly and cost-effectively rule out people without substance abuse problems and to identify the need for specialized substance abuse treatment.

The basic questions asked in the screening process are: 1) is a substance abuse problem present; and 2) does it require specialized care. Although we often think individuals seeking clinical treatment have been previously screened, some individuals seek specialized treatment directly.

If screening suggests an individual probably has a problem likely to require specialized treatment, the next step in the sequence may be thought of as the problem assessment.

Assessment

Assessment is the systematic process of interaction with an individual to observe, elicit, and subsequently assemble the relevant information required to manage his or her problems, both immediately and for the foreseeable future. An assessment gauges which of the available clinical treatment and recovery services options are likely to be most appropriate for the individual being assessed. Hence, assessment must occur prior to any referral of the individual to a particular kind of clinical treatment and/or recovery support service. When the same general approach is applied to all or most clients, assessment may have little impact.

Purpose of Assessment

- To characterize a problem –

  Substance abuse problems differ from person to person, often both in degree and in kind. What should emerge from an assessment is a detailed picture of the particular kind of substance abuse problem manifested by a particular individual at a particular point in time.

  In the absence of a clear, unambiguous picture at initial contact, appropriate decisions regarding care for the present and future may be difficult.

- To characterize an individual –

  Substance abuse problems do not occur in a vacuum. Individuals who manifest them are at least as different from one another as they are from people without substance use disorders. Some of these problems may be the result of abuse of drugs or alcohol; some may result in using drugs or alcohol; others may be independent problems. All are important in themselves, requiring assessment, (and often attention), in clinical treatment and/or recovery support programs. Individual characteristics may affect a person's acceptance (and, in consequence, the eventual outcome) of various forms of clinical treatment and/or recovery

support services. Thus, detailed knowledge of individual characteristics can help provide the client with a list of appropriate clinical treatment and/or recovery support service options.

- To identify appropriate clinical treatment and/or recovery support service options–

  Assessment prior to clinical treatment and/or recovery support forms the basis on which individuals are provided a list of clinical treatment and/or recovery support options appropriate to their needs.

  Additional information on the individual will need to be gathered by program staff following the selection of a clinical treatment and/or recovery support program to plan the individual's ongoing course of care.

Level of Care Determination

Level of care determination is achieved through the client's selection of clinical treatment and recovery support alternatives that are both available and most likely to facilitate a positive outcome in a particular individual. Level of Care Determination:

- Focuses on matching clinical treatment and/or recovery support services to individual needs within the framework of client choice

- Defines expectations for each stage of care:
  - Acute intervention, including detoxification
  - Rehabilitation
  - Maintenance and relapse prevention

While choice among the various clinical treatment and/or recovery support services options resides with the individual, the assessor is responsible to ensure that the individual is fully conversant with all of the therapeutic alternatives available from eligible providers.

The Level of Care Determination Process

Level of Care determination is a complex matter, requiring consideration of individuals and their substance abuse problems, and knowledge of available clinical treatment and recovery support services by both the assessor and the client.

The following general descriptors of clinical treatment and recovery support services represent the kinds of information most useful to help identify appropriate levels of care and clinical treatment and/or recovery support service options for individuals with substance abuse problems. When presented to clients in every-day language, the following information can assist clients in making an informed choice of the clinical treatment and/or recovery support service option(s) that may meet their needs:

- Philosophy and orientation of the program (e.g., medical model, social model, spiritual model, etc.);
- Stage of substance abuse problem or recovery at which the clinical treatment and/or recovery support service is directed (e.g., detoxification, rehabilitation, maintenance);

- Setting of the program (e.g., inpatient, outpatient, residential) and staffing; and
- Therapeutic approach/type of intervention

Additional Resources for Screening, Assessment, and Level of Care Determination

I. Resources to Implement Screening

In health care, screening is a process to identify people who have, or are at risk for, an illness or disorder. The purpose of screening is to target persons for clinical treatment and/or recovery support services, thus reducing the long-term morbidity and mortality related to the condition. In addition, by intervening early and raising the individual's level of concern about risk factors and substance-related problems, screening for drug and alcohol problems in community settings can reduce subsequent use.

Two types of screening procedures are typically used. The first includes self-report questionnaires and structured interviews; the second, clinical laboratory tests that can detect biochemical changes associated with excessive alcohol consumption or illicit drug use.

A variety of screening instruments are available. The majority of studies and implementation efforts have focused on screening for alcohol problems. The CAGE and AUDIT are the most commonly used screening tools. The DAST has also been used in conjunction with the AUDIT in several projects, where there has been an effort to implement this approach for persons with or at risk for a substance use disorder. Several new instruments have been developed, but not yet rigorously tested, to assess harmful use of either alcohol or drugs (e.g., the CAGE-D, the ASSIST, the TCUDS, the GAIN-QS, the PDES).

Brown, RL and Rounds LA. 1995. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*, 94, 135-140.

Brown R, Leonard T, Saunders LA, et al. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, 151-160.

A bibliography with descriptions and evaluations of various interview, questionnaire, and laboratory test screening approaches is available from Project Cork.

Project Cork. 2002. *CORK Bibliography: Screening Tests.* 2001-2002, 58 Citations. http://www.projectcork.org/bibliographies/data/Bibliography_Screening_Tests.html

Screening instruments have been developed or modified for use with different target populations, notably adolescents, offenders within the criminal justice system, welfare recipients, women, and the elderly. Several have been translated into other languages and have been evaluated for cultural sensitivity. Again, SAMHSA is not requiring a specific instrument or protocol, but choice of instruments or laboratory tests must be justified.

It is well recognized that screening instruments used with adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical settings. One example of a brief substance abuse screening instrument recently developed specifically for use with adolescents is the CRAFFT test.

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. 2002. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med*. 156(6): 607-14.

Additional screening tests and procedures targeted at adolescents, including the PDES and the GAIN-QS, are described in these publications:

Winters KC. 1992. Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addict Behav*. 17(5): 479-90.

Winters KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.

Winters KC. 1999. *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA*)* 99-3283.

Winters KC. 2001. Assessing adolescent substance use problems and other areas of functioning: State of the art. In: PM Monti, SM. Colby, and TA. O'Leary (eds). *Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions.* New York, Guilford Publications, Inc., pp. 80-108.

Dennis ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications. http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Martino S, Grilo CM, and Fehon DC 2000. Development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors* 25(1): 57-70.

Screening tests and procedures targeted at the elderly are described in these publications:

Blow, F.C. Consensus Panel Chair. 1998. *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.

Blow FC and Barry KL. 1999-2000. Advances in alcohol screening and brief intervention with older adults. *Advances in Medical Psychotherapy*. 10:107-124

Screening tests and procedures targeted at persons in the criminal justice system are described in these publications:

Inciardi JA Consensus Panel Chair 1994. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076

Peters, RH, Greenbaum, PE, Steinberg, ML, Carter, CR, Ortiz, MM, Fry, BC, Valle, SK. 2000. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal Substance Abuse Treatment*: 18(4): 349-58.

Simpson DD. 2001. Core set of TCU forms. Fort Worth: Texas Christian University, Institute of Behavioral Research. www.ibr.tcu.edu.

Efforts are ongoing to develop methods to better screen people with co-occurring substance use and mental disorders.

II. Assessment Instruments

Substance abuse assessment instruments are designed to determine the precise nature and severity of an individual's problems. Some instruments are also designed to help pinpoint specific diagnoses. While the results of assessment instruments do not necessarily specify the service needs of clients, the data collected from these instruments can help determine a client's level of care need and, thus, the options of eligible service providers.

- **Adult Assessment Instruments**

Addiction Severity Index (ASI)
ASI is a 30 to 40-minute, interviewer-administered instrument that assesses severity of alcohol and drug problems across several domains. The ASI has been tested extensively and used widely for initial client assessments and to measure client progress and outcomes. The ASI should be administered by trained clinicians.
McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E. An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *J Nerv Ment Dis* 168:26-33, 1980.
--and/or--

McLellan, A.T.; Kushner, H.; Metzger, D.; Peters F.; et al. The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat* 9:199-213, 1992.

Substance Use Disorders Diagnostic Schedule (SUDDS-IV)
"The SUDDS-IV is a comprehensive diagnostic assessment interview providing definitive documentation for substance-specific abuse or dependence diagnoses based on DSM-IV-TR criteria. It also screens for depression and anxiety disorders. In addition to diagnostic documentation, the SUDDS-IV provides valuable information for treatment planning and patient placement." (Source: www.evinceassessment.com)
Harrison, P. & Hoffman, N. (1987). Substance Use Disorders Diagnostic Schedule (SUDDS). St. Paul, MN: Norman G. Hoffman.

Minnesota Multiphasic Personality Inventory (MMPI)
"The Minnesota Multiphasic Personality Inventory (MMPI) is an objective verbal inventory designed as a personality test for the assessment of psychopathology consisting of 550 statements, 16 of which are repeated. The replicated statements were originally included to facilitate the first attempt at scanner scoring. Though they are no longer needed for this purpose, they persist in the inventory." (Source: http://www.cps.nova.edu/~cpphelp/MMPI-2.html)
Hathaway, S. & McKinley, J. Manual for the Minnesota Multiphasic Personality Inventory. New York: Psychological Corporation; 1951, 1967, 1983.
--and/or--
Hathaway, S.; McKinley, J.; Butcher, J.; Dahlstrom, W.; Graham, J.; Tellegen, A.; et al. Minnesota Multiphasic Personality Inventory-2: manual for administration. Minneapolis: University of Minnesota Press; 1989.

The Recovery Attitude and Treatment Evaluator (RAATE)
"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)
Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

- **Adolescent Assessment Instruments**

Comprehensive Adolescent Severity Inventory (CASI)
CASI measures education, substance use, use of free time, leisure activities, peer relationships, family history and intrafamilial substance use, psychiatric status, and legal history. The CASI also incorporates results from urine drug screens and observations

form the assessor. Psychometric studies on the CASI support the instrument's reliability and validity.
Meyers, Kathleen. *Comprehensive Adolescent Severity Inventory (CASI).* Philadelphia, PA : Penn/VA Center for Studies of Addiction, 1996. c. 176 p. [RJ 503.7 M4 1996]

Global Assessment of Individual Needs (GAIN)
Dennis, ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications. http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Winters, KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.

III. Diagnostic Criteria

***Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (DSM-IV)**
DSM-IV includes the most widely accepted criteria for diagnosing substance abuse and mental disorders. Based on data collected during an assessment, the DSM criteria for substance use disorders can be used to determine if someone has a "substance abuse" or "substance dependence" diagnosis. DSM-IV was first published in 1994 by the American Psychiatric Association, Washington D.C.

IV. Level of Care Determination, Continued Stay, and Discharge Criteria

Patient Placement Criteria for the Treatment of Substance-Related Disorders
The American Society of Addiction Medicine (ASAM) published the second edition of its *Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2) in 1996. ASAM's PPC-2R presents the criteria for determining which level of services best fits a client's needs. The PPC-2R now has both adult and adolescent criteria and the appropriate criteria should be used for each of these groups.

RAATE
"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)
Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

Appendix E: Example of How a State Could Implement a Voucher Program

The following is an example of how a State (hypothetically named "PIB") could use vouchers for assessment and level of care determination as well as for substance use clinical treatment and recovery support services.

Please note that technical assistance is available to all applicants to assist them in the development and implementation processes. We encourage all applicants to seek such assistance.

1. Outreach and Client Choice

Prior to launching its voucher program, PIB conducted outreach to a wide range of substance abuse service providers—both those involved in clinical treatment and those involved in other recovery support services. PIB explained to the providers that the State's new voucher program would differ from traditional treatment services. Instead of the State choosing a particular treatment for an individual, clients would receive vouchers to redeem at the providers of their choice. PIB encouraged providers to become eligible providers, explaining that the program would be most successful if clients have access to a variety of treatment and recovery service choices.

Before implementation, PIB also conducted significant outreach to clients, prior to implementing its voucher system, to ensure individual clients were aware of how the program would operate, and that the program would give individuals a choice among various eligible service providers. PIB also established a 24-hour, seven-day-a-week telephone line in place (800-FOR-HELP). This number made available a list of eligible assessment, treatment, and recovery service providers (throughout the State) for the voucher treatment system. PIB was committed to providing an administrative process to be used to ensure individuals received appropriate services in safe settings and services delivered by appropriate individuals.

2. Standards, Eligible Providers, Voucher Process, and Incentives

PIB recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. Therefore, in accordance with State administrative procedures, PIB published eligibility criteria and standards and, based on provider response to the standards, created a list of eligible entities to provide assessment and level of care determination as well as treatment and recovery services. Two major eligibility conditions were required of providers: 1) meeting standards required by PIB for other providers that provide the same type of clinical treatment and recovery support services within the State and 2) agreeing to provide the relevant outcomes and financial data. The list of eligible entities included 10 new providers who had never been funded by the State before, four of which were faith-based providers, three of which were proprietary providers, and three of which were community-based, recovery support organizations.

At the outset of the voucher initiative, PIB developed an eligibility application process and incentives to improve outcomes. As part of the application process, providers agreed to receive 90% of the reimbursement rate for their services; 10% was withheld and set aside to be used to reimburse and incentivize positive client outcomes.

3. The role of PIB's Information System

A critical component of PIB's voucher program was its electronic information system (EIS). As clients submitted a *request for services* from the State of PIB, they entered an electronic voucher system. A first task was to establish a client's identity and ascertain whether she or he previously had participated in the voucher program. If a client was new to the voucher system, they received a *unique client number* and an initial client record was created. Initial contact information included, at a minimum, name, social security number, birth date, and – where possible- substance abuse problem information. The client was then given a voucher for an assessment and a list of various assessment sites. The client was also provided with notice of the right to genuine and independent choice among eligible providers, including the right to an alternative provider to whom the client had no religious objection. After the client redeemed the assessment voucher, the client received a full assessment, involving the administration of an assessment instrument, resulting in the creation of a new case number, a sequence number that essentially counted the client's assessments (if they were re-assessed following an initial assessment) within the voucher system. This allowed level of care determination and subsequent client activity to be associated with particular assessment events.

The entire assessment packet, for use in the development of an interim treatment and recovery plan, was then sent to the provider(s) chosen by the client. When the level of care determination was entered into the EIS system, a summary of the assessment and disposition were made available electronically to the chosen provider. PIB provided detailed requirements for data reporting, including data definitions to be used.

4. How vouchers are issued

In the State of PIB, clients who were determined to be financially eligible for subsidies had 30-day vouchers for an assessment created for them by the State. Once an assessment occurred, the assessor created a treatment/recovery services voucher with an active life of one-year (365 days). PIB specified that creation of a treatment voucher was <u>not</u> a guarantee of payment for services up to the full voucher value. It represented a commitment on the part of the State of PIB to pay for services up to that maximum while funding was available and the client remained eligible. If at any point in the fiscal year funds for that year were exhausted, all subsidies ended for that year, *without regard to the existence of vouchers that still retained value.* When the next fiscal period began and new money was allocated to the funding pool, vouchers that had not expired and were not fully expended remained chargeable for services, but only for those services rendered *after* the beginning of the new fiscal period.

Vouchers were created and information about them was forwarded to participating providers as follows:

1) The staff responsible for the client's assessment determined eligibility and created a computer record of the treatment and/or recovery voucher based on the determined level of need, including client identification, voucher type and value, and effective and expiration dates for the voucher. The vouchers were not available to be charged against until written or electronic notification of client admission to a participating provider's program was received at PIB's State Substance Abuse Authority.

2) Assessment staff provided the client with a recommendation regarding level of care and a list of the various eligible providers. The client selected a provider and assessment staff determined whether the provider had an opening. If an appropriate opening existed, an appointment was made with the provider. The client was given the date and time of the appointment and directions to the provider, and a voucher packet was sent to the provider. If the client was not prepared to make a provider selection at assessment, the client was given a voucher packet, which included a list of eligible providers and information regarding the client's time-limited voucher eligibility.

3) Printed notification of the client's voucher eligibility was included in the voucher packet sent to the provider, as part of the 'Voucher Letter'. Another document included in the packet, the 'Voucher Completion Form,' was provided so the treatment or recovery agency could record the outcome of the placement, including the date the client was admitted, if appropriate. This admission date had to be communicated to the State agency administering the program – either via electronic submission through the PIB Voucher Client System, or by filling out the 'Voucher Completion Form' – before services could be entered against the corresponding treatment voucher. PIB specified that the information returned by the provider must include both verification of client admission and date of admission.

4) Upon receipt of verification of client admission from the provider, the computerized voucher record became available for use by the provider.

5. Invoicing and payment for services

PIB specified that payments to providers be calculated on a service-by-service basis, using a standardized rate schedule. PIB specified that 90% of the rate be invoiced when services were delivered, and that the additional 10% be generated following outcomes reporting. In the State of PIB, the services allowable were determined by the particular type of voucher that was issued for the client and by the services offered by the submitting provider. Individual services were restricted to clearly defined minimum and maximum time limits. PIB provided a detailed account of the voucher and service types, rate schedule, incentive payment conditions, and restrictions that were in effect for the voucher program in the State of PIB.

Charges for payment available to providers could be submitted in one of two ways: electronic submission on-line from the provider's facility, or submission at PIB's administrative agency.

Invoices for voucher services were generated once a month at the PIB' administrative agency and submitted to PIB for payment. PIB specified that providers could not generate their own invoices; only administrative agency staff could do so. Services performed on or after the start day for the invoice period were not invoiced until the next invoice period.

6. Voucher closure/expiration and subsidy shortfalls

PIB specified that a voucher was in effect for 365 days from the date of assessment, when client eligibility was determined. If at the end of this period all subsidy funds had not been expended and the client was still in treatment or recovery, a client might – on a case-by-case basis – receive a time extension on the voucher's expiration date. If the client sought another assessment *subsequent to* the expiration of a previous voucher, voucher eligibility also might be reconsidered on a case-by-case basis. This process, however, required review of the client's circumstances by a designated PIB Utilization Review person/board.

PIB specified that only two circumstances could necessitate the closure of a voucher prior to its 365-day life: 1) change in the client's residence beyond the State of PIB; and 2) death of the client.

Providers were responsible for notifying the PIB administrative agency when either of the above situations occurred. In addition, providers were required, as part of their eligibility to participate in the PIB voucher program, to communicate discharge/separation information to the PIB administrative agency via the 'Treatment/Recovery Services Discharge Summary' form, or through the automated *Voucher Client System*. This information included outcome information on each client, such as achieving abstinence from substance use. In addition, outcome information became an important part of "report cards" issued in the second year of the program.

PIB monitored provider reporting of outcomes information on a monthly basis. At the end of the first six months of the first year, PIB recognized that six providers needed technical assistance to accurately report outcomes information. PIB provided such technical assistance in a timely manner. At the end of the first year, however, four of the six providers were still unable to provide the outcomes information in each of the seven domains. As a result, PIB declared these four providers ineligible for the voucher program for the next year.

Clients could not receive subsidies for the same type of clinical treatment or recovery support service from more than one provider at a time, so separation information was necessary if a client was being re-placed and the new provider was expecting the client to be subsidized with a voucher.

Because the voucher program operated with limited money, PIB told providers it was unlikely that each year's subsidy fund will cover all services provided to all qualified clients. In order to reduce the impact of funding shortfalls to providers, PIB agreed to allocate subsidy funds on a quarterly basis during the fiscal year (July 1 to June 30), one-fourth being made available July 1st, one-fourth added in on October 1st, and so on. If the quarterly allotment was exhausted prior to the end of the quarter service subsidies stopped until the new quarter began and a new allotment was added. At that point services rendered after the beginning of the new quarter

could be entered and subsidized. PIB felt that, while this approach to fund allocation might produce a brief period of non-payment at the end of each quarter, it would guarantee that funding was available in all four quarters, and avoid any long, disruptive interruption of subsidies in the last months of the fiscal year.

PIB frequently reviewed its program to ensure clients had genuine, free and independent choice of clinical treatment and/or recovery support providers. It committed to recruiting a broad array of eligible providers, contacting traditional providers, faith-based providers, proprietary providers, and other community organizations. PIB ensured that clients were notified of their right to choose among eligible providers, and it educated assessment staff on the importance of allowing clients to make this choice. PIB also maintained an up-to-date, client friendly information service in order to ensure client choice was always available (e.g. a website or 24-hour manned help line) with a list of provider organizations and an associated list of available services from the continuum of treatment and recovery. The lists developed by PIB were constantly evolving to incorporate the most accurate information. The list of provider organizations was searchable by category of available services and by location.

Appendix F -Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. ***If you do not adhere to these requirements, your application will be screened out and returned to you without review.*** *In addition to these formatting requirements, programmatic requirements (e.g., relating to eligibility) may be stated in the specific funding announcement. Please check the entire funding announcement before preparing your application.*

- ❑ Use the PHS 5161-1 application.

- ❑ Applications must be received by the application deadline. Applications received after this date must have a proof of mailing date from the carrier dated at least 1 week prior to the due date. Private metered postmarks are not acceptable as proof of timely mailing. Applications not received by the application deadline or not postmarked at least 1 week prior to the application deadline will not be reviewed.

- ❑ Information provided must be sufficient for review.

- ❑ Text must be legible.

  - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
  - Text in the Project Narrative cannot exceed 6 lines per vertical inch.

- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.

- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded.
  - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the page limit for the Project Narrative stated in the specific funding announcement.
  - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by the total number of allowed pages. This number represents the full page less margins, multiplied by the total number of allowed pages.
  - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

- ❑ The page limit for Appendices stated in the specific funding announcement cannot be exceeded.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in the application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- ❑ The 10 application components required for SAMHSA applications should be included. These are:

  - Face Page (Standard Form 424, which is in PHS 5161-1)
  - Abstract
  - Table of Contents
  - Budget Form (Standard Form 424A, which is in PHS 5161-1)
  - Project Narrative and Supporting Documentation
  - Appendices
  - Assurances (Standard Form 424B, which is in PHS 5161-1)
  - Certifications (a form within PHS 5161-1)
  - Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
  - Checklist (a form in PHS 5161-1)

- ❑ Applications should comply with the following requirements:

  - Provisions relating to confidentiality, participant protection and the protection of human subjects stated in the specific funding announcement.
  - Budgetary limitations as specified in Sections I, II, and IV-5 of the specific funding announcement.
  - Documentation of nonprofit status as required in the PHS 5161-1.

- ❑ Pages should be typed single-spaced with one column per page.

- ❑ Pages should not have printing on both sides.

- ❑ Please use black ink and number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- ❑ Send the original application and two copies to the mailing address in the funding announcement. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix G: Managing On The Basis Of Reasonable Costs

States are encouraged to manage the program on the basis reasonable costs. Proposed per person costs for treatment and recovery support services to be provided under this initiative should be included in the application. In cases where it is not possible to include costs that are based on prior experience, the application should include an estimate of the cost of the service, as well as a plan and timeline for developing cost data based on experience.

The following are considered reasonable ranges by treatment or modality:

- Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services - $200 to $1,200
- Outpatient (Non-Methadone) - $1,000 to $5,000
- Outpatient (Methadone) - $1,500 to $8,000
- Residential - $3,000 to $10,000

If the State deviates from these costs, it should provide a justification for doing so, in order for SAMHSA to determine reasonableness of costs. Reasonable cost is based on actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program (Center for Medicare and Medicaid Services, 2003). While cost ranges for recovery support services are not specified above, due to the great variations that exist, applicants are expected to provide costs for recovery support services that they intend to provide. Per person costs for each modality should be computed by dividing the number of persons served in each modality by the amount of the project budget used to fund that program component after subtracting out the costs of required data collection and submission.