TI11-02
Application #: 1 H TI023819-01
Bus Off: Jeffers, Karin
Council: 08/2011
Receipt Date: 06/10/2011

Application for Federal Assistance SF-424

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application:
- ☒ New
- ☐ Continuation
- ☐ Revision

*3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION

*a. Legal Name: Clinical and Support Options, Inc.

*b. Employer/Taxpayer Identification Number (EIN/TIN): 04-2206041

*c. Organization DUNS: 185070612

d. Address

*Street1: 111 Federal Street
Street2:
*City: Greenfield
County/Parish: Franklin County
*State: Massachusetts
Province:
*Country: USA
*Zip/Postal Code: 01301

e. Organizational Unit

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Ms.
*First Name: Karin
Middle Name:
*Last Name: Jeffers
Suffix:

Title: President and Chief Executive Officer

Organizational Affiliation:
Clinical and Support Options, Inc.

*Telephone Number: 413-773-1314 ext 1010
Fax Number: 413-774-1197

*Email: kjeffers@csoinc.org

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

A. **9. Type of Applicant 1: Select Applicant Type:**

Nonprofit with 501c3 IRS Status (other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify)

10. Name of Federal Agency:

Substance Abuse and Mental Health Services Administration

11. Catalog of Federal Domestic Assistance Number

93.243

CFDA Title:

TCE Health IT

*12. Funding Opportunity Number:

TI-11-002

*Title:

Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need

13. Competition Identification Number:

TI-11-002

Title:

Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need

14. Areas Affected by Project (Cities, Counties, States, etc.):

Hampshire, Franklin and Berkshire Counties, Massachusetts

15. Descriptive Title of Applicant's Project:

RECOVERe

Attach supporting documents as specified in agency instructions.

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

16. Congressional Districts Of:

***a. Applicant** MA-001 **b. Program/Project** MA-001

Attach an additional list of Program/Project Congressional Districts if needed:

17. Proposed Project:

*a. Start Date: September 29, 2011 b. End Date: September 28, 2014

18. Estimated Funding($):

*a. Federal	$280,000
*b. Applicant	$0
*c. State	$0
*d. Local	$0
*e. Other	$0
*f. Program Income	$0
*g. TOTAL	$280,000

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on _____.
☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.
☒ c. Program is not covered by E.O. 12372.

*20. Is the Applicant Delinquent on Any Federal Debt? (If "Yes", provide explanation in attachment.)

☐ Yes ☒ No

If "Yes", provide explanation and attach.

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties (U.S. Code, Title 218, Section 1001)**

☒ **** I AGREE**

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

a. Authorized Representative

Prefix: Ms. *First Name: Karin

Middle Name:

Last Name: Jeffers

Suffix:

*Title: President and Chief Executive Officer

*Telephone Number: 413-773-1314 ext 1010 Fax Number: 413-774-1197

*Email: kjeffers@csoinc.org

*Signature of Authorized Representative: Karin Jeffers Date Signed: 6/24/2011

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* Applicant Federal Debt Delinquency Explanation

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

n/a

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OMB Approval No. 4040-0006
Expiration Date 07/30/2010

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1. TCE Health IT	93.243	$ 0	$ 0	$ 280,000.00	$ 0	$ 280,000.00
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00	$ 280,000.00	$ 0.00	$ 280,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$ 119,510	$ 144,500	$ 144,500	$	$ 408,510.00
b. Fringe Benefits	$ 26,292	$ 31,790	$ 31,790	$	$ 89,872.00
c. Travel	$ 3,192	$ 3,600	$ 3,600	$	$ 10,392.00
d. Equipment	$ 38,000	$ 25,000	$ 25,000	$	$ 88,000.00
e. Supplies	$ 1,900	$ 3,000	$ 3,000	$	$ 7,900.00
f. Contractual	$ 70,000	$ 53,000	$ 53,000	$	$ 176,000.00
g. Construction	$ 0	$ 0	$ 0	$	$ 0.00
h. Other	$ 21,106	$ 19,110	$ 19,110	$	$ 59,326.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 280,000.00	$ 280,000.00	$ 280.000.00	$ 0.00	$ 840,000.00
j. Indirect Charges	$	$	$	$	$ 0.00
k. TOTALS *(sum of 6i and 6j)*	$ 280,000.00	$ 280,000.00	$ 280,000.00	$ 0.00	$ 280,000.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. TCE-Health IT	$ 0	$	$	$ 0.00
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 280,000.00	$ 70,000	$ 70,000	$ 70,000	$ 70,000
14. Non- Federal	$ 0.00	$	$	$	$
15. TOTAL *(sum of lines 13 and 14)*	$ 280,000.00	$ 70,000.00	$ 70,000.00	$ 70,000.00	$ 70,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. TCE-Health IT	$ 280,000	$ 280,000	$ 280,000	$
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ 280,000.00	$ 280,000.00	$ 280,000.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
$280,000.00	$0

23. Remarks

Indirect charges not calculated as a % of direct charges. They are items of administrative cost broken out separately.

OMB Approval No. 0348- 0041

BUDGET INFORMATION - Construction Programs

n/a

NOTE: *Certain Federal assistance programs require additional computations to arrive at the Federal share of project costs eligible for participation. If such is the case you will be notified.*

COST CLASSIFICATION	a. Total Cost	b. Costs Not Allowable for Participation	c. Total Allowable Costs (Column a- b)
1. Administrative and legal expenses	$ .00	$ .00	$ 0.00
2. Land, structures, rights-of-way, appraisals, etc.	$ .00	$ .00	$ 0.00
3. Relocation expenses and payments	$ .00	$ .00	$ 0.00
4. Architectural and engineering fees	$ .00	$ .00	$ 0.00
5. Other architectural and engineering fees	$ .00	$ .00	$ 0.00
6. Project inspection fees	$ .00	$ .00	$ 0.00
7. Site work	$ .00	$ .00	$ 0.00
8. Demolition and removal	$ .00	$ .00	$ 0.00
9. Construction	$ .00	$ .00	$ 0.00
10. Equipment	$ .00	$ .00	$ 0.00
11. Miscellaneous	$ .00	$ .00	$ 0.00
12. SUBTOTAL *(sum of lines 1- 11)*	$ 0.00	$ 0.00	$ 0.00
13. Contingencies	$ .00	$ .00	$ 0.00
14. SUBTOTAL	$ 0.00	$ 0.00	$ 0.00
15. Project (program) income	$ .00	$ .00	$ 0.00
16. TOTAL PROJECT COSTS *(subtract #15 from #14)*	$ 0.00	$ 0.00	$ 0.00

FEDERAL FUNDING

17. Federal assistance requested, calculate as follows: (Consult Federal agency for Federal percentage share). Enter the resulting Federal share.	
Enter eligible costs from line 16c Multiply X (include decimal point in number) _____	$ 0.00

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ABSTRACT

Project name: RECOVERe, Technology-Supported Substance Abuse Services

Population to be served: The population of focus are rural adult residents 18-64 with diagnosed substance use disorder in three counties of Western Massachusetts.

Project goals and measurable objectives:

Expand Service Capacity: The project will substantially increase the current treatment capacity of the Western Mass region's programs for substance abusers. The proposed program will increase publicly funded capacity for adults by an estimated 18%.

Increase Access to a greater range of substance abuse services: We will augment face to face therapy and strengths-based case management with technological tools like Web-based services, video conferencing and mobile phone support to offer access to an array of treatment and support customized to the needs of the participant.

Increase Retention in and Adherence to Treatment: The extent to which a person's behaviors follow the advice given by clinicians may include entering a treatment program, attending appointments and group sessions, using community self-help resources maintaining and completing a treatment program or keeping aftercare appointments have all been demonstrated to lead to better psycho-social outcomes. A range of technology support can increase length of stay and will support adherence to treatment.

Extend aftercare to reduce relapse potential: Adherence to aftercare therapy in substance abuse treatment is associated with improved outcomes. To increase the likelihood of maintaining, and even enhancing, treatment gains, we will incorporate the use mobile phones into aftercare and continue Web-based input to provide an ongoing link for the client once therapy has ceased.

Number of people to be served annually and throughout the lifetime of the project: The program will treat 75 clients at any given time, 150 a year and a total of 450 over 3 years.

Summary of project: RECOVERe is a technology-supported interactive system of outreach, intake, treatment and aftercare using mobile telephony, Web site with personal portals and video conferencing for individual and groups therapy and support. Technology tools will be used to support three evidence-based practices: MI, MET and SBCM

Strategies/interventions: Multi-modal communication involving increased frequency and time of contact between rural patients and clinicians help patients to engage in behavior change. RECOVERe and its components - i2i (video conferencing), ChangeAgent (Web site and portal) and text4recovery (the use of networked mobile communications) are proposed as pathways of action of several forms of self-management interventions and contact with program staff.

PROGRAM NARRATIVE

Recovery can be thought of as a set of passages in a person's journey from substance abuse and other problems toward physical, emotional and spiritual health and well being. The **RECOVERe Program** is based on the philosophy that recovery from addiction is a life-long process that happens in different stages, each with distinct and different needs for support. It is a program that both recognizes these stages and offers a variety of technological tools to support treatment and beyond. Clinical and Support Options proposes to implement a technology-supported interactive system of outreach, intake, treatment and aftercare for residents of three rural counties in western Massachusetts. Clients receiving and enrolling in RECOVERe will be adult men and women over 18 who are assessed as having substance use disorders living in rural area of the three counties. We anticipate 75 people to be enrolled in active treatment at any given time, serving 150 people a year and 450 over the grant period.

Section A: Statement of Need

1. Population of focus

The acknowledged gap between substance abuse treatment demand and capacity is exacerbated in the rural setting. While rural and urban areas experience alcohol and drug use problems, the consequences may be greater for rural residents because of limited access to substance abuse treatment. Given that higher rates of substance abuse are associated with higher levels of poverty and unemployment and lower levels of income, substance abuse strains rural service systems, which are often overextended and under-resourced in comparison to urban systems. The ability to organize effective substance abuse delivery systems in rural communities is hampered by limited supplies of specialized providers and services, low population densities, and long travel distances for rural persons to obtain care. Aspects of rural substance abuse are:

- In 2008, over 20 million people who needed treatment for alcohol or illicit drug abuse or dependence were unable to access this service.[1]
- Rural communities have experienced significant increases in overdose death rates, rapidly outpacing the rate increases in urban and suburban communities, largely attributable to the rise in misuse of prescription painkillers. [2]
- People who were unemployed in rural America were about seven times more likely than those unemployed in urban areas to meet criteria for stimulant abuse
- Approximately 13% of rural residents and 15% of urban residents reported using drugs.
- In 2003, 47% of rural admissions to publicly funded substance abuse treatment centers were referred by the criminal justice system, compared to 35% for urban populations.[3]
- Only 10.7% of hospitals in rural areas offer substance abuse treatment services compared to 26.5% of metropolitan hospitals.[4]
- The number of treatment facilities in Massachusetts has decreased from 352 in 2002, to 312 in 2006[5] and several hospital have shut down detox and outpatient in the past two years.

The rural population of focus for the project is an historically underserved population from a behavioral health care perspective. In general, the situation can be attributed to three converging regional characteristics: low socioeconomic status reflecting low education levels and the lack of quality employment; low health literacy; and limited access to treatment and support, reflecting the economics and rural geography of the area. Many residents of the service area have a lack of knowledge about available resources, do not understand what they are eligible for and experience physical and psychological barriers to obtaining health care. Breakdown of access within the service system, inappropriate use of the emergency room and unnecessary hospitalizations are major costs where there is lack of access to less restrictive, less expensive and more effective community

services. Rural residents in the tri-county service area do not readily reveal personal information or even acknowledge aches and pains. Many patients down play their symptoms by actively minimizing them. They tend to be wary or mistrustful of health care systems as unaffordable and unresponsive. In addition, the lack of coordination in the health, behavioral health care and social services system leads to a lack of access for the indigent and working poor of the area to services they need. There are scarcities and large gaps in the service system.

Demographics of the service area: The service area is a predominantly rural region of 186,000 people and a total of 2,025 square miles in Berkshire County, Franklin County and northern Worcester County (North Quabbin area). The vast majority of the services area's 66 towns are designated as rural. *Berkshire County:* The total service area population is 98,953 with a population density of 73 people per square mile in an area of 946.27 square miles. The only city in the service area is Pittsfield with 45,793 residents. Over 10% of residents the service area live below the Federal Poverty Level and 29.1% live below 200% of FPL. The per capita income is $20,549. About 95% of the service area population is White. Berkshire substance abuse admissions rates are twice the state average; hospitalizations for mental illness are over 4 times the state average. Pittsfield's SA admission rate is over 3 times the state average. Likewise, Pittsfield's suicide rate is more than double the state rate.[1] The rate of unintentional injuries, often used as a proxy for substance abuse issues is 13,447 per 100,000 compared to a state rate of 11,869. In 2010, Berkshires had 2,903 admissions for substance abuse services, 51% of the Western Region's total. *Franklin County's* population is 71,778. The county covers 725 square miles with a population density of 102.2 people per square mile. Franklin County population is 95.3% white, 1.3% Black or African American, 1.4% Asian and 2.8% Hispanic or Latino (of any race). The area is 93% white; In Greenfield, the only population center, 34% lives under 200% of federal poverty, compared to the state rate of 21.7%. Greenfield's rate of admission to SA treatment programs is well over double the state average. Greenfield hospitalizations for mental illness are 2,260.12 per 100,000 population compared to a state rate of 849.93. In 2010 Franklin County had 972 admissions foer SA treatment, 17% of the Western Region's total. *North Quabbin,* the most rural part of northern Worcester County and eastern Franklin County, includes a total area of 344 square miles. Five towns in the two-county region have a population density of less than 30 people per square mile. The 4 North Quabbin towns have a combined population of 15,354 and are 98% white, 0.8% African American, 0.6% Asian, and 1.7% Hispanic. The per capita income is only $16,299. The North Quabbin area has a very high rate of domestic violence and the highest rate of sex offenders in the state.

Barriers to Treatment Access: Among barriers to substance abuse treatment in rural areas is the perceived social stigma associated with substance abuse treatment in combination with geographical isolation, and financial burden. Health plans continue to shift greater financial responsibility to the patient leading to a reduction in services used. Alcohol dependence is higher in rural areas, and drug use is not significantly different for urban and rural settings.[6] Access to substance abuse treatment is limited in rural areas by fewer treatment beds. Less populated rural areas contain a small proportion of facilities offering a range of core services and varying levels of outpatient and intensive services.[7] Rural communities are less likely to proactively address substance abuse problems. While residential stability and a strong sense of community can lead to a stronger support network in rural areas than in urban areas, close-knit communities often discourage help from "outsiders." Rural families are more reluctant to use treatment services and a stigma can exist around the need for treatment. Stigma, cultural beliefs, and values hinder the acceptability of mental health services in rural areas (Intermill & Rathbone-McCuan, 1991). Rural residents tend to

[1] MassCHIP 2002

value self-reliance and view help-seeking behavior in a more negative light than do urban residents (Rost et al., 2002). In addition, belief in self-reliance and limited anonymity in small town settings combine to limit more significantly a rural person's likelihood of seeking services.

Rural treaters face serious clinical limitations every day. Rural clinicians commonly provide care without optimal supports, services, and safeguards for their patients. It is necessary at times to ration care; to provide care outside of their usual areas of expertise and competence; or to deal with patients' "noncompliance" related to access problems. Among more intensive services - such as detoxification, day treatment, and methadone treatment - the proportion of rural facilities providing these services declines as the rural area becomes less populous.[8]

Since access to treatment services is a fundamental hurdle in addressing substance abuse in rural areas, alternative methods of providing education and counseling are relevant, such as those offered through Alcoholics Anonymous meetings, schools, churches, and community-sponsored awareness campaigns. When technology support is added to these "distributed services," access increases exponentially. Internet access, videoconferencing, and various computer applications offer an opportunity to enhance the quality of care in rural behavioral health services.

2. Describe the nature of the problem and document the extent of the need

Massachusetts: Among persons 26 years of age or older, Massachusetts ranks among the top ten states in the 2007 National Survey on Drug Use and Health (NSDUH) in the following categories:[9]

o Marijuana use in the past year	o Alcohol dependence or abuse in the past year
o Cocaine use in the past year	o Dependence on or abuse of illicit drugs or alcohol in the past year
o Alcohol use in the past month	o Needing but not receiving treatment for alcohol use in the past year

According to this survey data, illicit drug use among older Massachusetts adults has increased since the beginning of this decade. As with youth and young adults, the prevalence of adult alcohol use, binge drinking and illicit drug use are higher than national averages. Alcohol use at 64% is 18% higher while binge drinking and illicit drug use is 11% and 14% higher. At-risk drinking (consuming two or more drinks per day) is a problem as well with 17% of men and 11% of women ages 50 and older reporting such activity in the previous month. The percentage of adults ages 50 to 59 in the US who reported using at least one illicit drug in the past year jumped from 5.1% in 2002 to 9.4% in 2007. Overall, Massachusetts residents in every age group experience higher rates of dependence and abuse than national averages; this difference is most pronounced among the 18-25 year-old age group, with state rates approximately 20% higher than national rates. In addition to alcohol and illicit drug use, the use of non-medical pain relievers has become a significant issue with steadily increasing incidence of deaths and emergency visits related to opioid use. In Massachusetts, the percentage of adults using non-medical pain relievers is 4%, which is 9.5% higher than the national average. Incidences of deaths and emergency room visits related to opioid use have been increasing steadily in recent years as well.[10]

Berkshire, Franklin and North Quabbin: For the Tri-County region, 2010 enrollment data from MADPH's Bureau of Substance Abuse Services[11] for publicly funded services shows a detailed picture of need and capacity for the rural Western Massachusetts region. Seventy percent of admissions were male and 30% female. Whites accounted for 88.4% of admissions; Hispanic 5.9%; and Black 2.9%. Most clients were in the 25-64 age group (73-77%) with the exception of North Quabbin where 30.3% were in the 18-24 age group and only 60% were in the 24-64 group. In the other areas, the 18-24 group accounted for an average of 24% of admissions.

Alcohol is the reason for admission for 59.1% of admissions, with heroin a distance second at 18.3%. All opiates combined (heroin, other opiates and Oxycodone) total 26.6%. The Berkshires

appears to have a higher rate of prescription drug abuse, with 60% of the admissions for Oxycodone and other opiates. Of the services received, only .25% received case management and only 2.9% received outpatient counseling while 11.9% were in detox and 7.1% received day treatment services. Over 9% were referred to and attended driver alcohol education. No one received OBOT and only 3% were in methadone programs. Less than 2% were in residential services. These numbers demonstrate that there is a very limited capacity for most substance abuse programs and that there is a lack of integrated treatment options and limited service capacity that go beyond initial detoxification. Detox or driver alcohol education may be the most frequently used front doors into the SUD treatment system but there are few places to go after that and little tangible support for extended recovery.

Scarce Resources in rural Western Mass: The service area has a limited range of services as well as a limited capacity for the numbers of people in need. The Brien Center offers the only inpatient psychiatric and detoxification services in Berkshire County. CSO and ServiceNet offer outpatient and recovery home services in Franklin County. Two hospitals, Baystate Franklin Medical Center and Cooley Dickinson Hospital that were major SA providers in the service area have shut down substance abuse services completely (detox, inpatient and most outpatient). Only Berkshire Medical Center continues detox services. Wait times for appointments are long. In the Berkshires it takes an average of 4 weeks for intake and assessment and another 2 weeks to set up a therapy appointment (new patients). In North Quabbin, the wait is 3 weeks for intake and 3 weeks for therapy. In Franklin County, it is 2 weeks for intake and 2 weeks for an appointment. There are few groups for substance use: two in Berkshire County, one relapse prevention, one family support group in North Quabbin and a co-occurring disorder group in Franklin County.[12]

Baseline: The project baseline - against which program progress and program success - will be established through the collection of quantitative data from participants. Formats and instruments to collect data and measure individual and collective progress are contained in Appendix 2 and discussed in Section E. Baselines will be measured for the following indicators:

Table 1. Baseline Measures

▪ Number of persons seen in outreach and pretreatment
▪ Number of enrollments into the treatment and case management program
▪ Number of clients engaging in all treatment components
▪ Number of clients completing all treatment requirements
▪ Number of treatment completers clean and sober at follow-up
▪ Number of relapsers reengaged in treatment in CSO substance abuse services
▪ Number of enrollees assessed and referred for co-occurring disorders.
▪ Number of enrollees assessed and referred for other needs

Benchmarks and targets are contained in Table 2 in the following section.

Section B: Proposed Evidence-Based Service/Practice

Suitability of Technology Tools: Multi-modal communication involving increased frequency and time of contact (difficult to manage in rural area) between rural patients and clinicians help patients to engage in behavior change. RECOVERe and its components – **ChangeAgent** (web-based tools and portals), **i2i** (video conferencing and the Voice over Internet Protocol (VoIP) system) and **text4recovery** (the use of networked telephonic communications) are proposed as pathways of action for several forms of interventions and self-management, where enhanced personal contact with treaters is difficult, as in rural areas. The combination of information with additional services (behavior change support, decision support or clinical support) may allow the patient to more effectively internalize the interventions. Enhanced self-efficacy can support motivational changes and changes in behaviors, leading to positive clinical outcomes.

In a 2007 study, 87% of clients offered online services with therapeutic e- mail participated in the program, and use of these services was positively associated with treatment retention.[13] However, it is important to note that this project does not "add on" technological adjuncts simply because they are available. Rather, these adjuncts must adhere to the goals and aims of the treatment process, and match the specific characteristics of the client and environment for which they are to be implemented. The use of technology will be based on certain EBP structures and processes: Motivational Interviewing as an initial assessment tool and pretreatment intervention and Motivational Enhancement Therapy as a treatment model and intensive, strength-based case management (SBCM) as an adjunct to treatment, becoming the primary service in the aftercare setting.

1. Describe the purpose of the project, with a clear statement of its goals and objectives

The purpose of the RECOVERe program is to improve substance abuse treatment access and outcomes for residents suffering SUDs in three rural counties of western Massachusetts. The goals of the project are to:

Expand Service Capacity: By serving 150 adults per year, the project will substantially increase the current treatment capacity of the Western Mass region's programs for substance abusers. The proposed program will increase capacity for adults by an estimated 18%.

Increase Access to a greater range of substance abuse services: We will augment face-to-face therapy and strengths-based case management with technological tools like Web-based services, video conferencing and mobile phone support, to offer access to an array of treatment and support customized to the needs of the participant.

Increase Retention in and Adherence to Treatment: The extent to which a person's behaviors follow the advice given by clinicians may include entering a treatment program, attending appointments and group sessions, using community self-help resources maintaining and completing a treatment program or keeping aftercare appointments have all been demonstrated to lead to better psycho-social outcomes. A range of technology support can increase length of stay and will support adherence to all treatment components.

Extend aftercare to reduce relapse potential: Adherence to aftercare therapy in substance abuse treatment is associated with improved outcomes. To increase the likelihood of maintaining treatment gains, we will incorporate the use mobile phones into aftercare and continue Web-based input to provide an ongoing link for the client once therapy has ceased.

Table 2: Goals and Objectives

Goal	Objectives
RECOVERe will achieve significant reductions in substance abuse.	▪ Establish a program of psychosocial interventions for adult substance abusers, coupled with intensive case management and technological supports. ▪ 150 people will enroll in the program annually; 450 over the project period. ▪ Abstinence from substances will improve and relapses will be reduced. ▪ 70% will report no drug use within the past 30 days at completion of treatment.
Treatment will be readily available and accessible.	▪ The treatment resources will be organized in order to facilitate client usage such as location and hours of operation. ▪ Use of and training in technology-based tools will begin at outreach or intake. ▪ Intake will occur within 2 days of referral; treatment will begin within 1 week. ▪ The program will be located in 4 outpatient clinic sites serving the rural areas of Western Mass. ▪ Technology tools for direct support will be available at 4 sites, on line and through mobile phones.
Program participants will have improved adherence to treatment	▪ 85% of those enrolled will attend program for 6 months or more. ▪ 85% will stay in active aftercare (weekly contact) for 6 months.

	▪ 75% will have used mobile phone support. ▪ 50% will have participated in video conferencing for individual or group sessions. ▪ 85% will have accessed Web data and support.
Substance-abusing adults with coexisting mental disorders will have both disorders treated in an integrated way.	▪ 100% of participants will be assessed for co-occurring disorders at intake. ▪ Those with an MI diagnosis will be referred to appropriate CSO programs or referred to other agencies as needed as well as treatment in the program. Staff will collaborate on and integrate treatment plans. ▪ 70% of those with a dual diagnosis will receive additional treatment.
Effective treatment attends to multiple needs of the individual, not just his or her addiction.	▪ 60% will show a significant improvement in coping skills as measured by the CBI. ▪ Intensive case management will be available to all clients for the program duration. ▪ The program will strengthen relationships with grassroots agencies through mutual referrals so that clients will have access to social supports. ▪ Coalition building with other agencies will be maximized for greater access to services including legal services, family support, employment and education.
Improvements in quality of life	▪ 70% will report no substance use within 30 days after discharge. ▪ Program enrollees who use all program components will experience fewer relapses. ▪ 90% will have had no new criminal involvement or parole or probation violation.
Programming is based on culturally informed and evidence-based practice.	▪ There will be access to staff who are bicultural or bilingual. ▪ Staff knowledge about rural culture will be incorporated into the practice, intervention, and policies of the program. ▪ Staff will receive ongoing training in culturally informed practice. ▪ The program will offer a culturally inviting and supportive environment.
The region wide capacity for substance abuse treatment will be significantly enhanced.	▪ The program will address adequacy of the supply of qualified therapists and trained case managers through aggressive recruitment, retention and training strategies. ▪ The program will train clinicians and case mangers in new evidence-based practices. ▪ Program technology will be cost effective, creating greater capacity at less cost.

The **RECOVERe** program is designed to address two major gaps in substance abuse treatment in rural Western Massachusetts. First is a large gap in treatment and case management capacity. Second is the nearly non-existent capacity for recovery support specifically for substance abuse. This program will increase access to and regional capacity for substance abuse treatment by about 20%. Capacity for integrated outpatient treatment integrated with and supported by technology will be increased by 100%; there are no programs using technology for direct service. We expect to reduce the time between the referral and intake to 2 days and one week until services commence for RECOVERe participants.

CSO's wraparound vision is enhanced through technological tools, combining facilitated access to all services with the development of individual's strengths and resources while maximizing the existing resources of CSO, community agencies and the region. We have specific procedures for communication among outpatient sites, ability to mobilize crisis plans, emergency psychopharmacology, and access to information across programs, utilizing electronic patient records, voicemail, and fax. Our fellow community agencies have extensive experience in mutual referral and other kinds of linkages for individual clients. We share a common perspective and underlying philosophy about integrated service delivery.

Concurrent with treatment, case management services and support will address the numerous issues that our clients face in becoming clean and sober. There are multiple community options for ancillary or enabling services through referral: housing, legal services, and family support. The Strength-based Case Managers will be skilled in assessing eligibility for other benefits, in addition to housing: food stamps, benefits eligibility, health insurance, etc. They will be supported through Web-based resource inventories and linkages to other agencies as well as facilitated secure contact (voice and text messaging) with clients.

2. Identify the evidence-based service(s)/practice(s) that you propose to implement

a) Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) (Source NREPP at http://nrepp.samhsa.gov/) The Transtheoretical Model, an integrative model of behavior change as known as Stages of Changes Theory[14], describes how people modify a problem behavior or acquire a positive behavior. The Processes of Change are ten cognitive and behavior activities that facilitate change. This behavioral model is driven by the resources, assets and capacities of the patient. Motivational enhancement therapy, which incorporates motivational interviewing, is an empathic, respectful technique for promoting behavior change, and is consistent with cognitive behavioral therapies such as harm reduction therapy.[15] Motivational Enhancement Therapy is based on the principles of the Stages of Change and uses motivational interviewing techniques.

These two related treatment models have been shown to be effective with and have beneficial outcomes in treating substance abuse (Burke, Dunn, and Atkins, 2004), those with co-occurring disorders (Martino et all, 2002) and as used in an Internet context (Woodruff et all 2007).

b) Comprehensive Case Management for Substance Abuse Treatment (TIP 27) (Source: NCBI Bookshelf at http://www.ncbi.nlm.nih.gov/books/NBK14660/) will guide the operations of the RECOVERe intensive case management program. Utilizing an intensive case management model is effective in helping to reduce the fragmentation of social services and it fosters greater retention. Even clients who are ready to change their substance-using behaviors can find it very difficult to remain motivated when faced with the interaction of personal problems and service delivery obstacles. "Strengths perspective" case management will help rural clients motivate themselves to engage and complete drug and alcohol treatment.

A significant part of its operations will be supported with technology. The TIP will be adapted to address delivery of case management services in rural areas where effective access and coordination is difficult, by using technology support tools. In addition, case managers working in rural areas must frequently deal with a culture in which "everyone knows everyone else," from both the client's and the service provider's standpoint. Telecommunication and video-conferencing practice models have been used to allow clients relatively easy access to providers and to facilitate providers' communication and recordkeeping[16] (Alemi et al., 1992).

Strengths-based case management (SBCM) has been demonstrated to lengthen retention in treatment (Marty et al., 2001) and to be effective for low income populations with SUD (Morgenstern et al., 2006) and applicable to rural populations. It has been implemented with both female (Brindis and Theidon, 1997) and male substance abusers (Rapp, 1997; Siegal et al.,1995). These evidence-based practices were chosen because they promote self-efficacy and strength based recovery and, implemented together, address the all phases of recovery. They have been demonstrated to be effective with the ranges of ages and ethnicity of our population of focus.

MI and MET are manualized with specific standards for fidelity of practice, so that we may make adaptations to use technology that are not likely to fundamentally change the models or affect their efficacy. We will use the MITI coding system to ensure that every aspect of RECOVERe including technology-based content maintains fidelity to the EBP model.

Adaptations: Computer-based interventions for drug use disorders show initial evidence of efficacy during treatment; some effects continue after treatment.[17] Studies have shown improved self-reported and urinalysis outcomes for computer-based interventions compared to control conditions. In addition, computer-based interventions have been associated with high levels of client satisfaction as measured by direct assessment, and participants exhibited similar levels of engagement and retention as those in therapist-provided treatments.[18] However, despite the promising findings, research of computer-based treatments for drug use disorders is still clearly in

its infancy. Thus we are "pairing" evidence-based practices in programming with technology-based means of delivering them.

i2i - Video conferencing: Telehealth is not an established evidence-based adjunctive practice. The NIMH and the National Institute on Drug Abuse (NIDA) are currently conducting research to establish the data needed to formally label telehealth as an EBP. Five studies have used video-conference or teleconference (voice only interface) interventions; three studies have explored the potential for videoconferencing to be used in conducting telepsychiatry and treatments for OCD and ADHD. In two papers the technologies were used with patients who had difficulty accessing (e.g. due to geographical location) their regular health care providers.

According to the Office of Rural Health Policy (1997), telemental health is one of the five most common applications for telemedicine in rural hospitals. Telemedicine is also useful for purposes other than therapy including case management, medication management, psychiatric consultations, and psychiatric referrals (Rost et al., 2002). Evaluations of provider-patient encounters interactive two-way video have generally demonstrated that the reliability of psychiatric assessment is comparable with that of face-to-face interviews (Baigent et al., 1997; Rost et al., 2002; Zarate et al., 1997). Video conferencing allows increased access to professional, anonymous care with a significant decrease in the disruption of major travel. Another major advantage is the cost savings through reduction in travel expenses for service providers and clients. Clients have increased access to immediate care when needed without disruption to their jobs or home life.

The use of videoconferencing for substance abuse treatment will allow CSO clinicians to provide two major types of services form the Northampton outpatient treatment hub to CSO sites in outlying areas: Direct clinical services and training/supervision. The interventions will involve routine therapy directly with clients. Therapies suitable for adaptation used routinely by CSO clinicians include CBT, Motivational Interviewing and Motivation Enhancement (our chosen EBPs), Parent/Child Interactive Therapy Interpersonal Therapy for depression, and DBT. In addition, we will establish support groups targeted toward those in treatment and recovering from substance abuse for interactive televising.

Text4Recovery - Use of mobile phones: Although it has long been recognized that telephone counseling may operate as an effective intervention (Leach & Christensen, 2006), it has been less clearly acknowledged that mobile phones provide enhanced opportunity for the completion of therapy tasks. We will create a text-messaging platform to serve three functions: 1. Chat: patients send in a question and have it answered by a clinician or case manager. 2. Byte: a snippet of substance abuse education or motivational messages every week. 3. Appointment reminders: patients opt in for reminders (daily or weekly) to go to therapy, groups and meetings. 4) Info exchange: direct phone or face-to-face contact is not appropriate or feasible, but information still needs to be exchanged. To protect patient confidentiality, questions sent via text come to a password protected on-line platform. Text messages can either be sent at the time of writing or be programmed by staff for delivery at a predetermined date and time.

Mobile phone messages can either be read immediately or be stored electronically for later retrieval and action by the case manager. There is software available to enable a PC to operate as a text message receiver and storage device, thus further enhancing the possibilities of efficient data collection, security, and storage without adding to staff time. CSO will set up a pool of pre-purchased minutes and all clients who do not have a cell phone will be given one. In this way, phones can be cut off if there is any abuse or if clients leave the program.

ChangeAgent: Web Site services and interactive health portal: In a study of pregnant cocaine abusers, those who used online services three or more times per week were found to be two

to three times more likely to participate in self-care activities and treatment than clients assigned to the usual face-to-face support.[19] Use of Internet-based support tools for personal recovery from substance abuse, alcoholism, and mental illness is not new[20]; however, several factors appear to have stalled investigation of the use of these tools in the prevention, outreach, support, recovery, and aftercare for those affected by substance abuse and/or alcoholism.[21] Again, they do not qualify as EBPs. However, there are several easy-to-implement Web-based components that are obvious supports to adherence and recovery.

Resources Inventory: Listings of services, support groups, and personal advocacy resources in catchment area communities; CBOs for housing employment, legal services, etc.; schedules and directions to NA/AA meetings, inspirational literature; will have semi-annual updating.

Linkages: Links directly to recovery-related Websites and discussion groups, on line meetings, chat rooms set up just for people in RECOVERe to share stories, work on recovery program, and mutually support one another as they recover from alcohol or drug addiction a good function in the aftercare process.

Personal Portal

- Take the AUDIT or other assessment.
- Secure emailing with case manager
- Secure Chat rooms only for RECOVERe program participants
- On line calendar of appointments and appointment reminders. A portal to the CSO appointment/scheduling database will be developed.
- Connect to personal health records; interfaces will be built as part of installation of new EHR system over the next year.

3. Describe how the proposed practice will address:

Race and Ethnicity: While CSO staff reflects the racial mix of our service area (white and English-speaking), we welcome diversity. CSO uses panoply of approaches to embed cultural competency in our service delivery. Case discussions, team meetings and supervision are all seen within CSO as opportunities to incorporate information about diversity into our understanding of client problems and concerns, clients' response to services and any issues of or barriers to client engagement. Linguistic issues, culturally mediated patterns of response to services and providers and religious, cultural and ethnic traditions are all openly discussed and considered in the course of assessment and treatment. MI, MET and SBCM have been demonstrated to be effective with diverse ethnicities and races including White English speakers.

Gender: There is evidence for the efficacy of these EBPs for both men and women. However, women often have greater barriers in access because of child caring responsibilities that are exacerbated in a rural context. Technology can give them access to treatment and support at home, acting as antidote to the sense of isolation that accompanies SUD.

Age: CSO is experienced in providing services to transitional age youth (TAY) over 18 (many come through the CSO Crisis and the Quabbin clubhouse programs). The proposed technology tools are particularly useful to youth 18-24, are accustomed to technology-driven social networking. Social networking technologies are an ideal environment for youth to share what they are learning and create or strengthen a sense of community for rural youth.

In a recent study on Internet Recovery Services,[22] the users' mean age was 46+ years - surprising, given common perceptions of the Internet as a 'Generation X' medium. Approximately 17% of the study sample were over the age of 55, and 70% were between the ages of 36 and 55. We can be confident about the use of the RECOVERe technology tools by the full ranges of ages in our population of focus (18-55).

Geography: The service area, totaling over 2,000 square miles, can be rugged and navigating secondary roads is difficult. It is characterized by mountainous terrain and is poorly served by public transportation. The Berkshire area has only one major two-lane road running from the Connecticut border to Vermont. Winter weather is often severe enough to force this road to close, as well as make other secondary roads impassable, especially in the hill towns. The other geographical barrier is that of preference and perception. The lack of access to transportation and the paucity of major roads create an "isolationist" mentality where travel to another area is a major endeavor. This leads to problematic under-utilization of services and may exacerbate existing substance abuse problems.

The program is designed specifically to increases access and support in rural areas of Western Massachusetts. Technology-supported services assume that participants have difficulty in travelling to outpatient facilities on a regular basis and that technology will support connectedness and networking that addresses both rural isolation and the isolation attendant to substance use disorders.

Socio-economic status: It is anticipated that the large majority of participants will be in low to very low income brackets. This will not deter access to services, since the plans under Massachusetts Health Care Reform offer public subsidies to all low income populations. We anticipate that over 85% of RECOVER clients will be eligible for and use MassHealth or coverage under the Health Safety Net Trust Fund that provides for case management services under the Community Support Program (CSP). The program will provide mobile phones to those who don't have them and computer stations with access to the Web site will be established at all 4 outpatient sites.

Language and literacy: Although the vast majority of people in rural Massachusetts speak English, CSO have always prioritized a diverse, culturally competent, bilingual staff. CSO has Spanish-speaking clinicians for Latino clients. All curricular and educational materials will be available in English, Spanish and pitched to a 7th grade reading level. The population of focus is over 93% white with English as a primary language (95% across the 3-county area).

Sexual orientation and gender identity: CSO is known as a safe place for people of different sexual orientations to come for services; we have a high proportion of gay, lesbian and transgendered staff who bring a high sensitivity to issues of identity and culture for our clients who include same-sex parent families and gay-identified youth clients. Program case managers will know which 12-Step meetings, clinics, and other resources are available, knowledgeable, and accommodating to the gay and lesbian communities. Resources and educational information pitched to the gay community will be available through the RECOVERe Web site.

Disability: CSO has had training on serving the deaf and hard of hearing in the past and currently sees one deaf client on a regular basis who presents at the crisis program. We use our interpreter services if we need to use American Sign Language and a TTY operator for the crisis phone line. The technology component will allow Video Relay Service, a telecommunication service for deaf, hard-of-hearing and speech-impaired (mute) communicating with hearing persons at a different location. CSO makes accommodations to those who are blind/visually impaired. CSO outpatient clinics are smoke-free and physically ADA-accessible, generally located in downtown business districts, near to transportation hubs.

Veterans: In the rural service area, many vets reportedly use a dual system of care, accessing primary care from a local physician and additional specialty services from the VA. CSO works with veterans with ongoing psychiatric and co-occurring disorders. We collaborate with the VA outpatient clinic in nearby Greenfield, VA clinicians, primary care physicians and periodically

consult directly to the VA psychiatrist. Veterans in recovery have access to the VA's personal health record system and personal health portals for recovery planning.

Fidelity to Practice: Responsiveness in program design and operational structure to subpopulations and their attributes and issues will not strain fidelity to MET, motivational interviewing and intensive strength-based case management. These EPBs were chosen because they promote self-efficacy and strength-based recovery and, implemented together, responds to all phases of recovery. MI and MET are manualized with specific standards for fidelity of practice, so that we may make technology adaptations that are not likely to fundamentally change the models or affect their positive impact on treatment and recovery.

The RECOVERe evaluation plan has been adapted from the Motivational Interviewing Treatment Integrity Code System (MITI) 3.1.1.[23] The MITI is a simplified coding system that is intended to be used: (1) as a treatment integrity measure for clinical trials of motivational interviewing and (2) as a means of providing structured, formal feedback about ways to improve practice in non-research settings (see Section E.3, page 29 for a complete description).

Direct Service Components

Intake. All clients will have a comprehensive psychosocial assessment that will review the client's current and historic substance use, current mental status as well as history of psychological functioning, treatment histories for substances and psychiatric problems, their family's substance and psychiatric histories, current level of psychological and social functioning, risk status, and social environment and needs (e.g. housing, employment, etc.). They will be assigned a secure password to the Web site and will be trained in its feature. The Technology Coordinator and the Case Manager will assist in setting up numbers and feeds for broadcast messages to the mobile phone (owned by client or on loan from CSO.)

Case Management: RECOVERe case managers will promote the client's engagement in informal and formal support networks as well as in substance abuse treatment. Such networks of services support the participants' involvement in the local community to access resources and strengthen their progress toward self-sufficiency and will be available through linkages on the Web site. RECOVERe participants will have available all services necessary to assist in staying clean and sober, to regain or maintain physical psychological and spiritual health and to establish and strengthen ties with family and community.

Comprehensive Treatment Planning. The case managers and clinicians will collaborate with the RECOVERe participant to create an individualized, integrated, and evidence-based treatment and relapse prevention plan that addresses the psychological, spiritual and social needs of the client. The plan will identify priorities and obstacles to change, define objectives and outcomes for change, and recommend strategies to overcome obstacles to achieving these objectives. Progress in the plan will be reviewed at case conferences. An interactive journal feature to track progress toward treatment plan goals is easily added to the Web site, if a client desires to use this kind of tool.

Motivational Enhancement Therapy. CSO clinicians will employ motivational counseling techniques.[24] Motivational enhancement therapy is an empathic, respectful technique for promoting behavior change, and is consistent with cognitive behavioral therapies.[25] These modalities will help clients remain in treatment and working on relapse prevention and improvement of coping skills. Individual MET and group sessions will be offered through video conferencing among remotes sites and the Northampton outpatient hub.

Case Review. Weekly case conferences, which can be held as video conferences for staff in different sites, will be coordinated by the Clinical Coordinator and will be attended by all those involved with a case. This will include clinicians and case managers, psychiatrist (if assigned). The

case review team will be responsible for comprehensive monitoring of service delivery to all RECOVERe participants, regardless of what mix of services the person is receiving. The Web site portal will serve each participant as an email system, with a capacity for informal notes, client updates and an "alert" capacity for urgent messages.

Discharge and Aftercare: Clients and staff will regularly review and revise treatment plans according to changes in their substance use, health and mental health status. Clients will be ready for discharge when the apparent risk for further substance abuse is low, coping skills have improved and clients have acquired the services necessary to stabilize their lives. Participants will transition from counseling and intensive case management to a system of technology supported aftercare through the RECOVERe Web site and regular check-ins and broadcast messages through mobile phones. Recovery/relapse prevention groups will be video-conferenced.

Section C: Proposed Implementation Approach

1. Describe your experience using health information technology

CSO currently uses electronic medical records in two regional Emergency Services Programs (ESP), which are networked among our ESP sites, all other CSO agency sites, and our 3 hospital sites. Hill is our electronic billing system with capacity to track authorizations and flag timing to submit new authorizations; it is used to track CANS and TOP data (see page 14); and it provides data on service utilization and reports to assess utilization, lengths of stay, and service mix—by individual or family. The Hill system provides reports for subcontract utilization and payment and financial data for analysis. Comprehensive client charts are maintained on line for all patients seen as part of the Emergency Services and related programs. We can confidentially access charts, policies, forms, and resources through Web based remote access to our server where this information is available and organized. Client charts can be entered, revised, and updated in real time at all sites. The same remote access technology currently allows authorized program staff to access the same information available to Crisis staff including both client and resource information.

Common Ground: Common Ground is a Web-based personal health portal with a software application that empowers those with psychiatric diagnoses to communicate with psychiatrists and to arrive at shared decisions about next steps in the management of long-term psychiatric conditions. A module called "Personal Medicine" provides a framework to ensure that all important information and observations are shared, communication around follow up is clear, questions are appropriately formulated and answered, and that the appointment time is used in the most productive way, addressing patient concerns directly. It has been developed for use around psychopharmacology issues but is applicable to health care decision making in general. At the Greenfield Outpatient clinic, there is a peer-run Decision Support Center where clients create a one-page computer-generated report for use in the medication consultation from Common Ground

TOP: The Treatment Outcome Package has been effectively used at CSO for program monitoring and performance contracting for a number of years. TOP provides a comprehensive behavioral treatment outcome report that can gather information about the full range of presenting problems and case-mix variables that clients bring to treatment. The TOP uses clinically relevant scales to generate reports that assist in diagnosis, treatment planning, outcome assessment, and improving the therapeutic relationship. In addition, the TOP collects data about relevant risk factors that directly influence the treatment of behavioral health patients (e.g. life stress and co-morbid medical conditions). Unlike short research or screening scales, the TOP is designed to maximize the chances of measuring meaningful change over the course of treatment through measures of symptom severity at those intervals designated for evaluation.

Table 3. Logic Model

Conditions	Inputs/Activities	Outputs/Short term Outcomes	Long term Outcomes
Environment - Limited range of treatment in rural region - Limited capacity for substance abuse treatment in rural region; long waits	- Outreach - Local Web-based resource inventory and self-help tools	- Increased service provision - Broader ranges of service delivered - Increased access to substance abuse services	- Coordinated and responsive system of substance abuse treatment - Long term support for continued recovery - Less drug-related crime
Population of focus - High rates of alcohol and illicit drug abuse - High rates of poverty - Limited knowledge of available resources	- Intake and Assessment - Pretreatment - Technology tools and training - Treatment Planning and Management	- Increased adherence to treatment plan - Increased contact with staff - Increased treatment completion - Increased clinician and case manager expertise - Change in recent use of alcohol/drugs	- Decreased substance abuse - Improved quality of life - Better connections to family, friends, community - Improved coping skills - Better opportunities for employment - Less criminal justice involvement
Resources - Geographically distributed accessible outpatient centers - Grants - Patient services revenue for wide range of services - Web site	- Development of greater organizational technology - Experienced and skilled staff - Use of evidence-based practices -Robust system of staff supervision and training	- Increased lengths of abstinence - Increased life stability - Technology know-how for self-help - Staff skilled in new evidence-based practices	- Sustainability of programs after grant period - Cost effectiveness of treatment and support - Technology-enabled Web linkages among community agencies serving population of focus

Table 4: Technology Supported Program Components

Technology support	Outreach 200 people annually	Intake	Induction 150 people annually	Therapy 150 people annually	Case Management 150 people annually	Discharge
i2i video conferencing; all sites are connected	Identify outreach target populations: Outreach for court referrals, family referrals, health care practitioner	One face to face session or One video session	One face to face session with case manager or One video session	4 MET sessions - may be all video Groups may be all video	One meeting with CM; may be face to face or video Simultaneous with Tx	Aftercare contact may extend to one year post discharge; relapse groups may be conducted on

	referrals					remote basis
	Orient CSP case managers to RECOVERe for those on caseload with untreated SUD	Assessed by (case manager or clinician or other?)	Appointment made to meet case manager face-face to face	Assignment to clinician and initial face-to-face meeting	Treaters and client agree to readiness for discharge (video case conference)	Client is discharged
Text4recovery: Mobile phone programming	Part of outreach is information about and orientation to technology available for precontemplation / contemplation stages	Stage of change assessed (of four below)	Case manager works with Technology Coordinator to customize mobile phone package	Instant messaging and automated direct dial to therapist; emergency protocols agreed to	Transition and termination of treatment – client and CM develop aftercare plan	Aftercare plan implemented
ChangeAgent: Web site and secure portal	Anyone can access parts of RECOVERe Website: resource inventory; self-administered AUDIT and other assessments; intake contacted if person wants to enroll in treatment	Enrollment – informed consent, signed releases, orientation can be completed on line	Client and CM negotiate a schedule of contacts by email Client goals on Web site in a secure and private domain	Clinician and client works with Technology Coordinator to set up secure email and password-protected portal	Instant messaging and secure email to case manager	Phone messaging set up for "Recovery maintenance" messages and linkages to case manager
Text4recovery		Mobile phone set up for precontemplation /contemplation bytes	Mobile phone set up for "Preparation" messaging	Mobile phone set up for "Action" messaging	Instant messaging and automated direct dial to case manager	Mobile phone set up for messaging related to aftercare
i2i text4recovery ChangeAgent		Client training on mobile phone system. Training can take place through video conferencing	Introduction to RECOVERe Web site - Training through video conferencing	Client and clinician assigned secure emails addresses though Web site and agree on emailing protocols	Web site use for directory of resources and contacts so that client can be self-directed	Added Web site tools for aftercare
ChangeAgent		GPRA by evaluator Put questionnaire, releases, informed consent on Web site	Set up data collection through Web site portal for reporting		GPRA by evaluator at 6 months	GPRA by evaluator at discharge
Stages of Change	*Precontemplation*	*Contemplation*	*Preparation*	*Action*	*Transition from action to maintenance*	*Maintenance*

Challenges: CSO is aware that communications is a key factor in the successful implementation of any EHR. Simply put, the right information needs to be at the right place at the right time. To do this well, communication systems must be clear, technologically integrated and, in some cases, redundant. We are working with network consultants on an assessment of the adequacy of all systems across all agency sites in order to implement necessary improvements to the technology "backbone" in preparation for EHR. We do not have an interoperable health records system in operation at present. As a result of our technology planning process, we have begun the process of selecting an EHR system that is certified by ONC-ATCBs.

Two other BH service providers in the western region had engaged in a joint purchase of an EHR a few years ago that has proven completely inadequate; they both have been forced to purchase and install new systems at great additional expense. CSO has bided time to ensure that we "dodge the bullet", waiting until the state of the art in behavioral health records systems is solid and has a long term future. It is the right time for CSO to proceed with EHR.

2. Describe your organization's current capacity in HIT.

CSO has in place an integrated information technology network that permits confidential communication of essential client related data between staff, between programs, and between sites (both within and external to the agency), according to HIPAA regulations. This is possible due to our server based information storage that permits access by authorized CSO staff from any site with a computer station.

System Capacity and functionalities: 24/7 broadband access (laptops also have broadband access). We submit claims and encounter forms electronically to third parties. The automated claims/billing system is Hill A/R Plus. Data encompassed on our systems include: Financial Reports, Utilization Reports, Clinician Profiling, Client Profiling, Quality Measurements and Statistical Analysis. Electronic Encounter Form data is used extensively for continuous quality improvement: flow, high utilization and outliers, individual case and collective trends, in planning modifications to program policies, procedures, staffing patterns, or operations.

Type	*Number*	*Operating systems*
Servers	**6 (New server Windows 2008 installed 10/10)**	**Windows 2000 Windows Server 2003 Windows XP**
PCs	**120 desktops; 10 laptops**	

Is your existing EHR system interoperable with general medical/primary care systems? No.
If partnering with a primary care provider, do they have an electronic health record (EHR) system? Not applicable.

3. Explain how your current HIT infrastructure enhances or limits quality of care

CSO has more than doubled in operational budget and staff in 5 years, has expanded from three service areas to five and has broadened and expanded programming to new populations. Technology-wise we need increased server capacity and an enhanced WAN. CSO's lack of systems-based infrastructure across all sites and all programs that allows all patient information to be available when and where it is needed limits both the quality and integration of care at the agency. It has hampered our ability to conduct performance and quality monitoring, in particular, that we need for comprehensive CQI.

CSO needs an EHR that supports seamless coordinated services across the region and its organizations (behavioral health, medical and social service) and provides ready access to comparative reporting and performance assessment and analysis. However, an EHR is no panacea for quality service delivery. There are serious technical and business barriers that limit the capacity for data exchange across independent practices and organizations, limited the systems; utility for

integrated programming. We regard the technology tools we propose for RECOVERe as independently useful from an EHR but the agency needs this entire range of tools for maintaining quality.

4. How electronic tools will reach the specified population(s) of focus.

The technology initiatives will be aimed toward enhancing outreach. The work of educating residents is ongoing and involve community clinicians and referring agencies. We will engage in ongoing education of the provider community in order to make ourselves widely known as an enhanced substance abuse program resource. We will publicize the Web site, distribute written information that can also be found on the CSO RECOVERe Web site and will link ChangeAgent on other CBO and state and local agency Web pages. As part of a community marketing plan, we will inform the general public and consumers, families and other stakeholders about the increased capacity and range of outpatient services and technology support available through listservs, other agencies' online newsletter and Web site links.

5. CSO EHR meets the requirements of the Office of the National Coordinator for Health Information Technology- Authorized Testing and Certification Bodies (ONC-ATCBs).

Having completed our agency-wide Network Assessment (performed by Advent Technologies) we are currently in the process of selecting an EHR that meets ONC-ATCB standards to replace our limited client health record system. The projected timeline for the system to be fully operational is by June 2013.

6. Explain how you will address the following factors:

Organizational factors: This year CSO assessed e-records expansion potential for the five outpatient sites in terms of capacity needs; confidentiality issues; implementation issues and full cost analysis. At the same time, pursuant to out 2010-2012 Strategic Plan, we reorganized the senior management level to consolidate substance abuse services under one Director which will allow the implementation of standard policies and procedures across all sites, and also facilitate data collection and client tracking. Part of the network assessment is to examine how data is collected on clients and for funding agencies and to recommend changes in workflow, policies and procedures. Each Clinic Site Manager will need to incorporate video conferencing and client technology training into space requirements and scheduling systems at all 4 sites.

Provider training and competence factors: Our staff survey on technology competencies is ready but cannot be conducted until union negotiations have concluded. However, we estimate that 60% of staff have solid computer competencies that would enable to use the proposed technology tools. We have incorporated technology competencies into all job descriptions and will offer training to meet these standards once the survey is completed and analyzed.

Relationship factors between provider and persons in treatment: Overall, engagement with providers and adherence to treatment will be improved by use of technology tools for those with SUD. In the short run, the client's confidence in treatment and the treater will be enhanced by use of technology for just-in-time delivery of tailored messages and experience that speak to each person based on their unique characteristics, their performance on key behaviors and their needs at that moment in time. In the long run, continuing contact with the program, other participants and staff will be a boon to recovery in aftercare. Initially the technology tools may be off-putting to some (fewer than we would think); however, we will have a hands-on training session for each client in all tools and offer ongoing "help-desk" support by phone.

Technical factors requiring additional staff or consultants: We are now using two sets of consultants (prior to selecting an EHR vendor): We have already begun to examine the process and specifications of the ChangeAgent Web site with the developer. Advent Technologies is performing

our Network Needs Assessment. The work is being funded through CSO's operational budget. The following tasks have been performed.

- Determining best method for consolidating remote sites into single corporate infrastructure.
- Identifying current status of the network and making recommendations for changes.
- Develop roadmap for network changes to address tactical as well as strategic objectives including EHR implementation.
- Review current status of network and to determine any specific areas to focus review on.
- Meet with main IT contact and business stakeholders to review strategic concerns as it relates to IT. Determine what corporate initiatives and other business drivers that will impact IT.
- Review (Microsoft) Core Infrastructure Optimization model and perform assessment to determine what IO model level the network currently sits at.
- Review and document current network configuration, including:

- Server – basic server hardware information along with software and update levels. Note applications installed on server. Review basic performance counters of server – free drive space, processor utilization and memory usage.

- Workstations – review sampling of PCs to document antivirus software configured and verify signature updates are occurring.

- Network Infrastructure – Document make and model of switches along with free port information. Review Internet connection and document hardware information for firewall and router/modem.

- Documentation - Review and collect any IT documentation that the client has for their network such as network diagrams, sever information or any other technical documentation

- IT Procedures - Review and collect any IT documentation that the client has for their network such as backup procedures, disaster recovery plan or user setup guides, security compliance protocols.

- Remote Sites - Visit one remote location to gain understanding of base configuration.

Based on information gathered during the network review, CSO will receive a network recommendations report in the next few weeks.

Financial factors: We have a comprehensive financing plan for infrastructure enhancements (hardware and installation costs and EHR purchase). The Board of Directors has restricted $300,000 in cash for use for purchase and implementation of an EHR and related technology improvements to support. There is also a plan for applications to local foundations that are known to support such infrastructure improvements. CSO's bank has been supportive of financing such needed activities.

7. Describe how the proposed health information technology service(s) or practice(s) will be implemented.

RECOVERe will be implemented in coordination with but independent from EHR installation. The two technology consultants currently employed will also develop and implement technology tools. The assessment for video conferencing will involve assessing the need for server capacity and band width at each site and training from the vendor for each Site Manager.

8. Describe how you will automatically screen, assess and track persons in treatment

Outreach and Pretreatment: Project staff will engage potential clients through information sharing—using motivational interviewing—about the availability of substance abuse treatment services and connecting clients to treatment. These conversations will be guided by the principles of the Stage of Change. Outreach staff will employ motivational counseling techniques.[26] Pretreatment interventions will be limited to individuals in the pre-contemplative and contemplative phases. Once clients are in the preparation phase, they will be assigned a case manager and encouraged to begin treatment. At this point, we will formally enroll clients into the program and administer the baseline

GPRA. There will be an electronic registry of all program participants where as much information as possible is both download and uploaded to the /Web site. As soon as the EHR is installed, a portal to client records accessible to CSO staff and to clients themselves will be developed. Until then portals will be built among the Web site and other CSO electronic systems (e.g. scheduling) to allow a broad flow of useful information.

9. Describe how you will leverage messaging systems and personal health records to effectively engage persons in treatment in their own care.

Increase Access to a greater range of substance abuse services: to augment face to face therapy with technological tools like video conferencing. Mobile phones will also be used to enhance services The project will involve sending a series of tailored text messages to each participant, customized on the basis of their responses to an initial MI-based questionnaire. The messages contained coping statements, suggestions of activities to manage risk, and encouraging statements such as the number of abstinent days.

Increase Adherence: A person's behaviors follow the advice given by clinicians may include entering a treatment program, maintaining and completing a treatment program or keeping aftercare appointments. Adherence can also include engaging in therapy sessions, openness and personal disclosure, and cooperation. Risk characteristics for drop-out or non-attendance include having a current diagnosis of substance abuse disorder, minority status, economic disadvantage and limited education and longer waits. Appointment reminder strategies will include incorporating text messaging and email reminder systems, incorporating orientation components into electronic reminders. On-line orientation components will contain information about the clinic, staff, and what to expect during therapy and the first appointment.

10. How the use of home-based monitoring tools will improve health outcomes.

Extend aftercare: The purpose of aftercare is to maintain psychological gains made in primary treatment and to prevent relapse (McKay et al., 1998). The first month after discharge has been identified as a critical period when problems may occur and risk of relapse is highest (Ilgen, Hu, Moos, & McKellar, 2008. Aftercare is associated with increased likelihood of maintaining enhancing, treatment gains.

Use of cell phones in aftercare will aid client monitoring and provide an ongoing link for the client. Participants will be sent messages once weekly in a standard format relating to their substance abuse issues. Participants will be required to reply to these messages, and are also able to send additional free messages to the case managers throughout the week. The CMs will reply with at least one message per week offering support and advice.

11. Describe how effective consent will be obtained and tracked, including any special conditions dictated by State law and 42 CFR part 2.

The informed consent process will be part of the intake process (see Attachment 4) administered by the case managers. Any other necessary releases will also be explained and executed at that time.

CSO has implemented both physical and electronic security measures to protect confidential Personal Health Information (PHI) as a part of its commitment to the highest quality care, storing PHI in both physical and electronic forms with different security measures for each as required. CSO maintains hard-copy data that is stored in a secure location at each service site. Access to the secured location is restricted to agency personnel via locking doors and file cabinets. The secure location is locked when left unattended by agency staff for any reason. CSO has in place an integrated information technology network that permits confidential communication of all data on individuals served between staff, between programs, and between sites (both within and external to the agency), according to HIPAA regulations, as a function of our server based information storage

which permits access only by authorized CSO staff. CSO has never been involved in a breach or a complaint involving security, confidentiality or integrity of data of an individual.

CSO has policies and procedures in place for "Use and Security of Electronic Information and Equipment" (including cell phones). All employees sign a form that that they have read, understood and will comply with these policies, which reflect HIPAA standards. There is a HIPAA section of the new employee orientation manual and all program directors/supervisors address security and confidentiality in basic program orientation to the agency and its programs and in ongoing training.

12. Table 5: Implementation Plan and Timeline

Timeline	Start-up Activities	Who Responsible
Month 1	o Establish executive-level RECOVERe Implementation Team and create schedule of meetings o Establish consumer advisory group o Initiate hiring process and hire RECOVERe Technology Coordinator o Implement outreach and marketing strategies	CEO, HR director RECOVERe Implementation Team (co-executive directors and clinical coordinator)
Month 2	o Plan scope of Web portal and engage developer o Plan scope and implementation plan for video conferencing o Obtain cellphones (shared pool plan) for clients and program them to be ready for first clients in Month 4 o Development of policies and procedures: informed consent, intake, coverage, care planning process, crisis response, etc. o Develop orientation materials process for participants o Develop staff training plan and training materials o Establish coordinated supervision and program mgmt plan o Purchase increased bandwidth and video conferencing hardware Site 1 & 2 (45 days for installation of dedicated circuits)	Implementation Team (add Technology Coordinator) Evaluator RECOVERe Program Staff
Month 3	o Establish on-call and coverage system o Update referral arrangements and agreements o Orientation and training for all staff o Create work group to plan data collection and evaluation systems o Developer begins on Web site portal development o Develop interim informational website and resource inventory linkages o Set up computer workstations for client use at 4 sites	Implementation Team Evaluator Technology consultant
Month 4	o Begin taking referrals o Deploy interim Web site (informational use) o Implement evaluation systems interface and ACCESS database o Test drive data collection and reporting systems o See first patients: assign Case Manager and Therapist	Clinical Coordinator Technology Coordinator RECOVERe Program Staff Evaluator
Month 6	o Beta testing of Web portal o Begin assessment of baseline, start-up benchmarks and progress o Make corrections and adjustments to program model	Implementation Team and Evaluator Technology consultant
Month 7	o Web portal training for all staff	Technology consultant
Month 8	o Deploy Web portal for all clients	Technology consultant
Month 12	o Evaluate first year of operations o Make corrections and adjustments o Administer GPRA and client satisfaction survey o Evaluate usage of mobile phone systems and web portal	Implementation Team and Clinic Site Directors
Month 13	o Purchase increased bandwidth and video conferencing hardware Site 3 (45 days for installation of dedicated circuits) o Bridge scheduling system and web portal for on- line client schedule access o Training for staff in use of video conferencing	Implementation Team and Evaluator Technology consultant
Month 18	o Plan interface with EHR development team o Bring on additional video conferencing site Site 3	Implementation Team and Evaluator

	o Administer GPRA surveys gather all electronic data for 2nd year evaluation	Technology consultant
Month 24	o Interface with EHR o Perform second year performance assessment o Evaluate usage of mobile phone systems and web portal o Purchase increased bandwidth and video conferencing hardware Site 4 (45 days for installation of dedicated circuits) o Administer GPRA and client satisfaction survey	All staff with Evaluator
Month 26	o Bring on additional video conferencing site Site 4	
Month 30	o Bring on additional video conferencing site o Administer GPRA surveys gather all electronic data for final evaluation	Implementation Team Evaluator
Month 36	o Summative evaluation begun	All staff with Evaluator

13. Unduplicated number of individuals you propose to serve

Table 6. Number of People Served

Service	Year 1	Year 2	Year 3	Years 1-3
1. Screening and Pretreatment	130 (8 mos. of operations)	200 (16-17 /month)	200 (16-17 /month)	430
2. Strength-based Case Management	150 enrolled (operational for 8 mos.)	150 enrolled (75 each 6-mos. period)	150 enrolled (75 each 6-mos. period)	450
4. Substance Abuse Treatment	150 enrolled (SA TX operational for 8 mos.)	150 enrolled (75 each 6-mos. period)	150 enrolled (75 each 6-mos. period)	450
5. After-Care	75	150	150 and (75 post grant)	375

Table 7: Service Elements, Units and Outcomes

Service/Activity	Units Delivered	Anticipated Outcomes
Outreach, Screening, Pretreatment		
Outreach substance abuse education, in person, through brochures and referral to Web site	Average of 5 community sites contacted a month in Year One	Community-wide awareness of issues; 200 individual referrals and self referrals to RECOVERe Program a year
Screening and Pretreatment Motivational Interviewing,	16-17 at-risk adult screened and counseled a month	150 enrollments in RECOVERe annually
Substance Abuse Services		
Case management	16,200 annual hours of case management services for 150 RECOVERe participants	100% of RECOVERe participants will have access to support needed to stabilize their lives and support their recovery.
Motivational Interviewing, Motivation Enhancement Therapy	Est. 1,000 annual hours of service in individual, group and family sessions for 150 RECOVERe participants	100% of RECOVERe participants will receive SA counseling; 70% of participants will be abstinent after 6 months in the program.
Technology Supported Recovery		
Text4recovery ChangeAgent	200 outreach and pretreatment contacts will have information about and access to ChangeAgent and text4recovery	Increased enrollment in RECOVERe and other substance abuse/dual diagnosis programs
Text4recovery ChangeAgent I2i	150 program enrollees will have access to and trained in test4recovery and ChangeAgent; will have secure email and will be assigned a pre-programmed mobile phone if needed.	Increased adherence to treatment longer stay in treatment, longer periods of abstinence, /fewer relapses, increased retention in aftercare.

14. Project components will be embedded within the existing service delivery system.

The SBCM component of RECOVERe will be almost entirely funded as part of the Community Support Services program for Medicaid-insured. An additional Case Manager has been added for the uninsured and those without coverage.

CSO is widely known in our community for being available as a resource for clients with a multiplicity of behavioral health needs. CSO enjoys the broad range of working relationships that are designed to quickly move clients into needed community services or into CSO programs. Each of these relationships has been developed over time and recognizes our interdependence. The letters of support are from agencies with whom we have systems of mutual referrals. Also CSO chairs three active, geographically tailored System of Care committees to deal with the service delivery gaps and barriers that have impact on children and families. These groups tackle local issues, assess local capacity and address service gaps and will be seeking leveraging strategies for the technology tools that RECOVERe puts in place.

15. Identify any other organizations that will participate in the proposed project.

There are no other organizations formally participating in the project beyond the current network of mutual referral and linkages. The community agencies lending support have been referral partners for many years. See Letters of Support.

16. Show that the necessary groundwork has been completed or is near completion

Substance Abuse Strategic Planning: CSO acquired the outpatient substance abuse program from Cooley Dickinson Hospital last year and initiated a Substance Abuse Strategic Planning process at the first of the year to integrate Northampton SA treatment and programming with Greenfield and Athol SA outpatient services and to extend SA licensing to Pittsfield and Springfield. A needs assessment for the tri-county communities is underway.

Training: Priorities to enhance substance abuse services, already beginning implementation, include Motivational Interviewing training for ALL CSO staff, SBIRT training for all intake (both MH and SA) staff at all sites. The enhancement of dual-diagnosis services will be accomplished through number of new training opportunities. Recruiting, staffing and training are all being strengthened. The integrating of MI and MET into a technology-supported model, combined with installation of a new EHR, will allow CSO to implement an SBIRT model across all departments in the agency.

Technology Plan: The Technology plan, inclusive of all programs, all sites and all staff, was one of the top priorities in the 2010-2012 and is currently in its second phase (Section C.6)

Veteran's Administration: We have reached out to Kellie Condon, the National Coordinator for substance abuse technology support in the Veterans Administration to see if we could adapt "My Recovery Plan" [27]for our Web site. However it is still under construction and modified to interface with the My Health*e*Vet platform, which will not be accomplished until next January at the earliest. However, if there is a possibility for collaboration, we will pursue it.

Fidelity: In addition to training, our selected evaluator is supporting the use of MITI coding to strengthen fidelity to practice for the motivational interviewing component. (Section B.3.) She is attending and additional session of MITI and is working on using it for case management.

17. Describe the potential barriers to successful conduct and how to overcome them.

Technology limitations: Mobile telephones are embraced with varying enthusiasm by different age groups. Some age groups may simply not have access to, or the ability to use, mobile phones. For example, the older participants in the study of mobile phone monitoring of gambling and mood withdrew because of discomfort with mobile phone use (Gee et al., 2005). Training each patient in

the use of the mobile phone for assessment and treatment augmentation can take a considerable amount of time. Wade and Troy (2001) suggested that having the patient incorporate the phone into their daily routine, carrying it on their person at all times, is essential to its effective and secure use. Sensitive monitoring of the patient's response to the mobile phone is therefore an essential component of the program as well as access to help desk support.

A significant concern related to technology is information security and for clients, maintenance of anonymity. The Web site portal will allow confidential communications among staff and clients and between clients. Program participants will be informed that use of a mobile phone does not entail privacy or confidentiality.

18. Describe your plan to continue the project after the funding period ends.

Financial sustainability: Public insurance carriers will reimburse many of the services delivered to our target population. Substance abuse services will be nearly all reimbursed since CSO can also bill for mental health and substance abuse services as a licensed outpatient clinic. Massachusetts also had recently enacted universal health care, which includes coverage for behavioral health services so that rural populations, long an underinsured group, will have health insurance coverage. CSO intends to pursue increased revenue by advocating for tele-encounter reimbursement among state policy makers.

Project continuity: Our plan for managing the project is intended to maximize program continuity. The management for the project will be conducted on three levels. The first is where the Co-Executive Project Directors ensures that program staff adhere to the timetable outlined in Section C.11, and maintain the data sources and oversee data collection described in Section E. Reporting and coordinating are the key functions of this staff. The senior program and clinical staff involved in the project will review the accomplishments in monthly team meetings as well as leading the development of initiatives internal to their departments. These staff will issue a report to the executive staff/department heads at each agency monthly Executive Team meeting. Executive staff will be responsible for 1) briefing the Board of Directors; 2) identifying and or responding to resources needs for the project; and 3) convening for the purpose of higher level policy analysis/planning/brokering, conflict resolution, review evaluations and assessments and other functions that require senior leadership and authority.

Community sustainability: We hope to build involve an ongoing process featuring systems of mutual referrals and a high level of collaboration among community-based providers and with service users in setting priorities, evaluating outcomes and assuring access to service. By facilitating processes for integrated services and community-wide involvement with our clients, we will build relationships among our program participants, the organizations that they use and other stakeholders and leaders in the region.

Section D: Staff and Organizational Experience

1. Discuss the capability and experience of the applicant organization

Clinical and Support Options is a multi-service agency with a $19 million operating budget that serves low-income people in Berkshire County (Pittsfield clinic), Hampden County (Springfield Spectra Center), Hampshire County (SA outpatient clinic and ESP), Franklin County (Greenfield Clinic, ESP, respite and clubhouse), and the North Quabbin area (Athol clinic and Orange Clubhouse). CSO services include: adult and child counseling and psychiatry; family support services; family stabilization and community support program; parent education; outreach and case management to children, adolescents and adults; peer counseling to elders; vocational training and job placement services to adults with mental illness; crisis evaluation and stabilization; short-term respite; day rehabilitation; two Fountain House model Clubhouses (Quabbin House and Green

River House); court diversion services for adolescents; and transitional services for families. CSO serves well over 1,000 families and 2,000 individuals, which include 821 clients with a substance use disorder diagnosis and 793 clients with mental illness, SUD and co-occurring disorders who receive intensive case management in the Community Support Program (CSP). CSO's expertise lends itself to the development of a wraparound model of comprehensive, holistic services to people with multiple, complex issues.

The Substance Abuse Outpatient Services Program employs multidisciplinary licensed staff who have many years of both substance abuse and mental health treatment experience. The staff includes LICSW clinicians, psychologist, psychiatrists, certified alcoholism and drug counselors, and other masters level clinicians. Collectively this staff group has the following specialized experience with: dual diagnosis, children, adolescents, family/couples, adult, elderly, depression, codependency, compulsive gambling, criminal justice issues, psychoeducational services, anxiety, chronic illness/pain, sexuality, ADD/ADHD, domestic violence, banterers, PTSD, eating disorders, gay/lesbian issues', men's and women's issues, personality disorders, bereavement, parenting concerns, schizophrenia, HIV/AIDS. A number of the staff have also experienced problems with substance use and are in recovery. All staffing, clinical supervision and clinical training meet the Outpatient Counseling regulations.

We have one bilingual Spanish and one African American clinician, a 1.5 FTE Spanish speaking, Hispanic support staff and two bicultural staff on the Evaluation Team.

CSO Training and Professional Development Series: Through the development of a multi-disciplinary and multi-level staff Training Committee, CSO continues to invest significant labor and financial resources to an agency-wide training and professional development series. Trainings are targeted to both management development and multi-level direct care staff. CEUs are offered when applicable for agency staff, free of charge. In-house trainings have been well attended and well received, and have contributed to quality initiatives over the past year. CSO also offers bi-weekly Grand Round case presentations and monthly integrated program Grand Rounds presentations, giving staff an opportunity to consult with multi-disciplinary staff and learn from actual case presentations. Motivational Interviewing training has begun through this system, with the aim of training all CSO personnel within 12 months.

2. Provide a complete list of staff positions.

Table 8: Staffing Chart

Title, Staff Name	% Effort	Roles and Responsibilities
Executive Project Director, Technology: Joanne Jackson	10%	Performs executive oversight of program start up (first two years) and coordinates with Executive Staff.
Executive Project Director, Outpatient Services: Peter Wood, LICSW	10%	Oversees and directs all aspect of substance abuse services in this project and directs the Northampton outpatient clinic, which serves as the "hub ' of the RECOVERe program.
Technology Coordinator To be hired	100%	To maintain and support management information systems in supporting clinical and related services for substance use disorders including participating in the development of tools, training staff and clients and setting up systems for clients.
Clinical Coordinator: Maureen Blackmore, LICSW	100%	Responsible for coordinating all aspects of the substance abuse programs and other group therapy services, ensuring high quality program delivery for RECOVERe clients among CSO sites and internal referrals among CSO programs.
Therapists: NA	50%	Provides MET substance abuse treatment and therapy for program participants; coordinates with case managers. (20 hrs/wk, multiple staff)

Case Manager: LW Cooper	100%	Assists in accessing support services; makes referral to and advocacy with CBOs on behalf of client; provides substance abuse education and direct connections to Tx, assists set up and train in technology tools; provides extended aftercare.

3. Key staff has demonstrated experience and are qualified to serve the population(s) of focus.

Technological Experience: As Co-Executive Project Director, *Joanne Jackson* has expertise in Microsoft Windows NT, Windows 9X, Windows 2000 Microsoft Exchange 5.5, Microsoft SQL 7.0, Visual Studio Suite 6, Crystal Reports 8.5, Web development (HTML, ASP), programming (Visual Basic 6), phone systems (PBX), and Cisco networking products.

Substance Abuse Treatment Experience: *Peter Wood, LICSW*, who oversees all clinical aspects of RECOVERe and clinical staff training as Co-Executive Project Director, has had 15 years of clinical experience in substance abuse and mental illness, including co-occurring disorders. He has been a NIATX Change Team Leader and is trained in motivational interviewing and SBIRT systems. He has been providing therapy and counseling to the population of focus in the Western Mass. region since 1995. *Maureen Blackmore, LICSW*, the Clinical Coordinator, has 15 years of experience in treating rural populations in Western Massachusetts and is trained in substance abuse, mental illness, dual diagnosis, DBT certified, DBT weekly & monthly consultation groups, Acceptance and Commitment Therapy (ACT), Motivational Interviewing (MI) & Seeking Safety (Trauma EBP). The Case Manager, *L.W. Cooper* (also a CSP staff member) who will be assigned to RECOVERe has 15 years of substance abuse program experience in the northern and central Berkshires, had experience in methadone maintenance services and has been training in DBT.

4. Describe the resources available for the proposed project

CSO maintains 5 outpatient clinic sites located in the main population center of each county, all of which are convenient to major bus routes and county transportation hubs. Each one meets all ADA requirements (ramps, rest rooms, parking spaces, etc.); current DPH outpatient mental health and substance abuse licenses document official 100% compliance with ADA. Technology equipment specifications are contained in Section C.2. CSO offers full array of multidisciplinary mental health and substance abuse services including case management, outpatient therapy that can be delivered either in-office or home based, and adult and child psychiatry and clients will be referred to any additional service they need.

Section E: Performance Assessment and Data

The primary focus of the evaluation is to determine the effects of participation in CSO's RECOVERe on clients' substance use and other key indicators of successful recovery at six months after entry into the program and at program discharge. The Center for Addiction Recovery (CAR) will be contracted to conduct the process and outcome evaluation of the proposed enhancement services. Specifically, the team consists of two PhD. Level Data Analysis Specialist, a Masters level Quality Assurance Evaluator, a Data Collection Specialist, and two Data Management staff. The team takes pride in having bi-lingual (Spanish/English) capacity, bicultural staff, and all are well known in the community.

1. Ability to Collect and Report Findings; Plan for Data Collection

The CAR team draws from the collective experience of evaluating 7 SAMHSA CSAT TCE and homeless projects; 3 CSAP HIV/HEP C projects; a SAMSHA-funded Effective Adolescent Treatment project; 4 CMHS projects, 2 with people who are homeless, one with elderly Americans and the other with Cape Verdean Youth; and a SAMHSA-funded Drug Free Coalition. CAR has extensive experience collecting and reporting on required performance measures, achieving 100% intake rates, and 80% or better follow-up rates. Two currently funded CSAT programs evaluated by CAR have 90% or better follow up rates. CAR has participated in several SAMHSA GPRA

trainings and conducts local GPRA and tracking hard-to reach client trainings with staff at all its projects. CAR meets GPRA data submission and reporting obligations in a timely fashion. CAR has independent office space, with state of art information technologies that are used to develop data collection tools, analyze data, and report findings. In terms of abilities, CAR has worked extensively with treatment providers and community agencies, allowing them to develop practical experience integrating research activities within service settings. This integration requires balancing evaluation and program activities, concerning the timing and burden of data collection, confidentiality and data storage.

Study Population: Program participants will be eligible to participate in the evaluation, pending their informed consent. The estimated number of evaluation participants is based on an expected yearly total of 150 adults diagnosed with SUD. To increase participation in the evaluation, we will give a $20.00 incentive to participants at follow-up and discharge. When data collection and clinical functions are conducted by different individuals, the use of incentives for follow-up interviews cannot be interpreted as payment for engagement with treatment or use of services.

Data Collection Plan: Prior to implementation of the evaluation plan, CAR will train its Data Collection Specialist on obtaining contact information, releases for follow-up tracking methods, and releases for sharing of contact information with other agencies. CAR has expertise on tracking hard-to-reach populations, including homeless individuals with substance abuse issues and co-occurring disorders. CAR anticipates retaining at least 80% of clients in the evaluation study. Using the resources proposed below, retention in the RECOVERe Program will be facilitated by the bond built between the client and the Data Collection Specialist. Resources that will be used in this project to maximize GPRA retention will include a detailed Participant Locator Form for each participant (see Attachment 2) completed at the time of informed consent, at each follow-up interview, and, on an as-needed basis, between follow-ups; a comprehensive release form specifying which tracking methods a participant grants the Data Collection Specialist permission to use; releases of information naming each provider agency at which the evaluation participant gives the Data Collection Specialist permission to contact him or her. Additionally, the agreements concerning sharing of client information that CSO currently has in place with agencies that will collaborate on RECOVERe will also facilitate achieving an 80% or better follow-up rate. CAR staff will also facilitate an in-service training for the implementation staff in November 2011. During the training the team will review the goals, objectives, and quantifiable outcomes for the project, and to provide hands-on training, with role plays and time allocated for discussion regarding data accuracy and timeliness. Thereafter, CAR will train any new staff in the event of staff changes. CAR has expertise on tracking hard-to-reach populations, including homeless individuals with substance abuse issues and co-occurring disorders. CAR staff will attend all staff meetings and be available on an as-needed basis for consultation when a clinician or case manager is experiencing particular difficulty in finding an evaluation participant for follow-up.

Data Collection: Once the consumer is deemed eligible for the program and before data collection occurs, the Informed Consent (see Attachment 3), will be completed by the assigned Data Collection Specialist in the language of preference of the consumer (Spanish or English). Additionally, the GPRA will be administered at intake to establish the baseline, followed by the Coping Behaviours Inventory, (CBI), and the Participant Locator Form (see Attachment 2). This entire process should take approximately 60 minutes. The Dosage Logs (see Attachment 2) will be completed based on staff interaction with consumers on a continuous basis. The IT Dosage Logs will be compiled within the technological system based on electronic interaction with consumers on a continuous basis. And, the Referral Log will be completed each time a client receives and successfully accesses a referral to a service provider. The GPRA and CBI will be administered

again at discharge and 6 months post the baseline. The Satisfaction Survey (see Attachment 2) will be completed upon client discharge. Original copies of the above-mentioned tools will be placed by staff into the consumer's individual files and copies of the completed GPRAs, CBIs, Dosage Logs, Referral Logs and Satisfaction Surveys will be given to the evaluation team to be entered into the appropriate database systems. All the tools are available in Spanish and English.

Table 9. Tools and Frequency of Administration

Tools	Intake	6 Months	Discharge
Informed Consent	X		
GPRA	X	X	X
CBI	X	X	X
Participant Locator Form	X	Ongoing	
Staff Dosage Logs	Ongoing		
IT Dosage Logs	Ongoing		
Referral Logs	Ongoing		
Satisfaction Survey			X
Focus Groups	Annually		

Data Storage, Management: The evaluation team will adhere to strict protocols to insure consumer confidentiality. Specifically, consumers will be assured that any information collected in the evaluation-related interviews will be kept confidential. To this end, all instruments will be individually administered. Consumers will be assigned a unique identification number. Moreover, all files will be kept in locked files and lists with consumer names will be routinely shredded. In terms of data entry, CAR staff will enter the completed GPRAs into the SAMHSA-CSAT web-based system within 7 days of collection; The data collection instruments will be entered into a CAR-created database. CAR operates data entry and management for many of its clients and is skilled in GPRA data entry. CAR creates Access databases for all collected local data. Data will be kept by the RECOVERe Program in a secure file cabinet until such time as it can be transferred to CAR offices. The CAR databases are security protected and only accessible to the evaluation staff. The CSO electronic systems will store the IT Dosage Logs, which are security-password protected. All CAR staff are trained in HIPAA security concerns and security.

Data Quality Assurance: CAR will further assure the quality of data collected and the standard administration of the treatment protocol and procedures through the implementation of a comprehensive Quality Assurance (QA) plan. A QA Plan protects the integrity of the program by maximizing the reliability and validity of the treatments delivered and the measurements conducted. The QA plan will include: development of a program operations manual; user-friendly data forms and question-by-question (QxQ) specification guides clearly linked to the program objectives; management sign-off procedures for all program data forms; central training and certification of data collectors and data managers using standardized quality control checklist; certification of all treatment providers in the treatment procedures; verification of client eligibility; monitoring of protocols, data collection and entry. The team will also control quality of data entry on a regular basis by generating reports to identify and correct responses, internal consistency across questions and outliers.

Data Analysis: During data analysis, the team will use basic descriptive statistics, tables and graphs to describe the participants' demographics (age, race, income and education level), psychosocial characteristics (living condition, criminal history, physical and mental health and prior history of substance use), service use (dosage, referrals etc.) and program status (active, discharged, lost to follow-up) at several points during the treatment process. Having said that, the statistical analyses of client characteristics and standardized outcome measures, which will be conducted using SPSS statistical software, will examine: (1) baseline measurements, (2) multi-trait outcome

measures scales, and (3) longitudinal effects. Statistical methods to be used will include descriptive statistic (frequencies, means, ranges, etc.) cross-tabulations with chi-square tests, t-tests, and analysis of variance. These analyses will assess: (1) selection bias by comparing (a) clients retained in the evaluation and drop-outs, (2) dose response by looking at outcomes in relationship to amount of enhanced services received, (3) relevant subgroup analyses, and (4) Factors related to retention and outcomes by conducting regressions using client-related and other covariates. To enhance the evaluation, client outcomes will also be compared with outcomes measured with the same instruments of similar interventions for similar populations. Finally, descriptive information on activities and processes collected through focus groups, intervention observations, observations during staff program, and clinical meetings, quantitative and qualitative interviews, and program from documents will be documented by the evaluation team. These will provide sufficient documentation of key aspects of the program model so that others may assess the model's appropriateness to similar populations and for replication.

Reporting: The primary objective of the evaluation is to provide information to program staff that is useful to program development and refinement. This objective will be accomplished through regular report to program staff about process data (admission, departures, service delivery, units delivered, barriers to service delivery and staff and client perceptions) and outcome data as available. Baseline data collected in the intake interview will be presented in the form of aggregate participant profiles, service delivery units will be tracked overtime and outcomes of key variables (e.g. drug use, employment, stable housing, criminal involvement, etc.) will be analyzed by participant characteristics and services received. Finally, descriptive information on program components and process gathered from observations, quantitative and qualitative interviews and program documents will provide sufficient documentation of key aspects of the program model so that others may assess the model's appropriateness to other populations and for replication. The evaluation staff will also prepare semi-annual evaluation reports for SAMSHA, and participate in dissemination of findings to others in the field through conferences and national meetings.

Additional Measures and Justification for their Use: All instruments have been used widely among substance-abusing populations. The Coping Behaviours Inventory (CBI) was created by researchers to measure self-efficacy to maintain sobriety. The index asks participants to rank on a four-point scale, ranging from "Usually Stops Me" to "Don't Know", 36 strategies (e.g., telephone a friend, go to an AA meeting, go for a walk) they might use to stop themselves from using drugs.[28] The CBI is justified because it has demonstrated predictive validity for relapse and has been translated into Spanish. The RECOVERe Program will collect Dose Logs from all staff providing services. Dose Logs provide an account of activities undertaken and contacts made by the clinical and case management staff on behalf and with their clients. Each activity/contact is recorded, documenting where the activity took place and the content and length of the discussion. The form also has space for any interesting "street knowledge" learned regarding the community at large, alcohol/drug use, or HIV knowledge and behavior that could inform project referrals, outreach, education, or evaluation. This tool is also used for clinical and supervision purposes. The RECOVERe Program will collect IT Dosage Logs electronically. CSO will integrate the IT Dosage Log in the electronic system in order to document the number of times consumers access a variety of technological treatment settings provided by the program. The evaluation team will also document the number of consumers who are trained on how to effectively use the technology tools. The evaluation team will document the expansion and enhancement technologies that are integrated into the provider infrastructure. Staff will fill in a Referral Log whenever a client is referred to services inside or outside RECOVERe to document when referrals are made and whether or not the client accessed the referral. The Participant Locator Form will also be used to document client

contact information so that enabling staff can be prepared to track hard-to-reach clients for follow up data collection. The Satisfaction Survey is a tool that collects the clients' perceptions of the care that was provided during his/her time with the program. This form is also used as an opportunity to receive direct feedback for the population of focus and use that information to inform program improvement strategies.

The evaluation team will facilitate at least one focus group with consumers annually to gather additional information, enabling the team to have consistent feedback from the population of focus to ongoing program assessment and implementation of quality improvement strategies. The Evaluator will also use an adaptation of the Motivational Interviewing Treatment Integrity Code System or MITI 3.1.1.[29] (see Section D.3 for details). The MITI coding system will be used to rate the fidelity of all technology-based "messages," both the Web site and the mobile phone broadcast content. Evaluation coding will also be shared with frontline staff and senior management on a regular basis, creating a feedback loop that will improve and make more adherent the content of messaging. The evaluation team will attend staff and clinical meetings on a regular basis. This provides information regarding the internal system of the program and an opportunity to give feedback to staff on a regular basis. CAR also encourages and supports project staff participation in all aspects of the work from the design of the evaluation through the implementation of the research and interpretation of the findings and will take an engaged rather than an observing stance.

(Copies of all forms and instruments can be found in Attachment 2 and 3)

2. Assuring Continuous Quality Improvement

The CQI process will begin as soon as the project staff and evaluators come into contact with the data. The team will control quality of data entry on a regular basis by generating interim reports to identify and correct responses, internal consistency across questions and outliers. From the preliminary analysis of the 6-month outcomes to the completion of the final report, CAR will work collaboratively with project staff to interpret the evaluation findings. CAR's approach to the evaluation of the project will be participatory. CAR will encourage and support consumer participation in all aspects of the work from the design of the evaluation through the implementation of the research and interpretation of the findings and will take an engaged rather than an observing stance, eliciting input during the planning phase from staff and clients and providing ongoing feedback during the evaluation phase to inform programming and to permit adjustments. The Evaluator will attend staff and other meetings on a regular basis and solicit input on available data or discuss any concerns the evaluators or the Project may be having. Client focus groups will take place on an annual basis. In Year 3, the Evaluator will present the preliminary evaluation findings to a group of clients and facilitate a discussion of the data's possible interpretation and help the group arrive at a set of recommendations. Additional quality control methods include intensive training, collaboration, and ongoing oversight of the project clinician, case manager, IT staff who will be responsible for collecting data. CAR will be responsible for data cleaning and storage.

3. Performance Assessment

The process evaluation will document the origin, design and implementation of the program and describe the process through which it is implemented. process evaluation will utilize a program case study to examine the following questions: 1) How closely did implementation match the plan? 2) What types of deviation from the plan occurred and what led to it? 3) What effect did deviations have on the planned intervention and evaluation? 4) Who (program, staff) provided what services (modality, type, intensity, duration) to whom (individual characteristics), in what context (system, community) and at what cost (facilities, personnel, dollars)? (5) What strategies maintain fidelity to

the evidence-based practice across providers and interventions (IT or in person) over time? (6) How many individuals were reached through the program?

This case study will document program development and implementation through the use of participant-observation, behavioral observation and program archival data such as meeting minutes, MIS data, participant characteristics and staff dosage, IT dosage, referrals, program costs, and staff turnover. The evaluation team will attend all planning meetings. Using the logic model of program planning, the evaluation team will document (1) the resources dedicated to or consumed by the program (staff and staff time, facilities, equipment, etc.) and constraints on the program (funding requirements, regulations, etc.); (2) what the program does with the resources (inputs) to fulfill its mission (activities); and (3) the direct products of the program activities (the number of sessions provided, number of hours of service, number of participants served).

CAR staff will compare the structure of the implemented program to that proposed in the grant, along with any modifications made during planning phase, regarding resources, the nature of the activities identified and program products. Deviations will be analyzed in the context of program constraints and environmental/systemic factors. Program records, meeting minutes and observation will provide data for this analysis. We will hold key informant interviews with referring partners to get their perspective on program implementation: successes, shortfalls, strengths and weaknesses of the collaborative process, and recommendations for future projects. We will document the evaluation process itself with respect to how program deviations might affect the evaluation design. Using the logic model and a time line format, the evaluation team will document changes made and the resources, activities, inputs and outcomes of those changes on the integrity of the evaluation.

Archival data on program resources and inputs will be used to determine program costs per participant. A separate calculation will be made for costs per "successful" participant, where success is defined as a participant who has maintained satisfactory status (i.e. substance free and other social gains made in program) at follow-up. Collectively, the program case study and the key informant interviews will provide "lessons learned" about the design and effective implementation of this type of substance abuse recovery program for rural adults.

Outcome Evaluation: The outcome evaluation is a structured assessment of the EBP, Motivational Enhancement Therapy, using an adaptation of the Motivational Interviewing Treatment Integrity Code System or MITI 3.1.1.[30] The MITI is a simplified coding system that is intended to be used: (1) as a treatment integrity measure for clinical trials of motivational interviewing and (2) as a means of providing structured, formal feedback about ways to improve practice in non-research settings. The unique piece (adaptation) is that we have talked to experts in the field who have given us guidelines for adapting and using the MITI for front line staff as well as clinicians. For clinicians the coder is looking for competency; the coding is focused on proficiency for Case Managers. The MITI has two components: the global scores and the behavior scores: Global Score: coder assigns a single number from a five-point scale to characterize the entire interaction, with 3.0 to 3.5 a sufficient score for frontline staff as compared to 4.0 and better for clinicians; and Behavior Counts, the coder tallies instances of a particular interviewer behavior, with a one-to-one ratio of MI-adherent behavior being sufficient for frontline staff as compared to a higher ratio for clinicians. The MITI coding system will be used to rate the fidelity of all technology-based "messages," both the Web site content and the mobile phone broadcast content. Evaluation coding will also be shared with frontline staff and senior management on a regular basis, creating a feedback loop that will improve and make more adherent the content of messaging.

The outcome evaluation will include panel study using repeated measurements of intended outcome indicators on the same group over time to estimate net program effects. This design will

also help us to tie treatment intensity to shifts in outcome measures. The evaluation will look in particular at the following questions: related to the goals discussed above in Section B: 1) To what extent did the intervention lead to increased retention? Can specific program components or participant characteristics be linked with successful outcomes? 2) To what extent did the intervention help achieve the six goals outlined in Section B: a) expand service capacity by 150 adults per year, increasing capacity for adults by an estimated 18%; b) increase access to a greater range of substance abuse services, utilizing face-to-face therapy and SBCM with technological tools, including web-based services, video conferencing, and mobile phone support; c) increase retention in and adherence to treatment, again using technological tools that increase use of treatment programming and self-help resources; d) extend aftercare to reduce relapse potential. 3) Have linkage activities improved the delivery of services to this population? The evaluation team will document and report; (1) How many individuals have access and use the technology tools? (2) How many consumers are trained on how to effectively use the technology tools? and (3) How many expanded and enhanced technologies are integrated into the provider infrastructure?

TABLE 10 The RECOVERe Program Quantitative Outcomes Evaluation

Client Measures	Instrument/Data Source	Schedule (Collected by)
1. Demographics (Descriptors and Possible Covariates)	GPRA Client Measures: Demographics	Baseline (Data Collection Specialist - DCS)
2. Substance Use	GPRA Client Measures: Drug and Alcohol Use Questions	Baseline, 6, & discharge (DCS)
3. Mental Health	GPRA Client Measures: Mental/Physical Health Factors	Baseline, 6, & discharge (DCS)
4. Self Efficacy to Maintain Sobriety	Effectiveness of Coping Behaviours Inventory (CBI)	Baseline, 6, & discharge (DCS)
5. Residential Stability	GPRA Client Measures: Family Living Condition factors	Baseline, 6, & discharge (DCS)
6. Criminal Justice Involvement	GPRA Client Measures: Crime and Criminal Justice Status Questions	Baseline, 6, & discharge (DCS)
7. Education, Employment, Income	GPRA Client Measures: Education, Employment, & Income Questions	Baseline, 6, & discharge (DCS)
8. HIV Risk Behaviours	GPRA Client Measures: Injection Drug Use/Sexual Behaviors questions	Baseline, 6, & discharge (DCS)
9. Treatment Dose	RECOVERe Staff Dosage Log; RECOVERe IT Dosage Log	Ongoing (RECOVERe staff and Electronic System)
10. Referral to Service	RECOVERe Referral Log	Ongoing (RECOVERe staff)
11. Satisfaction with Program	RECOVERe Satisfaction Form	Discharge (DCS)

CAR has conducted, analyzed, and provided yearly and final reports of qualitative and quantitative performance assessments for 15 SAMHSA grants over the last 13 years. We attend staff and supervision meetings and are closely engaged in the day-to-day execution of a SAMHSA grant. Our team provides training to staff on how to effectively combine data collection and service provision paperwork. In addition, when appropriate we train staff on how to work across cultures when collecting performance measures. The training includes understanding language, class, cultural, sexual identity, and gender differences that may exist between the Data Collector and his or her client and how to bridge differences through awareness and understanding. Quantitative client outcome data will be collected and analyzed using the GPRA, CBI, Staff and IT Dosage, and the Satisfaction Survey which will be obtained at baseline 6-month and at discharge. CAR will conduct overview training and provide staff ongoing GPRA tracking supervision. CAR's Project Data Manager will check hard copies of the data collection tools for accuracy and completeness and will obtain clarification on missing or ambiguous data from the clinician or case manager.

SUPPORTING DOCUMENTATION

F. LITERATURE CITATIONS

Endnotes

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SECTION G. BUDGET JUSTIFICATION, EXISTING RESOURCES, OTHER SUPPORT

Proposed Project Period

a. Start Date:	09/30/2011	b. End Date:	09/29/2014

Budget Summary

Object Class Category	Year 1	Year 2	Year 3
Personnel	119,510	144,500	144,500
Fringe Benefits	26,292	31,790	31,790
Travel	3,192	3,600	3,600
Equipment	38,000	25,000	25,000
Supplies	1,900	3,000	3,000
Contractual	70,000	53,000	53,000
Construction	0	0	0
Other	21,106	19,110	19,108
Total	**280,000**	**280,000**	**280,000**

Line Item Budget

Personnel:	Level of Effort	Annual Salary	Year One	Year Two	Year Three
Executive Project Director for Technology		85,000	in kind	in kind	in kind
Executive Project Director for Substance Abuse Services		85,000	in kind	in kind	in kind
Project Director/Clinical Coordinator	1.00	50,000	50,000	50,000	50,000
Technology Coordinator	1.00	42,000	34,860	42,000	42,001
SA/MH Clinician	0.50	45,000	14,850	22,500	22,500
Case Manager	1.00	30,000	19,800	30,000	30,001
Total FTEs	3.50		119,510	144,500	144,502
Fringe Benefits	22%		26,292	31,790	31,790
Personnel Total			**145,802**	**176,290**	**176,292**
Direct Costs:					
Travel (SAMHSA related)			2,400	2,400	2,400
Local Travel			792	1,200	1,200
Total Travel			**3,192**	**3,600**	**3,600**
Supplies	3		1,900	3,000	3,000
Total Supplies			**1,900**	**3,000**	**3,000**
Computer Equipment and Servers			10,000	5,000	5,000
Video conferencing equipment and installation	4 locations		28,000	20,000	20,000
Total Equipment			**38,000**	**25,000**	**25,000**
CAR: Project Evaluation			40,000	40,000	40,000

Consultant					
Web site developer and technology support			30,000	13,000	13,000
Total Contractual			**70,000**	**53,000**	**53,000**
Rent/occupancy			4,150	5,000	5,000
Phone/cell phone			900	900	900
Advertising			500	0	0
Printing and Postage			2,056	1,960	1,958
Client incentives			6,000	6,000	6,000
Training			7,500	5,250	5,250
Total Other			**21,106**	**19,110**	**19,108**
TOTAL PROGRAM COSTS			**280,000**	**280,000**	**280,000**

Budget Narrative

A. Personnel

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
(1) Co-Executive Project Director	Peter Woods	$85,000	10%	in kind
(1) Co-Executive Project Director	Joanne Jackson	$85,000	10%	In kind
(2) Clinical Coordinator	Maureen Blackmore	$50,000	100%	$50,000
(3) Technology Coordinator	To be hired	$42,000	100%	$42,000
(4) Case Manager	L.W. Cooper	$30,000	100%	$30,000
(5) Clinicians	Extra hours for video conferencing for a number of SA counselors	NA	20 hours a week	$22,500
			TOTAL	**144,500**

JUSTIFICATION:

1. The Co-Executive Project Directors will provide daily oversight of the grant and will coordinate with other senior staff across program divisions.

2. The Clinical Coordinator will coordinate substance abuse treatment services, case management and project activities, including training, communication, referrals and integrated services (e.g. dual diagnosis).

3. Technology Coordinator maintains and supports information systems in supporting clinical and related services for substance use disorders including participating in the development of tools, training staff and clients and setting up systems for clients.

4. Case Manager assists in accessing support services; makes referral to and advocacy with CBOs on behalf of client; provides substance abuse education and direct connections to Tx, assists set up and train in technology tools; provides extended aftercare. CM assigned to clients without insurance benefits for this service.

5. Clinicians conducts video-conferenced sessions (MET substance abuse treatment and therapy) for program participants – not third party reimbursable.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form SF424A) **$144,500**

B. Fringe Benefits

FEDERAL REQUEST

22% of total salaries, as follows

FICA	7.0%
Unemployment	0.8%
Health and Dental Insurance	9.5%
Long Term Disability Insurance	0.2%
Life Insurance	0.2%
Workers Compensation Insurance	0.2%
Other Employee Benefits	0.1%
Retirement, etc.	4.0%

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF424A) **$176,290**

C. Travel

FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
(1) Grantee Conference	Washington, DC	Airfare	$400/RT flight x 2 persons	$800
		Hotel	$200 night x 2 persons x 3 night	$1200
		Per Diem (meals and incidentals)	$100 day x 2 persons x 2 days	$400
(2) Local travel		Mileage	3,000 miles@.40/mile (2 staff – 1500 miles each)	$1,200
			TOTAL	**$3,600**

JUSTIFICATION:

(1) Two staff (Clinical Coordinator and Technology Coordinator) to attend mandatory grantee meeting in Washington, DC.

(2) Local travel for Technology coordinator to train clients at 4 sites and for a case manager. Local travel rate is based on organization's policies/procedures for privately owned vehicle reimbursement rate@$.40/miles

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF424A) **$3,600**

D. Equipment

FEDERAL REQUEST

Item(s)	Rate	Cost
1. High-end multi-media presentation room used for audio/video conferencing– 2 sites, Screens, projectors, increased band width	$14,000 each site, initial sites ($10,000 each for sites 3 and 4)	$28,000 ($20,000 in out years)
2. Server and installation	$5,000	$5,000
3. 5 Computers	4@ $1000 $1000 for Computer for Tech Coord.	$5,000
	TOTAL	$40,000

1. Video conferencing will be established at 4 sties: the Northampton clinic as the hub, broadcasting to Greenfield, Pittsfield and Athol clinics. Video conferences will include individual and groups sessions and will enable training, clinical supervision and case conferences.

2. The server will be used to create a WAN for the purpose of Web-based treatment applications and personal portals.

3. The laptop computers and software are needed tor create client workstations at each site for the use of treatment-based technology tools.

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF424A) **$ 40,000** (Year one; $25,000 in Years 2 and 3)

E. Supplies

FEDERAL REQUEST

Item(s)	Rate	Cost
Office supplies	3 staff at $1,000 per staff	$3,000
	TOTAL	$3,000

JUSTIFICATION

Office supplies minor office equipment, copies and postage are needed for general operation of the project.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF424A) **$ 3,000**

F. Contractual

FEDERAL REQUEST

NAME	SERVICE	RATE	OTHER	COST
1. Technology Developer: Geode Software	Web site	320 hours at programmer rate of $75 and 48 hours at the project manager rate of $125.		$30,000 Year One; 13,00 Years 2 and 3

2. Center for Addiction Recovery	Evaluation	Various	Personnel $37,147 Travel at $2853 (see breakout below)	$40,000
			TOTAL	$70,000

JUSTIFICATION

1. Technology Development

Technology Developer will develop web and mobile phone functionalities that integrate with one another includes secure messaging, chat room, personal portals and readiness for EHR interface.

GEODE SOFTWARE HOURLY RATE SCHEDULE

Hourly Consulting Rates	
Consultant	**Rate**
Senior Software Consultant/Project Manager	$125
Software Consultant	$100
Applications Programmer	$75

Consulting rates to not include out-of-pocket expenses such as software, equipment, distribution media (such as CD-ROMs), Internet access, travel expenses, etc. All expenses will be billed to the client separately. All consulting hours are billed in quarter hour increments and are rounded up to the nearest quarter hour. For all on-site, hourly consulting, there is a minimum billing of 2 hours, regardless of actual time spent.

2. Evaluator is provided by an experienced individual (Ph.D. level) with expertise in substance abuse, research and evaluation, is knowledgeable about the population of focus, and will report GPRA data.

CAR EVALUATION CONSULTANT ANNUAL BUDGET:

(Salaries include 26% fringe and 14% indirect)

Senior Data Analysis Specialist: Dominique Simon Ph.D. **$ 2, 067**

Job Description: will oversee all phases of the implementation of the evaluation. Her responsibilities include the overseeing of the development of the process and outcome evaluation plans, supervising the development of the program evaluation manual, forms, and procedures, overseeing quality assurance in data collection and management, assisting in writing of the interim and yearly program evaluation reports, facilitating evaluation team meetings, participating in data analysis and supervising CAR staff. Dr. Simon will devote 1% of her time to the project.

Data Analysis Specialist: Marianna L. Litovich Ph.D. **$ 1, 911**

Job Description: will be responsible for the analysis of quantitative and qualitative data that is collected for the RECOVERe project. She is also responsible for reporting the quantitative and qualitative data results for the projects annual and final reports. Dr. Litovich will devote 1% of her time to this project.

Quality Assurance Evaluator: Gwen D Gannon MA **$ 14, 742**

Job Description: will be responsible for the design and implementation of quality assurance mechanisms. She will assist the agency in the development of the process and outcome evaluation plans, collecting process evaluation data and the daily operations of the evaluation. Gwen will also be responsible for the development and implementation of training modules on data collection for the project, in addition to; attending program meetings, attending SAMHSA grantee meetings, writing interim and yearly evaluation program reports, and participating in data analysis. Ms Gannon will devote 13% of her time to the project.

Data Management Staff: Chris Tormanen AA **$ 8, 482**

Job Description: will serve as the Data Manager for this project. His responsibilities include managing the day to day collection of quantitative data, coding, entry and analysis. He will be required to attend evaluation team meetings. Mr. Tormanen will devote 15 % of his time to this project.

Bicultural Bilingual Data Collection Specialist: Anthony Batista AA $ 9, 945

Job Description: will be responsible for working with the project staff to identify and track potential participants for the evaluation study. He will provide data training to agency staff for the administration of the informed consent process, the GPRA tool and additional measures to be collected. He will receive additional training in collecting data and tracking hard to reach clients in order to maximize collection of all quantitative data. Mr. Batista will also attend evaluation planning meetings with the project staff and will devote 17% of his time to the project.

Total Personnel: $37, 147

Other Expenses		Total
Out of Town Travel	$400 round trip airfare, $200 hotel each night for 3 nights $100 per diem for food and ground transportation/2 days $1200.00 one staff per conference-one required	$1200
Local travel	$.505 x 3273	$1653
	Total Other Expenses	**$2853**

TOTAL **$ 40,000**

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF424A) $70,000 (Year One; $53,000 in years 2 and3)

G. Construction: NOT ALLOWED

H. Other:

FEDERAL REQUEST

Item	Rate	Cost
1. Rent	$17/sq.ft x 1667sq. feet (3 staff @ 98 sf each)	$5,000
2. Mobile Phones	$30 pre-paid mobile with minutes – 30 for clients without them @$30/apiece.	$900
3. Client Incentives	$20/client for2 sessions x150 persons in treatment	$6,000
5. Brochures and mailing	$1.00 for printing and mailing brochure X 1900.	$1960
6. Training	$500 per staff for 17 staff Yr 1, $350 yrs 2 and 3	$5250
	TOTAL	**$19,110**

JUSTIFICATION: Break down costs into cost/unit (e.g. cost/square foot). Explain the use of each item requested.

1. Office space is included for 3 staff and calculated as $17/ square foot for 3 staff for a total of 1667 square feet.
2. The mobile phone costs reflect 30 clients who cannot afford cell phones – $30 for phone and pre-paid minutes.

3. The $20 incentive is provided for two GPRA sessions for 150 clients.
4. Advertising to hire into 1 position (Technology Coordinator); 1 ad at $750.

5. Brochures on RECOVERe will be distributed at community events and will mailed community partners and local state offices. Higher costs year One for broader reach across the region .

6. Training for 17 staff at $500 each in Year one and $350 a year in Years 2 and 3. – MI, MET, and related subjects and training and orientation to technology tools used in program. Includes 8 CSP case managers and 9 substance abuse counselors.

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF424A) **$19,110**

TOTAL DIRECT CHARGES:
FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF424A) **$280,000**

INDIRECT CHARGES: none
FEDERAL REQUEST – (enter in Section B column 1 line 6j of form SF424A) ***$0***

TOTALS: (sum of 6i and 6j)

FEDERAL REQUEST – (enter in Section B column 1 line 6k of form SF424A) **$280,000**

14% of the grant is projected to be spent on evaluation and 11 % of grant is project to be spent on infrastructure.

SECTION H. BIOGRAPHICAL SKETCHES AND JOB DESCRIPTIONS

Co-Executive Project Director: Peter K. Woods, LICSW

EMPLOYMENT

8/10-Present Clinical and Support Options, Northampton, MA

Director of Substance Abuse Services

Director of Northampton Outpatient Services

Program development , management and evaluation, clinical supervision DPH licensure, collaboration with state and local agencies, strategic planning, development of policies and procedures, implementation of agency substance use disorder training, coordination of referrals, marketing, utilization review.

2/03-8/10 Cooley Dickinson Hospital, Northampton, MA

Manager, Outpatient Behavioral Health Services

Intensive Outpatient Program Coordinator

Niatx Change Team Leader

DAEP and Second Offender Program Coordinator

Outpatient Clinician

- Clinical responsibilities: Assessment and outpatient individual and group therapy for adolescents, adults and couples experiencing the spectrum of presenting problems from life transitions to major mental illness and addiction. Daily orientation to agency services to new clients, weekly ongoing relapse prevention group for 6 years. Development and implementation of adolescent substance abuse group.
- Administrative responsibilities: Niatx Change Team Leader, program evaluation and development, treatment planning, chart mgmt, coordination of referrals, insurance review, collateral contacts/consultation, scheduling, supervision, marketing, utilization review.
- Coordinating and standarding DAEP and Second Offender Program.

3/02-12/05 Private Practice, Northampton, MA

Clinician

Assessment and treatment of individuals and couples utilizing EMDR, Cognitive Behavioral, Psychodynamic and Solution Focused therapy, and relapse prevention.

5/00-12/05 Divorce Done Differently, Northampton, MA

Clinician/Partner

Assisting partners to dissolve relationships collaboratively towards healthy resolution and sustaining the integrity of mutual interests such as children and assets.

11/00-11/02 DramaWorks, Northampton, MA

Facilitator/Inter-actor

Facilitating workshops using vocal improvisation as a metaphor and means for developing insight and skills related to teamwork. Emphasis on identifying areas of strength and improvement for interpersonal effectiveness in personal and professional relationships. Developing concepts and curricula for national corporate trainings.

3/02-12/02 Providence Hospital, Holyoke, MA

Clinical Social Worker

Inpatient assessment and treatment of patients in the acute phase of mental illness, group and individual intervention utilizing DBT, CBT, Relapse Prevention, Symptom Mgmt and Psycho-

education. Extensive collaboration with community, daily participation in a multi-disciplinary team. Safety Tool Committee.

8/97-2/02 North Central Counseling Services, Enfield, CT

Psychotherapist – Partial Hospital Program

- Clinical responsibilities: Development and facilitation of therapeutic and psycho-educational groups including Dual Diagnosis and DBT skills training, crisis intervention, intake and assessment, treatment planning, case mgmt, individual, couples and family therapy for clients with acute symptoms of a multitude of mental illnesses including psychosis, addiction, trauma, mood disorders, anxiety and personality disorders.
- Administrative responsibilities: Program development, multi-disciplinary utilization review, insurance review, Agency and State Co-Occurring Disorders Committee, supervision, providing training in treatment planning and Dual Diagnosis at multiple agencies.
- Family Violence Educator for male perpetrators of domestic violence.

1996-1997 River Valley Counseling Center, Holyoke, MA

Social Work Intern

Sexual Abuse Treatment Team and Employee Assistance Program

Assessment, treatment planning, individual, couples and family therapy for a diverse population children including children affected by domestic violence and sexual abuse. Organization, implementation and facilitation of life skills group for adolescent boys. Provided Stress Management training at correctional facility.

1995-1996 Providence Hospital, Holyoke, MA

Social Work Intern (see above for description of duties)

1991-1997 Tri-County Youth Programs, Inc., Northampton, MA

Teacher's Aide/Interventionist & Life Skills Teacher (High School)

Counselor and Relief Shift Manager (Residential)

Providing a safe, therapeutic environment conducive to academic and social development, behavior mgmt, development and implementation of treatment education plans, vocational and life skills training, coordination of activities, substitute Art and Academic teaching, documentation, staff supervision and training.

EDUCATION

1995 – 1997 University of Connecticut, West Hartford, CT, Master of Social Work

1986 –1990 University of Massachusetts, Amherst, MA Bachelor of Arts in Psychology; Cum Laude

1985 – 1986 New York University, New York, NY, Tisch School of the Arts

Co-Executive Project Director: Joanne Jackson

Experience

2005 - Present Clinical & Support Options, Inc. Greenfield, MA

Director of Administrative Operations

- Oversee the agency's IT, billing, payroll, facilities, and accounts payable departments and ensure maximum efficiency of administrative operations.
- Responsible for interfacing with technical consultants and vendors on behalf of the agency, and providing billing and other statistical reports to management on a scheduled and ad-hoc basis.

- Assists the CFO in ensuring setup of proper internal controls related to administrative and technological operations, and alerts management to potential problems.

2000 - 2005 Lyon Travel Agency, Inc. Brattleboro, VT
Information Service Manager

- Managed and maintained a network of 75 users, multiple servers, and IS staff.
- Played a major role in the design, installation, and ongoing maintenance of a new 20,000 sq. ft. facility with the placement of new hardware.
- Suggested and designed new software applications for development to increase productivity and replace out dated systems.
- Managed the import process of several client data formats into SQL database for use in a custom written travel management database application.
- Trained and supported staff as new systems were developed and implemented.

1999 - 2000 Lyon Travel Agency, Inc. Brattleboro, VT
Technical Support Specialist

- Supported new custom application for users as well as assisted in the day-to-day network administration. Phone, e-mail, and face-to-face support
- Created training curriculum, materials, scheduled and performed training sessions for staff.
- Assisted with Y2K compliance across company systems.

1997 – 1998 International Software ProductsBrattleboro, VT
Technical Support Specialist

- Supported and assisted users with installation and use of software via phone.
- Traveled for on-site installations, training and system troubleshooting.
- Created training materials and assisted in beta testing software.

1994 - 1997 Phoenix Insurance CompanyGreenfield, MA
Group Policyholder Customer Service Representative

- Serviced customers, communicating verbally and in writing to insurance policy inquiries..

Education
1991 - 1994 Greenfield Community CollegeGreenfield, MA

- A.S., Computer Information Systems
- Continuing studies in Management Information Systems and Administration.

Computer Skills:

- Microsoft Windows NT, Windows 9X, Windows 2000
- Microsoft Exchange 5.5
- Microsoft SQL 7.0, Visual Studio Suite 6, Crystal Reports 8.5
- All Microsoft Office Products
- Repair/maintenance of Macintosh computers. (Diversified Computers, Keene, NH 1999)
- Some experience with web development (HTML, ASP), programming (Visual Basic 6), phone systems (PBX), and Cisco networking products.

Clinical Coordinator: Maureen Blackmore, LICSW

EDUCATION

Dec 1998	University of Connecticut, Hartford, CT Master of Social Work
May 1997	Elms College, Chicopee, MA Bachelor of Arts in Social Work

EMPLOYMENT

Nov 2010 – Present Coordinator, Structured Outpatient Addiction Program, Clinical & Support Options

Dec 2009 – Oct 2010 IOP Substance Abuse Lead Clinician, ServiceNet

August 2003 – Dec. 2009 Baystate Franklin Medical Center

Provide group outpatient substance abuse counseling to clients who are self referred, court referred, or step downs from in patient settings. Co-lead ACT group. Plan, develop and evaluate program activities. Complete psychosocial assessments to determine proper level of care. Perform case management activities, obtain insurance verification and complete utilization reviews with insurance companies.

Sept. 2000 – August 2003 Day Treatment Counselor, River Valley Counseling

Lead dual diagnosis and activity groups for individuals dually diagnosed with mental health and substance use issues. Co-lead DBT groups. Provided assessments, intakes, individual counseling. Coordinated treatment with providers.

April 2000 - Sept.2000 Crisis Team Supervisor, BHN Mount Tom MH Center

Reviewed cases with clinicians and determined appropriate level of care for clients. Interface with other providers.

Jan 1999 - March 2000 CLINICIAN, Community Substance Abuse Center

Completed psychosocial assessments for individuals being admitted into this methadone treatment program. Provided individual and group therapy.

May 1998 - March 2000 CRISIS CLINICIAN, BHN Mount Tom Mental Health Ctr

Jan 1997 - Feb 1998 RESPITE COUNSELOR
BHN Psychiatric Crisis Service, Springfield, MA

May 1996 -Feb. 1998 BHN Mount Tom Mental Health Center, Holyoke, MA

Set guidelines, monitored people in crisis. Provided individual and group counseling, responsible for admissions, discharge summaries and referrals.

INTERNSHIPS SUBSTANCE ABUSE COUNSELOR, Challenges-Providence Hospital,

Sept. 1998 - Dec. 1998 Co-led 5 groups per week for men with substance abuse problems. Did intakes and individual counseling.

May 1998 - Sept 1997 CRISIS CLINICIAN BHN Mount Tom MH Center

Evaluated individuals in hospital emergency departments or in community based settings and determined the level of care that was needed.

Sept. 1996 - Dec. 1996 TRANSITIONAL COUNSELOR, BHN Mount Tom MHCenter

Assisted clients in crisis stabilization with daily functioning, obtained housing, and interacted with mental health and generic services.

OTHER TRAININGS Substance abuse, mental illness, dual diagnosis, DBT certified, DBT weekly & monthly consultation groups, Acceptance and Commitment Therapy (ACT) Motivational Interviewing (MI) & Seeking Safety

LAWRENCE WILLIAM COOPER
30 Charles Street
North Adams, MA 01247
Home phone: 413-664-9703
Work phone: 413-281-5511
e-mail: liamc2@verizon.net

PROFILE Competent and dedicated individual exploring opportunities for personal and professional development in the Mental Health/Substance Abuse treatment field. Excellent communication skills developed during twelve years as business owner. Familiar with conventional and alternative treatment modalities.

EDUCATION **Cambridge College** Springfield, MA
Masters of Education with Concentration in Counseling Psychology
Graduated Spring of 2002

Springfield College Springfield, MA.
Bachelor of Science in Human Services.
Graduated May of 1999

Westfield State College Westfield, MA.
Alcoholism/Substance Abuse Treatment Services Program.
Graduated Spring 1996.

University of Maine Orono, ME.
College of Arts and Sciences
Fall 1970- 1971

PRACTICA **Berkshire Medical Center, Pittsfield MA – Fall 1996**
Completed three-hundred hour internship at Jones-II Inpatient Psychiatric Unit.
Participated in individual and family counseling, group facilitation, substance abuse assessments, and treatment planning.

McGee Substance Abuse Unit, Hillcrest Campus of Berkshire Medical Center.
10/01- 5/02
Counseled clients individually and in large and small groups.
Performed intakes, assessments, participated in treatment and recovery planning and aftercare placement.

EXPERIENCE Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)

Community Support Program (CSP) – 2/08 to present
Clinical case management for 10-16 clients with multiple disorders, psychosocial issues, homelessness, substance abuse, domestic violence, financial instability, lack of supports, and limited knowledge of and/or access to community resources.
Advocate for clients with medical and psychiatric providers, courts and probation, housing authorities, emergency housing providers, for fuel assistance, disability benefits.
Assist clients who have had multiple hospital admissions to develop strategies and interventions for resolving psychosocial crises on an outpatient basis.

Community Enterprises, Inc./Project AIM - 74 North St., Pittsfield MA

Community Social Worker (CSW) – 7/03 to 1/08
Case management for eight clients with multiple disorders.
Created treatment plans, advocated for clients in medical and psychiatric settings, arranged housing, assisted clients to access community resources.
Managed medications and supervised medication administration for all outreach clients.
Facilitated weekly dual-diagnosis groups at agency residential program.
Supervised manager, direct care staff, and interns at residential program.
Supervised agency food bank.

Mental Health and Substance Abuse Services of the Berkshires (Brien Center)
333 East St., Pittsfield, MA

Employed in Residential Direct Care and Community Outreach (DCW-IV). 3/99 – 6/2003
Worked directly with clients with major mental illnesses, assisting them in development of social skills to promote independent living and re-integration into the community. Administered medications, assisted clients with medication compliance as part of Medication Outreach program.

TRAINING/PROFESSIONAL DEVELOPMENT

Berkshire Community College – Therapeutic Nutrition- Spring 1994

Massachusetts Medication Administration Program (MAP) training, June 1999. Recertified in September 2007.

CPR and First Aid certified, November 1999. Recertified September 2006

Dialectical Behavior Therapy (DBT) training, March 2000, July 2004.
Massachusetts Department of Mental Health – Dr. Charles Swenson

Dialectical Behavior Therapy (DBT-S) for Substance Abusing Populations, December 9-10, 2003. Brattleboro Retreat, Brattleboro VT.

Integrating Spiritual and Psychotherapeutic Elements in Counseling Practice: Dr. John Messerschmitt, Berkshire Medical Center, 2/2006

Methadone Treatment and Maintenance: MA DMH, Northampton MA 4/2006

Creative Revolution in Healing - Mind Freedom International
Wisdom House Retreat , Litchfield, CT 7/11 - 7/14 2007

Organizational Biorgraphy

The Center for Addiction Recovery (CAR) has a long history and proven track record in designing and executing culturally and linguistically competent program evaluations utilizing quantitative and qualitative methodologies. Specifically, the team consists of two Ph.D. level Data Analysis Specialist, one Masters level Quality Assurance Evaluator, one Associate level Data Collection Specialist, and two Data Management staff. The team takes pride in having bi-lingual (Spanish/English) capacity, bicultural staff, and all are well known at the community level. Prior to evaluation work, members of the team worked for many years delivering addiction prevention, treatment, and aftercare services. CAR has worked extensively with treatment providers and community agencies allowing them to develop practical experience integrating research activities within service settings. This integration requires balancing evaluation and program concerns, specifically issues concerning the timing and burden of data collection, confidentiality and data storage. CAR draws from its experience evaluating nine SAMHSA CSAT TCE and homeless projects; three CSAP HIV projects; a SAMSHA-funded Effective Adolescent Treatment project; four CMHS projects, two with people who are homeless, one with elderly Holocaust survivors, and the other with Cape Verdean Youth; and a SAMHSA-funded Drug Free Coalition grant. CAR has extensive experience collecting and reporting on required performance measures, and achieving 100% for intake rates, at least 80% follow-up. The two CSAT grants that CAR currently evaluates are demonstrating 90% or better follow-up rates. CAR has consistently met data collection, submission, and reporting obligations in a timely fashion.

CAR Key Personnel

CAR Quality Assurance Evaluator: Gwen D. Gannon

Professional Experience
Center for Addiction Recovery
Montague, MA 01351
October 2005 to Present
Quality Assurance Lead Evaluator

Franklin County Community Corrections Center
Greenfield, MA 01301
October 2004 to October 2005
Woman's Program Director

Service Net
Greenfield, MA 01301
October 2003 to January 2005
Duel Diagnosis Clinician/ SAMHSA Grant

Tobacco Treatment Outreach Project
Greenfield, MA
March 1996 to August 2002
Director

Education

Antioch New England, Keene, NH
Graduated May, 2003
M. A. Applied Psychology, Addictions Concentration

University of Massachusetts Medical School, Worcester, MA
Certification August, 2001
Master Certified Tobacco Treatment Specialist

University of Massachusetts, Amherst, MA
Graduated May, 1995
B. S. Family and Community Services

Greenfield Community College, Greenfield, MA
Graduated June, 1992
A. A. Business Administration

Certifications
Certified GAIN Administrator 2001

Massachusetts C. A. D. A. C. II (pending)

Workshop Facilitation Experience
CSAP HIV Close Out Conference 2008
Close Out Strategies: Transitioning Staff

CSAT HIV TCE Annual Conference 2010
TOPIC: Successful GPRA Tracking and Follow up Strategies

CMHS Supportive Services in Housing Annual Conference 2011
TOPIC: Motivational Interviewing Treatment Integrity Coding System

Training Attendance
Health Education training Institute, May 2011
Motivational Intervewing Treatment Integrity Coding System

SAMHSA/CSAT/CMHS
Treatment for the Homeless: Regional Evaluation Training

CSAT GPRA
Web-Based Data Entry, Reporting System
Tool Administration

CSAP NOMS
Web-based Data Entry, Reporting System
Tool Administration

Internships and Community Volunteerism
The Consortium
Leadership Council

Reinventing Justice
Franklin County Juvenile Board

The Literacy Project
Masters Degree Internship

Pioneer Valley Regional High School
Master Degree Internship

Data Analysis Specialist: Dominique Marie Simon

EDUCATION

- Ph.D., 2001, Anthropology, University of Massachusetts, Amherst, MA
  Dissertation: Women's Social power and Child Malnutrition in Mali
- M.A., 1996, Development Anthropology, Binghamton University, Binghamton, NY
  Thesis: African Labor Migrancy, AIDS, and Women
- M.A., 1995, Public Health, University of Massachusetts, Amherst, MA
- B.A., 1991, African Studies, McGill University, Montreal, PQ, Canada, Faculty Scholar 1988-1990
  Thesis: The Privatization of Health Care in Africa
- A.A., 1979, Marketing, Strayer College, Washington, DC, Academic Honors

RESEARCH EXPERIENCE

Data Analysis Specialist: *Center for Addiction Recovery, Montague MA, 2003 to present.*

Senior Researcher, *Health and Addictions Research, Inc., Boston, MA, 1998 to 2003.*

Research Analyst, *Study of AIDS Counseling and Testing Services, Boston University, School of Public Health, Boston, MA, May through December 1997.*

Site Director, *Women's Social Networks and Health, Mali, West Africa, Center for Population and Development Studies, Harvard University, 1996 to 1998.*

Principal Investigator, *Migrant Farmworkers in the Connecticut Valley: Needs Assessment, May through December 1995.*

Evaluator, *School of Public Health, Partners for Public Health Project, May through December 1994.*

Evaluator, *School of Public Health, Northern Berkshire Neighbors Project, North Adams, MA, Spring 1994.*

Research Assistant, *Binghamton University, National Science Foundation Grant: Biocultural Dimensions of Pain, 1992-1993.*

Evaluator and Researcher, *Rural Development Associates, Tanga, Tanzania, 1990-1992.*

SUCCESSFUL GRANT APPLICATIONS

2001 Substance Abuse and Mental Health Services Administration, Targeted Capacity Expansion Grant, $2,500,000.

2001 Blue Cross and Blue Shield Foundation of Massachusetts, Children's Mental Health Integration Grant, $160,000.

2003 Substance Abuse and Mental Health Services Administration, Targeted Capacity Expansion Grant, $2,000,000.

2003 US Conference of Mayors, HIV Prevention Grant, $60,000.

2004 US Conference of Mayors, HIV Prevention Grant, $60,000.

2004 Substance Abuse and Mental Health Services Administration, Targeted Capacity Expansion Grant, $2,000,000.

2004 Blue Cross and Blue Shield Foundation of Massachusetts, Catalyst Grant, $2,500.

2005 Community Foundation of Western Massachusetts, $3,000.

2006 Substance Abuse and Mental Health Services Administration, Elderly American with Mental Illness Grant, $1,200,000.

2006 Substance Abuse and Mental Health Services Administration, HEP C/HIV/Substance Abuse Prisoner Reentry Grant, $1,500,000.

SELECTED PUBLICATIONS

Adams, Alayne, Sangeetha Madhavan, Dominique Simon, Under Review. Measuring Social Networks in Cross-cultural Settings, Social Science and Medicine.

Adams, Alayne, Dominique Simon, Sangeetha Madhavan, 2004. Women's Social Support Networks and Contraceptive Use in Mali in *The Power of Informal Networks: Lessons in Social Change from South Asia and West Africa,* Lexington Press

Madhavan, Sangeetha, Alayne Adams, Dominique Simon. 2003. Women's Networks and the Social World of Fertility Behaviour, International Family Planning Perspectives, June, 29, 2, 58-68.

Simon, Dominique, Sangeetha Madhavan, Alayne Adams. 2002 Women's Social Power and Child Malnutrition in Mali, *Journal of Biosocial Science*, 34, 193-213.

Adams, Alayne, Dominique Simon, Sangeetha Madhavan. 2004 "Women's Social Support Networks and Contraceptive Use in Mali," *The Power of Women's Informal Networks*, Lexington Books, Oxford, 31-46.

Adams, Alayne, Sangeetha Madhavan, Dominique Simon. 2002 Women's Social Networks and Child Survival in Mali, *Social Science and Medicine,* 54, 2, 165-78.

Simon, Dominique, Nina Kammerer, Mary Brolin. 2001 *Final Evaluation Report Dual Diagnosis Demonstration Project*, Massachusetts Department of Public Health, Bureau of Substance Abuse Services.

Simon, Dominique, Nina Kammerer, Ellen Stewart, Mary Brolin. *2001 Final Evaluation Report Relapse Prevention Management Demonstration Project*, Massachusetts Department of Public Health, Bureau of Substance Abuse Services.

Simon, Dominique, Nina Kammerer, Mary Brolin. *2001 Final Evaluation Report Community Housing Demonstration Project*, Massachusetts Department of Public Health, Bureau of Substance Abuse Services.

Simon, Dominique, Nina Kammerer. 2000 *Evaluation of Demonstration Projects Year-End Report Dual Diagnosis,* Massachusetts Department of Public Health, Bureau of Substance Abuse Services.

Simon, Dominique, Nina Kammerer. *1999 Evaluation of Demonstration Projects Year-end Report Community Housing*, Massachusetts Department of Public Health, Bureau of Substance Abuse Services.

Simon, Dominique, Nina Kammerer. *1999 Evaluation of Demonstration Projects Year-End Report Dual Diagnosis,* Massachusetts Department of Public Health, Bureau of Substance Abuse Services.

Amaro, Hortensia, Keri Conron, Kyoko Pena, Dominique Simon, Catherine Riessman. 1997 *Study Report: Clients of MDPH Funded Agencies who Present Frequently for HIV Counseling and Testing,* Boston University School of Public Health, Boston.

Simon, Dominique, Hillary Koziol. 1997 Translation from the French *Societies and Nature in the Sahel,* 350 page monograph by Claude Raynaut, Routledge/SEI Global Environment and Development Series, Stockholm Environment Institute, Stockholm.

Simon, Dominique. 1995 *Migrant Farmworkers in the Connecticut Valley: Health Needs Assessment,* The New England Community Health Center Association.

Simon, Dominique. 1990 *Treating Symptoms Related to AIDS in Tanzania, Results of a Literature Search on Seven Indigenous Plants*, Danish International Development Agency.

JOB DESCRIPTIONS

Title: Director of Administrative Operations, Co-Executive Project Director

Summary of Duties To oversee the agency's billing, payroll, accounts payable and IT departments and ensure maximum efficiency of administrative operations. The Director of Administrative Operations is responsible for interfacing with technical consultants and vendors on behalf of the agency, and providing billing and other statistical reports to management on a scheduled and ad-hoc basis. The Director of Administrative Operations also assists the CFO in ensuring setup of proper internal controls related to administrative and technological operations, and alerts management to potential problems.

Job Responsibilities:

1. Supervise and oversee agency's day-to-day operations related to third party billing, payroll, accounts payable and IT functions.
2. Provide oversight and internal control for all billing processes, ensuring timely turnaround for all claims; supervise staff in proper use of electronic systems and billing procedures; develop and revise systems, and make recommendation regarding process improvements to ensure maximum efficiency and collections.
3. In coordination with Billing Manager, ensure proper identification of uncollectable receivables, preparation of write-off authorizations, and proper posting to billing system.
4. Oversee payroll activity to troubleshoot problems; ensure accuracy of payroll data; and ensure that forms related to payroll information are input timely and accurately into payroll system.
5. Oversee and supervise network administration to control access to computer systems and to maintain security and compliance with technology usage policy; make recommendations to CFO and CEO on agency's technology needs and related benefits, options and cost analyses.
6. Oversee maintenance of all computer systems, hardware, and software for the agency.
7. Work with software vendors to resolve problems and to develop new reports as needed.
8. Negotiate and oversee leasing, service, and purchase agreements for all organizational electronic devices, office equipment, telecommunication hardware and software or other items as requested by CFO.
9. Possess working knowledge of all agency software including billing and payroll systems, and ensure staff have appropriate training and supervision to utilize such software/systems with maximum efficiency.
10. Ensure proper creation and maintenance of reports as required to satisfy needs of organization.
11. Work on special projects related to department as requested by CFO or CEO.
12. Conduct interviews for vacant positions within the departments; work with HR to recommend personnel actions as required, including hiring, transfers, promotions, discipline, or dismissal.
13. Provide ongoing supervision to administrative staff and ensure regular departmental supervision meetings occur.
14. Attend staff and Senior/Agency Management meetings as directed/scheduled.
15. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.

16. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation as an added value member of the Senior/Agency Management team; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
17. Communicate regularly with staff on progress toward defined goals of Senior/Agency Management team; complete and conduct annual performance evaluations in a timely fashion, providing specific feedback and work with HR to initiate corrective action when defined goals and/or required results are not met.
18. Motivate staff to embrace the philosophies and goals of the Senior Management team.
19. Perform other duties as assigned by supervisor.

Qualifications: College degree in a related area of study or equivalent experience, and three years' management and supervisory experience in MIS and billing, preferably in behavioral health or related field. Working knowledge of electronic billing and payroll software/systems in addition to the ability to work with email and word processing software. Excellent oral and written communication skills. Ability to work independently and follow through with projects. Ability to perform multiple tasks and assignments over an extended period of time; understand and relate ideas and concepts; and identify and prioritize issues in a responsible manner. Ability to function effectively as a member of the Senior/Agency Management team with demonstrated collaborative, cooperative, supportive and flexible attitude. Must possess valid driver's license and reliable transportation.

Title: Clinic Director, Northampton Outpatient Services and Director of Substance Abuse Services, Co-Executive Project Director

Purpose: To provide clinical and administrative leadership for the Northampton Outpatient Program and agency-wide Substance Abuse programs, including all Northampton OP services, Medication Clinic, START Program, DAE, Second Offenders Program, and any related contract services; oversee day-to-day operations, fiscal management, and program planning, development and evaluation.

Job Responsibilities:

1. Supervise the day-to-day operations of the outpatient clinical program.
2. Provide administrative and clinical supervision for all clinical staff, including weekly monitoring and management of productivity levels.
3. Develop and supervise day-to-day operations of all substance abuse programming at BSAS-licensed sites.
4. Monitor staff scheduling and clinical caseloads to maintain quality service to consumers, while maintaining expected productivity levels and including appropriate and efficient use of office space.
5. Develop and implement management systems that maximize staff productivity and efficient service delivery.
6. Provide clinical and administrative oversight of licensing process for all agency BSAS-licensed sites, including assessment and development of substance abuse programming capacity within CSO programs and addition of BSAS licenses at other CSO sites.
7. Participate in ongoing meetings with DPH, DCF, DMH, local school personnel, other providers and relevant association and community coalitions/substance abuse meetings, etc. to develop and maintain positive working relationships and to maintain effective service delivery.

8. Represent or ensure representation of CSO at ABH substance abuse committee meetings; ensure integration of best practices, updated policies or statewide initiatives from such subcommittees within CSO substance abuse programs.
9. Ensure evaluation and outcomes measures are consistently performed and evaluated, including consumer satisfactions, TOPS, CANS etc.
10. Develop assessment and treatment forms and agency protocols for all substance abuse programming, ensuring regulatory compliance.
11. Oversee and develop substance abuse contracts and responses to RFRs together with other team members; ensure substance abuse contracts are appropriately utilized and billed out by fiscal year end.
12. Participate in contract negotiations and implementation with the Executive Team, as required
13. Oversee and coordinate the intake and referral process and the scheduling of psychiatric providers.
14. Participate in the Multi-disciplinary Review Team and coordinate the activities of the utilization review process.
15. Provide probationary and annual staff performance evaluations.
16. Participate on the agency's Management Team and participate in regular management meetings as required.
17. Identify in-service training needs and arrange for them to be met, in coordination with the Director of Outpatient Services.
18. Meet regularly with the Director of Outpatient Services for supervision.
19. Monitor budget and ensure monthly target productivity is met. Work with supervisor monthly to evaluate necessary staffing patterns.
20. Monitor compliance with requirements of managed care companies and other payors.
21. Participate in agency-wide Quality Management Plan, including active development and implementation of program specific Quality Assurance/Quality Improvement goals.
22. Monitor contractual obligations and ensure that programmatic and fiscal obligations are being met.
23. Participate in budget planning process; review finance reports monthly with supervisor; participate in quarterly budget review meetings with Executive Team and make recommendations to ensure programs are meeting budget expectations.
24. Participate in recruitment, hiring, and training of program staff, in coordination with supervisor. Make disciplinary/corrective action personnel recommendations to supervisor, and follow through on any approved corrective action plans with staff.

Qualifications: Clinical Master's degree or Doctorate with five years' experience in treatment of children, adolescents, adults, and families, mental illness, and the developmentally disabled; extensive knowledge of outpatient programs; at least three years supervisory and management experience, including fiscal management (monitoring of state contracts and commercial insurances and monitoring of program budgets) and supervising staff; extensive knowledge of DSS, DMH and DPH; experience with Utilization Review and Quality Improvement; grant writing skills. Prior experience in Substance Abuse program management required. Excellent clinical, interpersonal, organizational and administrative skills. Computer proficiency including ability to work with email and word processing software required. Must hold valid independent clinical license in Massachusetts.

Title: Technology Coordinator, RECOVERe

Summary of Position: To maintain and support management information systems in supporting clinical and related services for substance use disorders including participating in the development of tools, training staff and clients and setting up systems for individual clients.

Job Responsibilities

1. Maintain RECOVERe management information systems including individual computers, computer systems, network servers, Web site, email, phones, and related hardware/software.
2. Work closely with RECOVERe direct care staff and managers to gather necessary information, troubleshoot, and resolve software or hardware problems in a timely and effective manner.
3. Train staff regularly on how to use information systems technology, including the use of secure email, electronic timesheet system, intranet, mobile phones, video conferencing system and various other software programs as appropriate.
4. Coordinate with Administrative Director and network consultant on necessary interfaces with EHR installation and interoperability functions.
5. Support staff and client in the proper and efficient use of all RECOVERe technological tools and systems.
6. Monitor and remain current on the newest software and hardware available for use by the program.
7. Ensure appropriate documentation is submitted, coded, and filed in support of all purchases.
8. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and clients.
9. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
10. Other administrative tasks as needed, including computer input and administrative support.

QUALIFICATIONS: Proven computer and Information Technology skills required; a degree in a computer/MIS field is preferred. Must be able to set goals and meet deadlines, and be able to work independently. Must possess good organization and interpersonal skills, and the ability to handle situations in a professional manner at all times with clients, staff and external sources. Must be able to handle multiple tasks and a variety of people at the same time and as part of a team. Valid drivers' license and reliable transportation required.

Title: Clinical Coordinator, RECOVERe

Summary of Position: Responsible for coordinating all aspects of the substance abuse programs as well as coordinating other group therapy services, ensuring high quality program delivery.

Job Responsibilities

1. Plan, develop and evaluate program activities and services to meet program goals.
2. Plan, develop and evaluate group therapy activities and services.
3. Provide supervision of counseling personnel to include participation in therapy sessions, consultations regarding specific cases, regular counseling, and HIV/AIDS and hepatitis

education. Ensure adequate coverage for psycho-educational and group therapy portions of program, as well as intake activities on a daily basis.

4. Perform or coordinate intakes for RECOVERe program participants within 48 hours of referral, ensuring all needed information is obtained. Complete and / or coordinate assessments on all new referrals, including diagnostic assessment as well as development and documentation of the treatment plan.
5. Provide confidential HIV risk assessment and access to counseling and testing.
6. Develop and implement agency's ADA/504 self-evaluation and annual updates.
7. Perform case management activities to maximize program compliance.
8. Coordinate SOAP insurance verification process and obtain insurance authorizations when required to ensure payment of services; provide appropriate service planning for HIV positive clients.
9. Market and represent program to referral sources including community agencies, court services, DPH, and other social service agencies.
10. Survey referral sources and participants to assess satisfaction levels; utilize survey data in quality improvement efforts.
11. Ensure all documentation required by law and accrediting agencies is completed within required timeframes.
12. Maintain professional growth and development through attendance at seminars, workshops, conferences or in-services, professional affiliations or journals to stay abreast of current trends in field of expertise.
13. Attend staff and Agency Management meetings as directed.
14. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.
15. Attend all scheduled individual and group supervision.

Qualifications: Master's or Doctoral degree in one of the following disciplines: clinical psychology, education counseling, psychiatric nursing, rehabilitative counseling or social work required. Certification in a substance abuse discipline preferred. Licensure in the Commonwealth of Massachusetts as an independent practitioner or the ability to obtain a license within six (6) months of appointment to position required. Failure to obtain license within six months of appointment will result in forfeiture of position. Current CPR certification required. Certification in substance abuse counseling preferred. Three (3) years of supervised substance abuse counseling, mental health counseling and psycho-education experience required. Program management experience is highly desirable. Be an effective member of a Team. Demonstrated sensitivity to the needs of families from diverse cultural or linguistic backgrounds.

Title: OUTREACH WORKER, COMMUNITY SUPPORT PROGRAM (CSP)

Purpose: To provide intensive, clinical case management to adults with serious mental illness and/or substance use disorders needing such support to maintain their independence in the community, or who have been hard to engage in the mental health system. Services will be provided on an outreach basis and may be provided in a supported living site, apartment, or family home. The Outreach Worker may be assigned to a supported home where s/he will have regular contact with residents. The Outreach Worker will also provide support services for family members and others in the "natural helping network."

Responsibilities:

1. Provide skills training and assistance in areas of daily living activities including transportation, money management, cleaning, laundry, food preparation, personal grooming, and health care.
2. Assist with advocacy needs; facilitate "mediation" as appropriate.
3. Provide assistance in identifying and obtaining entitlements, which meet consumer's needs.
4. Provide counseling and intensive support to consumers during psychiatric crises or periods of transition.
5. Assist consumer with identifying appropriate substance abuse, mental health and medical services and accessing services of choice.
6. Provide assistance with developing and maintaining a "natural support network" of family and friends.
7. Assist in locating acceptable housing, negotiating leases, and obtaining furniture and other necessary fixtures;
8. Assist consumer in maintaining the appropriate upkeep of apartment that will ensure healthful and safe living. When needed, assist in contacting landlords to make needed repairs.
9. Assist consumer in negotiating relationships with roommates, landlords, and others.
10. Coordinate development of meaningful day activities, including clubhouse participation, schooling, employment, or volunteer activities.
11. Assist with finding or developing recreational and social activities of the consumer's choice;
12. Provide transportation for consumers as appropriate, following program guidelines.
13. Maintain appropriate contacts with family members, others in the "natural helping network," DMH case managers, outpatient therapists, and others as necessary to support consumers.
14. Develop a proactive working relationship and team concept with MBHP Case Manager, establishing a single point of contact for coordination, communication and follow up
15. Participate in team discussions regarding program consumers in order to provide back up for other team members as needed.
16. Participate in design, review, and revision of Program Specific Treatment Plans with consumer, family members, and other providers.
17. Participate in weekly team meetings, ISP meetings, inter-program and inter-agency case conferences, and other interactions with other providers to promote integrated consumer services. Receive supervision on a regular basis.
18. Maintain neat, accurate, and timely records in accordance with agency policies and procedures along with all regulatory bodies.
19. Comply with all applicable agency clinical and administrative protocols.
20. Attend in-service training as required.
21. Perform other duties as assigned by the Program Coordinator.

Qualifications: Bachelor's degree in a mental health discipline required. Experience treating individuals with a serious mental health illness and/or substance use disorders strongly preferred. Must have excellent oral and written communication skills, and computer competency. Must be able to work independently and follow through with projects. Must possess valid driver's license and reliable transportation.

SECTION I. CONFIDENTIALITY AND SAMHSA PARTICIPANT PROTECTION (SPP)

Protection of Participants and Staff from Potential Risks

The Center for Addiction (CAR), the Evaluation firm conducting the RECOVERe program evaluation, will practice due diligence to protect clients from potential risks.

Risks

The foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects of participation in The RECOVERe Program arise from the subject matter addressed in the interviews and from the fact that the Data Collection Specialist is a mandated reporter. Clients in the evaluation interviews will be asked questions about their substance use and about their perceived self-efficacy in reducing or eliminating drug use and injection use practices. Any of these questions might cause distress. Clients in these interviews might also reveal information that an interviewer is mandated to report. Additionally, the Data Collection Specialist visiting a client for an interview outside the provider setting, such as an emergency shelter or private home, might witness an instance of child, elder, or disabled persons abuse that would have to be reported.

Clients who agree to take part in the evaluation will be informed that their participation is unlikely to cause them physical harm, but that the topics to be addressed in standardized interviews may be sensitive. The informed consent form clearly states that a participant has a right not to answer any questions, and that all information gathered will be treated in the strictest confidential manner except when mandated by laws. In addition, the informed consent form clearly states that a participant can withdraw from the evaluation at any time. In no cases will clients be denied services if they elect not to participate, decline to answer a given question, withdraw from participation, or withdraw from any component of the evaluation.

The Data Collection Specialist who will be conducting the interviews will be trained to handle a participant who might experience emotional distress during an interview. The Data Collection Specialist will also offer to immediately contact the client's clinician, should that be preferable to the client.

Fair Selection of Participants

The target population consists of men and women who are 18 years of age or older and who are substance users. If the client agrees to take part in the evaluation, the Data Collection Specialist will describe the evaluation and request an informed consent from the client. The choice of whether or not to be part of the evaluation is up to the client.

Absence of Coercion

No client will be mandated by a court to participate in the evaluation. Participation in the evaluation will be entirely voluntary. A client will not lose any services if s/he chooses not to enter or withdraws from the evaluation. To enter the evaluation, a client must willingly give her/his written consent, signing an informed consent form. As part of the informed consent process to enter the evaluation, the Data Collection Specialist will review the informed consent form with the client, give her/him time to read it on her/his own, and ask questions to make sure that s/he understands its contents before asking the client to decide whether or not to sign. Each signed informed consent form will be witnessed by the Data Collection Specialist. Each client will be given a copy of her/his signed consent form, which contains contact information for the

study's Project Director, Karen Jeffers; and the Data Analysis Specialist, Dr. Dominique Simon, so that s/he may call any of them should s/he have any questions about the study or rights as a participant.

Participants in the target population will be compensated for their time with a $20 grocery store gift certificate after each of the follow-up interviews. This rate of pay is approximately $10 an hour, which is not likely to be coercive because it is in line with the current wage structure.

Appropriate Data Collection

The Data Collection Specialist will collect the interview data from clients. The Data Collection Specialist will also be instructed to collect collateral names and phone numbers to facilitate participant tracking. The specific data that the Data Collection Specialist will collect at baseline and through follow-up interviews from the participant are: (1) drug and alcohol use, (2) employment situation, (3) financial support, (4) legal situation, (5) new treatment episodes, and (6) risky sexual behavior. These data will be collected using the GPRA. Additional data to be collected will utilize the Coping Behaviours Inventory (CBI), an index with a four-point scale, ranging from "Usually Stops Me" to "Don't Know", 36 strategies (e.g., telephone a friend, go to an AA meeting, go for a walk) they might use to stop themselves from using drugs. Satisfaction with services is collected at 6 months and at discharge. A unique participant identification number will be created for each participant, which will appear on all completed instruments.

Evaluation records that will contain a client's name include the Participant Locator Form, the Informed Consent Form, and master logs that record participants' identification numbers. Interview protocols completed by Data Collection Specialist will only contain the client's identification number. All records on participants in the evaluation will be stored in locked file cabinets.

Privacy and Confidentiality

The first obligation of the Evaluation is to maintain clients' privacy and confidentiality, except in instances for which reporting is mandated.

The Data Collection Specialist will complete the federal training on confidentiality and protection of human subjects that is available on the internet. He/she will sign a document pledging to protect the confidentiality of participants.

Completed interview protocols will be identified by the date, the client's identification number, and the Data Collection Specialist's name.

The Data Collection Specialist will use a unique identification number for each client. The Data Collection Specialist will maintain a master log on which each participant's name is linked to the identification number.

Data will be entered into SAMHSA's web-based databases or ACCESS database at CAR. Access to these databases will be password protected and limited to selected evaluation staff.

After a participant has consented to enter the evaluation, the Data Collection Specialist will ask for information about how to contact him/her for follow-up interviews. The Participant Locator Form will have space in which to write down any information the client gives about what name s/he prefers and how the Data Collection Specialist should self-identify. If someone

other than the client should answer the phone, the Data Collection Specialist will only self-identify by first name and phone number. The Data Collection Specialist's phone answering message will only include first name. It will make no mention of the RECOVERe Program Evaluation.

In summary, the procedures the RECOVERe Program evaluation will follow to protect the confidentiality of clients include the following: only authorized staff have access to records; all records are kept in locked file cabinets; identification code numbers are assigned to all subjects; and no identifying information is kept on data collection forms, with the exception of the Informed Consent Forms; Participant Locator Forms, maintained for the purpose of tracking clients for follow-up interviews; and master logs that record clients' identification numbers. In reporting and publishing findings, no personal identifiers will be used.

Adequate Consent Procedures

Participation in the Evaluation is voluntary. The Informed Consent Form for the evaluation clearly states the client's rights to leave the evaluation at any time without losing the services s/he is receiving, choose not to answer any question, stop an interview at any time, and withdraw from the evaluation at any time. It also makes clear that the Data Collection Specialist is mandated to report child, elder, or disabled person's abuse and if the client is in immediate danger of suicide or threatens to harm someone else.

Since clients may not remember their rights or the Data Collection Specialist's mandatory reporting obligations, the introduction to each follow-up interview will repeat this information.

All clients will receive a copy of their Informed Consent Form, which includes contact information for the Project Director and Evaluator.

All clients will be informed that no identifying information will be included in any oral or written reports.

Risk/Benefit Discussion

Clients in the evaluation will be told by the Data Collection Specialist that the purpose of the evaluation is to assess the RECOVERe Program services. The knowledge gained from this evaluation is expected to be useful in advancing ways of developing a comprehensive model for serving adults with substance problems in rural areas with technological treatment tools.

We do not anticipate major risks to either the physical or psychological health of clients. Risk in the form of psychological discomfort brought on by thinking or talking about drug use, injection drug use, and safe sex is possible.

Possible benefits to clients in the evaluation are that some of the questions and discussions may help them clarify the ways in which they still may or may not be at risk for drug abuse or STD infections. In addition, participation in the study may afford an opportunity to help inform the development of services to individuals like themselves. Moreover, participants may appreciate the chance to contribute to knowledge that improves services for adults suffering from substance abuse problems.

ATTACHMENTS

ATTACHMENT 1

1) Experienced, licensed service provider organization: Clinical and Support Options. Inc., in operation for 50 years as a behavioral multi-service agency, licenses include outpatient mental health clinic and outpatient substance abuse clinic.

(2) **Applicant agency:** Clinical and Support Options. Inc.

Partners: None that are subcontracted; referrals only.

(3) the Statement of Assurance

Statement of Assurance

As the authorized representative of Clinical and Support Options, Inc., I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in Appendix 1 of the application, that has agreed to participate in the project;

- official documentation that the applicant organization participating in the project has been providing outpatient mental health and/or other behavioral health services for individuals with SMI for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and

- official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

Karen [illegible]
Signature of Authorized Representative

5/27/2011
Date

(4) Letters of commitment/support and Memorandum of Agreement

06/07/2011 15:30 413-445-5404 BERK CHILD+FAMILIES PAGE 02/02

Berkshire Children & Families
480 West Street
Pittsfield, MA 01201

Invest in a sustainable future for young children, their families and our community

Berkshire Children & Families

June 1, 2011

Karin Jeffers, CEO
Clinical and Support Options, Inc.
215 Shelburne Road.
Greenfield, MA 01030

Re: TCE-Health IT: SAMHSA TI-11-002

Dear Karin:

Berkshire Children and Families is extremely pleased to support Clinical and Support Options' proposal to the Substance Abuse and Mental Health Services Administration for a grant to fund innovative technology tools for the residents in rural areas of Berkshire County, Franklin County and North Quabbin communities who suffer from substance use disorders.

Berkshire Children and Families is a long time advocate for services that promote the health and well being of our communities. We believe that it is imperative to combine treatment and community support for our clients who have become isolated and have little practical access to the range of services that meet their needs. This project will provide the necessary resources to move forward to benefit the collective health of our entire community by addressing the serious issue of access to substance abuse treatment and recovery support.

Berkshire Children and Families has been providing family support, child care, foster care and adoption for over 124 years and served many people suffering from substance abuse disorders. The opportunity that this project represents will build on our existing relationship with Clinical and Support Options and other local agencies. Collaborative efforts will begin to address the needs of our low income and at-risk families and individuals to address behavioral health issues that stand in the way of their and their families well being.

Berkshire Children and Families supports this application and will work with CSO on the project to ensure that treatment and support are accessible to residents in need. Please contact me if you would like any additional information regarding our support and commitment to the success of this application.

Sincerely,

Carolyn Mower Burns
President and CEO

phone: 413.448.8281 toll free: 888.742.7443 fax: 413.445.5404

A United Way Agency

06/08/2011 11:01 FAX 9785750474 NQCC 001

NQCC

June 1, 2011

Karin Jeffers, CEO
Clinical and Support Options, Inc.
215 Shelburne Road.
Greenfield, MA 01301

Re: TCE-Health IT: SAMHSA TI-11-002

Dear Karin:

North Quabbin Community Coalition is extremely pleased to support Clinical and Support Options' proposal to the Substance Abuse and Mental Health Services Administration for a grant to fund innovative technology tools for the residents in rural areas of Berkshire County, Franklin County and North Quabbin communities who suffer from substance use disorders.
North Quabbin Community Coalition is a long time advocate for services that promote the health and well being of our communities. We believe that it is imperative to combine treatment and community support for our clients who have become isolated and have little practical access to the range of services that meet their needs. This project will provide the necessary resources to move forward to benefit the collective health of our entire community by addressing the serious issue of access to substance abuse treatment and recovery support.

North Quabbin Community Coalition has been providing community support services for over 27 years. North Quabbin Community Coalition has taken the lead has been a tireless advocate for region at the local, state and national level. The opportunity that this project represents will build on our existing relationship with Clinical and Support Options and other local agencies. Collaborative efforts will begin to address the needs of our low income and at-risk families and individuals to address behavioral health issues that stand in the way of their and their families well being.

North Quabbin Community Coalition supports this application and will work with CSO on the project to ensure that treatment and support are accessible to residents in need. Please contact me if you would like any additional information regarding our support and commitment to the success of this application.

Sincerely,

Rebecca J. Bialecki, PhD
Executive Director

427 Main Street, Athol, MA 01331
Ph: (978) 249-3703 Fx: (978) 575-0474
www.nqcc.org info@nqcc.org

Working to improve the quality of life in the North Quabbin region for over 25 years

June 1, 2011

Karin Jeffers, CEO
Clinical and Support Options, Inc
215 Shelburne Road
Greenfield, MA 01301

Re: TCE Health IT, SAMHSA TI-11-002

Dear Karin

The western regional office of the Massachusetts Behavioral Health Partnership (MBHP) is pleased to support Clinical and Support Options' proposal to the Substance Abuse and Mental Health Services Administration for a grant to fund innovative technology tools for the residents in rural areas of Berkshire County, Franklin County and North Quabbin communities who suffer from substance use disorders

MBHP is a long time advocate for services that promote the health and well being of our communities. We believe that it is imperative to combine treatment and community support for our Members who have become isolated and have little practical access to the range of services that meet their needs. This project will provide the necessary resources to move forward to benefit the collective health of our entire community by addressing the serious issue of access to substance abuse treatment and recovery support

MBHP has been working with mental health and substance abuse treatment providers in the region and state for over 15 years, advocating for coordinated and accessible services at the local, state and national level. The opportunity that this project represents will build on our existing relationship with Clinical and Support Options and other regional agencies. Collaborative efforts will begin to address the needs of low income and at-risk families and individuals to address behavioral health issues that stand in the way of their and their families well being

MBHP supports this application and will work with CSO on the project to continue to ensure that treatment and support are accessible to residents in need. Please contact me if you would like any additional information regarding our support and commitment to the success of this application

Sincerely,

Linda Trott, Regional Director

489 Whitney Avenue • Third Floor • Holyoke, MA 01040 • 413/322-1800 • Fax: 413/322-1810

ATTACHMENT 2: DATA COLLECTION INSTRUMENTS/INTERVIEW PROTOCOLS

The Effectiveness of Coping Behaviours Inventory (CBI)

INSTRUCTIONS: If there are times when you want to start drinking again, how do you try to stop yourself? Here is a list of ways some people have tried to stop themselves from drinking. We would like you to tell us how well each strategy has worked for you. That is, how effective has each strategy been in stopping you from drinking. We want to know about your own experience, not what you have observed in others. There are four choices for each item: "Usually stops me", "Sometimes stops me", "Usually doesn't stop me" and "Don't know". Please read each question, then circle the response that is right for you. If you don't remember or have no experience with a particular item, circle the number under "don't know". There are no right or wrong answers or trick questions. We want to know what has worked for you.

		Usually stops me	Sometimes stops me	Usually doesn't stop me	Don't know
1.	Thinking about how much better off I am without drink	0	1	2	3
2.	Telephoning a friend	0	1	2	3
3.	Keeping in the company of non drinkers	0	1	2	3
4.	Thinking positively	0	1	2	3
5.	Thinking of the mess I've got myself into through drinking	0	1	2	3
6.	Stopping to examine my motives and eliminating the false ones	0	1	2	3
7.	Thinking of the promises I've made to others	0	1	2	3
8.	Staying indoors - hiding	0	1	2	3
9.	Pausing and really thinking the whole alcoholic cycle through	0	1	2	3
10.	Leaving my money at home	0	1	2	3
11.	Recognizing that life is not a bed of roses but drink is not the answer	0	1	2	3
12.	Going to an A.A. meeting	0	1	2	3
13.	Knowing that by not drinking I can show my face again without fear of what others will think	0	1	2	3
14.	Cheering myself up by buying myself something special instead	0	1	2	3
15.	Facing up to my bad feelings instead of trying to drown them	0	1	2	3
16.	Working harder	0	1	2	3
17.	Realizing it's just not worth it	0	1	2	3
18.	Waiting it out until everything is shut	0	1	2	3
19.	Remembering how I've let my friends and family down in the past	0	1	2	3
20.	Keeping away from people who drink	0	1	2	3
21.	Going for a walk	0	1	2	3
22.	Looking on the bright side and trying to stop making excuses for myself	0	1	2	3
23.	Realizing it's affecting my health	0	1	2	3

EVALUATION PARTICIPANT'S NAME: _____
DATE 1st COMPLETED: __ __/__ __ /201__

month day year

PARTICIPANT TRACKING FORM

Instructions to Project Staff Person: Update the contact information at each follow-up interview. Always date corrections or new information entered.

Introduction (explain to evaluation participant): The CSO Evaluation is requesting that you give as much contact information as possible to help us locate them for the follow-up interviews at discharge and 6 months post intake. The information you give at the follow-up interviews will help us learn how to improve the Project, so we really want to be able to talk with you those 3 times during the next 9 months.

If a Staff Person calls any of the contacts you give, he or she will identify her or himself in whatever way you think is best. The Staff Person is happy to just give a first name and to say that he or she spoke to you some months ago and would like to talk to you again. Also please give us contacts who are 18 years old or older. For each contact, please tell us who else might answer the phone or come to the door, whether they are 18 or not, and what we can say to them.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

☐ Home / Phone: _____

How should we identify ourselves? _____

May we say the clinic name? ☐ Yes ☐ No

☐ Work / Phone: _____

How should we identify ourselves?

_____

May we say the clinic name? ☐ Yes ☐ No

☐ Other / Phone: _____

How should we identify ourselves?

_____

May we say the clinic name? ☐ Yes ☐ No

☐ Texting: _____

How should we identify ourselves?

_____

May we say the clinic name? ☐ Yes ☐ No

☐ Email: _____

How should we identify ourselves?

_____

May we say the clinic name? ☐ Yes ☐ No

UNDER SPECIAL INSTRUCTIONS: GET DAYS AND TIMES WHEN BEST TO REACH CLIENT.

Any family we could contact to get in touch with you?

Name: _____ **Relationship:** _____

Address: _____

Telephone: _____ **Cell phone/Pager:** _____

Special instructions: _____

By signing, I _____ **give consent for RECOVERE staff to contact the person in this box.**

Al firmar, Yo _____ **autoriso a los trabajadores de RECOVERE a contactar a la persona indicada**

en esta caja. _____ **(sign here).**

Any other family we could contact?

Name: _____ **Relationship:** _____

Address: _____

Telephone: _____

Cell phone/Pager: _____

Special instructions: _____

By signing, I _____ **give consent for RECOVERE staff to contact the person in this box.**

Al firmar, Yo _____ **autoriso a los trabajadores de RECOVERE a contactar a la persona indicada**

en esta caja._____ (sign here).

Do you have A Friend That Doesn't Use Drugs Or Alcohol we could contact? (be clear the person is over 18 years old)

Name: _____ Relationship: _____

Address: _____

Telephone: _____ Cell phone/Pager: _____

Special instructions: _____

By signing, I _____ give consent for RECOVERE staff to contact the person in box.

Al firmar, Yo _____ autoriso a los trabajadores de RECOVERE a contactar a la persona indicada en esta caja._____ (sign here).

Where do you hang out?

Name: _____

What time can you be found there_____

Special instructions: _____

By signing, I _____ give consent for RECOVERE staff to contact the person in box.

Al firmar, Yo _____ autoriso a los trabajadores de RECOVERE a contactar a la persona indicada en esta caja_____ (sign here).

Do you have a pastor, priest, rabbi, or other clergy we could contact? (Staff: confirm you have a two way release signed by the parent to contact this one)

Name: _____ **Relationship:** _____

Address: _____

Telephone: _____

Cell phone/Pager: _____

Special instructions: _____

By signing, I _____ **give consent for RECOVERE staff to contact the person in box.**

Al firmar, Yo _____ **autoriso a los trabajadores de RECOVERE a contactar a la persona indicada en esta caja.**_____ **(sign here).**

If you were sick, what emergency room, hospital, detox, clinic, counseling or psychiatric facility would you go to?

Name of agency: _____

Location/address: _____

Name of person you might be with: _____

Relationship: _____

Telephone: _____ **Cell phone/Pager:** _____

Special instructions: _____

By signing, I _____ **give consent for RECOVERE staff to contact the person in box.**

Al firmar, Yo _____ **autoriso a los trabajadores de RECOVERE a contactar a la persona indicada en esta caja.**_____ **(sign here).**

Where were you born? _____

Driver's license or state ID # _____

If you have a car, what is its make, model, license plate number?_____

Interviewer please note:

Approximate height: _____ **Hair Color:**_____ **Eye Color** _____

Please note any permanent identifying physical characteristics (scars, tattoos, disabilities, etc.)

_____

_____

_____

RECOVERe Referral Log

Client Name:	Date:
Staff:	GPRA ID:

Location	Mode of Contact
o 1=CSO o 2=Community o 3= Other Agency o 4=Home o 5=School o 6=Street o 7=Shelter o 8=Transport o Other	o 1=Face to face o 2=Telephone o 3=Written o 4=Text o 5=Email o 6=IT Group o 4=Group o Other

Referrals Made	Referrals Accessed
o Date made dd/mm/yyy o 1=Substance Abuse o 2=Relapse Prev o 3=STD risk o 4=Testing HIV o 5=Testing HEP o 6=Medical o 7=Mental Health o 8=Med Compliance o 9=Health Ins access o 10=Housing o 11=Education o 12=Employment o 13=Job training o 14=Legal o 15=Social functioning o 16=Food clothing o 17=Entitlements o 18=Self Help o 19=Gen. Support o 20=Technology Training o Other _____	o Date Accessed dd/mm/yyy o 1=Substance Abuse o 2=Relapse Prev o 3=STD risk o 4=Testing HIV o 5=Testing HEP o 6=Medical o 7=Mental Health o 8=Med Compliance o 9=Health Ins access o 10=Housing o 11=Education o 12=Employment o 13=Job training o 14=Legal o 15=Social functioning o 16=Food clothing o 17=Entitlements o 18=Self Help o 19=Gen. Support o 20=Technology Training o Other _____

NOTES:

The RECOVERe Program
Satisfaction Survey
This instrument is collected at program discharge only

A. Functioning

Since coming to the RECOVERe Program...	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	N/A	DK	RF
1. I do things that are more meaningful to me.	1	2	3	4	5	6	7	8
2. I am better able to take care of my needs.	1	2	3	4	5	6	7	8
3. I am better able to handle things when they go wrong.	1	2	3	4	5	6	7	8
4. I am better able to do things that I want to do.	1	2	3	4	5	6	7	8
5. My symptoms are not bothering me as much.	1	2	3	4	5	6	7	8

B. Perception of Care

Please indicate your agreement/disagreement with each of the following statements.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	N/A	DK	RF
1. I like the services that I received here.	1	2	3	4	5	6	7	8
2. If I had other choices, I would still get services from this agency.	1	2	3	4	5	6	7	8
3. I would recommend this agency to a friend or family member.	1	2	3	4	5	6	7	8
4. I found the technology tools useful.	1	2	3	4	5	6	7	8
5. I found the weekly recovery text message to be helpful.	1	2	3	4	5	6	7	8
6. I felt free to complain.	1	2	3	4	5	6	7	8
7. I was given information about my rights.	1	2	3	4	5	6	7	8
8. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	6	7	8
9. Staff supported me to reduce my use and/or avoid relapse	1	2	3	4	5	6	7	8
10. Staff respected my wishes about who is and who is not to be given information about my treatment.	1	2	3	4	5	6	7	8

11. I, not staff, decided my treatment and recovery goals.	1	2	3	4	5	6	7	8
12. Staff was sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	6	7	8
13. Staff helped me obtain the information I needed so that I could take charge of managing my recovery.	1	2	3	4	5	6	7	8
14. The staff here believe that I can grow, change and recover	1	2	3	4	5	6	7	8

Comments:_____

_____

_____

RECOVERe Dosage Log

Client Name: **Date:**

Staff: **GPRA ID**

Contact	Location	Mode of Contact	Duration
o 1=Client o 2=Family o 3=Professional o 4=Tracking o Other=	o 1=CSO o 2=Community o 3= Other Agency o 4=Home o 5=School o 6=Street o 7=Shelter o 8=Transport o Other	o 1=Face to face o 2=Telephone o 3=Written o 4=Text o 5=Email o 6=IT Group o 4=Group o Other	o 1=1-10 o 2=11-20 o 3=21-30 o 4=31-40 o 5=41-50 o 6=51-60 o 7=61-70 o 8=71-80 o 9=80-90 o 10=91-100 o 11=101-110 o 12=111-120 _____

Topic

o 1=Substance Abuse o 2=Relapse Prev o 3=STD risk o 4=Testing HIV o 5=Testing HEP o 6=Medical o 7=Mental Health o 8=Med Compliance o 9=Health Ins access o 10=Housing o 11=Education o 12=Employment o 13=Job training o 14=Legal o 15=Social functioning o 16=Food clothing o 17=Entitlements o 18=Self Help o 19=Gen. Support o 20=Technology Training o Other _____	o 21=Int. Screening o 22=GPRA Intake o GPRA ID _____ o 23=GPRA 6 month o 24=GPRA Discharge o 25=Tracking Other

Progress Note:

D

A

P

Staff's goal for next meeting:

Client's goal for next meeting:

Appendix Three - Readiness to Change Questionnaire

Please read the sentence below carefully. For each one please tick the answer that best describes how you feel. Your answers will be private and confidential.

	Strongly	Disagree disagree	Unsure	Agree	Strongly agree
1 My drinking is okay as it is	☐	☐	☐	☐	☐
2 I am trying to drink less than I used to	☐	☐	☐	☐	☐
3 I enjoy my drinking but sometimes I drink too much	☐	☐	☐	☐	☐
4 I should cut down on my drinking	☐	☐	☐	☐	☐
5 It's a waste of time thinking about my drinking	☐	☐	☐	☐	☐
6 I have just recently changed my drinking habits	☐	☐	☐	☐	☐
7 Anyone can talk about wanting to do something about drinking, but I am actually doing something about it	☐	☐	☐	☐	☐
8 I am at the stage where I should think about drinking less alcohol	☐	☐	☐	☐	☐
9 My drinking is a problem	☐	☐	☐	☐	☐
10 It's alright for me to keep drinking as I do now	☐	☐	☐	☐	☐
11 I am actually changing my drinking habits right now	☐	☐	☐	☐	☐
12 My life would still be the same, even if I drank less	☐	☐	☐	☐	☐

ATTACHMENT 3: SAMPLE CONSENT FORMS

THE RECOVERE PROGRAM
Informed Consent to Participate in an Performance Assessment

INTRODUCTION AND INVITATION: You are being invited to participate in the Performance Assessment of the RECOVERe Program, a project designed to deliver technologically-assisted treatment to adults who suffer from substance abuse.

PURPOSE OF THE PERFORMANCE ASSESSMENT: The goal of this Performance Assessment is to assess the effectiveness of the RECOVERe Program. The knowledge that is gained from this Performance Assessment is expected to be useful in improving technological services for adults who live in rural areas.

DESCRIPTION OF THE PERFORMANCE ASSESSMENT: If you agree to participate in the Performance Assessment, a Data Collection Specialist will interview you in person three times over the course of approximately 9 months, at the time of this interview, at 6 months post intake and at program discharge. The questions asked will be about your background, alcohol and drug use, criminality, housing, employment and education, emotional and physical health, and safe sex behavior. Information will only be used for the purpose of evaluating the Project. Your name will never be mentioned in presentations or publications about the Project Performance Assessment findings.

If you agree to participate in the Performance Assessment, a Data Collection Specialist will ask you questions. To properly assess the RECOVERe Program, it is important that we interview each individual participating in the Performance Assessment at 6 and approximately 9 months after the interview today. To help the Specialist complete as many follow-up interviews as possible, the Specialist will share contact information (s)he has on individuals participating in the Performance Assessment with Project staff.

PARTICIPANT RIGHTS

- **Participation in this Performance Assessment is completely voluntary.**
- **Participants are free not to answer any Performance Assessment question that they do not want to answer.**
- **Participants may decide not to take part or decide to withdraw from the Performance Assessment at any time, without any penalty.**

RISKS: You will be asked to disclose personal information about your history. You may find this stressful or upsetting and/or may have unexpected reactions to questions. If you do not want to answer any question, you do not have to. You may take breaks during an interview or stop an interview altogether at any time. There are exceptions to the rule of confidentiality. Evaluators are obligated to report if an individual is in immediate danger of killing himself or herself or threatens to harm another person, if child, elder, or disabled person's abuse or neglect is suspected.

BENEFITS: While there are no direct benefits from participating in the Performance Assessment, the information learned from the Performance Assessment is intended to be used to assess and improve services for adults who suffer from substance abuse. Knowledge gained from the Performance Assessment may help others in the future.

ALTERNATIVES: The alternative is to not participate in the Performance Assessment.

CONFIDENTIALITY: Performance Assessment records will be confidential to the extent possible by law. Exceptions to the rule of confidentiality are listed above in the section on RISKS. Your name will not appear in any presentations or publications that report the Performance Assessment findings. On the form for each follow-up interview you will be identified by an Performance Assessment identification number, and written Performance Assessment records will be stored in locked file cabinets. All records will be securely destroyed approximately 10 years after publications on the Performance Assessment findings have been completed.

PERFORMANCE ASSESSMENT RESULTS: Performance Assessment information will be used to improve services for adults who have issues with substances.

You may request a copy of reports generated at the conclusion of the Performance Assessment.

QUESTIONS: You may contact **XXXXXXX , CSO, at XXX XXX-XXXX, or Dr. Dominique Simon, Data Analysis Specialist XXX-XXX-XXXX** with any questions regarding the Performance Assessment or participant rights.

CONSENT TO PARTICIPATE IN THE RECOVERe PROGRAM PERFORMANCE ASSESSMENT

Participant's Name:

_____

(Please Print)

The purpose and procedures of this Performance Assessment and the predictable discomfort, risks, and benefits that might result have been explained to me. I have been told that unforeseen events may occur. I have had an opportunity to discuss the Performance Assessment with a Project staff member and all of my questions have been answered. I agree to enroll as a participant in this program Performance Assessment. I understand that I may end my participation at any time. I have been given a copy of this consent form.

_____ Date:__ __ / __ __ / 200__

Participant's Signature *month day year*

PERFORMANCE ASSESSMENT INTERVIEWER'S DECLARATION

I have explained to the above-named participant the purpose and procedures of the Performance Assessment described above and the foreseeable risks, discomforts, and benefits that may result from participation in the Performance Assessment. I have asked the participant if s/he has any questions about the Performance Assessment and its procedures and have answered these questions to the best of my ability.

_____ Date:__ __ / __ __ / 200__

Performance Assessment Interviewer's Signature *month day year*

Clinical & Support Options

CS

Enhancing Lives. Strengthening Communities.

111 Federal Street
Greenfield, MA 01301
Phone: 413.773.1314
Fax: 413.774.1197

1 Arch Place
1st Floor
Greenfield, MA 01301
Phone: 413.774.1000
Fax: 413.774.1776

491 Main Street
Athol, MA 01331
Phone: 978.249.9490
Fax: 978.249.9514

130 Maple Street
Suite 325
Springfield, MA 01103
Phone: 413.737.9544
Fax: 413.737.4455

53 Eagle Street
Pittsfield, MA 01201
Phone: 413.236.5656
Fax: 413.499.6572

17 New South Street
Suite 116
Northampton, MA 01060
Phone: 413.582.0471
Fax: 413.582.1807

140 High Street
Greenfield, MA 01301
Phone: 413.774.2880
Fax: 413.773.8429

29N Main Street
Florence, MA 01062
Phone: 413.586.5382
Fax: 413.582.1832

37 Franklin Street
Greenfield, MA 01301
Phone: 413.772.2181
Fax: 413.772.2032

21-25 W Main Street
Orange, MA 01364
Phone: 978.544.1859
Fax: 978.544.1860

June 1, 2011

Michael Botticelli, Assistant Commissioner
Bureau of Substance Abuse Services
Massachusetts Department of Public Health
250 Washington St., 3rd Floor
Boston MA 02108

Dear Mr. Botticelli:

Enclosed please find the face sheet and project abstract for our application to SAMHSA for a project for technology support for substance abuse service. Our grant request is to create video conferencing for counseling and group sessions, interactive Web-based support and mobile phone outreach. The population of focus are adults ages 18 and older with a diagnosis of substance abuse disorder. We will build on our existing DPH-funded substance abuse outpatient programs to create a comprehensive system of technology-supported service delivery to rural area residents in North Quabbin, Franklin and Berkshire Counties in order to provide treatment and recovery support to residents who have poor access to services.

If you wish to make comment on the application, please send them within 60 days of the grant deadline to:
Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration, Room 3-1044
1 Choke Cherry Road, Rockville, MD 20857
ATTN: SSA – Funding Announcement No. SM-09-011
We would appreciate a copy of your comments and I would be happy to discuss this application with you at your convenience

Sincerely,

Karin Jeffers
Chief Executive Officer

United Way
Partner Agency

PROJECT/PERFORMANCE SITE LOCATION(S)

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Project/Performance Site Primary Location

Organization Name: Clinical and Support Options

DUNS Number: 185070612

* Street 1: 1 Arch Place

Street 2:

* City: Greenfield

County: Franklin County

* State: Massachusetts

* Country: USA

* ZIP / Postal Code: 01301

* Project/Performance Site Congressional District: First

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Project/Performance Site Location

Organization Name: Clinical and Support Options

DUNS Number: 185070612

* Street 1: 491 Main Street

Street 2:

* City: Athol

County: Worcester County (North Quabbin)

* State: Massachusetts

* Country: USA

* ZIP / Postal Code: 01331

* Project/Performance Site Congressional District: First

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Project/Performance Site Primary Location

Organization Name: Clinical and Support Options

DUNS Number: 185070612

* Street 1: 491 Eagle Street

Street 2:

* City: Pittsfield

County: Berkshire County

* State: Massachusetts

* Country: USA

* ZIP / Postal Code: **01201**

* Project/Performance Site Congressional District: First

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Project/Performance Site Primary Location

Organization Name: Clinical and Support Options

DUNS Number: 185070612

* Street 1: 29 North Main Street

Street 2:

* City: Florence

County: Hampshire County

* State: Massachusetts

* Country: USA

* ZIP / Postal Code: **01062**

* Project/Performance Site Congressional District: First

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO
11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Karen [illegible]	President and CEO
APPLICANT ORGANIZATION	**DATE SUBMITTED**
Clinical and Support Options, Inc.	June 13, 2011

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Kami [illegible]	President and CEO
APPLICANT ORGANIZATION	DATE SUBMITTED
Clinical and Support Options, Inc.	June 13, 2011

SF LLL: DISCLOSURE OF LOBBYING ACTIVITIES
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action:

[b]
a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

[a]
a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

[a]
a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____

date of last report _____

4. Name and Address of Reporting Entity:

☒ Prime ☐ Subawardee

Tier

City: Greenfield

Clinical and Support Options, Inc
111 Federal St.
Greenfield, MA 01301

Congressional District, *if known:* First Congressional

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* First

6. Federal Department/Agency:

SAMHSA, U.S. DHHS

7. Federal Program Name/Description:

TCE-Health IT - No. TI-11-002

CFDA Number, *if applicable:* 93-243

8. Federal Action Number, if known:

Not applicable

9. Award Amount, if known:

$280,000

10.a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*

Not applicable

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

Not applicable

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: Karin Jeffers

Print Name: Karin Jeffers

Title: President and CEO

Telephone No.: (413) 773-1314 ext 517 Date: June 13, 2011

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

Statement of Assurance

As the authorized representative of Clinical and Support Options, Inc., I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in Appendix 1 of the application, that has agreed to participate in the project;

- official documentation that the applicant organization participating in the project has been providing outpatient mental health and/or other behavioral health services for individuals with SMI for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and

- official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

Karen [illegible]
Signature of Authorized Representative

5/27/2011
Date

CHECKLIST

PHS 5161-1 HHS CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 hours perresponse, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application:	☒ NEW	☐ Noncompeting Continuation	☒ Competing Continuation	☐ Supplemental

PART A: The following checklist is to assure that proper signatures, assurances, and certifications have been submitted.

	Included	Not Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	☒	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☒	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☒	

4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)

☐ Civil Rights Assurance (45 CFR 80)	To be filed
☐ Assurance Concerning the Handicapped (45 CFR 84)	To be filed
☐ Assurance Concerning Sex Discrimination (45 CFR 86)	To be filed
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91).	To be filed

5. Human Subjects Certification, when applicable (45 CFR 46) ☐ ☒

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	Yes	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☒
2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☒	☐
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	☒	☐
4. Have biographical sketch(es) with job description(s) been attached, when required	☒	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	☐
6. Has the 12 month detailed budget been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☒	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Name	Karin Jeffers
Title	President and CEO
Organization	Clinical and Support Options, Inc.
Address	111 Federal St, Greenfield, MA 01301
E-mail Address	kjeffers@csoinc.org
Telephone Number	(413) 773-1314x517
Fax Number	(413) 774-1197

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN

FEIN: 04-2206041

Program Director/ designated to direct the proposed project

Name	same
Title	same
Organization	same
Address	same
E-mail Address	same
Telephone Number	same
Fax Number	same

SOCIAL SECURITY # 151-42-1994

HIGHEST DEGREE EARNED MA

OMB Approval No. 0990-0317
Expiration Date: 08/31/2010

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 - 50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to HHS Reports Clearance Officer, 200 Independence Ave., SW, Humphrey Bldg., Room 531H, Washington, DC, 20201, ATTN: PRA (0990-0317). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete each page of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last pages of the signed original of the application.

Type of Application: ☒ New ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date on the SF 424 (FACE PAGE)	☒	
2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690)		
☐ Civil Rights Assurance (45 CFR 80)	_____	
☐ Assurance Concerning the Handicapped (45 CFR 84)	_____	
☐ Assurance Concerning Sex Discrimination (45 CFR 86)	_____	
☐ Assurance Concerning Age Discrimination (45 CFR 90 and 45 CFR 91)	_____	
3. Human Subjects Certification, when applicable (45 CFR 46)	☐	☒

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☒	☐
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☒	
3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)?	☒	
4. Have biographical sketch(es) with job description(s) been provided, when required?	☒	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	
6. Has the 12 month narrative budget justification been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☒	☐
8. For a Supplemental application, does the narrative budget justification address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Prefix: Ms. First Name: Karin Middle Name:
Last Name: Ieffers Suffix:
Title: President and Chief Executive Officer
Organization: Clinical and Support Options, Inc
Street1: 111 Federal Street
Street2:
City: Greenfield
State: MA ZIP/Postal Code: 01301 ZIP/Postal Code4:
Email Address: kieffers@csoinc.org
Telephone Number: 413-773-1314 ext 1010 Fax Number: 413-774-1197

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Prefix: Mr. First Name: Peter Middle Name:
Last Name: Wood Suffix:
Title: Director of Substance Abuse Services
Organization: Clinical and Support Options, Inc
Street1: 111 Federal Street
Street2:
City: Greenfield
State: MA ZIP/Postal Code: 01301 ZIP/Postal Code4:
Email Address: pwood@csoinc.org
Telephone Number: 413-773-1314 Fax Number: 413-774-1197

Massachusetts
Department of
Revenue

Form ST-2
Certificate of Exemption

Certification is hereby made that the organization herein named is an exempt purchaser under General Laws Chapter 64H, sections 6(d) and (e). All purchases of tangible personal property by this organization are exempt from taxation under said chapter to the extent that such property is used in the conduct of the business of the purchaser. Any abuse or misuse of this certificate by any tax-exempt organization or any unauthorized use of this certificate by any individual constitutes a serious violation and will lead to revocation. Willful misuse of this Certificate of Exemption is subject to criminal sanctions of up to one year in prison and $10,000 ($50,000 for corporations) in fines. (See reverse side.)

* CLINICAL & SUPPORT OPTIONS, INC.
CLINICAL AND SUPPORT OPTIONS INC
215 SHELBURNE ROAD
GREENFIELD MA 01302 1365

EXEMPTION NUMBER E
042-206-041
ISSUE DATE
01/02/05
CERTIFICATE EXPIRES ON
01/02/15

COMMISSIONER OF REVENUE
ALAN LEBOVIDGE

NOT ASSIGNABLE OR TRANSFERABLE

Approved by OMB
0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: Clinical and Support Options, Inc. **Page** 1 **of** 1

No Lobbying activities performed.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Project/Performance Site Primary Location

Organization Name: Clinical and Support Options, Inc.

DUNS Number: 185070612

* Street1: 1 Arch Place

Street2:

* City: Greenfield County: Franklin County

* State: MA

Province:

* Country: USA

* ZIP / Postal Code: 01301 * Project/Performance Site Congressional District: MA-001

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Project/Performance Site Location 1

Organization Name: Clinical and Support Options, Inc.

DUNS Number: 185070612

* Street1: 53 Eagle Street

Street2:

* City: Pittsfield County: Berkshire County

* State: MA

Province:

* Country: USA

* ZIP / Postal Code: 01201 * Project/Performance Site Congressional District: MA-001

See next page for instructions.

Project/Performance Site Location Instructions

ASSURANCE
of Compliance with SAMHSA Charitable Choice Statutes and Regulations
SMA 170

REQUIRED ONLY FOR APPLICANTS APPLYING FOR GRANTS THAT FUND SUBSTANCE ABUSE TREATMENT OR PREVENTION SERVICES

SAMHSA's two Charitable Choice provisions [Sections 581-584 and Section 1955 of the Public Health Service (PHS) Act, 42 USC 290k, et seq., and 42 USC 300x-65 et seq., respectively] allow religious organizations to provide SAMHSA-funded substance abuse services without impairing their religious character and without diminishing the religious freedom of those who receive their services. These provisions contain important protections both for religious organizations that receive SAMHSA funding and for the individuals who receive their services, and apply to religious organizations and to State and local governments that provide substance abuse prevention and treatment services under SAMHSA grants.

As the duly authorized representative of the applicant, I certify that the applicant:

Will comply, as applicable, with the Substance Abuse and Mental Health Services Administration (SAMHSA) Charitable Choice statutes codified at sections 581-584 and 1955 of the Public Health Service Act (42 U.S.C. §§290kk, et seq., and 300x-65) and their governing regulations at 42 C.F.R. part 54 and 54a respectively.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
[illegible]	President and CEO
APPLICANT ORGANIZATION	**DATE SUBMITTED**
Clinical & Support Options Inc.	6/24/11