

## Application for Federal Assistance SF-424

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision * If Revision, select appropriate letter(s): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
* 3. Date Received: 06/15/2011	4. Applicant Identifier: [Redacted]
5a. Federal Entity Identifier: [Redacted]	5b. Federal Award Identifier: [Redacted]
<b>State Use Only:</b>	
6. Date Received by State: [Redacted]	7. State Application Identifier: [Redacted]
<b>8. APPLICANT INFORMATION:</b>	
* a. Legal Name: Human Service Center	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 37-1004882	* c. Organizational DUNS: 0608608630000
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County/Parish:	
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Province:	
* Country: USA: UNITED STATES	
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**Application for Federal Assistance SF-424****\* 9. Type of Applicant 1: Select Applicant Type:**

M: 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 & Mental Health Services Adminis.

**11. Catalog of Federal Domestic Assistance Number:**

93.243

CFDA Title:

Substance Abuse and Mental Health Services\_Projects of Regional and National Significance

**\* 12. Funding Opportunity Number:**

TI-11-002

\* Title:

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

**13. Competition Identification Number:**

Title:

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

Areas affected by project - 10 county regio

[Add Attachment](#)

[Delete Attachment](#)

[View Attachment](#)

**\* 15. Descriptive Title of Applicant's Project:**

Mobile Wellness and Recovery Project

Attach supporting documents as specified in agency instructions.

[Add Attachments](#)

[Delete Attachments](#)

[View Attachments](#)

## Abstract

### Mobile Wellness and Recovery (MW&R) Project

The MW&R project will allow individuals with a substance use disorder living in rural regions to access a range of e-therapy options, combined with community-based clinical services and access to medical care. The MW&R will provide cognitive behavioral therapy (CBT) and recovery-based resources through multiple forms of media, including smart phone applications, telephonic communication, and automated internet-based, computer programs.

The project is a collaboration of two comprehensive behavioral health organizations: Human Service Center and North Central Behavioral Health Services, and multiple primary care organizations nested within a 10-county region of central Illinois (total population of 598,493). The target population includes men and women above the age of 17 living in rural settings as classified by the U.S. Census Bureau (40% of total population). The population is approximately 96% White (3% Hispanic, 1% Black), 51% female, 8% unemployed, 12% living below the poverty level, and 29,498 have a dependence diagnosis to alcohol and other drugs and another 24,581 have a substance abuse diagnosis.

The MW&R will use two master level clinicians and one nurse to engage individuals in rural locations who are not willing to access, or wait to enter, an office-based addiction treatment program, but would be willing to receive evidence-based CBT through multi-media options. These options include telephonic contacts with a clinician; access to internet based CBT programs; access to smart phone applications that provide a range of real-time recovery supports, prompts and CBT skills training; and access to an extensive library of resources and community linkages stored in one website location. CBT skills training will include smoking cessation for tobacco addiction. The nurse will also assist individuals in connecting with a medical provider and learning how to store essential health information in a free, online personal health record (PHR) database. The project has three overlapping goals to increase and expand services: 1) Develop an expedited screening protocol to engage clients on the same day of self-request or through a referral from primary care clinics; 2) Implement a range of e-therapy options to deliver CBT to individuals, including phone, internet, interactive applications through smart phones or in-person as needed, 3) Develop a series of protocols that keeps individuals involved in CBT skills training, relapse prevention, and continuing care for at least six months through e-therapy interventions. The goal is to enroll 120 individuals in year 1 and 165 in years 2 & 3 for a total of 450. Measurable objectives include engaging individuals within 24 hours, initiating telephonic CBT within 1 to 2 days, keeping 80% of candidates engaged for at least six months, and assisting 75% in using e-therapy options. Other measurable outcomes include reducing alcohol and drug use over time (80% show decline), linking 75% to primary care and enrolling 60% in a PHR, increasing self efficacy and access to social support.

## Application for Federal Assistance SF-424

### 16. Congressional Districts Of:

\* a. Applicant

b. Program/Project

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

### 17. Proposed Project:

\* a. Start Date:

\* b. End Date:

### 18. Estimated Funding (\$):

* a. Federal	<input type="text" value="279,087.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="279,087.00"/>

### \* 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.

### Authorized Representative:

Prefix:

\* First Name:

Middle Name:

\* Last Name:

Suffix:

\* Title:

\* Telephone Number:

Fax Number:

\* Email:

\* Signature of Authorized Representative:

\* Date Signed:

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# BUDGET INFORMATION - Non-Construction Programs

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

## 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. N/A	93-243	\$ 837,940.00	\$	\$	\$	\$ 837,940.00
2.						
3.						
4.						
5. Totals		\$ 837,940.00	\$	\$	\$	\$ 837,940.00

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### SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	\$ [ ]	\$ [ ]	\$ [ ]	\$ [ ]
9.	[ ]	[ ]	[ ]	[ ]
10.	[ ]	[ ]	[ ]	[ ]
11.	[ ]	[ ]	[ ]	[ ]
12. TOTAL (sum of lines 8-11)	\$ [ ]	\$ [ ]	\$ [ ]	\$ [ ]

### SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 279,087.00	\$ 69,772.00	\$ 69,772.00	\$ 69,771.00	\$ 69,772.00
14. Non-Federal	\$ [ ]	[ ]	[ ]	[ ]	[ ]
15. TOTAL (sum of lines 13 and 14)	\$ 279,087.00	\$ 69,772.00	\$ 69,772.00	\$ 69,771.00	\$ 69,772.00

### 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. N/A	\$ 279,517.00	\$ 279,335.00	\$ [ ]	\$ [ ]
17.	[ ]	[ ]	[ ]	[ ]
18.	[ ]	[ ]	[ ]	[ ]
19.	[ ]	[ ]	[ ]	[ ]
20. TOTAL (sum of lines 16 - 19)	\$ 279,517.00	\$ 279,335.00	\$ [ ]	\$ [ ]

### SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	[ ]	22. Indirect Charges:	[ ]
23. Remarks:	[ ]		

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**SECTION B - BUDGET CATEGORIES**

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) N/A	(2)	(3)	(4)	
a. Personnel	\$ 391,882.00	\$	\$	\$	\$ 391,882.00
b. Fringe Benefits	141,078.00				141,078.00
c. Travel	65,520.00				65,520.00
d. Equipment	4,650.00				4,650.00
e. Supplies	3,000.00				3,000.00
f. Contractual	124,600.00				124,600.00
g. Construction	0.00				
h. Other	44,210.00				44,210.00
i. Total Direct Charges (sum of 6a-6h)	774,940.00				\$ 774,940.00
j. Indirect Charges	63,000.00				\$ 63,000.00
k. TOTALS (sum of 6i and 6j)	\$ 837,940.00	\$	\$	\$	\$ 837,940.00
 <b>7. Program Income</b>	\$	\$	\$	\$	\$

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## Section A: Statement of Need

The proposed project will both increase and expand addiction treatment services to rural adults who have a substance use disorder (SUD) through the use of e-therapy interventions. The project includes two not-for-profit behavioral health agencies and three federal qualified health centers (FQHC) that provide services within the proposed target region. The two behavioral health agencies include the Human Service Center (HSC) in Peoria and North Central Behavioral Health Services, Inc. in La Salle, Illinois. The target region is a 10-county area in west central Illinois that includes mostly rural populations and one urban center (total population = 598,493). Unemployment rates range from 6% to 10%. The 10 counties are located in the Illinois region III (total population = 1,195,432) used in the National Survey of Drug Use and Health (NSDUH) reports.

**Table 1: Demographics of the 10-County Region**

County	Total Census	Rural/ Urban	%White Non- Hispanic	% Black	% Hispanic	Median Age	% Female	% below poverty level
Bureau	34,699	Rural/ micropolitan	90.4	0.8	7.1	42	51	9.9
Fulton	36,652	Rural/ micropolitan	93.3	4.0	1.5	41.3	48	15.1
LaSalle	112,498	Rural/ micropolitan	88.8	1.8	7.6	40.3	51	10.4
Marshall	12,702	Rural	94.9	1.1	2.7	43.4	50	8.8
McDonough	32,770	Rural/ micropolitan	88.9	5.0	2.0	24.7	51	20.8
Peoria	185,816	Medium metro	75	17.4	3.1	35.9	52	15
Putnam	6009	Rural/ micropolitan	93.4	0.8	4.7	44.2	50	7.4
Stark	6019	Rural	97	0.3	1.6	43.5	51	10.8
Tazewell	132,466	Medium metro	95.3	1.4	1.6	39.7	51	7.8
Woodford	38,862	Medium metro	96.3	1.1	1.4	39.1	50	5.9

## Nature of the Problem and Extent of Need

HSC and North Central provide a range of addiction and mental health treatment services to children and adults in the region. However, the demand for services far exceeds the treatment slots available. Approximately 29,498 (6.0%) of individuals 12 years and older in the 10-county target area have a diagnosis of dependence for alcohol or other drugs and another 24,581 (5%) have a diagnosis of abuse based on estimates in region III from the 2008 NSDUH survey from SAMHSA's Office of Applied Studies (2010).

HSC provided residential and outpatient addiction treatment services to 1,431 unduplicated individuals in 12 months. North Central provided outpatient only services to 3408 individuals during the same time period. The two agencies had a capacity to serve approximately 4839 adults annually or 16.4% of those who have an alcohol or drug dependence diagnosis and 9% of all adults who have a SUD. Approximately 5949 (11%) individuals 12

years or older in the 10-county region in 2008 needed, but could not access addiction treatment services as reported in the 2008 NSDUH (SAMHSA, 2010).

U.S. Census (2011) figures indicate that 40% (241,349) of individuals in the ten-county region live in rural settings. Individuals with a SUD living in rural regions encounter more barriers to accessing addiction treatment than their urban counterparts. The Health Resource and Services Administration (HRSA; 2005) outlined three categories of barriers that undermine an individual's likelihood of receiving medical or behavioral health services in rural settings: 1) availability, 2) accessibility, & 3) acceptability. Two additional barriers common to all individuals seeking addiction treatment include limited access to health care to address co-occurring health problems and the need for a treatment system that can provide ongoing, continuous support over time.

**Limited Availability of Addiction Treatment Services.** The primary barrier to any type of medical or behavioral healthcare in rural regions is the paucity of healthcare organizations and professionals (HRSA, 2005). HSC and North Central provide effective and affordable addiction treatment to individuals with limited or no resources. Services include detoxification, residential (at HSC) and outpatient treatment, medication assisted treatment, and access to a full range of community mental health services. Despite the range of services, the two organizations can only serve approximately 9% of those who have a SUD based on NSDUH estimates (SAMHSA, 2010). The significant imbalance between demand and supply has also led to increased waiting times for both assessment and treatment. HSC and North Central have average waiting times of 11 and 6 days, respectively, between the first contact and assessment, and 16 and 9 days, respectively, between assessment and treatment enrollment.

Researchers involved with the Network for the Improvement of Addiction Treatment (NIATx) project in Oregon found that longer periods of time between assessment and initiating treatment led to lower rates of engagement; whereas shorter periods led to improved rates (Hoffman et al., 2011). Other researchers have reported similar findings (Chawdhary et al., 2007; Festinger et al., 1995; Pollini et al., 2006). Access to and engagement in treatment is also related to the complex diagnostic issues of clients, such as their readiness to enter treatment, sociological factors and the severity of the individuals' addiction (Brucker, 2010; Brown et al., 2011; Carr et al., 2008). Individuals with severe problems or barriers to care can be more difficult to engage in office-based treatment, regardless of waiting times (e.g., Brucker, 2010).

**Limited Accessibility of Addiction Treatment Services.** Increasing capacity will allow more individuals to access services, but expansion alone will not remove other barriers to treatment. Only 10% of adults with a SUD perceive the need for treatment (Edlund et al., 2009; Grella et al., 2009; SAMHSA, 2009a; Greenfield et al., 2004; Woodward et al., 2008). Common barriers reported by men, women and minority populations include (Zemore et al., 2009; SAMHSA, 2007b & 2009b):

1. not being ready to stop (42%),
2. concerns over cost of treatment (34.5%),
3. concerns over social stigma associated with addiction treatment (18.8%),
4. access barriers, including transportation, childcare or language (11.7%),
5. perception that SUD is controllable (11.6%),
6. unaware of how to access treatment (11.1%),
7. lacking enough time for treatment (4.1%), and
8. unsure treatment will work (3.1%).

These barriers to effective addiction treatment are compounded for individuals living in rural areas. Compared to individuals in urban centers, those living in rural regions tend to have higher rates of poverty and unemployment, are more likely to be uninsured and older, and have longer distances to travel to a treatment provider (Rainer et al., 2010; Werth et al., 2010). Women, in particular, face multiple barriers to accessing health services, including increase risk of abuse, lack of childcare, and isolation (e.g., limited access to transportation; Smally et al., 2010).

**Limited Acceptability of Addiction Treatment Services.** Individuals living in rural settings are less likely to seek behavioral health services due to increased stigma associated with mental illness or a SUD (HRSA, 2005; Smally et al., 2010). Individuals living in small towns have less anonymity and privacy when seeking behavioral health care (Rainer et al., 2010; Smally et al., 2010). To be effective, addiction treatment services would need to be delivered in a discreet location or media format while also being easy to access.

**Increased Health Risk in Rural Settings.** Most individuals with a SUD receive services through a medical provider either to treat their SUD or to treat the health problems caused by their SUD (Cherpitel & Ye, 2008; Draper et al., 2005; Institute of Medicine [IOM], 2006; Schutte et al., 2009). Medical illnesses associated with drug abuse include infectious diseases, obstetrical complications, cirrhosis, stroke, seizures, unresponsive diabetes, postoperative complications, some cancers, and physical injuries (Draper et al., 2005; Edlund et al., 2009; IOM, 2006; Schutte et al., 2009). Between 25% and 36% of individuals receiving primary care services can be classified into a substance abuse category (Cherpitel & Ye, 2008; Hawkins et al., 2007; Madras et al., 2009).

Individuals living in rural settings have higher rates of tobacco use, obesity, and suicide compared to those living in urban settings (SAMHSA, 2010; Smalley et al., 2010). Pringle et al., (2006) found that individuals with a SUD from rural settings are less likely than their urban counterparts to receive needed services. Many of the individuals who need addiction treatment services in the 10-county region also need access to these primary care providers. Considering that addiction is a chronic behavioral health condition that can impact a person's physical and mental health, effective interventions that address the addiction would also need to address other aspects of the individual's health (Draper et al., 2005; Edlund et al., 2009; IOM, 2006; Schutte et al., 2009).

Furthermore, tobacco use in both rural and urban populations has been found to have a detrimental impact on individuals with a SUD. There is mounting research indicating that cigarette smoking during and after treatment will decrease an individual's likelihood of sustaining abstinence from alcohol and other drugs (Barrett et al., 2006; Daeppen et al., 2000; Dawson, 2000; TURN project, 2009). The impact of smoking on recovery rates can be significant considering that 80% to 98% of all individuals in an addiction treatment program are active smokers (Baca & Yahne, 2009). Approximately 50% of all individuals who enter treatment will die of cigarette smoking, not from alcohol or other drugs (Hser et al., 1994; Hurt et al., 1996; DHHS, 2004). Estimates from the NSDUH (SAMHSA, 2010) indicate that 165,189 individuals 12 years and older in the 10-county region smoked cigarettes (28%) or used any tobacco products (33.61%) in the past 30 days. Illinois has the 11<sup>th</sup> highest rate of cigarette smokers in the United States at 21.3% (Center for Disease Control, 2011).

**Acute Care of Addiction Treatment Services.** Another substantial barrier to effective addiction treatment is the structure of the existing treatment system (McLellan, 2006; McKay, 2009b). Addiction is considered a chronic condition, yet the treatment system is designed on a an acute care framework (White & Kelly, 2011; McLellan et al., 2000). Even evidence-based

addiction treatment interventions are limited in impact if provided in acute care episodes (McKay, 2009a). The researchers argued that treatment services need to be based on a continuous care model that can be adapted over time. The concepts of adaptive and continuous treatment is based on primary care interventions for diabetes and other chronic, but treatable conditions (McLellan et al., 2000). An effective treatment system would look similar to primary care models for chronic health conditions (White & Kelly, 2011). Addiction could be treated with the Chronic Care Model developed for incurable health conditions (Wagner et al., 2005).

Both HSC and North Central treatment services are funded primarily through Illinois General Revenue Funds (82%) or Medicaid dollars (18%). Treatment options in Illinois under these two funding streams are limited to acute care episodes delivered in office- or residential-based settings. Limited funding is available for case management services, but at a 24% reduced rate compared to office-based counseling and capped at 20% of total funding from IL-DASA.

Numerous researchers have argued for the development of addiction treatment interventions that can be delivered proactively to individuals, rather than requiring clients to return to a facility week after week (McKay et al., 2009). Addiction treatment interventions that promote a proactive, disease management model include:

- recovery management checkups (Scott & Dennis, 2009),
- phone-based continuing care (McKay et al., 2005 & 2010),
- smart-phone technologies that provide real-time feedback and prompts (Gustafson et al., 2011a & 2011b),
- computer-based skills training (Bickel et al., 2008; Carroll et al., 2008 & 2009), and
- community based models (Godley et al., 2007; Siegal et al., 1997).

These mobile interventions would be useful in rural settings where geographical and economic barriers can limit individual's access to treatment (CSAT, 2009). Further, phone and internet-based models of care can provide increased privacy and anonymity for rural individuals who experience more stigma associated with behavioral health treatment (Cunningham et al., 2011).

#### **Established Baseline of Need**

Table 3 provides a summary of baseline counts for people requesting services for an SUD, receiving services, number of clients from rural regions served, and the total number of individuals living in the 10-county area who have a SUD and need treatment.

**Table 3: Baseline Rates and Need for Addiction Treatment Services**

Agency	Annual Request for SUD tx	Residing in rural areas	Annual available tx slots	% rural served	Total # of SUD in region	Total # needing SUD tx
HSC	2598	16% (413)	1431	19% (280)	31,906	3541
North Central	Not known	100%	3408	100% (3408)	22,172	2408
Total			4839	76% (3688)	54,079	5949

The proposed project will increase capacity by enrolling an additional 150 individuals annually from rural locations. The total number enrolled will be 450 over the course of three years.

## **Section B: Proposed Evidence-based Services/Practices**

### **Purpose of the Proposed Project**

The project will be referred to as the Mobile Wellness and Recovery team or MW&R. The project is an evolution of multiple programs and research projects being tested at HSC as well as North Central's extensive experience with teleconferencing. HSC is one of two research sites for the University of Wisconsin A-CHESS smart phone project funded through the National Institute of Alcoholism and Alcohol Abuse. A-CHESS is the Alcohol – Comprehensive Health Enhancement Support System project.

The primary purpose of the project is to provide an array of evidence-based addiction treatment interventions through multiple forms of media in order to reach individuals with a SUD who have limited access, capacity or readiness to enter an office-based addiction treatment.

Individuals targeted for the project will live in a rural settings and historically:

- avoid treatment due to low levels of readiness or awareness of their SUD,
- disengage due to financial and logistical barriers,
- disengage after being placed on a waiting list for an assessment or treatment as a result of limited availability of treatment slots, or
- relapse after completing a single episode of office-based treatment.

These individuals could be engaged in e-therapy interventions that can be:

- accessed immediately upon request and tailored to the resources of each individual (e.g., access to the web, use of smart phones, access to a phone),
- tailored to each individual's level of readiness to change or severity of SUD,
- provided over extended periods beyond standard episodes of treatment to support the necessary time needed for learning and relapse prevention, and
- provided at no or minimal cost to individuals while minimizing the cost associated with providing additional office-based interventions to HSC or North Central.

Individuals enrolled in the project will have access to:

- two master-level clinicians who can provide phone or in-person clinical interventions,
- a nurse who can provide wellness services through multiple forms of communication,
- web-based, automated Cognitive Behavioral Therapy (CBT) interventions for alcohol, tobacco, and other drugs,
- ongoing phone-based skills training over many months,
- web-based resources to support recovery,
- smart phone applications developed by CHESS that can promote self-directed recovery and relapse prevention skills,
- web-based and smart phone applications tailored to resources in each County (e.g., location of AA meetings or access to chat rooms based on cultural categories),
- guidance on how to engage in 12-step meetings with the use of a structured manual, and
- online support groups designed throughout the study.

The Chronic Care Model (CCM) is used as the guiding framework for the project (Wagner et al., 2005). The CCM was developed in the primary care field to effectively treat individuals with chronic health conditions that required a conceptual shift from the acute, disease-based model that had driven the medical field. The CCM framework has been recommended for addiction treatment for the same reasons (Committee on Crossing the Quality Chasm, 2005; Sheedy & Whitter, 2009; Schutte et al., 2009). Wagner and colleagues (2005) outlined a comprehensive model for helping individuals with chronic health conditions learn how

to better manage these conditions. The overarching goal of the CCM is to teach individuals to be stewards of their own healthcare. The CCM model overlaps with the principles of the recovery oriented systems of care (ROSC; Sheedy & Whitter, 2009).

### **Goals & Objectives of the Proposed Project**

#### **Goal 1: Develop and expedited screening and referral protocol for rural clients.**

- Objective 1.1: Organize a steering committee to identify and coordinate community resources across the 10-county region of the project
- Objective 1.2: Establish a screening protocol for behavioral health and primary care centers to detect SUD
- Objective 1.3: Establish a screening protocol to identify rural residents, capacity to use e-therapy technologies, and readiness to engage in SUD services.
- Objective 1.4: Develop a triage protocol at the front door that supports real-time enrollment in the MW&R team
- Objective 1.5: Begin enrollment in the MW&R on January 10, 2012

#### **Goal 2: Implement web & phone-based technologies for addiction treatment interventions to deliver CBT skills training**

- Objective 2.1: Modify the HSC website to house computer programs and resources.
- Objective 2.2: Purchase and install automated, web-based computer protocols of CBT for alcohol/drug behaviors
- Objective 2.3: Develop protocols for loading A-CHESS smart phone applications onto personal smart phones and using the CHESS web-based program for smoking cessation
- Objective 2.4: Develop a web-based resource center for clients with a SUD

#### **Goal 3: Develop a series of protocols that keeps individuals engaged in CBT skills training and relapse prevention for at least six months through the use of multiple e-therapy options**

- Objective 3.1: Hire and train project staff
- Objective 3.2: Develop protocols for linking clients to healthcare centers
- Objective 3.3: Develop protocols for engaging clients over time and providing continuous care through multiple media options

### **Evidence-base for Proposed Interventions**

All interventions proposed are based on established research for best practices. As noted by CSAT (2009) e-therapy and other technological innovations can be used as a therapeutic bridge to reach individuals in rural areas and other underserved populations. Mallen and Vogel (2005) noted that e-therapy is well suited for structured, CBT interventions. For this project, e-therapy includes telephonic contact, other forms of communication via the phone; e.g., texting & email, internet-based CBT programs, and self-directed smart phone applications. Gustafson and colleagues (2011a) reviewed 34 randomized clinical trials of e-therapy interventions for a range of chronic health conditions, including alcohol, tobacco and other drug addictions, diabetes, cancer and heart disease. Twenty-nine (85%) of the studies yielded positive results in terms of improved health outcomes, increased self efficacy, and increased rates of engagement.

The project will use motivational interviewing (MI), cognitive behavioral therapy (CBT), and brief versions of these interventions to treat individuals who have a SUD. Brief interventions are structured, manualized interventions that combine MI and CBT techniques, with advice and guidance provided by a trained clinician. Brief interventions require less than one hour for a single session, and range from one to four sessions. The goal of most brief

interventions is to assist individuals in reducing their alcohol or drug use. Brief interventions have an extensive and strong evidence-base for effectiveness (Miller & Wilbourne, 2002; Bien et al., 1993). Brief structured protocols have led to significant decreases in substance use behaviors that are comparable to longer, outpatient models (Miller & Wilbourne, 2002; Carroll & Rounsville, 2006). All three interventions are considered evidence-based by the National Institute of Drug Abuse (NIDA, 1999) and have an extensive body of research supporting their application with men and women, criminal justice populations, and minority population (Carroll & Rounsville, 2007; Miller & Wilbourne, 2002; Dutra et al., 2008; Magill & Ray, 2009; Prendergast, 2009).

**Limited Availability of Addiction Treatment Services.** The project is designed to increase the number of individuals who can receive addiction treatment services through the application of a web-based skills training programs. Two computer-based addiction treatment programs were identified in the literature that included a range of behavioral skills training techniques, could be used for individuals with any SUD, and have been tested under a randomized clinical trial (Moore et al., 2011). The two programs include:

- a CBT program (Carroll et al., 2008 & 2009) based on the NIDA CBT manual (Carroll, 1998) and
- a CRA program (Bickel et al., 2008) based on the community reinforcement approach of addiction treatment (Meyers & Smith, 1995) and principles of the NIDA CRA manual (Budney et al., 1998).

CRA is an evidence-based program (Meyers & Squires, 2004; Miller & Wilbourne, 2002) that includes the same behavioral skills training used in CBT programs, but places more of an emphasis on behavioral training in multiple domains of living. CBT combines behavioral skills training with cognitive therapy techniques and a more narrow focus on skills training for avoiding alcohol and other drugs.

Both computer-based programs combined self-directed computer training with office-based clinical interventions. Both programs led to significant reductions in SUD behaviors over time and outperformed a treatment as usual condition. Bickel et al.'s (2008) computer version of CRA was comparable in outcomes to a clinician-directed CRA group that include all the same skills training modules and reward vouchers, but less time with an actual clinician. Other research projects that have tested computer-based CBT programs for individuals with a SUD have found similar results (Gustafson et al., 2011b; Hester et al., 2005 & 2009; Kay-Lambkin et al., 2008). The CRA computer program is available to providers and will be used in the proposed project (Carroll's CBT version is not available for use).

There is also a substantial collection of studies that have tested the effectiveness of online interventions for smoking cessation (Gustafson et al., 2011a; Strecher et al., 2005; Japunitich et al., 2006; Glenn & Dallery, 2007) with similar, positive results. Computerized smoking cessation programs are also used to augment other evidence-base interventions for smoking cessation, such as nicotine therapy and in-class, CBT skills training. The CHESS smoking cessation protocol (Japunitich et al., 2006) website will be used in conjunction with in-person and e-therapy CBT protocols provided by the MW&R team and resources on the HSC website.

**Limited Accessibility of Addiction Treatment Services.** The proposed project will use a combination of telephonic and computer/internet-based skills training, access to smart phone applications and community-based services to reach individuals across the 10-county region. These interventions are designed to minimize the geographical, financial, and childcare burdens that individuals living in rural locations frequently encounter in an attempt to access behavioral

health services. Individuals can receive a range of services without having to leave their home. As noted by CSAT (2009), e-therapy interventions can be used to engage individuals in their homes, rather than having individuals travel to a distant location. Proactive, telephonic clinical interventions have been successfully used to deliver CBT-based relapse prevention (McKay, 2009b; McKay et al., 2010), recovery management checkups (Scott & Dennis, 2009), health and wellness coaching (Butterworth et al., 2007), smoking cessation in multiple formats (Stretcher et al., 2005) and disease management of chronic health conditions (Handley et al., 2008).

**Limited Acceptability of Addiction Treatment Services.** The project will use a variety of motivational interventions and e-therapy options to engage individuals in addiction treatment. MI and brief interventions were designed specifically for individuals in the early, pre-contemplative stages of readiness to change or unwilling to consider an abstinence option, but open to a harms reduction approach. Both techniques lead to significant reductions in substance use over time as summarized in numerous literature reviews (Butterworth et al., 2007; Hettema et al., 2005; Miller & Wilbourne, 2002; Bien et al., 1993). The SBIRT screens will be used in primary care settings to help identify rural clients who have a SUD. The SBIRT protocol was developed for medical care settings to assist individuals in becoming more aware of the potential risk associated with their heavy drinking or drug use (Babor et al., 2007; Madras et al., 2009).

Gustafson and colleagues (2011a) noted numerous benefits of e-therapies in research that increased individual's motivation and self-management skills. Individuals who had used technologies in the process of recovery from a SUD:

- found computer-based interventions as helpful toward their recovery,
- tended to report higher rates of substance use with internet-based programs,
- increased their motivation toward recovery and decreased alcohol consumption, and
- had high show rates for telephonic contacts.

For example, Gustafson et al. (2005) found that women living in impoverished environments actively engaged in and benefited from their interactive, internet-based CHESS protocol (discussed in detail below) who were recovering from breast cancer. Cunningham et al., (2011) noted that underserved populations now have access to the internet and could be served through these forms of media. Rural clients will have several options for accessing addiction treatment services delivered through secure, private forms of communication.

**Increased Health Risk in Rural Settings.** The MW&R nurse and other members of the team will assist individuals in receiving both behavioral health and medical care. The project will also use a mix of in-person and internet based CBT instructions for smoking cessation combined with medical care. The phone-based relapse prevention protocol will be used for individuals learning how to avoid using tobacco in addition to alcohol and other drugs.

Integrated healthcare services have consistently shown to be effective at lowering SUD as well as improving health outcomes (Babor et al., 2007; Mertens et al., 2008; Tegger et al., 2008). Integrated services can also lower the use of expensive, crisis-based services (Snowden et al., 2009). Integration of services creates multiple doorways for engaging individuals with a SUD. There is also mounting research evidence indicating that individuals who received treatment for their tobacco addiction while enrolled in an addiction treatment program had significantly higher rates of abstinence from alcohol and other drugs compared to those who continued to smoke cigarettes during and after treatment (Baca & Yahne, 2008; DHHS, 2007; Prochaska et al., 2004 & 2006). The research indicates that tobacco cessation programs can be used simultaneously with addiction treatment (TURN project, 2009).

The project will work with federal qualified health clinics and other medical providers in rural regions to adopt the SBIRT protocol for screening clients for SUDs. Research on the SBIRT (screening, brief-intervention, & referral to treatment) model has led to the development of effective protocols for screening, treating and referring individuals who enter primary care facilities and community organizations (Barbor et al., 2007; Madras et al., 2009). Brief interventions have been used effectively in primary care settings where the majority of rural and urban clients with a SUD will seek help (Babor et al., 2007).

**Acute Care of Addiction Treatment Services.** A variety of addiction treatment interventions are needed to meet the complex needs of individuals with a SUD. The proposed project is designed to keep individuals engaged and actively involved in the recover process over many months, while providing timely and sufficient dosages of skills training. The MW&R team will use three well established clinical interventions for addiction treatment: Motivational Interviewing, brief interventions, and an array of skills training interventions, to engage and retain clients over time. These interventions can be delivered through face-to-face contacts, phone, internet, and smart phone applications.

The team will provide clients with ongoing, relapse prevention training after they complete a series of basic CBT skills. The relapse prevention training, referred to as continuing care, will be delivered through structured phone contacts, internet applications, in-person contacts when needed, and smart phone applications. The continuing care protocol will include an emphasis on expanding social supports through community- or internet-based support groups and other indigenous resources.

CBT and CRA interventions are used to teach individuals a range of social and cognitive skills-training techniques to help them learn how to avoid alcohol and other drugs as well as develop behaviors to achieve goals without relying on these substances (Carroll & Rounsaville, 2006; Marlatt & Witkiewitz, 2005). A specific model of CBT, known as relapse prevention, is used to help individuals who have acquired the basic skills to live without alcohol and other drugs, but require ongoing training to effectively navigate around common relapse triggers (Marlatt & Gordon, 1985; Marlatt & Donovan, 2005).

Alcohol and drug use are learned behaviors that evolve into automated habits (Marlatt & Witkiewitz, 2005). The challenge in addiction treatment is to teach individuals how to disrupt the automation of drug using behaviors while learning new behaviors that promote recovery. Between 50% and 70% of individuals relapse within the first year after treatment, with most relapses occurring within one to three months (Scott & Dennis, 2011). Continuing care protocols were developed to assist individuals in the learning process of recovery by extending the time needed to integrate new behavioral skill sets. Effective continuing care interventions provided:

- skills training based on CRA or CBT protocols,
- extended periods of follow-up; i.e., six or more months,
- were proactive in design and actively engaged clients through phone or case management interventions, and
- integrated community supports and resources (Mckay, 2009b & 2011).

These continuous care interventions have also been effective at re-engaging individuals in treatment who began to show signs of relapse (Scott & Dennis, 2009).

Social support, including the use of 12-step support groups and other mutual aid programs, is an essential element of the recovery process and consistently linked to improved recovery rates (Humphreys & Gifford, 2006; Kaskutas & Subbaraman, 2011; Kelly & Yeterian, 2011). Individuals who use 12-step programs, in particular, are found to have lower substance

use over time compared to individuals who receive similar forms of professional treatment, but don't use 12-step resources during or after treatment (Mckellar et al., 2003; Moos & Moos, 2006; Ouimette et al., 1997 & 1999; Timko et al., 2000). Effective continuing care interventions incorporate social support development, including active training in the use of 12-step programs. Members of the MW&R team will use a manual guided approach to helping individuals use 12-step interventions online or in the community. The manual is the Making Alcoholics Anonymous (and NA) Easier (MAAEZ; Kaskutas & Oberste, 2002) that is free to download.

One of the challenges in teaching individuals the relapse prevention protocol is delivering useful, problem-solving learning experiences in a timely fashion before individuals experience a slip or return to a full relapse (Gustafson et al., 2011). Self-efficacy increases every time a person can use relapse prevention techniques to avoid alcohol and other drugs. Conversely, self efficacy decreases every time a person slips and is unable to use relapse prevention techniques (Marlatt & Witkiewitz, 2005). Continuing care protocols appear to be helpful because individuals have time to learn how to identify high risk situations, work through challenging or novel high risk situations, and master an array of relapse prevention skills (Mckay, 2009a). The challenge is in delivering the proactive phone calls in a timely manner, prior to when a person is likely to slip. Because clinicians cannot anticipate a slip, individuals need an additional support that is timely and instructive, like a clinician providing skills training.

Gustafson and colleagues (2010 & 2011) with the A-CHESS project have developed a set of electronic applications that assist individuals in the learning process of relapse prevention while simultaneously disrupting the automation of drug using behaviors. The research team has developed computer applications that can be installed on a smart phone. The applications include a variety of CBT-type learning protocols, problem solving ideas, and self-help instructions. The applications are standard procedures in most CBT and CRA manuals; however, these protocols can be initiated by the individual in real-time application and before the person experiences a slip. In essence, the applications on the smart phone achieves what clinicians cannot; i.e., provide real-time relapse prevention training that is available 24 hours a day. In addition, smart phones can be programmed to notify individuals when they are entering a high risk situation through global positioning systems (GPS) that are available on all smart phones with internet access. Individuals can program in their own high risk situations. The phone can provide warning signals designed to disrupt the automated and unconscious behavior of seeking alcohol or other drugs when individuals approach a high risk situation. The phone also uses the GPS function to assist clients in accessing self-help programs in the area. The phone also utilizes a check-in protocol where individuals complete a brief digital survey that can be submitted to the research team through a text function. The phone is also used as a portal for online social support groups. The A-CHESS team developed online information centers for clients enrolled in the study grouped by gender. The smart phone facilitates access to social outlets without the need for transportation or even knowledge of self-help groups. Finally, the phones include a panic button that individuals can push when they enter a high risk situation. The button triggers a text message that is sent to a phone number programmed by the client. Many individuals find it difficult to call and ask for help, but can easily push a button on a phone. For the proposed project, the text message could be sent to both a supportive friend and to a 24-hour call center housed at HSC.

The A-CHESS research project at HSC is ongoing; therefore, no results have been published. The CHESS interactive technology has been tested on other populations of individuals with chronic conditions, such as parents with children who have asthma, women

recovering from breast cancer treatment, and both teenagers and adult smokers wanting to quit (Gustafson et al., 2008 & 2011b). In all these studies, clients showed significant improvements in quality of life and health indicators compared to those who were assigned standard models of medical care without the use of the interactive, internet-based programs.

### **Modifications to Evidence-based Practices**

Nearly all the phone and computer-based protocols in published research have been provided to individuals who completed a standard episode of addiction treatment or were enrolled in a program and offered the e-therapy option as an augmented element. The proposed project will use a range of e-therapy and in-person treatment options to engage individuals in treatment. Mckay and Hiller-Sturmhofel (2011) noted that the potential benefit of flexible, telephonic protocols is the ability to reach individuals who are unwilling to enter an outpatient program or withdraw before accessing the continuing care protocol.

### **Plan for Serving Diverse Populations in the Project**

Table 5 provides a summary of interventions that will be used to reach and serve rural clients. Both HSC and North Central are committed to providing culturally competent and linguistically appropriate services that value the diversity of all clients seeking help for a SUD or other behavioral health disorders. The project will use a comprehensive survey to identify the needs of individuals who enroll. Family and friends will be encouraged to participate in the skills training programs. A primary task of the MW&R is to organize and coordinate resources across the 10-county area. The project will organize focus groups and key stakeholder meetings across counties to identify resources, social supports, and recruiting options.

Project staff will be trained to use a client-centered model of care tailored to the self-defined needs and cultural preferences of each participant. Members of the MW&R will use evidence-based behavioral interventions that promote a strength-based orientation and a collaborative relationship with all clients.

**Table 5: Interventions Tailored to Individuals Unique Needs**

category	Specific strategies	Research to develop	Male – Female
Race and ethnicity	The team will provide a list of support groups in all Counties that are based on ethnicity. Educational materials will be posted on the HSC website for specific racial or ethnic groups. Family and friend will be involved based on client preferences.	E-chat groups will be organized through the smart phones similar to the A-CHESS study based on ethnicity. The team will recruit racial and ethnic groups through community centers, healthcare programs, and faith-based services.	All E-chat & social support groups will be organized and controlled by male or female similar to the NIAAA smart phone study.
Spirituality and religious preferences	The team will provide clients with a listing of faith-based services (on the smart phones & phone calls)	The team will reach out to local faith based organizations about the program and develop a resource guide for clients – updated over time	
	Individuals of all ages will receive education on how to use smart phones or access the internet – age specific	The team will also work with local community organizations to identify volunteer transportation for individuals who need	

Age	materials will also be provided on the website. The relapse prevention module will incorporate recommendations from SAMHSA (2005) Relapse Prevention manual for older adults <a href="http://kap.samhsa.gov/products/manuals/pdfs/substanceabuserelapse.pdf">http://kap.samhsa.gov/products/manuals/pdfs/substanceabuserelapse.pdf</a>	assistance accessing healthcare appointments.	
Geography and socio-economic status	All services are free to clients. Individuals will have the option of any version of CBT or support based on their ability to engage in services or their access to a phone, car, or internet	MW&R team will provide in-house services when needed, to help individuals use the web or download resources (MW&R will have portable laptops, printers).	Services will be tailored to the needs of men and women, including evening hours for phone-contacts, assistance identifying childcare services reading materials will include
Language and literacy	All educational materials will be provided in English and Spanish. Audio files of CBT protocols are used on the smart phones and will be provided via the web resource center to individuals who have literacy problems or are blind. All 65 modules of the CRA computer program include audio instructions and some include video presentations of skills training	One or both primary project staff will be bilingual. The project will develop a call-in line for Spanish speaking clients. Additional audio files will be developed for smart phones and the web resource center.	
Sexual identity	The MW&R team will survey clients on their sexual orientation & needs for social supports. LGBT clients can select from a variety of interventions that maintain privacy & support	The team will develop or identify online and community-based support programs for LGBT clients. The team will also provide clients with resources specific to LGBT needs.	gender specific information
Physical disability	Individuals will have the option of receiving phone, internet, or in-house services without the need to travel to another location.	The nurse can deliver wellness services to client's homes or assist through phone and email communication	

Table 6 provides a logic model for the proposed project.

**Table 6: LOGIC MODEL**

<b>Inputs</b>	<b>Activities</b>	<b>Outputs</b>	<b>Outcomes</b>
1. ACHESS team & applications for smart phones	1. develop & implement screening protocols	1. Time between calling for help and first contact	1. Scores on BAM,
2. Online CBT & CRA tools	2. develop protocol to quickly engage clients	2. # of clients enrolled in the program	2. scores on the 3-rulers for behaviors change
3. Enhance HSC website	3. develop resource center on website	3. # of clients who use e-therapy options	3. Baseline and 6-month scores on the AUDIT, ASSIST
4. 24-hour call in center	4. Provide access to online CBT/CRA programs	4. # of clients who complete one or more CBT modules via phone or web-based,	4. Baseline and 6-month scores on the SF-12 for medical & mental health assessment,
5. Use of free, online personal health record		5. # of clients who complete one or more phone-based continuity of care calls	5. UA and breathalyzer tests for alcohol & other drugs
6. Two Master level clinicians	5. Organize key stakeholders in communities to recruit clients and disseminate information	6. # of clients who access a medical provider	6. Fagerstrom scores for smoking (and CO levels)
7. Mobile nurse		7. # of clients who smoke cigarettes use a smoking cessation program	7. # using online or community-based mutual support
8. access to mental health services & psychiatry	6. Develop protocol for engaging clients in e-therapy options	8. # of clients who use smart phone applications provided	8. self efficacy scores for the drug taking confidence questionnaire & the smoking cigarettes scale
9. Multiple healthcare facilities		9. duration of engagement for all clients	9. # of family members involved in the person's recovery plan
10. Access to addiction treatment	7. Provide wellness services & nursing assessments, link with health care providers	10. # of agencies that adopt SBIRT screens and provide referrals	
11. Experience implementing e-therapy	8. provide ongoing care through e-therapy		
12. Established protocols for CBT interventions	9. create online support groups		

## **Section C: Proposed Implementation Approach**

### **Experience using Health Information Technology**

HSC and North Central have extensive experience using Health Information Technology. Both agencies have been using an EHR (North Central in 2000 and HSC in 2005), telecommunication, and websites that provide links and resources. North Central has developed the technical infrastructure to support an integrated web of teleconferencing centers for group counseling, telepsychiatry, individualized teletherapy interventions using laptops, and assessments across seven counties. North Central has the experience providing both individual and group counseling sessions through teleconferencing technology to rural clients. In addition, North Central is piloting the use of webinars to reach rural populations and using county funding options to finance the educational webinars.

Both agencies provide an extensive range of community-based services with mobile clinicians. Mobile staff have cell phones, laptop computers, aircards for transmitting emails and records, and VPN portals to the EHR system.

HSC is home to several grant-funded projects that can support the implementation of the proposed project, including the aforementioned A-CHESS trial. David Gustafson and colleagues are testing the feasibility of smart-phone applications to support individuals' recovery from alcohol and other drugs after they leave a residential addiction treatment program (Gustafson et al., 2011a & 2011b). HSC clinicians have been recruiting men and women from HSC's three residential programs for the past 18 months. HSC clinicians also provide ongoing support to clients assigned to the smart phone condition. .

HSC is using grant resources from SAMHSA Primary Behavioral Health Care Integration (PBHCI) program to upgrade the EHR and capacity for telepsychiatry and –medicine as well as develop protocols for integrating medical records for clients enrolled at HSC and Heartland Community Health Clinic. HSC has also been piloting and disseminating multiple e-therapy interventions, including a phone-based, relapse prevention protocol developed by McKay and colleagues (2009a). A copy of the HSC e-therapy, relapse prevention protocol and other CBT protocols can be downloaded at [www.fayettecompanies.org/csat](http://www.fayettecompanies.org/csat).

### **Current Capacity for Health Information and Technology**

HSC and North Central have the hardware, software capacity, and staff to implement all elements of the proposed project. HSC and North Central have seven full time staff members dedicated to HIT to maintain T-lines for internet and cable, EHRs, computers, mobile technology; e.g., VPN access and aircards, and equipment for teleconferencing. Both agencies have T-lines with sufficient bandwidth needed to operate all proposed e-therapy options.

HSC has a website that can support the software as well as the volume of traffic estimated in the study, although the website will be updated to be more functional and user friendly. The EHR systems of both agencies can be modified to include exclusive billing codes, service documentation forms, modules, and treatment plan functions to support the goals of the MW&R project. HSC operates a 24-hour emergency response service. The proposed text messaging system connected to smart phone panic buttons can be routed to clinicians or the ERS operator after hours. The A-CHESS applications can be loaded by MIS staff at HSC or North Central.

### **Plan for Expanding Electronic Tools for Reaching Rural Clients with a SUD**

Clients will have the opportunity to use all e-therapy options. Clients who have only a landline or basic cell phone service and no access to internet can receive telephonic interventions with materials mailed to their home as well as options for in-person services. Other alternatives

for accessing e-therapy options are noted in Table 7. Clients will receive instructions on how to use all the e-therapy options. Instructions can be delivered in-person, over the phone, and through printed manuals and guidelines. Clients will have to meet with the MW&R team to load the A-CHESS application onto their smart phone. Table 7 provides a summary of e-therapy tools and resources that will be used to engage and retain clients residing in rural regions. Clients will be asked to go through phases of treatment to allow them time to develop basic skills for avoiding alcohol and other drugs before moving to more advanced, relapse prevention skills and the continuing care protocol. The program flow is designed to purposely delay the access to all electronic resources until clients have received at least a basic skills training on SUD. The plan is to have clients complete at least one face-to-face and one telephonic CBT skills training session before they move into a continuing care phase for relapse prevention. Clients will always have the option of additional face-to-face meetings or office-based services.

**Table 7: Expansion of E-Tools for Proposed Project**

<b>Flow of clients</b>	<b>Process and protocols</b>	<b>e-tools used</b>
Potential candidates	Candidates are referred to HSC website to read through all the self-help materials available	A MW&R clinician can talk to candidates on the phone or in person about the program. HSC website will include a range of resources & informational pamphlets regarding the grant project
Expedited Screen & enrollment Phase I	The phase begins with in-person & telephonic contacts with a MW&R team member within hours of the call – goal is to complete GPRA, other screens & assessment tools for Medicaid billing	E-therapy calls using CBT, MI or brief interventions will be initiated. MW&R team will begin sending out reminders via texting, email, or mail to engage clients in additional calls. Clients will be directed to the website to access resources. Screens can be emailed to clients & completed over the phone. Clients can use phones, HSC website, texting or email to contact the 24-hour crisis center at HSC when needing help or guidance
Basic CBT or MI – Phase I	Clients stage of readiness is assessed & begins MI, CBT or brief intervention on the phone (in person is available)	E-therapy calls using CBT/MI begins, clients will have access to CBT materials on HSC website. Text or email messages will be used as reminders of meetings. Clients without email will be shown how to open up free email account. Clients can begin using the weekly check in on the HSC website or on the phone with MW&R clinician
Basic skills training - Phase II	Clients will receive telephonic & internet CBT/CRA skills training. Clients can begin using the two web-based CBT/CRA programs. Nurse will assist clients in initiating a PHR	Begin using web-based skills training programs for CRA & CHESS smoking cessation in addition to ongoing telephonic skills training. Clients will be given passwords to access internet programs housed at HealthSim LLC & University of Wisconsin (UW) CHESS. Clients will be guided to the AHIMA website to enroll in the free personal health record (PHR). Clients will also be guided to online support groups and information boards.
Relapse prevention	Clients will meet with a MW&R staff to develop	Clients with smart phones will receive the A-CHESS interactive applications or the web version

and continuing care – Phase III	a continuing care plan, staff will use the MAAEZ manual to assist clients who wish to use 12-step programs or other resources	without a smart phone. Clients will learn to use social networks via the phone/web that are exclusive to the MW&R. Continuing care contacts will include telephonic, email, texting, & a face-book account. Clients can continue to use internet skills training programs for CRA or smoking cessation. The CRA program includes 65 skills training modules
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### **EHR Standards at HSC and North Central**

North Central's EHR is Anasazi, which is already approved for meaningful use under the ONC and is applying for full accreditation on July 7, 2011. HSC's current EHR was developed in-house and is not certified. HSC will update the EHR with the NextGen system, Anasazi, Qualifax or other EHR systems that are ONC certified. The new system will be installed on July 1, 2012.

### **Organizational and Staff Factors Associated with the Project**

**Organizational factors and staff training needs.** Both agencies use a comprehensive assessment tool to collect information needed for enrollment in the State mental health or addiction treatment systems. The assessment is needed for State billing, but adds additional time to the enrollment process. The intake process will be modified to maximize clinical engagement at the front door by delaying the completion of the entire assessment until clients have been enrolled in the MW&R. Candidates will be screened and enrolled within a few hours of the first call with additional assessment completed over time.

All clients will be enrolled in HSC's EHR to centralize the storage of information and services provided. North Central intake staff will have access to HSC's system for completing intakes or integrating treatment plans for clients who continue to receive other services at North Central. MW&R staff will have laptops with VPN access to complete all electronic forms at any location.

Emergency Response Services (ERS) staff at HSC will be trained to monitor text messaging from clients enrolled in the project. The digital check-in survey; i.e., Brief Addictions Monitor (BAM), will be available on clients' smart phone, on the HSC website, or via a phone call to the MW&R office. ERS staff will be trained to follow protocols for assisting clients who are calling or texting for help at night or on weekends.

MW&R staff will be trained to operate the e-therapy options and train clients. HSC and North Central will develop a tracking system within the EHR to monitor the number of clients who receive both the basic CBT training on the phone and the continuing care protocol. Researchers at the HealthSim LLC will provide usage information for the CRA program. The UW CHESS team will provide information on the number of clients who use the A-CHESS program or the interactive smoking cessation program.

HSC and North Central will develop a tracking system for e-therapy forms of communication, including texting, email, and the use of computer programs on the internet. MW&R staff will use service documentation notes installed in the EHR to record various forms of communication. IT staff will develop voice mail and emails specific to the MW&R team. Dr. Figlock and Dr. Loveland (noted in section D) will monitor phone calls and other forms of communication for fidelity to MI, brief interventions, CBT for basic addiction treatment, and the continuing care protocols.

**Relationship factors between provider and persons in treatment.** Table 8 includes projected hours of client time by media source, including phone or face-to-face time with MW&R staff.

**Table 8: Project Time with Clinicians and Self-directed E-therapy**

Media	Screen hours	Enroll/assess hours	Phase I hours	Phase II hours	Phase III hours
Time in weeks	1	2	1 to 2	2 to 6	16
Text or email messaging			Unlimited		
HSC website – hours			Unlimited		
Face to face - hours	0	2	2	2	2
Telephonic – hours	1	1	1 to 4	1 to 4	6 to 8
Computer/internet	0	0	2 to 4	6 to 8	2 to 16
CBT/CRA – hours					
A-CHESS on phone or web	0	0	0	Based on skill	unlimited
Nursing contacts – phone or in person	0	.5	1	2	2

**Technical Factors Requiring Additional Staff or Consultants.** HSC and North

Central will participate in the A-CHESS consortium. The consortium provides members with smart phone applications, web-access to A-CHESS for those without smart phones, technical assistance, and updates. The UW's project team will also provide consultation to enhance the smoking cessation program. HSC IT department will also hire a consultant to enhance the project website and maintain it beyond the grant project. Modifications to the website will be made to support the resource center and tracking mechanisms; e.g., recording the number of people who use the website. The website will include an interactive survey for check-ins that clients can complete on a weekly basis to keep MW&R staff updated. The survey is available on the smart phones and will be installed on the website. Both HSC and North Central will update the EHR systems to create billing codes and tracking mechanism for clients receiving MW&R services. Existing protocols for standard paperwork will be altered to meet the goals of the project, including:

- completing the GPRA survey at baseline and six months before other assessments are completed,
- using an expedited protocol to engage clients that delays the completion of the standard assessment processes,
- using e-therapy interventions that are not currently billable, and
- and providing a combination of e-therapy and in-person services for six or more months to both retain clients and provide ongoing, relapse prevention services that do not exist in the present IL-DASA treatment menu.

ERS staff will be trained to receive automated or typed text messages.

**Financial Factors Associated with the Project.** Financial resources for the new EHR have been allocated with possible help from a SAMHSA HIT grant for \$200,000.00 designated for PBHCI grantees. There are several costs associated with the enhanced electronic system that will be incorporated into the budgets of HSC and North Central. Maintaining the website will require an ongoing service contract. The use of smart phones will double the cost of monthly cell phone service for mobile staff. The CHESS consortium contract will cost the two agencies

approximately \$10,000 annually and provide 110 smart phone applications or use of the web-version of A-CHESS. The computerized versions of CBT/CRA for addiction treatment and tobacco cessation programs will require annual licensing fees of \$10,000 each. These added costs to support the e-therapy options can be offset by the savings in mobile staff time associated with locating clients, mileage paid to mobile staff, and the subsequent increase in billable show-rates associated with telephonic contacts and engagement with the expedited enrollment.

#### **Implementation Plan for the Proposed Technological Innovations**

Nearly all the technological innovations will be in place by the end of the first quarter of the project or have already been developed. HSC's implementation of the new EHR system will begin on July 1, 2012 and take approximately three months to complete. The CHESS smoking cessation program will require 60 days to update. The A-CHESS smart phone applications and website are already available. The CRA computer-based skills training program is available through a licensing fee. The HSC resource center on the website will be updated over time as the project team identifies resources in the community and from the web.

#### **Screening and Tracking Protocol**

The MW&R team will work with local healthcare providers to implement the SBIRT protocol. The SBIRT protocol will include the AUDIT for assessing alcohol use (Babor et al., 2001) and the ASSIST for assessing the use of tobacco and other drugs (NIDA, 2011). The MW&R team will work with healthcare providers to identify clients who may be interested in enrolling in the program.

North Central and HSC will screen clients at intake for rural status, SUD status, and interest in the program. Intake staff will refer clients to a MW&R to complete the screening process. MW&R staff are expected to call candidates back within a few hours. The quick screens will include the AUDIT and ASSIST screens. If clients agree to enroll, the MW&R clinician sets up a face-to-face appointment to complete the:

- GPRA survey and additional standard assessments for the agencies, including assessment of co-occurring mental health conditions,
- acquire commitment for six months as well as names of three contacts for tracking,
- acquiring information on e-therapy capacity and preferences,
- complete the survey on cultural and other needs,
- and begin the three phases of skills training/treatment.

Clients will also be trained to begin completing the online check-ins on the HSC website or by phone with a clinician. The clients' treatment plans and movement through the phases of treatment will be assessed with several, empirically established measures of behavior, including:

- The BAM scores from the weekly checkins (Mckay, 2009a),
- client's self-reports for the 3-rulers of readiness to change (Miller et al., 2004),
- scores from the Drug Taking Confidence Questionnaire (DTCQ; Sklar et al., 1997), and
- baseline information from the AUDIT and ASSIST tools for SUD behaviors.

The MW&R team will collect Urine Analysis (UA), breathalyzer and CO (carbon in lungs from smoking) measures throughout the phases of treatment. Scores from the screens and information from the UA tests will be stored in the EHR systems and used to develop a treatment plan.

#### **Use of Messaging Systems and Personal Health Records**

The MW&R team will use a mix of automated and electronic messaging protocols to keep clients engaged, provide updates and information, and provide reminders for appointments and healthcare reminders. Cell phone numbers and email accounts will be collected and used to provide clients with reminders via a team phone number or email account.

The team will assist individuals in using a free, online personal health record (PHR) housed on the website of the American Health Information Management Association. The PHR can be used to store essential medical information, medications, and contact information. Clients will control access to their PHR information and can provide access to providers. The MW&R nurse will assist clients in recording information that can help them integrate behavioral and health care services. The MW&R team will also educate providers on the use of the PHR.

#### **Use of Home-based Monitoring Tools to Improve Health Outcomes**

Clients with smart phones will have the A-CHESS applications installed on their phones, which includes a range of integrated and automated prompts to support their recovery program. Clients without smart phones can use most of the same options on the web version, except GPS. Clients will also be guided to use a variety of web-based programs that can provide automated reminders via texts messages or emails, including the CHESS smoking cessation program and online web programs for medication reminders; e.g., <http://mymedschedule.com/>. The MW&R team will also keep clients posted with text messages, emails, and posting on facebook page.

#### **Consenting Procedures**

Clients will be provided with the same education on their rights, confidentiality, and HIPPA laws provided to all individuals who receive behavioral health services at HSC or North Central. Clients will be asked to sign the standard package of consent forms for treatment and the release of information to other providers. Clients will receive additional education about the potential risks of e-therapy and how to protect confidentiality, such as using texts or emails without revealing sensitive information, setting up security locks on computers, using code names in chat rooms, and excluding information on the PHR that is not to be shared.

#### **Timeline of Activities, Milestones and Responsible Staff**

Table 9 includes a listing of goals, objectives, timelines, and responsible staff for completing the objectives.

**Table 9: Timeline and Projected Milestones**

Project objectives and milestones	Year 1				Year 2				Year 3				Responsible staff
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
1.1: Organize steering committee	M				Q				C				DF, DM, ML
1.2: Establish screening protocol for primary care	M				Q				C				DL, HD
1.3: Establish screening protocol	W	M	Q				C				DF, DL, DM, ML		
1.4: Develop triage protocol	W	M	Q				C				DF, DL, ML, DM		
1.5: Begin enrollment	D												DF, DM
2.1: Modify the website	W	A				JS, HD							
2.2: Purchase & install software programs	C	A				JS, DL, HD							
2.3: Develop protocols for A-CHESS applications	W	A				JS, HD, DL							
2.4: Develop and update web resource center	Q				HD, DF, DL								
3.1: hire & train staff	C	A				DF, DL							

3.2: develop data collection protocol		Q	DF, DL, ML, HD
3.3: Develop protocols for linking to healthcare		Q	MT,
3.4: Develop continuous care protocols	M	Q	DF, DL, MT

'M' means task that occurs monthly, 'Q' means task that occurs quarterly, P = done before first year, W = weekly activity, 'D' = daily, A= as needed, S=reviewed every six months, C = completed

DF=Dana Figlock- project director, MT=Mobile Wellness & Recovery team, SM = supervisor of mobile team, AC=advisory committee, DM = David Moore, quality improvement, ML = Mike Lau, Research Director, North Central, DL=D Loveland, program evaluator, HD=Hilary Driscoll, Research coordinator, JS =Jerry Sales, MIS director,

### **Unduplicated Number of Individuals Enrolled in the Project**

The unduplicated number of individuals who will be served in the project annually and over the entire project period with grant funds is noted in Table 10.

**Table 10: Unduplicated Count of Individuals Served in the Grant Project**

Agency	Year 1	Year 2	Year 3	Total by agency
HSC	50	62	62	174
North Central	70	103	103	276
Total by year	120	165	165	450

The goal is to have all clients' progress through all three phases of the project and to utilize all e-therapy resources available within six months. Table 11 provides an estimated flow of services received and primary outcomes of the project.

**Table 11: Estimated Number of Services Provided**

Service	Screened & access to project website	Enrolled & Phase I	Phase II CBT skills training	Phase III-Continuing care
Face-to-Face MI & CBT	600	450	400	300
web resources	500	450	400	375
Telephonic MI & CBT		450	400	375
nurse & wellness services		50	100	225
Link with healthcare		50	100	225
Reduce substance use		100	200	300
Increase social support		100	200	300
CRA computer program			375	300
A-CHESS applications			50	225
CHESS smoking cessation			100	250

### **Integration Plan with Service Continuum and SAMHSA Wellness Grant Program**

The project will be integrated within the treatment systems of HSC, North Central and primary care clinics. Clients enrolled in the MW&R will have access to the agencies' full range of behavioral health and ancillary services, including psychiatry, medication assisted treatment, mental health case management, supported employment, supported housing, and addiction treatment services. The project team will coordinate services with the PBHCI grant project at

HSC. The MW&R nurse will be supervised by the wellness grant project. Clients will have access to all wellness programs developed for the PBHCI grant project.

#### **Agencies Involved in the Project**

There are two primary behavioral health agencies involved in the project: HSC and North Central, and three identified federal qualified health clinics that work with HSC and North Central: Heartland Community Health Clinic in Peoria County, Eagle River in McDonough County and Aunt Marthas's in Stark County. Letters of commitment from all five organizations are attached.

#### **Groundwork for Proposed Project**

Clients will be enrolled in the project within 90 days of the start date. HSC and North Central have office space to house all members of the MW&R, including the use of satellite offices throughout the 7-County catchment area of North Central. HSC and North Central established a non-binding memorandum of understanding in January 2011 to share resources and develop a plan for integrating administrative functions. North Central has extensive experience working with rural communities, using teleconferencing for individual and group counseling interventions, and working with the two federal qualified health clinics in their catchment area. HSC and Heartland have established protocols for using the SBIRT screens, referrals, and sharing staff resources, clients and information. HSC has already established a working relationship with the UW-CHESS team. In addition, both The UW CHESS and HealthSim computer programs are ready for implementation.

#### **Potential Barriers and Contingency Plans**

Table 12 provides a summary of foreseeable barriers and contingency plans.

**Table 12: Barriers and Contingency Plans for the Proposed Plan**

<b>Barrier to the proposed plan</b>	<b>Contingency plan</b>
CSAT (2009) identified diagnostic profiles that may not work well with e-therapy options, including those who have an Axis II diagnosis of personality disorder or are actively psychotic, among other symptoms	The team will have access to psychiatry for assessments. The team will complete assessment for mental illness. Individuals who have a SMI can remain in the project, but will be assigned to a MH case manager. Individuals with an Axis II diagnosis will be enrolled in an outpatient addiction treatment.
Another challenge will be keeping clients engaged as they progress through the phases of treatment & remembering to receive/make calls, complete check-ins, or complete modules on the web	The team will use gas or gift cards for department/grocery stores to complete face-to-face meetings or surveys. The team will use a variety of reminders, text messages, phone calls and contacts to family members (with permission) to keep clients engaged
Individuals who do not have access to the internet, do not own a smart phone, or have limited access to any phone line	The team can meet with clients in locations across the 10-county region, provide information through the mail, and assist clients in accessing the web via libraries or agency offices in rural locations. The team can also purchase a number of smart phones with service for six months for those who would benefit from the smart phone option

#### **Funding Options – Post Grant**

HSC and North Central will work with IL-DASA to develop a funding model that can support e-therapy applications; e.g., an increase in hourly rates to cover the cost of technology and a case rate funding that is based on outcomes, rather than the current fee-for-service system.

North Central has acquired waivers to support funding for their group-based addiction treatment programs provided through teleconferencing. HSC and North Central can bill telephonic contacts at \$46.00/hour under DASA case management, but will seek a waiver to increase the rate to the counseling rate of \$64.00.

## **Section D: Staff Organizational Experience**

There are two behavioral health organizations responsible for implementing the grant project and three health care providers that will assist in identifying recruits and engaging clients who need affordable healthcare. The role of the three federal qualified health clinics will be to identify clients who have a SUD and reside in rural locations, implement the SBIRT protocol, and assist in engaging clients who need healthcare services. HSC will be primarily responsible for hiring, training and supervising the MW&R and housing the program website.

### **North Central's Capacity to Implement the Grant Project**

North Central has been providing behavioral health services to rural populations in the State for over 40 years. All seven counties within North Central's catchment area are classified as rural by the U.S. Census Bureau (2011). Further, North Central has been integrating e-therapy technology for over seven years to provide affordable behavioral health services to individuals in isolated areas. North Central relies extensively on teleconferencing for telepsychiatry, individual and group counseling. The agency has established a web of teleconferencing centers in five counties using Polycom Video Conferencing service (Polycom, 2011) and TherapyLiveMD for laptop based counseling sessions using portable cameras. Individuals in seven counties can attend the same group counseling session through teleconferencing or individual counseling sessions if they have access to a computer, internet, and digital camera for computers. North Central has also been recognized by the State as a leader in innovative behavioral health practices for children and adolescents in rural areas.

### **HSC's Capacity to Implement the Grant Project**

HSC has been testing and implementing many of the elements of the proposed project, including smart phone applications for individuals with a SUD, telephonic protocols for continuing care, and integrating services between behavioral health and medical providers.

**A-CHESS Smart Phone Study.** HSC staff contributed to the development of the A-CHESS applications and protocols. Clinical and research staff at HSC have been trained on using the A-CHESS smart phones, integrating text messaging into clinical care, responding to clients request for assistance in the community, and incorporating the smart phone training into the treatment environment.

**Continuing care and other evidence-based protocols.** HSC has developed and disseminated telephonic protocols for continuing care procedures and wellness coaching. The continuing care protocol is based on McKay's (2009a) model of continuing care and Marlatt's model for relapse prevention. HSC has also been moving toward the adoption of CBT and MI interventions in addiction treatment. HSC has incorporated the infrastructure to support evidence-based behavioral interventions recommended for sustaining best practices (Martino, 2010; Miller et al., 2006). These structural supports include.

- Training protocols for CBT and MI are provided to all clinicians in addiction treatment
- The Yale Adherence Competence Scale (YACS; Carroll et al., 2000) is used to assess the fidelity of MI and skills training for group and individual sessions. The YACS scoring protocol will be tailored to telephonic and other e-therapy forms of communication.

- Client progress within CBT programs is assessed with three empirically derived tools for skills training interventions; i.e., the three rulers of change (Miller et al., 2004), the Drug Taking Confidence Questionnaire for assessing self efficacy (Sklar et al., 1997), and the Brief Addictions Monitor (McKay, 2009a). Copies of these tools, training programs and CBT protocols are available on the HSC website.

**Peoria Integrated Healthcare Project.** HSC is one of 56 sites that has received SAMHSA's Primary Behavioral Health Care Integration grant. The grant project has lead to the development of multiple wellness-protocols, including nutrition, exercise, and a CBT-driven program for tobacco cessation, which is also available for review on the agency's website and will be used with the proposed project.

### **Experience with other Grant Projects**

HSC has had implemented numerous grant-funded projects that have required collaboration with multiple agencies and community stakeholders.

**Behavioral Health and Recovery Management (BHRM) project.** HSC is home to the Behavioral Health Recovery Management (BHRM) project ([www.bhrm.org](http://www.bhrm.org)) funded by a grant from the IL-DASA. The BHRM project was established in 1999 as a resource center and research-testing ground for the principles of recovery management in the behavioral health field (White et al., 2003). HSC and the BHRM project were recently featured in a SAMHSA white paper that identified model programs of recovery-oriented systems of care (Halvorson, Skinner & Whitter, 2009). The BHRM project led to the development of a community-based model of case management in addiction treatment, known as the Recovery Coach Program (Halvorson et al., 2009; Boyle, Loveland, & George, 2011).

**NIATx & Robert Wood Johnson Foundation (RWJF) Grant.** In 2004, HSC received a grant from the Robert Wood Johnson Foundation to implement quality improvement (QI) practices to increase access and retention in addiction treatment: the Network for the Improvement of Addiction Treatment (NIATx) project. HSC is one of the founding members of NIATx. HSC created the position of Vice President for Quality Improvement as a result of the NIATx project and hired David Moore, MPH to manage ongoing QI endeavors.

**CSAT Grant for Pregnant and Postpartum Women.** In 1993, HSC received a five-year grant from CSAT to provide residential treatment services to pregnant and postpartum women with a SUD and their children. This project was a collaborative endeavor with researchers from the Lighthouse Institute at Chestnut Health Systems in Bloomington, IL. The success of the project led to a continuation of funding from IL-DASA.

**CMHS Jail Diversion Grant:** HSC received a CMHS grant in 2002 to develop a community-based jail diversion program for individuals with a SMI. The program was a joint venture of the Peoria County Jail, Emergency Response Services (ERS), Peoria County Court Services, HSC, the City Police Department, and the Lighthouse Research Institute.

**DOL-SE project:** In 2002, HSC acquired a five-year grant from the U.S. Department of Labor to implement the IPS model of supported employment for individuals who have a serious mental illness. The IPS model was integrated into HSC's services and is now financed through existing funding streams. The success of the DOL project has generated additional funding for HSC to disseminate the model across the State through a IL DMH program and as a multi-site study through the U.S. Social Security Administration's Mental Health Treatment Study (2006).

**Emergency Department Diversion (EDD) Project.** In 2008, Heartland and HSC received a two-year grant from the US Department of Health and Human Services to develop an

integrated, crisis center to divert individuals experiencing a psychiatric crisis from emergency departments or jails.

#### **Linkage to Target Population**

North Central's entire target population is rural. Approximately 19% of HSC's clients are classified as living in a rural region. Both HSC and North Central are the primary providers of community mental health and addiction treatment services to individuals with limited or no resources in the 10-county area. North Central and HSC provide onsite facilities and services in 8 of the 10 counties within grant project area, with North Central covering seven rural counties and HSC covering Peoria. Tazewell and Woodford Counties are not covered by either agency, but border Peoria County (HSC serves clients from both counties).

Nineteen percent of HSC clients live in rural counties, but attend HSC for services that are not available in rural areas, including three residential programs, the only regional medical detoxification program, and medication assisted programs that use methadone or suboxone.

#### **Staff Positions for the Grant**

The MW&R team will be comprised of a project director, a coordinator from North Central, one full-time clinician who will supervise the program, one part-time clinician, one half-time registered nurse, and one half-time research coordinator.

**Dana Figlock, Ph.D. Project Director**. Dr. Figlock will oversee the implementation of the project and provide clinical training to the staff. Dr. Figlock graduated from the University of Iowa doctoral program in clinical psychology in 2010. Her doctoral training specialized in behavioral and cognitive behavioral therapies for addiction treatment. She has overseen the development of two CBT-based programs at HSC, including the application or translation of CBT protocols and the implementation of the YACS fidelity assessment protocol for clinicians. Her time on the grant will include .25FTE.

**Mike Lau, Ph.D., Project Coordinator with North Central**. Dr. Michael Lau has been employed at NCBHS, Inc. for 20 years holding numerous clinical and administrative positions. He has published numerous articles in the areas of quality management and corporate compliance. Dr. Lau holds a Master of Arts degree in Clinical Psychology, a Master of Science degree in Engineering: Quality Management and a Doctorate in Health Care Administration and is a Licensed Clinical Professional Counselor. Dr. Lau will dedicate .35FTE of his time.

**Master Level Clinicians**. The project will hire two master level clinicians for 1.5 FTEs who will have a LCSW or LCPC in the State of Illinois or the capacity to acquire a license within 12 months. These individuals will have a masters in social work, clinical or counseling psychology and have preliminary training in MI and CBT treatment models. Responsibilities will include the implementation of the MW&R protocols, in-person services, screening and enrolling clients, e-therapy interventions, and identifying and working with community providers in all 10 counties. At least one of the two clinicians will be bilingual. The two clinicians will provide the majority of e-therapy interventions and in-person CBT skills training.

**Nurse Care Manager**. The project will hire a registered nurse in the State of Illinois for the project for a .5FTE position. The nurse will work within the MW&R team, but receive clinical supervision from the Nurse Manager, Becky Weaver, APN, of the PBHCI grant program at HSC. This person will also be trained to administer e-therapy calls, complete screens and assessments as a back up to the two primary clinicians. This individual will assist clients in opening and using a PHR account, linking with a healthcare provider, completing nursing and wellness assessments, and developing wellness plans with clients.

**Hilary Driscoll, M.A. Research Associate.** Ms. Driscoll is the research associate for grant projects at HSC and oversees the research and management of the A-CHESS and SAMHSA PBHCI projects. Her work includes coordinating all data collection activities, developing assessment protocols, administering clinical assessment tools, developing research databases, tracking participants over time, producing management reports and other grant reporting requirements. Ms Driscoll's responsibilities will include coordinating data collection and evaluation activities, producing QI reports, providing back-up for completing screens & enrollments, entering GPRA data into the SAIS system, and completing quarterly data reports for CSAT. She will dedicate .30FTE of her time to the project.

**David Loveland, Ph.D. – Program Evaluator and Trainer.** Dr. Loveland is Director of Research at HSC and has overseen the evaluation of most of the aforementioned federal grant projects since 2002, including the current PBHCI grant. He is the primary author of the recovery coach manual (Loveland and Boyle, 2005) and the telephonic continuing care protocols used for the grant. Dr. Loveland provides consultation and training to agencies and CSAT grantees that are implementing the recovery coach model. He also has extensive experience training staff on CBT techniques. Dr. Loveland responsibilities will include directing data collection activities, supervising the research coordinator, completing quarterly and annual reports for CSAT, and assisting Dr. Figlock in training staff and assessing fidelity. He will assist the project director in training the MW&R team. He will provide .20FTE to the project.

**UW CHESS team & HealthSim LLC- consultants.** Dr. Kim Johnson and the research team from UW will provide ongoing consultation and technical assistance to HSC in support of the A-CHESS applications and the CHESS smoking cessation programs. Support will include updating the A-CHESS applications and website over time, on and off-site consultation and training, guidance for loading the applications, and evaluation reports on the usage of the phones. Dr. Lisa Marsch and her team from HealthSim LLC will provide consultation, support, and usage information for the computer-based CRA program, housed at HealthSim LLC .  
<http://www.healthsim.com/index.htm>

**Additional staff resources.** Multiple program directors from both agencies will be providing time and support for the project, including the MIS directors of both agencies, and the two clinical directors that oversee addiction treatment services at both agencies.

**ADA standards for buildings.** All facilities that will be used for satellite services are accessible; e.g., parking, offices located on first floor, meet ADA standards for accessibility and support, and have been inspected and approved by the Joint Commission and IL-DASA.

## **Section E: Performance Assessment and Data**

The research team at HSC is currently managing the evaluation of the PBHCI grant and will use their experience, infrastructure and data collection protocols to complete all data collection and reporting requirements for the CSAT grant. HSC will apply for institutional review board (IRB) oversight through the University of Illinois College of Medicine at Peoria, which is the IRB used for all HSC grant projects. A sample consent form used in prior grant projects is attached to the application.

### **Data Collection Plan for GPRA and Performance Measures**

**GPRA data collection plan.** Project staff at HSC will be committed to collecting the GPRA survey and all its elements for all clients enrolled in the project. The GPRA data collection plan will include the baseline enrollment, six-month follow up, and discharge. HSC

project staff will also enter all completed GPRA surveys into the Services Accountability Improvement System (SAIS) within 72 hours of completing the survey (seven days at the latest).

HSC grant project staff are currently completing similar data collection requirements for the PBHCI grant project. Staff members collect the NOMs survey at baseline, six months, and discharge and enter the information into the TRAC system within 72 hours. The research coordinator for the PBHCI grant project, Hilary Driscoll, will be assigned the responsibility of coordinating and entering GPRA data as well.

The baseline GPRA survey will be completed during the first in-person meeting between the client and MW&R staff person. Clients will be provided with a \$20.00 gas card or gift card to a department/grocery store for completing the GPRA survey at each time point. Table 13 provides a list of steps and time points for completing the GPRA and other screens.

**Table 13: Stages of Enrollment and GPRA Data Collection**

Steps to Enrollment	Stage of Enrollment	Time frame	Responsible Staff
Rural candidate contacts HSC or North Central	Pre-enrollment	First contact date	Intake staff
Client is referred to MW&R for assessment – phone contact – completes AUDIT or ASSIST	Phone screen for enrollment	1 to 24 hours from contact	MW&R clinician or nurse
Client agrees to complete GPRA, consent forms and other screens in-person	Face-to-face screen for enrollment	1 to 7 days from contact	
Client completes GPRA survey	Enrolled in project	1 to 7 days from contact	
MW&R staff hands GPRA survey & other screens to research coordinator who enters the survey into the SAIS system	Enrolled in project	2 to 14 days from contact	research coordinator

Project staff from the PBHCI grant will assist HSC staff in completing the GPRA baseline or other time points. The six-month and discharge GPRA surveys will also be completed by the MW&R team. The Spanish version of the GPRA will be used for clients whose primary language is Spanish. The database, built in MS Access, includes information from multiple sources, such as service data from the two EHR systems, screens, and biological tests; e.g., reports from UA and breathalyzer tests and blood work data, and process data that are also described in the following subsections.

**Collection of Performance Measures for MW&R.** The project will record the variety and volume of e-therapy interventions used by all clients enrolled in the project. The data collection plan for each type of e-therapy is described in Table 14. Data elements noted in Table 14 will be collected on a monthly basis, unless noted otherwise in the Table. Service data elements will be stored in HSC's EHR. Other data elements, such as usage of web-based programs stored on the A-CHESS, CHESS smoking cessation or HealthSim CRA databases will be collected by the research coordinator and stored in the research database.

Individuals will be surveyed about their IT capacity in terms of accessing the internet, owing a smart phone with a data package, and overall comfort using these forms of media when they enrolled in the project. The survey will identify base rates of access to the various form of media as well as usage in the past 90 days; e.g., number of times used email in the past 90 days. Base rates will be stored in the research database.

**Table 14: Performance Measure Associated with E-Therapy Interventions**

E-therapy	Data collection	Measurable outcome
# of clients trained to use e-therapy options	team will use a tailored service documentation note that captures specific grant-related activities,	# of clients who receive training on various e-therapy techniques
Face-to-face CBT skills training	Pulled from the service documentation records stored in the both agencies EHR system	Total frequency & sum hours of time in face-to-face meetings
Email or text with MW&R clinician	tailored service documentation note that captures non-traditional forms of communication; e.g., email & text & time associated with the communication	Total frequency of email or text communication noted for each client
Telephonic or skype CBT skills training	tailored service documentation note that captures telephonic and skype forms of communication	Total frequency & sum hours of telephonic/skype communication
HSC web resource center	HSC website access will be monitored with a sign in by clients & recorded by the # of times each sign in is used in a month	Total # of times each client accesses the website/month
CRA & CHESS-CBT computer programs	UW & HealthSim programs will provide a report on a monthly basis documenting the # of times & types of modules used by clients/month	The frequency & number of modules that are completed by each client by month & total
CRA self-test	The CRA computer program includes 65 training modules and a quiz at the end of each module to measure each individuals level of knowledge acquired from the module	The project team will download quiz scores associated with each CRA module completed
A-CHESS smart phone application - installed	The project will record how many individuals have a smart phone and can download the A-CHESS package – all clients are eligible for the program	The total number of clients who receive the A-CHESS package and training to use the program
A-CHESS smart phone application	The UW A-CHESS team provides a detailed report on all smart phone applications used – these reports will be sent to HSC	The total number of applications used on the phone/client/month

HSC will report on the number of e-therapy interventions used within the treatment infrastructure for clients enrolled in the grant project, including the percentage of services to clients delivered through e-therapy interactions.

**Collection of Additional Measures for MW&R.** The project will collect the scales noted in section C for screening. The scales are identified under the process and outcomes sections below.

#### **Quality Improvement Process**

**Quality Improvement Process for GPRA & Enrollment.** QI procedures will be used to track and maintain the collection of GPRA data and target numbers for enrollment. HSC uses multiple tracking reports to maintain data collection standards for the current SAMHSA PBHCI

grant program. PBHCI grant staff receive weekly reports of NOM assessment dates that are 60 days in advance of due dates, with weekly reminders until the NOMs follow-up survey is completed. The grant team receives weekly reports of targets for enrollments; e.g., targets to reach in the year, month, and week and numbers reached by the end of each week, which are reviewed weekly by the project team. Barriers to enrollment are addressed weekly with action plans for corrective procedures. The QI process has led to a significant increase in enrollments for the PBHCI grant and a 100% follow up rate for clients who have reached the six-month milestone.

David Moore, Vice President for Quality Improvement, oversees the tracking of NOMs data collection and will provide his time in-kind to completing the GPRA data collection as well. The QI process will include the collection of weekly enrollment figures for the MW&R and the percentage of enrollments who have completed GPRA surveys at baseline (this figure will always be 100%), six months and at discharge. This report will be generated by the research coordinator and emailed to the project team every Monday with updated data from the prior week. The report is reviewed every Friday with the project team. Action plans will be initiated if the actual enrollment figure decreases below the projected count by 10; i.e., - 10 below projected enrollment. The same process is used for the percentage of GPRA surveys completed at six months and at discharge. The plan is to maintain 90% follow-up; so an action plan is used if the follow-up completion rates decrease below 90% at any point.

**Quality Improvement for Target Population and Project Goals.** The QI process will include a quarterly analysis of enrollments and retention rates, services received, and the types of e-therapy services delivered or used by demographics and county of origin. The report is generated quarterly due to the small number of enrollment that occur monthly; i.e., 12 to 16. The report is organized by the evaluation team and used to examine possible disparate outcomes across geographical locations, ethnicity or race, gender, age, or disability. The QI process will include identifying outliers in data based on a demographic or geographical category that is significantly below the projected rates for the category. All reports are reviewed by the steering committee on a monthly basis and weekly by the MW&R team.

#### **Performance Assessment Plan**

The performance improvement plan includes an assessment of three dimensions: 1) a process assessment of the implementation plan, 2) assessment of the outcomes, and 3) an analysis of both expenses and dollars earned through the application of the interventions.

**Process and Performance Assessment.** Table 15 includes information on Goals 1 & 3 (evaluation plan for goal 2 is noted in Table 14) and objectives of the project with procedures that will be used to assess how closely the implementation matches the proposed plan. QI procedures outlined previously will be used to modify any objectives that appear to be drifting from the intended plan. The evaluation team will also document any objectives that require modifications as a result of unforeseen barriers to the plan and why the changes had to be made. All changes to the plan will be noted in the quarterly reports submitted to CSAT similar to the process used for the PBHCI grant.

The project team will develop a protocol for using the YACS fidelity tool for MI, CBT & brief interventions noted in section D. The project director and evaluator will complete a YACS fidelity assessment on each team member once a month on each form of e-therapy that involves a clinician. Phone calls and in-person sessions will be recorded and scored by the evaluation team. In person sessions and phone calls are recorded with a hand-held, digital recorder (with permission from clients). The goal is to have all clinicians maintaining 80% fidelity to the

YACS scale for MI, CBT or brief interventions. Fidelity scores are currently stored in an agency database for competency standards.

**Table 15: Process Evaluation of the MW&R Project**

Program Objectives	Method for assessing fidelity	Strategies to maintain Target for the project
<b>Goal 1: Develop and expedited screening and referral protocol</b>		
1.1: Organize Steering Committee & community resources	Meeting minutes will be stored & assessed for the # and types of key stakeholders that attend	Steering committee will meet monthly for the first year and quarterly thereafter.
1.2: Establish a screening protocol for SUD	The evaluation team will collect the # of providers & organizations that are trained and use SBIRT screens – collected quarterly	The team will collect the # of clients screened at each healthcare organization & the # referred to the MW&R
1.3: Establish a screening protocol to identify rural residents, capacity to use e-therapy	The project will track the # of clients who call for treatment & live in rural areas. The team will also track the # of these clients who were offered the MW&R at the front door and if they accepted	Screen 90% of clients with a SUD from rural areas who may want the MW&R. The project will track the # and % of clients screened who enroll
1.4: Develop a triage protocol that supports real-time enrollment	The team will record the # of clients who receive a MW&R interview within 24 hours (or less) after making contact with the HSC & North Central intake process	The target is to interview clients by a MW&R team member within 2 to 6 hours, & provide a face-to-face meeting within seven days
1.5: Begin enrollment in the MW&R on January 10, 2012	The team will track the starting date for the first person screened, the # of individuals who accept the program, & the total # who enroll each month – and related demographics	Begin enrolling by January 10, 2012, enroll 12 individuals/month by the first year & 16/month in years 2 & 3 – total enrollment goal of 600.
<b>Goal 3: Keep Individuals Engaged for six months through e-therapy options</b>		
3.1 & 3.2: Hire staff	The team will track the dates of hire and training for all staff members.	All staff hired within 90 days & trained within 180 days – fidelity assessment for all 3 years
Develop protocols for linking clients to medical care	The team will track the # contacts with the nurse, the # clients who access a healthcare provider each month, & the # of clients who set up a personal health record	Link 80% with the nurse, & link 80% to a healthcare provider, & have 70% open up a PHR account through the AHIMA website
Develop protocols for engaging clients in continuing care models	The team will track the # of contacts made with clients, the types of contacts, the resources used by clients, & the total duration clients remain engaged in the project	Keep clients actively engaged in continuing care for at least six months using a range of e-therapy techniques

**Outcome assessment.** The team will examine the impact of the MW&R and variety of e-therapy interventions. CBT interventions are designed to increase an individual's skills to achieve sustainable recovery. An outcome of MI and CBT programs is a measure of self-efficacy, which is an assessment of individuals perception of knowledge and mastery of behaviors needed to avoid alcohol and other drugs. The goal of the e-therapy interventions is to increase people's sense of self efficacy, increase social support, decrease risk associated with using alcohol and other drugs, and reduce the actual use of alcohol and other drugs. The evaluation and outcome plan for specific behaviors is provided in the following diagram. The SUD, readiness and efficacy scales will be collected at baseline, six-months and discharge. The BAM will be collected biweekly or monthly, and the biological measures of substance use will be collected monthly. All information will be collected by the MW&R and stored in the research database. All outcomes will be examined by demographic categories, access to healthcare and county location.

SUD	Scale of SUD baseline behavior	Internal rating of readiness	Internal rating of efficacy	Behavior change	Biological measures
Alcohol	AUDIT	3-rulers of readiness, & # of CBT sessions completed by any form of e-therapy, & duration of retention	DTCQ for alcohol	BAM social support & risk scores, & AUDT	UA & breathalyzer test
Tobacco	Fagerstrom Scale & ASSIST		Self efficacy temptation scale	Fagerstrom Scale & ASSIST	CO test
Prescription & illicit Drugs	ASSIST		DTCQ for drugs	BAM social support & risk score, & ASSIST	UA test with urine and swabs

**Financial assessment.** The team will calculate the staff time dedicated to direct and indirect client services. All staff services will be recorded in the EHR system at HSC. The team will also calculate the number of and amount of billable hours earned from IL-DASA or other sources of income, such as Medicaid through the FQHC system. The evaluation team will provide the steering committee and MW&R with updated financial reports every quarter.

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## G. Budget Justification

We are proposing a total CSAT budget of **\$837,939.43** for three years to cover the start up and operations cost of the Mobile Wellness and Recovery (MW&R) team. The annual budget will include CSAT dollars for each year of **\$279,087.00, \$279,517.01, and \$279,335.42**. Below is a detailed description of the first year of the grant and what changes will occur to each section in the following three years.

### A. Personnel

Job Title	Name	Annual Salary	FTE	CSAT Funded	Non-federal match	TOTAL
Project Evaluator	David Loveland, PhD	\$75,000	.20FTE	\$15,000.00	0	\$15,000.00
Research Coordinator	Hilary Driscoll, MA	\$35,000	.30FTE	\$10,500.00	0	\$10,500.00
Total of salaries for evaluation						\$25,500
Project Director	Dana Figlock, Ph.D.	\$65,000	.25FTE	\$16,250.00		\$16,250.00
*Clinician/supervisor	To be hired	\$40,000	1.0FTE	\$32,000.00		\$32,000.00
*Clinician	To be hired	\$35,000	.50FTE	\$14,000.00		\$14,000.00
*Registered nurse	To be hired	\$40,000	.50FTE	\$16,000.00		\$16,000.00
North Central Coordinator	Mike Lau, Ph.D.	\$55,000		\$19,250.00		\$19,250.00
Total for salaries for mobile team and oversight						\$97,500
<b>Total Salaries</b>						<b>\$123,000.00</b>

\*salaries are reduced by 20% to account for time to hire staff in first year

**Project Evaluator:** Dr. Loveland will oversee the evaluation of the project, provide training to clinical, produce reports for CSAT and provide QI reports to the project team.

**Research Coordinator:** Ms. Driscoll will coordinate the collection of GPRA data, including the entry of GPRA data into the SAIS database, collection of other scales, management of the database, and coordination of data for CSAT reports.

**Project Director:** Dr. Figlock will oversee the implementation of the project, hire project staff, provide clinical training to the staff, and chair the steering committee.

**Clinicians – supervisor and half time:** Two master-level clinicians will provide all in-person and e-therapy interventions, complete screens and enrollments, and complete the GPRA surveys and other assessments used in the project.

**Registered nurse:** a half time registered nurse will provide nursing assessments, assist clients in connecting with health care providers, assist clients in opening and managing a personal health record (PHR), and provide back up to the team for screens, assessments and GPRA surveys.

**Coordinator for North Central:** Dr. Lau will coordinate the screening and recruitment of clients through North Central, coordinate community providers involved in the project, co-chair the steering committee, and provide assistance in using e-therapy resources through North Central.

Salaries will increase by 2% in years 2 and 3.

## **B. Fringe Benefits**

HSC's fringe benefits package is 36% of a base salary. Breakdown of agency fringe benefits are as follows:

FICA	7.65%
Healthcare	21.00%
Pension	5.00%
Workers Compensations	1.50%
Unemployment Insurance	.85%
Total %	<b>36%</b>

	<b>CSAT Funded</b>	<b>Non-federal match</b>	<b>Total</b>
Total Costs of Fringe Benefits	<b>\$44,280.00</b>	0	<b>\$44,280.00</b>
<b>Total costs to CSAT grant</b>	<b>\$44,280.00</b>	0	<b>\$44,280.00</b>

The fringe benefits package should remain stable for all three years.

## **C. Travel**

<b>Description</b>	<b>CSAT Funded</b>	<b>Non-federal match</b>	<b>TOTAL</b>
Annual mileage x 6 staff x 12 months (\$ .50 mile x 500 miles/mo)	<b>\$18,000.00</b>		<b>\$18,000.00</b>
Annual conference airfare (3 staff x \$600 flights)	<b>\$1,800.00</b>		<b>\$1,800.00</b>
Annual conference hotel (3 staff x \$250/night x 2 nights)	<b>\$1,500.00</b>		<b>\$1,500.00</b>
Annual conference meals (3 staff x \$60/day x 3 days)	<b>\$540.00</b>		<b>\$540.00</b>

<b>Total</b>			<b>\$21,840.00</b>
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There are two types of travel expenses for the proposed project. The first row includes the cost of mileage for six MW&R treatment team members and project staff who will be traveling throughout the grant project. Staff members include two clinicians, one nurse, one research coordinator or the evaluator, a project director, and a project coordinator from North Central. Mileage includes the average number of miles that will be traveled each month across all six positions.

The second expenditure is for one CSAT sponsored conferences each year, including airfare, lodging, and food for 3 staff members. Travel expenditures will remain the same for years 2 and 3.

#### **D. Equipment**

There are multiple items listed under equipment and listed in the table.

Description	CSAT Funded	Non-federal match	TOTAL
4 Laptop & 2 Desktop computers	\$2,700.00	0	<b>\$2,700.00</b>
Two portable printers	\$750.00		<b>\$750.00</b>
6 smart phones	\$1,200.00		<b>\$1,200.00</b>
<b>Total</b>		<b>0</b>	<b>\$4,650.00</b>

The MW&R team will be equipped with four laptops and two desktop computers. The two desktop computers will be placed in the MW&R office. The MW&R clinicians and nurse will use portable printers for printing web documents in the community with clients who don't have access to the web (or equipment in their home for printing materials).

The MW&R team and emergency response staff will be equipped with six smart phones to communicate with clients who have smart phones and are using the A-CHESS smart phone applications or the A-CHESS website (that can send text messages to other phones).

#### **E. Supplies**

Description	CSAT Funded	Non-federal match	TOTAL
Copies and training manuals	\$1000.00		<b>\$1,000.00</b>

The cost of copying and purchasing training manuals; e.g., CBT manuals, will remain the same for all three years.

#### **F. Contractual**

Description	CSAT Funded	Match from another federal grant	TOTAL
UW – CHESS consultation team for A-CHESS phone applications	\$19,347.00	0	<b>\$19,347.00</b>
UW – A-CHESS consortium for smart	\$10,000.00	0	<b>\$10,000.00</b>

phone applications – includes 110 smart phone applications and unlimited use of A-CHESS website			
HealthSim, LLC – support and licensing fee for TES CRA computer program (unlimited use for one year)	\$10,000.00	0	\$10,000.00
UW-CHESS smoking cessation website consultation, technical staff to update website, and support for unlimited use	0	\$48,000	Not included in CSAT budget
Updating HSC website with a web developer – to be selected	\$3,000		\$3,000
<b>Total</b>		<b>\$48,000</b>	<b>\$42,347.00</b>

There are five contractual categories associated with three contractors. The first two rows include the combined contracts for University of Wisconsin's A-CHESS evaluation team and the A-CHESS consortium for the smart phone applications. The evaluation team will provide the actual supports, updates, guidance, and research on the smart phone applications, including providing reports to HSC regarding the specific usage of each phone. The cost of the consultation will increase slightly over years 2 & 3. The detailed breakdown of staff costs associated with consultation is listed in the table. A brief description of staff roles are noted below the table.

University of Wisconsin CHESS team	Time in months/year	Staff salaries	Salaries assigned to consultation
PI: Kimberly Johnson	0.24	\$ 105,921	\$ 2,118
Susan Dinauer, Tech Manager	0.36	\$ 67,517	\$ 2,026
Chris Judkins-Fisher, Programmer	0.36	\$ 60,000	\$ 1,800
Susann Ely, Graphic Artist	0.12	\$ 60,197	\$ 602
Leah Thomas, Web Designer, Developer	0.36	\$ 53,149	\$ 1,594
Amy Atwood, Database	0.24	\$ 70,000	\$ 1,400
Undergraduate assistant	0.24	\$ 18,720	\$ 374
Copying cost		\$ 100	\$ 100
Fringe benefits			\$ 4,211
Indirect			\$ 5,121
<b>Total cost in first year</b>			<b>\$ 19,347</b>

### Personnel

**Kimberly Johnson, MSEd, MBA, Principal Investigator (.24 cal mos).** Ms. Johnson is the primary point of contact for the University of Wisconsin on this project and will be responsible for all project activities. Ms. Johnson is currently the Co-Deputy Director for NIA Tx as well as the Director of the ACTION Campaign. She has worked in the field of substance abuse prevention and treatment since 1989. She has managed treatment programs and served as the single state authority for the state of Maine from 2000-2007, where she worked to increase available treatment capacity by 35 percent during that time.

**Susan Dinauer, B.A., Consortium Director and Technical Core Leader (.36 cal mos).** Ms. Dinauer has been a researcher on CHESS projects and development for over a decade. Ms. Dinauer is Director of the CHEC Research Consortium and is currently working with the implementation of ACHESS with the consortium member agencies. Ms. Dinauer has also been the supervisor for the technical teams for the past several years. For this project, Ms. Dinauer will assist agencies in the implementation of ACHESS and lead the technical core team throughout the project to assure that technical requirements are completed in a timely fashion.

**Chris Judkins-Fisher, B.S, Programmer (.36 cal mos).** Mr. Judkins-Fisher is a programmer for the ACHESS mobile application. He will work with the project PI and consortium director to program the changes needed on the application to better meet the needs of the participating agency.

**Amy Atwood, PhD, Database Manager (.24 cal mos).** Dr. Atwood recently joined CHESS after completing her PhD in Statistics. She worked with the Center as a graduate student and now serves as the database manager for the center. Dr. Atwood will work on data collection and analysis

**Leah Thomas, BS, Web Designer/Developer (.36 cal mos).** Ms. Thomas is the CHESS Director of Web Interface Design and Standards. She will ensure that all XHTML and CSS used for this project adhere to relevant standards and are tested for compatibility on the various platforms being utilized. Ms. Thomas will carry out the majority of the XHTML and CSS programming for the project.

**Susann Ely, B.A., Graphic Artist (.12 cal mos).** Ms. Ely is CHESS Director of Print and Graphics Design. She will direct the development of visual designs and graphics. Ms. Ely's level of design skill brings consistency and visual appeal to the web devices, mobile devices as well as the print materials used throughout the Center. She will also provide her design skills to the project as needed.

**Student Hourly, TBD: (.24 cal mos.)** A student hourly employee will be hired to assist with usability testing of changes to the ACHESS mobile application and other administrative duties as needed such as survey data entry and entering content.

#### **Printing/Duplicating**

Costs include copying of reference materials, as well as other miscellaneous duplicating services necessary to support this project. \$100 is requested per year.

The A-CHESS consortium disseminates the smart phone applications for a annual fee of \$10,000.00 that includes 110 A-CHESS applications and unlimited use of the A-CHESS website. The third row is the consulting and licensing fee for the TES-CRA computer program from the National Development and Research Institute (NDRI). Dr. Lisa Marsch will provide support and guidance for using the TES-CRA program. The \$10,000.00 free pays for unlimited use and support for the TES-CRA program, which is housed on the NDRI website. The cost of the consortium fee is expected to remain the same for all three years.

The fourth row includes the cost of updating the CHESS smoking cessation website, which will be covered by the SAMHSA PBHCI grant as well as other sources. The cost of updating the website is substantial. The project team will work with the CHESS team to identify two or more agencies that can share in the cost of updating the website. The project team will also submit a request to use SAMHSA PBHCI dollars to cover some of the cost. If the project is unable to cover the cost, another vendor with an internet-based CBT program for smoking cessation will be selected.

The fifth row represents grant dollars that will be used to update HSC website. A vendor will be identified when the grant is awarded. This is a one-time cost.

## **G. Construction**

There are no costs associated with construction.

## **H. Other**

Description	CSAT Funded	Non-federal match	TOTAL
Contingency management for GPRA, 125 individuals x 2 surveys x \$20 in gift cards for each survey completed	\$5,000	0	<b>\$5,000</b>
Usage fee for Therapylivevisit teleconferencing \$2.50 per connection	<b>2,250</b>	0	<b>\$2,250</b>
Aircards for internet connection/4 cards X \$50 month X 12 months	\$2,400	0	<b>\$2,400</b>
6 smart phones x \$60/month x 12 months	\$4,320	0	<b>\$4,320</b>
<b>Total</b>		0	<b>\$13,970.00</b>

The team will use gift cards, gas cards, and department store cards for contingency management; i.e., incentives, to increase participant's willingness to complete the GPRA survey at baseline, six months and discharge. The amount of dollars needed for contingency management will increase over years 2 and 3 as more individuals are enrolled in the following years.

North Central pays usage fee of \$2.50 every time a staff member transmits a message or video image through the Polycom conferencing system or the TherapistliveMD individual conferencing program. The fee is charged for staff and for clients (North Central pays the fee for clients who call into North Central through the TherapistliveMD program). CSAT grant dollars will be used to cover this fee for teleconferencing communications by a MW&R team member, which is estimated at 900 teleconferencing communications in the first year and a slight increase in usage in years 2 & 3.

MW&R staff members will use air cards attached to their laptops to connect with HSC's EHR system, the internet based programs, including A-CHESS, CHESS smoking cessation, and NDRI's computerized CRA program; email; the grant project research web page; and other internet options. The air card rate is expected to remain the same for all three years.

MW&R staff members will use smart phones to communicate with participants who have access to texting or the A-CHESS smart phone applications. Five staff members will use the smart phone service. In addition, one smart phone will be provided to HSC's emergency response services (ERS) for 24-hour service.

### **Indirect and Adminstrative Cost**

The grant project will use approximately \$28,000 in the first year to cover the cost of managing the grant through the finance department, utilities, building maintenance, and related maintenance cost; e.g., grounds and parking lots. The indirect/administrative cost will decrease in years 2 & 3.

### **Calculation of Future Budget Periods**

The overall budget for all three grant years is displayed here.

	Year 1	Year 2	Year 3	total
a. Personnel	\$123,000.00	\$133,110.00	\$135,772.20	\$391,882.20
b. Fringe Benefits	\$44,280.00	\$47,919.60	\$48,877.99	\$141,077.59
c. Travel	\$21,840.00	\$21,840.00	\$21,840.00	\$65,520.00
d. Equipment	\$4,650.00	\$0.00	\$0.00	\$4,650.00
e. Supplies	\$1,000.00	\$1,000.00	\$1,000.00	\$3,000.00
f. Contractual	\$42,347.00	\$40,527.41	\$41,725.23	\$124,599.64
g. Construction	\$0.00	\$0.00	\$0.00	\$0.00
h. Other	\$13,970.00	\$15,120.00	\$15,120.00	\$44,210.00
Total Direct	<u>\$251,087.00</u>	<u>\$259,517.01</u>	<u>\$264,335.42</u>	<u>\$774,939.43</u>
Total Indirect	<u>\$28,000.00</u>	<u>\$20,000.00</u>	<u>\$15,000.00</u>	<u>\$63,000.00</u>
<b>Total Cost</b>	<b><u>\$279,087.00</u></b>	<b><u>\$279,517.01</u></b>	<b><u>\$279,335.42</u></b>	<b><u>\$837,939.43</u></b>

## H. Biographical Sketches and Job Descriptions

### Biographical Sketches

Five biographical sketches are included in this section representing three key personnel for the proposed project and one consultant: Kim Johnson from the UW-ACHESS project. Two additional consultants are not included in this section, but their letters of support are included in the appendix: David Gustafson, Ph.D. Director of the UW A-CHESS project and Lisa Marsch, Ph.D. Chief Research Scientist at HealthSim, LLC.

Three job descriptions are included in this section, including two master level clinicians and one mobile nurse.

<b>Project staff</b>	<b>Responsibilities</b>
Dana Figlock, Ph.D.	Project Director
Michael Lau, Ph.D.	Coordinator from North Central
David Loveland, Ph.D.	Project Evaluator and Trainer
Hilary Driscoll, M.A.	Research Coordinator
Kim Johnson, MSEd	UW consultant for CHESS programs
David Gustafson, Ph.D.	Director of A-CHESS project – consultant – letter of support only
Lisa Marsch, Ph.D.	HealthSim, LLC consultant for CRA computer program – letter of support only
MW&R Master-level clinician and supervisor	Job description included
MW&R Master-level clinician, part time	Job description included
MW&R nurse – part time	Job description included

### David Figlock, Ph.D. – Project Director

#### Office

Fayette Companies  
600 Fayette St.  
P.O. Box 1346  
Peoria, IL 61654  
(309) 671-8065  
(319) 671-8021 (fax)

#### Home

2024 S 2<sup>nd</sup> Ave  
Morton, IL 61550  
(309) 363-1118

Email: [dfiglock@fayettecompanies.org](mailto:dfiglock@fayettecompanies.org)

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#### EDUCATION & TRAINING

2004 – 2010	Ph.D., Clinical Psychology University of Iowa, Iowa City, IA
2009 – 2010	Predoctoral Internship in Clinical Psychology VA Ann Arbor Healthcare System, Ann Arbor, MI

Accredited by the American Psychological Association (APA)

2004 – 2007 M.A., Clinical Psychology  
University of Iowa, Iowa City, IA

1999 – 2003 B.A., Psychology  
Muhlenberg College, Allentown, PA

## EMPLOYMENT

Sept 2009 – Present Staff Psychologist, Human Service Center/Fayette Companies.  
Peoria, IL

## CLINICAL APPOINTMENTS

Sept 2009 – Aug 2010      Psychology Intern. Department of Psychology, Veterans' Affairs Medical Center. Ann Arbor, MI.

June 2008 – Dec 2008 Practicum Student. Dept of Psychology, Outpatient Substance Abuse Treatment, Veterans' Affairs Medical Center, Iowa City, IA

Aug 2007 – Aug 2008 Practicum Student. Benton Neuropsychology Laboratory, University of Iowa Hospitals and Clinics, Iowa City, IA.

Aug 2006 – June 2009 Psychological Trainee. Seashore Psychology Clinic, University of Iowa, Iowa City, IA.

## HONORS & AWARDS

2008 University of Iowa Graduate College Summer Fellowship

2008 Executive Council of Graduate and Professional Students Research Grant

2008 University of Iowa Student Government (UISG) Scholarly Presentation Award

2007 American Psychological Association of Graduate Students  
*Excellence in Campus Leadership Award*

1999 Presidential Scholarship, Muhlenberg College

## **TEACHING ACTIVITIES**

Summer 2006, 2006, 2009 Course Instructor, The University of Iowa  
Behavior Modification, Elementary Psychology, Introduction to Clinical Psychology

Fall 2004-Spring 2009      Teaching Assistant, The University of Iowa  
Abnormal Psychology, Elementary Psychology, Introduction to Clinical Psychology, Laboratory in Psychology, Psychological Appraisal II

## **PUBLICATIONS & PRESENTATIONS**

Figlock, D., Brock, R.L., & Nathan, P.E. (2010). A daily diary study of the impact of Friday morning classes on Thursday night drinking by undergraduates. Annual Association for Behavioral and Cognitive Therapies (ABCT)—44<sup>th</sup> Annual Convention, November 19, 2010. San Diego, CA.

Figlock, D. (2010). Cognitive behavior therapy for insomnia. Clinical Training Seminar, Human Service Center. July 30, 2010. Peoria, IL.

Figlock, D. (2009). Impaired decision making as a risk factor for college student drinking. Grand Rounds, Department of Psychology, University of Iowa. April 6, 2009. Iowa City, IA.

Figlock, D. & Nathan, P.E. (2007). Ventromedial prefrontal cortical function of frequent drinking college students. Annual Association for Behavioral and Cognitive Therapies (ABCT)—41<sup>st</sup> Annual Convention, November 17, 2007. Philadelphia, PA.

Figlock, D., Suls, J. & Nathan, P.E. (2007). Effects of increased alcohol accessibility on college student drinking: A study of Iowa City from 1983-2005. *The Addictions Newsletter*, 14, 14-15.

Figlock, D., Suls, J. & Nathan, P.E. (2006). Social-contextual study of college student drinking in Iowa City. Research Society on Alcoholism Conference, June, 27<sup>th</sup>, 2006. Baltimore, MD.

Figlock, D. & Suls, J. (2005). Pluralistic ignorance concerning alcohol norms in high school and college. 7<sup>th</sup> Annual Student Health Interdisciplinary Poster Session, University of Iowa, April 21<sup>st</sup>, 2005. Iowa City, IA.

## **Michael Lau, Ph.D. – Coordinator for North Central**

**Michael Lau MA MS PhD LCPC  
Licensed Clinical Professional Counselor  
North Central Behavioral Health Center, Inc./Health  
Directions**

### **Professional Experience:**

**Director of Corporate Compliance, Grant Development, and Research**  
North Central Behavioral Health Systems, Inc.

- Responsible for the administrative functioning of all agency Corporate Compliance activities.
- Responsible for the research, adaptation, and writing of all agency grant activities.

### Licensed Clinical Professional Counselor

#### Health Directions

- Privileged as a Licensed Clinical Professional Counselor to provide individual, group, and family psychotherapy to children, adolescent, and adult populations through diverse therapeutic techniques and interventions.

### Adjunct Faculty Member

#### Illinois Valley Community College

- Responsible for developing the course structure and promoting Introduction to Psychology, Personality, and Abnormal Psychology curriculums designed for transfer course to four-year colleges, universities, and applied degree programs.

### Certified Mental Health First Aid Instructor

#### National Council for Community Behavioral Healthcare

- Certified to teach the twelve hour mental health first aid course which teaches the skills for providing initial help to individuals experiencing mental health problems such as depression, anxiety, psychosis, and substance use.

### Professional Editorial Boards:

#### Associate Editor

Compliance Watch Newsletter

National Council for Community Behavioral Healthcare.

### Professional Presentations:

National and State presentations covering clinical, quality management, and corporate compliance topics.

Individual Presentations listing available upon request.

### Professional Publications:

Professional publications covering the topics of statistical process control, quality management, performance improvement, and corporate compliance.

Individual publication references available upon request.

### Education:

Kennedy-Western University

Doctor of Philosophy: Health Care Administration

Kennedy-Western University

Master of Science in Engineering: Quality Management

Roosevelt University  
Master of Arts in Clinical Psychology

University of Wisconsin-Milwaukee  
Bachelor of Arts in Psychology

## **DAVID L LOVELAND, Ph.D. - Director of Research**

### **EDUCATION**

Michigan State University, East Lansing, Michigan	
Ph.D., Ecological/Community Psychology	2002
Cognate: Statistics and Methodology	
State University of New York at New Paltz	
M.A., Psychology Concentration: Counseling Psychology	1992
Eastern Connecticut State University, Willimantic, Connecticut	
B.A., Psychology	1988

### **GRANTS RECEIVED & CURRENT PROJECTS**

- Substance Abuse and Mental Health Services Administration (SAMHSA) – Primary and Behavioral Health Integration Grant Program – FY 2009 (SM-09-011). *Peoria Integrated Healthcare Program.* Michael Boyle, PI; David Loveland, project evaluator and co-author; \$2 million funded.
- Illinois Department of Healthcare and Family Services – Emergency Department Grant program FY-2008) through the U.S. Department of Medicaid and Medicare Services. *The Tri-County Emergency Department Diversion Program.* Farrell Davies, PI, David Loveland, project evaluator and co-author; \$815,000 funded.
- U.S. Department of Justice: Bureau of Justice Assistance-Drug Court Discretionary Grant Program-FY 2007 (BJA-2007-1461). *The Peoria Drug Court Enhancement Project.* David Loveland, author & project evaluator; John Flynn, PI; \$174,000 funded.
- U.S. Department of Labor: Office of Disability Employment Workforce Action Grant (SGA 02-21), 2002. *An Innovative Supported Employment Program for People with a Serious Mental Illness: A Demonstration Project.* Michael Boyle, PI; Patrick Corrigan & David Loveland, Research Project Coordinators (and co-authors); \$3.3 million funded.
- Aspen Institute, Michigan Nonprofit Research Program Dissertation Fellowship, 2000 – 2001. *Re-Evaluating Nonprofit Community Mental Health Services in Michigan: A Strengths-Based Perspective.* David Loveland, PI and author, \$25,000 funded.
- Janssen Research Foundation, 1999. *Improved Continuity of Pharmaceutical Care with an Integrated Clinical Database System: A proposed pilot study.* David Loveland, PI, Michael Boyle, Co-PI, \$50,000 funded.

### **PUBLICATIONS**

- Boyle, N., Loveland, D. & George, S. (2011). Implementing recovery management in a treatment organization. In J.F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory research & practice* (pp. 235-258). New York, NY: Springer.
- Loveland, D.L., Driscoll, H., Boyle, M. (2007). Enhancing Supported Employment Services for

- Individuals with a Serious Mental Illness: A review of the literature. *Journal of Vocational Rehabilitation*, 27, 177-189.
- Loveland, D.L. & Boyle, M. (2007). Intensive Case Management as a Jail Diversion Program for People with a Serious Mental Illness: A review of the literature. *International Journal of Offender Therapy and Comparative Criminology*, 51(2), 130-150.
- Loveland, D.L., Weaver-Randall, K., & Corrigan, P. (2005): Research Methods for Exploring and Assessing Recovery. In Ralph, R. & Corrigan, P. (Eds.). *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington, D.C.: American Psychological Association (pp 19-60).
- White, W., Boyle, M., & Loveland, D. (2005): Recovery from addiction and recovery from mental illness: Shared and contrasting lessons. In Ralph, R. & Corrigan, P. (eds.). *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington, D.C.: American Psychological Association (pp 233-258).
- Loveland, D. L., Boyle, M., Godley, M.D., & Gillette, C. (2003). Continuity of pharmacotherapy in mental health treatment: What happens to patients' psychotropic prescriptions after discharge from a state hospital? *Administration and Policy in Mental Health*, 31(1), 45-64.
- White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/Addiction as a Chronic Disease: From Rhetoric to Clinical Reality. *Alcoholism Treatment Quarterly*, 20 (3/4), 107-130.
- Godley, M.D., Godley, S.R., Funk, R.R., Dennis, M.L., & Loveland, D.L. (2002). Discharge Status as a Performance Indicator: Can it predict adolescent substance abuse Treatment Outcome. *Journal of Child and Adolescent Substance Abuse*, 11(1), 91-109.

### **TECHNICAL REPORTS AND OTHER MANUSCRIPTS**

- Loveland, D. (2011). Cognitive Behavioral Training, modules 1 – 3 – online training at [www.fayettecompanies.org/csat](http://www.fayettecompanies.org/csat)
- Loveland, D. & Driscoll, H. (2009). Recovery Coach Training Curriculum – online training at [www.fayettecompanies.org](http://www.fayettecompanies.org).
- Loveland, D. & Driscoll, H. (2009). Evaluating Drug Courts in Illinois: Procedure manual and data code book. [www.fayettecompanies.org](http://www.fayettecompanies.org).
- Loveland, D. & Driscoll, H. (2009). Navigating Drug Courts: A manual for drug court clients. [www.fayettecompanies.org](http://www.fayettecompanies.org).
- Loveland, D. & Driscoll, H. (2009). Achieving Recovery from Alcohol and Other Drugs: Information for families, partners, and friends. [www.fayettecompanies.org](http://www.fayettecompanies.org)
- Loveland, D. & Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*. Training manual prepared for the Illinois Division of Alcohol and Substance Abuse. Peoria, IL: BHRM project at <http://www.bhrm.org/guidelines/addguidelines.htm>.
- White, B., Boyle, M., & Loveland, D.L. (2003). A model to transcend the limitations of addiction treatment. *Behavioral Health Management*, 23(3).

### **RELEVANT RESEARCH, TRAINING AND EVALUATION EXPERIENCES**

- Director of Research  
*Human Service Center/Fayette Companies, Peoria, IL* July 2003 – Present
- Senior Research Professional  
*University of Chicago Center for Psychiatric Rehabilitation* Feb 2002 – July 2003

<b>Reviewer for Institutional Review Board (IRB)</b>		
<i>University of Illinois College of Medicine at Peoria, IRB I &amp; II</i>		July 2005 – Present
<b>Clinical Supervisor</b>		
<i>45<sup>th</sup> Street Mental Health Inc., West Palm Beach, FL</i>		Feb 1993 – Mar 1995
<b>Addiction Treatment Counselor</b>		
<i>Turning Point at St. Francis Hospital, Beacon, NY</i>		Feb 1992 – Jan 1993
<b>Coordinator of Clinical Treatment</b>		
<i>Stanley Street Treatment and Resources, Fall River, MA</i>		Jan 1990 – May 1991

## Hilary Driscoll- Research Associate

### Education

May 2007	Master of Arts, Community/Agency Counseling Bradley University, Peoria, Illinois
May 2000	Bachelor of Arts, Business Studies Western Illinois University, Macomb, Illinois
May 1998	Bachelor of Arts, Interpersonal Communication, Magna Cum Laude Western Illinois University, Macomb, Illinois

### Research Experience

Oct 2009-present	Project Manager, Center for Mental Health Services, Primary and Behavioral Health Care Integration Project <ul style="list-style-type: none"> <li>▪ Coordinate data collection and reporting activities</li> <li>▪ Create assessment and screening protocols for project</li> </ul>
Sept 2009-present	Project Manager, Emergency Department Diversion Project <ul style="list-style-type: none"> <li>▪ Develop data collection tools and research database</li> <li>▪ Conduct follow-up participant interviews</li> </ul>
Aug 2009-present	Project Site Coordinator, The Center for Health Enhancement Systems Studies, University of Wisconsin/Human Service Center <ul style="list-style-type: none"> <li>▪ Develop content for technology project</li> <li>▪ Recruit and consent research participants</li> </ul>
Nov 2007-March 09	Project Manager, Drug Court Enhancement Project, Human Service Center <ul style="list-style-type: none"> <li>▪ Developed assessment tool and database for Drug Court program</li> <li>▪ Trained staff and help implement cognitive behavioral practices throughout Drug Court program</li> </ul>
Aug 2005-April 09	Project Manager, Cognitive Remediation in Supported Employment, (RCT), Human Service Center <ul style="list-style-type: none"> <li>▪ Assessed research participants for cognitive impairments and symptoms using a cognitive battery and clinical assessment</li> <li>▪ Maintained research database and analyzed study results</li> </ul>
Jan 2007-present	Reviewer, Institutional Review Board (IRB), University of Illinois College of Medicine at Peoria, IRB I & II <ul style="list-style-type: none"> <li>▪ Reviewer of IRB applications for medical research</li> </ul>

### Manuscripts

Loveland, D., Driscoll, H., Boyle, M., (2007). Enhancing supported

employment services for individuals with a serious mental illness: A review of the literature. *Journal of Vocational Rehabilitation*, 27, 177-190.

Corrigan, P., Barr, L., Driscoll, H., & Boyle, M. (2008). The educational goals of people with psychiatric disabilities. *Journal of Psychiatric Rehabilitation*, 32, 67-70.

### Presentations

Loveland, D., Barr, L., & Driscoll, H. (2006, October). Attempting a holistic approach in a fragmented system of care: The trials and tribulations of treating people with dual diagnosis. Presented at Bradley University "Hot Topics!" Peoria, IL.

Loveland, D. & Driscoll, H. (2009, September). Addressing the paradoxes of Drug Courts: Updated research on drug courts and ideas for improving the performance of the problem-solving court model. Presented at the Illinois Association of Drug Court Professionals Annual Conference, Tinley Park, IL.

### Professional Experience

- Feb 2005-present      Research Associate, Fayette Companies  
Peoria, IL
- Conduct baseline and follow-up assessments for various research projects
  - Construct and maintain Access Databases
  - Design system change plans and train staff for implementation of evidence based treatment approaches
  - Participate in performance improvement activities
  - Develop reports for funding sources, administrators, and board members
  - Present program data to staff, board and community members
  - Provide staff training and consultation

### June 2006-May 2007 Master's Level Counselor Intern, Fayette Companies

- Peoria, IL
- Provided individual and group therapy using empirically supported cognitive behavioral treatments for people with serious mental illness and substance use disorders
  - Accompanied clients to civil and criminal court hearings and guided them through the legal process

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## **Kim Johnson, MSEd – UW – CHESS Consultant**

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### **BIOGRAPHICAL SKETCH**

Provide the following information for the key personnel and other significant contributors in the order listed on Form Page 2. Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

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NAME Kimberly Johnson  eRA COMMONS USER NAME KJOHNSON1	POSITION TITLE Deputy Director, Researcher
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EDUCATION/TRAINING (Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)

INSTITUTION AND LOCATION	DEGREE (if applicable)	YEAR(s)	FIELD OF STUDY
Smith College	AB	1984	Biology
University of Southern Maine	MSEd	1988	Counselor Education
University of Southern Maine	MBA	2006	Finance

#### A. Positions and Honors

##### Positions and Employment

1986-1988	Child and Family Therapist, Tri County Mental Health, Lewiston, ME
1990-1994	Program Manager, Adolescent Services, Y-Intervention, YWCA, Lewiston, ME
1994-2000	Executive Director, Crossroads for Women, Windham, ME
2000-2007	Director, Office of Substance Abuse, State of Maine, Augusta, ME
2007- 2008	Researcher, Network for the Improvement of Addiction Treatment, University of WI-Madison
2008-present	Deputy Director of Operations, Network for the Improvement of Addiction Treatment, University of WI-Madison

##### Other Experiences and Memberships

1995-2000	President, Maine Association of Substance Abuse Programs
2003, 2005	Treasurer, National Association of State Alcohol and Drug Abuse Directors
2006-present	Board Member, Community Anti-Drug Coalitions of America
2007	Vice President of Internal Affairs, National Association of Drug Abuse Directors
2007-present	Executive Committee, Community Alcohol and Drug Abuse Coalitions of America

##### Honors

- 2003: Federal DHHS Commissioner's Award for Child Welfare Efforts
- 2005: Maine Women's Addiction Treatment Council Annual Recognition
- 2006: American Association for Addiction Treatment: Friend of the Field
- 2007: National Association of State Alcohol and Drug Abuse Directors: Recognition for Service to the field of Substance Abuse Treatment and Prevention
- 2010: American Public Health Association, Community Based Leadership Award in the field of Alcohol and Drug Prevention and Treatment

#### B. Selected Publications

1. Treating Addicted Women in Maine: Rural Multicultural Issues and Women's Issues, Needs and Barriers to Treatment, 1996
2. The Joint Task Force on Substance Abuse: Status Report on Recommendations, January 2001
3. Oxycontin Abuse: Maine's Newest Epidemic, January, 2002 Substance Abuse Services Commission in conjunction with the Maine Office of Substance Abuse
4. Adolescent Alcohol and Drug Use in Maine: Progress and Needs, 2003
5. Substance Abuse on the Rise in Maine Women *Maine Women's Journal*, Fall, 2006

6. Don't Fumble the Treatment Hand-off, *Addiction Professional*, Sept/Oct 2008

**C. Research Support**

**Ongoing Research Support**

1 P50 HS019917-01 (AHRQ) Gustafson (PI)

10/01/10-09/30/15

Bringing Communities and Technology Together for Healthy Aging

As the Active Aging Resource Center, we propose to develop, test, and disseminate a low-cost, integrated information and communication technology (ICT) to attack 5 key reasons that several community groups conducted around the state identified on why elders leave their homes, while also creating an environment that fosters new community based pilot projects that would turn into major studies.

Role: Assets/Dissemination Project Leader

1 RC4 DA029975-01(NIH/NIDA) Gustafson, Johnson (PIs)

09/30/10-09/29/13

NIH/NIDA

ARRA: Building Sustainable Community-Linked Infrastructure to Enable Health Science Research

This project will enhance the NIATx network, heretofore focused on quality improvement practice projects, and engage them in community-based participatory research. The goal is to create a national community of treatment and recovery support providers who have the capacity to inform the national research agenda, to engage in research related to the improvement of care and the identification, adoption, and dissemination of evidence-based practices using a community based participatory research model.

MSN131044 Johnson(PI) NASADAD/RWJ

11/01/09-04/30/11

Medication Assisted Treatment (MAT)

Funding from National Association of State Alcohol and Drug Abuse Directors (To formulate and recommend measures and methodologies to assess how well public sector specialty substance abuse providers perform in delivery of medication assisted treatment (MAT)

HHSS283200700003 (JBS International/SAMHSA) Molfenter (PI)

07/06/09-07/05/11

SAMHSA Clinical Technical Assistance

Provide technical support to State and community-level entities participating in STAR-SI (Strengthening Treatment Access and Retention – State Implementation) and disseminate promising practices developed under STAR-SI to interested providers, payers and fiscal intermediaries in the substance abuse field.

Role: Task Manager, State Toolkit Development

10-233-SOL-00338 (PHS/SAMHSA) Johnson (PI)

09/01/10-08/31/11

NIATx Process Improvement - Pilot of Smart Phone Application

This project will fund a learning collaborative/pilot project of using a "smart phone application" to support and enhance the recovery of selected drug court participants.

MSN138765 (PHS/SAMHSA) Johnson (PI) 09/01/10-08/31/11

Process Improvement Leadership Award and Best Practices Diffusion Program

## **Completed Research Support**

National Resource Center on Quality in Addiction Treatment (Gustafson)

02/15/07 – 02/14/10

Robert Wood Johnson Foundation

Create the infrastructure for The National Resource Center on Quality in Addiction Treatment ("The Center"). The Center will combine the resources from Paths to Recovery, Resources for Recovery, Advancing Recovery, and Innovations for Recovery and will advance the development and dissemination of promising payer and provider strategies and products and address conditions that NIATx providers and payers have identified as unacceptable.

Strengthening Treatment Access and Retention – State Initiative (Gustafson)

06/12/06–9/30/09

Center for Substance Abuse Treatment (*Subcontract through Northrop Grumman*)

Build the capacity to use process improvement to improve access to and retention in addiction treatment by establishing a state/provider partnerships and leveraging state roles as payers, regulators, and conveners to support provider improvement and remove barriers to access and retention.

## Project Job Descriptions

### MW&R Clinician and Supervisor

**Description of duties and responsibilities.** This individual will supervise the other master-level clinician for the MW&R, provide CRA and CBT skills training to clients enrolled in the project, train clients on how to use various e-therapy interventions, provide educational workshops to organizations in the 10-county region about the project, work with families, complete screens and assessments with new candidates, collect GPRA data and provide the surveys to the research coordinator, assist in evaluating the fidelity of the interventions, and coordinate recruiting activities with the organizations involved in the project.

**Qualifications for position.** This individual will have a Master Degree in Counseling, Social Work or related fields and experience supervising staff and working with the target population. Bilingual skill is strongly preferred (either the full time or part time master level clinical will need to be bilingual in Spanish)

**Supervisory relationship.** This person will work under the project director, Dana Figlock, Ph.D. This individual will provide supervision to the part time master level clinician

**Skills and knowledge required.** This individual will have a comprehensive understanding of addiction, co-occurring conditions and subsequent treatment options. In addition, it is preferred that this individual have knowledge of behavioral and cognitive behavioral interventions, although HSC will train the individual if the person can demonstrate a openness to using a behavioral or cognitive behavior model of treatment. Other essential skills include supervisory skills, counseling skills (individuals, group, and family counseling skills), competent to administer and interpret standard assessment tools, such as the AUDIT, ASSIST, BAM and self-efficacy scales, accurately complete a five-axis diagnosis using the DSM-IV, and have extensive experience working with computers.

**Prior experience required.** Prior supervisory experience is preferred. This individual will also have experience working with individuals with a SUD (and psychiatric disorders), experience providing individual or group sessions, following a structured protocol, and experience in public presentations.

**Personal qualities.** This position requires someone who is comfortable working with community agencies, uses a strength-based view of people in early recovery, works well in a team, can work with a wide range of individuals, including those who have co-occurring psychiatric issues, can engage and motivate this wide range of individuals in treatment, is comfortable working with family and friends and with a manualized approach to treatment, willing to use the behavioral model of treatment, and is open to multiple pathways to recovery.

**Amount of travel and special conditions or requirements.** Position requires a substantial amount of travel, including two or more conferences annually and daily travel between locations.

**Salary range.** Full time position (1.0 FTE), \$40,000 annual salary

**Hours per day or week.** Approximately 40 hours per week.

## **MW&R Clinician Part Time**

**Description of duties and responsibilities.** This individual will work with the MW&R supervisor. This individual will provide CRA and CBT skills training to clients enrolled in the project, train clients on how to use various e-therapy interventions, provide educational workshops to organizations in the 10-county region about the project, work with families, complete screens and assessments with new candidates, collect GPRA data and provide the surveys to the research coordinator, assist in evaluating the fidelity of the interventions, and coordinate recruiting activities with the organizations involved in the project.

**Qualifications for position.** This individual will have a Master Degree in Counseling, Social Work or related fields and experience working with the target population. Bilingual skill is strongly preferred (either the full time or part time master level clinical will need to be bilingual in Spanish)

**Supervisory relationship.** This person will work under the project director, Dana Figlock, Ph.D.

**Skills and knowledge required.** This individual will have a comprehensive understanding of addiction, co-occurring conditions and subsequent treatment options. In addition, it is preferred that this individual have knowledge of behavioral and cognitive behavioral interventions, although HSC will train the individual if the person can demonstrate a openness to using a behavioral or cognitive behavior model of treatment. Other essential skills include supervisory skills, counseling skills (individuals, group, and family counseling skills), competent to administer and interpret standard assessment tools, such as the AUDIT, ASSIST, BAM and self-efficacy scales, accurately complete a five-axis diagnosis using the DSM-IV, and have extensive experience working with computers.

**Prior experience required.** This individual will have experience working with individuals with a SUD (and psychiatric disorders), experience providing individual or group sessions, following a structured protocol, and experience in public presentations.

**Personal qualities.** This position requires someone who is comfortable working with community agencies, uses a strength-based view of people in early recovery, works well in a team, can work with a wide range of individuals, including those who have co-occurring psychiatric issues, can engage and motivate this wide range of individuals in treatment, is comfortable working with family and friends and with a manualized approach to treatment, willing to use the behavioral model of treatment, and is open to multiple pathways to recovery.

**Amount of travel and special conditions or requirements.** Position requires a substantial amount of travel, including two or more conferences annually and daily travel between locations.

**Salary range.** Part time position (.5 FTE), \$20,000 annual salary

**Hours per day or week.** Approximately 20 hours per week.

## **MW&R Nurse – part time**

**Description of duties and responsibilities** This individual will be a registered nurse in Illinois who will work part time with the MW&R team. This person will provide nursing assessments, assist individuals in connecting with a medical provider, developing wellness plans for nutrition, diet and exercise, assist individuals in developing chronic health management plans based on a medical provider's recommendations, complete screens and the GPRA survey when needed, complete some basic follow-up calls or other forms of communication with clients; e.g., emailing or texting, recruit clients from primary care practices, assist in teaching providers how to use SBIRT screens, guide clients through the process of opening a personal health record account and assisting providers to use the PHR for ongoing, integrated care.

**Qualifications for position**. This individual will have an associates or bachelors degree in nursing and an active nursing license in Illinois.

**Supervisory relationship**. This person will work under the MW&R supervisor and receive clinical oversight from the supervisor and nurse case manager of the PBHCI grant project.

**Skills and knowledge required**. This individual will have knowledge of standard health indicators, completing nursing assessments, ordering blood work through standing orders or other established protocols, completing UA and breathalyzer screens, and extensive experience using an EHR for documentation and reviewing electronic files for medical care, labwork and medication regimens. Bilingual skill is preferred.

**Prior experience required**. Experience working with the target population is preferred, but can learn on the job.

**Personal qualities**. This position requires someone who is comfortable working with community agencies, comfortable working with clients in their homes in other community locations, works well with a variety of healthcare providers, is effective at multiple forms of communication; e.g., phone, writing, and conversations, uses a strength-based view of people in early recovery, works well in a team, can work with a wide range of individuals, including those who have co-occurring psychiatric issues, can engage and motivate this wide range of individuals in treatment, is comfortable working with family and friends, willing to use the behavioral model of treatment, and is open to multiple pathways to recovery.

**Amount of travel and special conditions or requirements**. Position requires a substantial amount of travel, including two or more conferences annually and daily travel between locations.

**Salary range**. Part time position (.5 FTE), \$20,000 annual salary

**Hours per day or week**. Approximately 20 hours per week.



Oquawka Site P.O. Box 198 Oquawka, IL 61469	Macomb Site P.O. Box 1350 Macomb, IL 61455	Stronghurst Site P.O. Box 240 Stronghurst, IL 61480
309-867-2202 877-350-2385 (toll-free)	309-833-2500 866-535-5941 (toll-free)	309-924-2424 866-346-1337 (toll-free)

June 7, 2011

Don Miskowiec, President  
North Central Behavioral Health Systems, Inc.  
2960 Chartres Street  
La Salle, IL 61301

Dear Don:

On behalf of Eagle View Community Health System, I am writing this letter in support of the proposal being submitted by North Central Behavioral Health Services for the Center for Substance Abuse Treatment grant to expand addiction services through the use of health information technology. It is our intent to collaborate with North Central to expand addiction treatment capacity and delivery for the patients we serve from rural areas.

Our organization provides primary medical care for individuals who have Medicaid or are uninsured in McDonough, Warren, Henderson and Mercer counties in Illinois. We recognize the need to provide behavioral health services to our patients who have a substance use disorder, but have limited resources or referral options. The proposed grant project would provide a needed service to our patients as well as an opportunity for us to integrate medical and behavioral health care. Access to the mobile wellness and recovery team would be a welcomed service to our providers.

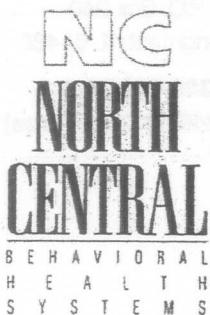
Eagle View Community Health System looks forward to the opportunity to collaborate in the proposed project, including:

- working with the mobile wellness and recovery team to develop a protocol for screening our clients for substance use disorders using the SBIRT screens,
- providing our patients with informational pamphlets on the mobile wellness and recovery, and
- assisting our patients in connecting with the mobile wellness and recovery team.

Please let me know if you need additional information.

Sincerely,

Melinda Whiteman  
Executive Director



Administrative Offices  
2960 Chartres Street • P.O. Box 1488  
LaSalle, IL 61301 • 815-224-1610  
FAX: 815-223-1634  
Web site: [www.ncbhs.org](http://www.ncbhs.org)

June 9, 2011

Fred Nirde, LCSW, CPA  
Chief Executive Officer  
Human Service Center  
600 Fayette Street, PO Box 1346  
Peoria, IL 61654-1346

Dear Fred:

This letter serves as a memorandum of agreement between North Central Behavioral Health Systems, Inc. (NCBHS) and the Human Service Center (HSC) for the Center for Substance Abuse Treatment's grant to expand addiction services through the use of health information technology. As the Chief Executive of our organization, I am pleased to offer our organization's support and resources in achieving the goals of the Mobile Wellness and Recovery project. The CSAT grant project is also a timely opportunity for combining the resources of our two organizations in meeting the needs of adults with a substance use disorder. As you are aware, it has been a daunting task meeting the treatment needs of individuals in our regions who are struggling with addictions and other levels of alcohol and drug problems.

As you and I have been discussing over the past several months, both NCBHS and HSC have learned how to efficiently use the limited resources available in the State to meet the needs of adults with alcohol and drug use disorders. However, we need to become more innovative in reaching individuals who won't access or wait for our traditional treatment services. Moreover, we need to become more creative in mining the resources of our communities in developing a recovery-oriented system of care. The Mobile Wellness and Recovery Team will greatly facilitate many of the innovations that we have been developing at NCBHS. Specifically, we have been developing the hardware and software applications to use teleconferencing and telephonic forms of therapy to reach clients across our seven county catchment area. NCBHS has had to become innovative considering that all potential clients in all seven counties of our region live in rural settings. Many of the e-therapy applications being tested at HSC, including the A-CHESS smart phone applications, would further the evolution of our plan for providing evidence-based treatment to individuals through multiple forms of media.

727 Elm Rd.  
Ottawa, IL 61350  
815-434-4727  
FAX: 815-434-0271

2960 Chartres Street  
LaSalle, IL 61301  
815-224-1610  
FAX: 815-224-1730

17 North Point Drive  
Streator, IL 61364  
815-673-3388  
FAX: 815-673-1437

Perry Plaza, Suite F  
526 S. Bureau Valley Parkway  
Princeton, IL 61356  
815-873-4458  
FAX: 815-872-0417

229 Martin Avenue  
Canton, IL 61520  
309-647-1881  
FAX: 309-647-1878  
301 East Jefferson  
Macomb, IL 61455  
309-833-2191  
FAX: 309-836-2118

NCBHS will work with HSC to both implement and achieve the three goals of the project. Specifically, NCBHS will:

- assign Dr. Michael Lau to coordinate all elements of the project from NCBHS
- commit agency leaders, including myself, to participating in the steering committee to oversee the grant project
- modify our intake process to facilitate the expedited enrollment of adults with a SUD into the Mobile Wellness and Recovery Team
- provide technical support, offices, and equipment for project team members who will use our teleconferencing systems for e-therapy applications
- provide satellite offices across our seven-county area
- work with our two Federally Qualified Health Centers in the region to recruit clients from these locations, and
- identify clients within our system who could benefit from the services or integrate new clients who have been enrolled in the program.

I look forward to working with your organization to implement the Mobile Wellness and Recovery project and to creating a treatment system that can be delivered into the homes of our residents. Let me know if you need additional information.

Sincerely,



Donald Miskowiec

Chief Executive Officer



HEALTHSIM, LLC • 101 WEST 23<sup>RD</sup> STREET • SUITE 525 • NEW YORK, NY 10011

June 13, 2011

Fred Nirde, LCSW, CPA  
President and CEO, Human Service Center  
600 Fayette Street  
Peoria, IL, 61603

Dear Fred Nirde:

As the Chief Research Scientist at HealthSim, LLC, I am pleased to write in support of providing the Human Service Center (HSC) with access to the web-based, Therapeutic Education System (TES) CRA program for your CSAT grant project. As a primary investigator involved in developing and evaluating the TES CRA computer program, I am excited about the opportunity of expanding the clinical application of our interactive computer program for individuals with a substance use disorder.

My colleagues and I developed and have been evaluating the TES CRA program for over six years. In our prior clinical trials research funded by the National Institute on Drug Abuse (NIDA), TES has been shown to produce significant decreases in (objectively measured) substance use compared to individuals assigned to treatment as usual conditions. Due to its efficacy base, TES was elected for evaluation on NIDA's Clinical Trials Network: CTN Protocol 044 entitled "*Web-delivery of Evidence-Based Psychosocial Treatment for Substance Use Disorders*" as well as a NIDA-funded multi-site trial being conducted on NIDA's CJ-DATS platform. Results to date from this work, as well as completed NIH-supported randomized clinical trials, are quite encouraging and underscore the acceptability and effectiveness of TES with multiple populations of individuals with a range of substance use disorders.

Our team continues to update the TES CRA program over time and these enhancements will be made available for your grant project. Notable benefits of the TES CRA program include access to over 65 interactive skills training models that include behavioral training, relapse prevention, cognitive training; i.e., CBT techniques, HIV education, relaxation techniques, and other useful training modules. All modules include accompanying audio instructions and many include video presentations of skills training; e.g., learning how to say no to alcohol and other drugs.

The TES CRA program is well suited to the goals of your proposed project. I am excited about the possibility of using TES to augment treatment interventions and, subsequently, increase the capacity of treatment by adding TES to your treatment model. Further, individuals can re-visit TES program modules overtime, repeat or expand skills training as needed, and involve family members or friends in the training modules (if they so choose) in the comfort of their homes.

HSC will be able to access to the TES CRA program via the Internet. The program is housed on secure servers and is password protected. Individuals can complete training modules at their

own pace, and program modules include quizzes that ensure mastery of key content by program users. Additionally, a back-end database tracks user activity and will enable your program to document the extent to which your clients mastered key program content. Scores from the quizzes are stored in the TES program and can be printed or downloaded for ongoing tracking.

I am also pleased to be a consultant on your CSAT grant project and to assist with the implementation and evaluation of the TES CRA program with the participants enrolled in the grant project. My team will provide you with monthly reports on usage, scores from modules, and any updates that occur during the grant project. I will also provide your team with training to operate the TES CRA program.

I look forward to working with you and your team. Please let me know if you need additional information regarding the TES CRA program.

Sincerely,



Lisa A. Marsch, Ph.D.

Chief Research Scientist

HealthSim, LLC

Director, Center for Technology and Health  
National Development and Research Institutes (NDRI)  
New York, NY



# AUNT MARTHA'S YOUTH SERVICE CENTER

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June 10, 2011

Don Miskowiec, President

North Central Behavioral Health Systems, Inc.  
2960 Chartres Street  
La Salle, IL 61301

Dear Don:

On behalf of Aunt Martha's Youth Service Center, I am writing this letter in support of the proposal being submitted by North Central Behavioral Health Services for the Center for Substance Abuse Treatment grant to expand addiction services through the use of health information technology. It is our intent to collaborate with North Central to expand addiction treatment capacity and delivery for the patients we serve from rural areas.

Our organization provides full medical care for individuals who have Medicaid or are uninsured in the Stark County area. We recognize the need to provide behavioral health services to our patients who have a substance use disorder, but have limited resources or referral options. The proposed grant project would provide a needed service to our patients as well as an opportunity for us to integrate medical and behavioral health care. Access to the mobile wellness and recovery team would be a welcomed service to our providers.

Aunt Martha's looks forward to the opportunity to collaborate in the proposed project, including:

- working with the mobile wellness and recovery team to develop a protocol for screening our clients for substance use disorders using the SBIRT screens,
- providing our patients with informational pamphlets on the mobile wellness and recovery, and
- assisting our patients in connecting with the mobile wellness and recovery team.

Please let me know if you need additional information.

Sincerely,

Jerry Lowell

Senior Vice President

Behavioral Health and Community Services

Aunt Martha's Youth Service Center

19990 Governor's Highway

Olympia Fields, IL 60461

708-747-7039

*Administrative Office*  
19990 Governors Highway  
Olympia Fields, IL 60461  
(708) 747-7100  
[www.auntmarthas.org](http://www.auntmarthas.org)

THE CENTER for  
Health Enhancement Systems Studies  
UNIVERSITY OF WISCONSIN - MADISON

June 9, 2011

David Loveland, PhD  
Fayette Companies/Human Service Center  
600 Fayette Street  
Peoria IL 61603

Re: University of Wisconsin Subcontract under RFA TI-11-002

Dear Dr. Loveland:

This letter confirms the University of Wisconsin-Madison's intent to collaborate with you in your Mobile Wellness and Recovery Project in response to the Substance Abuse and Mental Health Services Administration's (SAMSHA) above referenced RFA.

Kimberly Johnson at the Center for Health Enhancement Systems Studies is the Principal Investigator for the University of Wisconsin-Madison.

Attached is a budget and a description of the effort and resources that the University of Wisconsin-Madison will commit to this project. The proposed budget period is three years, from 10/1/11 through 9/30/14. The total budget for the University of Wisconsin is \$67,037.

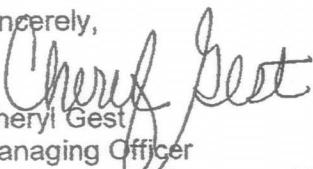
As part of this agreement the University of Wisconsin and the Fayette Companies/Human Service Center agree to share data for the performance assessment of the project following required standards in regard to patient confidentiality. As indicated in the ACHESS license agreement, the Fayette Companies/Human Service Center grants to the University a nonexclusive, royalty-free, irrevocable, paid-up license, with the right to grant sublicenses, to practice and use any improvements to A-CHESS that the Fayette Companies/Human Service Center may develop.

Our legal name is "The Board of Regents of the University of Wisconsin System". Our institution is subject to and compliant with the requirements of OMB A-133. Our EIN number is 396006492. Our DUNS number is 161202122. We are in Dane County and in the WI-002 congressional district.

The appropriate programmatic and administrative personnel of the University of Wisconsin-Madison involved in this application are aware of SAMSHA's policies and are prepared to establish the necessary inter-organizational agreement(s) consistent with those policies.

We wish you success in your submission and look forward to working with you.

Sincerely,

  
Cheryl Gest  
Managing Officer  
Research and Sponsored Programs  
21 N. Park Street, Suite 6401  
Madison, WI 53715-1218  
608-262-3822

  
Kimberly A. Johnson  
UW Principal Investigator

Center for Health Enhancement Systems Studies  
University of Wisconsin-Madison  
SAMSHA TCE-Health IT Grant Application  
6/8/11

## Fayette Companies/Human Service Center Mobile Wellness and Recovery Project

## **University of Wisconsin Scope of Work:**

Kim Johnson will assume responsibility as subcontract Principal Investigator and will serve as the liaison between the agency and the Center's project team members. She will oversee the following deliverables for the Center:

- 1) Two weeks of technical staff time for agency specific additions to the ACHESS smartphone application for each of the three years.
  - 2) Collection of identified outcome measures.
  - 3) Set up system for sharing project data between agency and the Center.

During the course of the project, Ms. Johnson will participate in calls as needed to discuss project progress and assist in problem resolution as needed. Ms. Johnson will also collaborate with other investigators in overall performance assessment goals and publications.

**Grants.Gov Budget Form**

Principal Investigator:  
Co-P1:

Center for Health Enhancement Systems Studies  
University of Wisconsin-Madison  
SAMSHA TCE-Health IT Grant  
6/8/11

**Fayette Companies/Human Service Center  
Mobile Wellness and Recovery Project  
BUDGET JUSTIFICATION**

**Personnel**

**Kimberly Johnson, MSEd, MBA, Principal Investigator (.24 cal mos).** Ms. Johnson is the primary point of contact for the University of Wisconsin on this project and will be responsible for all project activities. Ms. Johnson is currently the Co-Deputy Director for NIATx as well as the Director of the ACTION Campaign. She has worked in the field of substance abuse prevention and treatment since 1989. She has managed treatment programs and served as the single state authority for the state of Maine from 2000-2007, where she worked to increase available treatment capacity by 35 percent during that time.

**Susan Dinauer, B.A., Consortium Director and Technical Core Leader (.36 cal mos).** Ms. Dinauer has been a researcher on CHESS projects and development for over a decade. Ms. Dinauer is Director of the CHEC Research Consortium and is currently working with the implementation of ACHESS with the consortium member agencies. Ms. Dinauer has also been the supervisor for the technical teams for the past several years. For this project, Ms. Dinauer will assist agencies in the implementation of ACHESS and lead the technical core team throughout the project to assure that technical requirements are completed in a timely fashion.

**Chris Judkins-Fisher, B.S, Programmer (.36 cal mos).** Mr. Judkins-Fisher is a programmer for the ACHESS mobile application. He will work with the project PI and consortium director to program the changes needed on the application to better meet the needs of the participating agency.

**Amy Atwood, PhD, Database Manager (.24 cal mos).** Dr. Atwood recently joined CHESS after completing her PhD in Statistics. She worked with the Center as a graduate student and now serves as the database manager for the center. Dr. Atwood will work on data collection and analysis

**Leah Thomas, BS, Web Designer/Developer (.36 cal mos).** Ms. Thomas is the CHESS Director of Web Interface Design and Standards. She will ensure that all XHTML and CSS used for this project adhere to relevant standards and are tested for compatibility on the various platforms being utilized. Ms. Thomas will carry out the majority of the XHTML and CSS programming for the project.

**Susann Ely, B.A., Graphic Artist (.12 cal mos).** Ms. Ely is CHESS Director of Print and Graphics Design. She will direct the development of visual designs and graphics. Ms. Ely's level of design skill brings consistency and visual appeal to the web devices, mobile devices as well as the print materials used throughout the Center. She will also provide her design skills to the project as needed.

**Student Hourly, TBD: (.24 cal mos.)** A student hourly employee will be hired to assist with usability testing of changes to the ACHESS mobile application and other administrative duties as needed such as survey data entry and entering content.

**Printing/Duplicating**

Costs include copying of reference materials, as well as other miscellaneous duplicating services necessary to support this project. \$100 is requested per year.



# HEARTLAND COMMUNITY HEALTH CLINIC

*... A Community of Caring*

1701 W. Garden Street • Peoria, Illinois 61605-3531  
Phone (309) 680-7600 • Fax (309) 680-7686

June 8, 2011

Fred Nirde, LCSW, CPA  
CEO and President, Human Service Center  
600 Fayette Street  
Peoria, IL 61603

Dear Fred Nirde:

On behalf of Heartland Community Health Clinic, I am writing this letter in support of the proposal being submitted by the Human Service Center (HSC) for the Center for Substance Abuse Treatment grant to expand addiction services through the use of health information technology. I see this grant project as another opportunity to advance our two organizations' long term goal of creating an integrated healthcare system in Peoria and surrounding regions. As we have discussed through the SAMHSA PBHCI grant, we have a substantial need to expand addiction treatment services for our patients, including those who live in rural areas.

Heartland Community Health Clinic provides full medical care for individuals who have Medicaid or are uninsured in the region. We recognize the need to provide behavioral health services to our patients who have a substance use disorder, but have limited resources or referral options. The proposed grant project would provide a needed service to our patients as well as an opportunity for us to integrate medical and behavioral health care. Access to the mobile wellness and recovery team would be a welcomed service to our providers as is the current SAMHSA grant project for our patients who have a serious mental illness.

Our providers across the four Heartland clinics look forward to the opportunity to collaborate in the proposed project, including:

- working with the mobile wellness and recovery team to develop a protocol for screening our patients for substance use disorders using the SBIRT screens,
- providing our patients with informational pamphlets on the mobile wellness and recovery, and
- assisting our patients in connecting with the mobile wellness and recovery team following the referrals protocols that we have established with the wellness coaches.

Please let me know if you need additional information.

Sincerely,

  
Farrell Davies  
Chief Executive Officer

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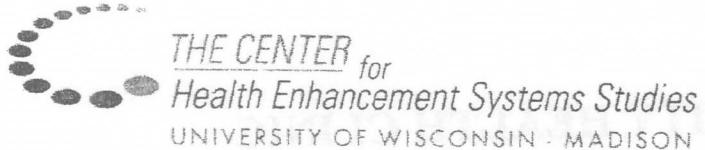
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June 9, 2011

David Loveland, PhD  
Fayette Companies/Human Service Center  
600 Fayette Street  
Peoria IL 61603

Dear Dr. Loveland,

I am very pleased to express my commitment to and enthusiastic support for your Mobile Wellness and Recovery Project utilizing the ACHESS smartphone technology to enhance or expand substance abuse treatment services to underserved populations. Based on my previous experience in individual change research we believe that ACHESS can help people suffering from an alcohol or substance use disorder by providing help around the clock.

Over the past 30 years I have been involved in developing and evaluating eHealth systems using as the test vehicle CHESS (the Comprehensive Health Enhancement Support System), a computer system delivered through laptop and mobile technology to help people facing serious health problems with a particular focus on cancer, asthma and addiction. The randomized trials of CHESS help understand acceptance, use and impact of eHealth on quality of life, behavior change and costs of care.

We are currently studying the effect of ACHESS in a randomized clinical trial with 350 study participants. Seven agencies have joined the CHESS Health Education Consortium. These agencies are using the ACHESS technology in order to assess the feasibility of implementing ACHESS into standards of care.

The Mobile Wellness and Recovery Project is an opportunity to examine how ACHESS can expand the capacity of a treatment provider to serve hard to reach populations. I will work closely with Kim Johnson, the University of Wisconsin PI for this project, to provide guidance on our role in the implementation and performance assessment of ACHESS.

I am look forward to collaborating with you on this significant project.

Sincerely,

David H. Gustafson, Ph.D.  
University of Wisconsin-Madison  
Research Professor of Industrial and Systems Engineering  
Director of the National Cancer Institute designated Center of Excellence in Cancer Communications  
Director of the Network for the Improvement of Addiction Treatment.

## Appendix 1

1.1 & 1.12 Identification of licensed service provider (and treatment programs).....	66
1.2. List of organizations involved in the grant project.....	67
1.3 Statement of Assurance.....	68
1.4 Letters of commitment and support.....	68

Original letters of support will be mailed along with signed documents.

Letters of support from the following organizations will be included:

• The National Alliance for Recovery Residences (NARR) (117,000+ members) (S1A, NARR, NARR.org, A-1000-450-A-0 sample A-117-000-000)

• The National Council for Behavioral Health (NCB) (1,000,000+ members) (S1A, NCB, NCB.org, A-1000-450-A-0 sample A-100-000-000)

• The National Center for Trauma-Informed Care (NCTIC) (S1A, NCTIC, NCTIC.org, A-1000-450-A-0 sample A-100-000-000)

• The National Council on Alcoholism and Drug Abuse (NACADA) (S1A, NACADA, NACADA.org, A-1000-450-A-0 sample A-100-000-000)

• The National Center for Trauma-Informed Care (NCTIC) (S1A, NCTIC, NCTIC.org, A-1000-450-A-0 sample A-100-000-000)

• The National Council on Alcoholism and Drug Abuse (NACADA) (S1A, NACADA, NACADA.org, A-1000-450-A-0 sample A-100-000-000)

• The National Council on Alcoholism and Drug Abuse (NACADA) (S1A, NACADA, NACADA.org, A-1000-450-A-0 sample A-100-000-000)

• The National Council on Alcoholism and Drug Abuse (NACADA) (S1A, NACADA, NACADA.org, A-1000-450-A-0 sample A-100-000-000)

• The National Council on Alcoholism and Drug Abuse (NACADA) (S1A, NACADA, NACADA.org, A-1000-450-A-0 sample A-100-000-000)

## Appendix 1.11 & 1.12: Identification of a Service Provider

The Human Service Center (HSC) is certified by the State of Illinois Department of Human Services (mention JCAHO). HSC is also JCAHO Accredited. HSC is a treatment provider organization and the applicant for the CSAT-TCE grant. All services proposed in the grant will be provided by HSC.

Below is a listing of programs that are certified by the State that will be available to individuals who enroll in the proposed project . Copies of State certification for each program listed below will be mailed to CSAT with a signed copy of the Face Page and other documents requiring signatures.

- (1) CICTA long-term residential program for women, outpatient services and recovery home (ASAM Level I, II & III): License # A-0324-0001-A (expires on 9/30/12)
- (2) White Oaks Knolls residential program for men, outpatient service and recovery home (ASAM Level I, II, & III): License #: A-0324-0003-A (expires on 9/30/12)
- (3) Whitman Medical Detoxification (ASAM Level III.7 D): License # A-0324-0004-A (expires on 9/30/12)
- (4) HSC Level I & II outpatient methadone treatment services (adults and adolescents, ASAM Level I & II): License # A-0324-0005-A (Expires on 9/30/12)
- (5) Rochelle Outpatient Services (ASAM Level I & II): License # A-0324-0007-A (Expires on 9/30/12)
- (6) New Leaf Retreat Intensive Outpatient Services for women (ASAM Level I & II): License # A-0324-0008 A (expires on 9/30/12)
- (7) New Leaf Retreat short-term residential program for women (ASAM Level III): License # A-0324-0009 – A (expires on 9/30/12)
- (8) New Leaf Lodge short-term residential program for women (ASAM Level III): License # A-0324-0010-A (expires on 9/30/12)
- (9) Hamilton Assessment and Outpatient for women and men (ASAM Level I & II): License # A-0324-0016-A (expires on 9/30/12)
- (10) HSC Community mental health services (an extensive range of mental health services: Certification # 04074 (expires on 10/31/12)

**Table 2: Organizations involved in the MW&R Project**

Organization	Description	County Location	Years providing services	Licensed provider of behavioral health or medical care	Letter of Support Included
Human Service Center (HSC)	Primary provider for the proposed project – behavioral health	Peoria	35	Yes – multiple licenses with IL-DSAS & IL-DMH	NA
North Central Behavioral Health Services, Inc.	Partner in the project – primary behavioral health provider to rural services	Seven Counties	40	Yes – multiple licenses with IL-DASA & IL-DMH	Yes
Heartland Community Health Clinic	Federal Qualified Health Clinic	Peoria	8	Yes – primary care & behavioral health	Yes
Aunt Martha's FQHC	Federal Qualified Health Clinic	Stark	4	Yes – primary care & behavioral health	Yes
Eagle River, FQHC	Federal Qualified Health Clinic	McDonough	6	Yes – primary care & behavioral health	Yes
University of Wisconsin CHESS program	University-based research shop – developer of CHESS & A-CHESS programs	NA	NA	NA consultant	Yes
HealthSims, LLC – New York City	Non-profit research shop and developer of software – developer of the TES CRA computer program	NA	NA	NA consultant	Yes

### Appendix 1.3: Statement of Assurance (A signed copy will be mailed to CSAT)

As the authorized representative of the Human Service Center (HSC), 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 from every mental health/substance abuse treatment service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services 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 mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and State requirements for licensing, accreditation, and certification; OR 2) official documentation from the appropriate agency of the applicable State, county, other governmental unit that licensing, accreditation, and certification requirements do not exist.<sup>1</sup> (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.)
- for Tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation, and certification; OR 2) documentation from the Tribe or other tribal governmental unit that licensing, accreditation, and certification requirements do not exist.

---

Fred Nirde, LCSW & CPA, President & CEO

---

June 15, 2011

---

<sup>1</sup> Tribes and tribal organizations are exempt from these requirements.

## Appendix 2

### Brief Addiction Monitor (BAM) DRAFT 11/02/2009

Participant ID: \_\_\_\_\_  
Interviewer ID (Clinician Initials): \_\_\_\_\_

Date: \_\_\_\_\_

**Method of Administration:**

Clinician Interview       Self Report       Phone

**Time Started:** \_\_\_\_\_ : \_\_\_\_\_

**Instructions**

*This is a standard set of questions about several areas of your life such as your health, alcohol and drug use, etc.*

*The questions generally ask about the past 30 days.*

*Please consider each question and answer as accurately as possible.*

**1. In the past 30 days, would you say your physical health has been?**

- Excellent
- Very Good
- Good
- Fair
- Poor

**2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

4. In the past 30 days, how many days did you drink ANY alcohol?
- 0 (Skip to #6)
  - 1-3
  - 4-8
  - 9-15
  - 16-30
5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer or 5 ounce glass of wine.]
- 0
  - 1-3
  - 4-8
  - 9-15
  - 16-30
6. In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?
- 0 (Skip to #8)
  - 1-3
  - 4-8
  - 9-15
  - 16-30
7. In the past 30 days, how many days did you use any of the following drugs:
- 7A. Marijuana (cannabis, pot, weed)?
- 0
  - 1-3
  - 4-8
  - 9-15
  - 16-30

**7B. Sedatives/Tranquilizers (e.g., "benzos", Valium, Xanax, Ativan, Ambien, "barbs", Phenobarbital, downers, etc.)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7C. Cocaine/Crack?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7D. Other Stimulants (e.g., amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", etc.)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7E. Opiates (e.g., Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7F. Inhalants (glues/adhesives, nail polish remover, paint thinner, etc.)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7G. Other drugs (steroids, non-prescription sleep/diet pills, Benadryl, Ephedra, other over-the-counter/unknown medications)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

**9. How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs in the next 30 days?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

**10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky “people, places or things”)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**12. Does your religion or spirituality help support your recovery?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

**13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependents?**

- No
- Yes

**15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

**16. In the past 30 days, how many days were you in contact or spent time with any family members or friends who are supportive of your recovery?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**17. How satisfied are you with your progress toward achieving your recovery goals?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

**Time Finished:** \_\_\_\_\_ : \_\_\_\_\_

## Appendix 3 – Sample Consent Form for Institutional Review Board

## RESEARCH SUBJECT INFORMED CONSENT FORM

Protocol Title: Mobile Wellness and Recovery Team Project

Principal Investigator: David Loveland, PhD  
600 Fayette Street  
Peoria, IL 61603  
309-671-8090

Co-Investigators: Dana Figlock, PhD  
600 Fayette Street  
Peoria, IL 61603  
309-671-8099

Emergency Contact: Emergency Response Services (ERS) 671-8084  
Human Service Center Mental Health and Addiction  
Treatment Services 671-8040, you can also contact David  
Loveland at 671-8090

### Why am I being invited to volunteer?

You are being invited to participate in a research study associated with the Mobile Wellness & Recovery Program. The “research” aspect of the project will use information collected from all participants of the program who are using technology services (i.e. computer based and smart phone interventions). Developers of the technologies would like data regarding the use of these interventions and surveys associated with these services. You are being invited to volunteer since you are entering the Mobile Wellness & Recovery Program. Everyone who enters the program is being asked to participate in the research. Your participation is voluntary which means you can choose whether or not you want to participate. Before you can make your decision, you will need to know what the study is about, the possible risks and benefits of being in this study, and what you will have to do in this study. The research team is going to talk to you about the research study, and they will give you this consent form to read. You may also decide to discuss it with your family, friends, or members of the Mobile Wellness & Recovery Team, your recovery specialist at HSC or North Central, or medical staff at Heartland. Please ask the research team about this form. If you decide to participate, you will be invited to sign this form. Your signature on this form is voluntary and does not waive any of your legal rights or make any institutions or persons involved in this research any less responsible for your well-being. Your refusal to participate will not influence your present or future care at HSC, North Central or Heartland.

## **Who is the Principal Investigator for this Study?**

David Loveland, Ph.D.  
Fayette Companies/HSC  
600 Fayette St.  
Peoria, IL 61603  
(309) 671-8090

## **What is the purpose of this research study?**

The purpose of the research study is to evaluate addiction treatment interventions being used as part of this project. Specific interventions to be evaluated include:

1. Computer based cognitive behavioral interventions for alcohol, tobacco and other drugs
2. Smart phone applications for recovery support from alcohol, tobacco, and other drugs

## **How long will I be in the study?**

During your participation in the Mobile Wellness and Recovery Team Program, data will be collected about your use of the computer based technologies, smart phone technologies and other mobile services. Your participation in the study will last as long as you are enrolled and receiving services from the program.

## **How many other people will be in the study?**

Approximately 600 people are expected to be enrolled over 3 years.

## **What is involved in this study?**

The Mobile Wellness and Recovery Team was developed with funds from a grant from the Center for Substance Abuse Treatment. The purpose of the project is to improve access and expand services for treating alcohol, tobacco and other drugs to people living in rural communities.

The developers of the technologies for this project (i.e. computer and phone based applications) would like to have data regarding the use of these programs. Use data will include frequency of use, pages accessed, as well as survey data that will be asked of participants who are using these technologies. Your data will be kept confidential and will be de-identified (without identifying information).

IRB USE ONLY
Approved: _____
Expires: _____
Initials: _____

We are asking for your permission to collect information about your use of the technologies on this project and to collect de-identified survey data.

Your consent is voluntary and if you choose not to participate, your overall treatment services will not be impacted, however, the use of the technology services may be limited (this is because using these technologies will lead to data being collected). You may choose whether or not your data will be included in the research study.

If you choose not to participate in the research, you will be given treatment though the Mobile Wellness and Recovery Project however, your treatment may not include access to web based or phone technologies.

### **What are the possible risks or discomforts?**

One potential risk involves the unauthorized disclosure of confidential information. The Mobile Team and the program developers will have access to confidential information, about you including your use of technology and your survey responses.

Confidential information will be kept secure from unauthorized access. Multiple procedures will be in place to minimize the risk of unauthorized access or distribution of identifiable information, such as de-identifying data in a database that can only be accessed by the program developers. Consent forms will be kept in a locked filing cabinet within a locked office.

### **What are the possible benefits of the study?**

There is no direct benefit to you for allowing us to use your information for research.

### **What other choices do I have if I do not participate?**

Instead of being in this study, you have these options:

- You could choose not to participate in this study by simply declining to sign the consent form.
- You can still participate in the Mobile Wellness & Recovery Team Program, even if you decline to sign the consent form. (however, services may be limited)
- Choosing not to participate in the research will not effect your treatment in any way at Human Service Center, North Central Behavioral Health or Heartland Clinic.

### **Will I be paid for being in this study or will I have to pay for anything?**

There are no costs or expenses for participating in the research. You will not be reimbursed for participating in research.

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Expires: _____
Initials: _____

## **What happens if I am injured or hurt during the study?**

The risk of physical injury from this project is extremely low. You are being asked to provide permission to the researchers to use data collected for research. You are not going to be asked to participate in any other activity outside of your standard treatment. Although the risk of injury is low, you may feel concerned about your confidentiality and what may happen to the information that is collected. Again, you can decline to participate without risk to your treatment. You can talk to the researchers about the research before you sign this form. You can also delay signing the form until you feel more comfortable about participating.

## **When does the Study end?**

Data will be collected during your use of technologies in the Mobile Wellness and Recovery Program. You can stop using the technologies at any time and data will no longer be collected.

## **Who can see or use my information? How will my personal information be protected?**

Your privacy and the protection of your health information are important to us. This section of the consent will cover:

- What personal health information about you will be collected in this study
- Who will use your information within the institution and why
- Who may disclose your information and to whom
- Your rights to access research information about you
- Your right to withdraw your authorization (approval) for any future use of your personal health information

### **1. Personal health information about you that will be collected in this study**

The following personal health information will be collected, used for research and may be disclosed or released during your involvement with this research study:

- Basic demographic information (name, age, gender, date of birth)
- Information about substance use difficulties, including any diagnosis or diagnoses
- Information on social support

### **2. Why your personal health information is being used**

Your personal information is being collected to examine data use trends of computer based and mobile technologies.

### **3. The personnel who may use or disclose your personal health information**

The following individuals and organizations may use or disclose your personal health information for this research project:

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Approved: _____
Expires: _____
Initials: _____

- The Principal Investigator and the Investigator's study team
- The program developers at the University of Wisconsin, Madison, Comprehensive Health Support Systems(CHESS)
- The Peoria Institutional Review Boards (the committees charged with overseeing research on human subjects)
- The Office of Human Research Oversight (the office which monitors research studies)

#### **4. Who, outside of this institution, might receive your personal health information**

No personal health information will be shared outside of the research team, University of Wisconsin CHESS team and the Community Institutional Review Board.

- In all disclosures outside of this institution's system, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier unless disclosure of the direct identifier is required by law.
- In records and information disclosed outside of this institution, you will be assigned a unique code number for this study. The Principal Investigator will ensure that the key to the code will be kept in a locked file. The key to the code will be destroyed at the end of the research study.

#### **5. How long will this institution be able to use or disclose your personal health information?**

Your authorization for use of your personal health information for this specific study does not expire. This information may be maintained in a research repository (database). However, the institution may not re-use or re-disclose your personal health information collected in this study for another purpose other than the research described in this document unless you have given written permission for the Principal Investigator to do so. However, the Peoria Institutional Review Board may grant permission to the Principal Investigator or others to use your information for another purpose after ensuring that appropriate privacy safeguards are in place. The Institutional Review Board is a committee whose job it is to protect the safety and privacy of research subjects. Results of all tests and procedures done solely for this research study and not as part of your regular care will be included in your medical record.

#### **6. Access to your records**

During your participation in this study, you will have access to your medical record and any study information that is part of that record. The investigator is not required to release to you research information that is not part of your medical record.

#### **7. Changing your mind**

You may withdraw from the study for any reason simply by explaining this to the Principal Investigator or a member of the study team. If you decide not to participate, you are free to leave the study at anytime. Withdrawal will not interfere with your future care.

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Approved: _____
Expires: _____
Initials: _____

You may also withdraw your permission for the use and disclosure of any of your personal information for research, **but you must do so in writing** to the Principal Investigator at the address on the first page. Even if you withdraw your permission, the Principal Investigator for the research study may still use your personal information that was collected prior to your written request if that information is necessary to the study. If you withdraw your permission to use your personal health information that means you will also be withdrawn from the research study.

### **Who can I call about my rights as a research subject?**

If you have questions regarding your participation in this research study or if you have any questions about your rights as a research subject don't hesitate to speak with the Principal Investigator listed on page one of this form. Concerning your rights as a research subject, you may also contact the Peoria Institutional Review Board by calling (309) 680-8630.

When you sign this form, you are agreeing to take part in this research study. This means that you have read the consent form, your questions have been answered, and you have decided to volunteer. Your signature also means that you are permitting this institution to use your personal health information collected about you for research purposes. You are also allowing this institution to disclose that personal health information to outside organizations or people involved with the operations of this study.

A copy of this consent form will be given to you.

---

**Printed Name of Subject**

---

**Signature of Subject**

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Approved: _____
Expires: _____
Initials: _____

(AIA 11-11-17, rev. 10-1-17, effective 10-1-17)

(AIA 11-11-17, rev. 10-1-17, effective 10-1-17)

Date

Printed Name of Person  
Obtaining Consent

Signature

Date

For subjects unable to give authorization, the authorization is given by the following authorized subject representative:

\*Printed Name of Authorized  
Subject Representative

Authorized Subject Signature

Date

\*According to Illinois law, unless there is a court-appointed proxy or guardian, the following persons are authorized to make health care decisions on behalf of an incapacitated or otherwise incompetent patient (listed in order of priority): spouse; adult child; either parent; adult sibling; adult grand child; close friend; and guardian of the estate.

Please designate Authorized Subject Representative's relationship to the subject:

IRB USE ONLY

Approved: \_\_\_\_\_

Expires: \_\_\_\_\_

Initials: \_\_\_\_\_

**Appendix 4: Letter to the SSA  
(mailed to SSA on June 17, 2012)**

Theodora Binion-Taylor  
Director, Department of Alcoholism and Substance Abuse  
100 West Randolph, Suite 5-600  
Chicago, IL 60601

Dear Director Binion-Taylor:

The Human Service Center is applying to the Center for a Substance Abuse Treatments' Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need (Short title: TCE – Health IT). As required for the application, we are submitting this Public Health Services Impact Statement to your office as the Single State Agency for substance abuse in Illinois.

Attached please find:

- A copy of the face page for our application (SF 424)
- A one page summary of the project that describes the population to be served, a summary of the proposed services to be provided and proposed coordination with the Illinois Division of Alcoholism and Substance Abuse if the project received approval.

If you wish to comment on our proposal, please send your comments to the following individual no later than 60 days from June 17, 2011.

Crystal Saunders, Director of Grant Review  
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. TI-11-002**

I look forward to our continued collaboration to promote recovery oriented services in Illinois regardless of the outcome of this proposal.

Fred Nirde, LCSW, CPA  
President/CEO Human Service Center  
Fayette Companies  
PO Box 1346  
Peoria, IL 61654-1346  
(309) 671-8025  
E-mail: [fnirde@fayettecompanies.org](mailto:fnirde@fayettecompanies.org)

# DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB  
0348-0046

<b>1. * Type of Federal Action:</b> <input type="checkbox"/> a. contract <input checked="" type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. * Status of Federal Action:</b> <input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. * Report Type:</b> <input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change
<b>4. Name and Address of Reporting Entity:</b> <input checked="" type="checkbox"/> Prime <input type="checkbox"/> SubAwardee * Name: Human Service Center * Street 1: 600 Fayette Street      Street 2: PO Box 1346 * City: Peoria      State: IL: Illinois      Zip: 61654-1346 Congressional District, if known: IL-018		
<b>5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:</b> (This section is not applicable for this form)		
<b>6. * Federal Department/Agency:</b> Department of Health and Human Services		
<b>7. * Federal Program Name/Description:</b> Substance Abuse and Mental Health Services_Projects of Regional and National Significance CFDA Number, if applicable: 93.243		
<b>8. Federal Action Number, if known:</b> _____		
<b>9. Award Amount, if known:</b> \$ _____		
<b>10. a. Name and Address of Lobbying Registrant:</b> Prefix:      * First Name: none      Middle Name: _____ * Last Name: none      Suffix: _____ * Street 1: _____      Street 2: _____ * City: _____      State: _____      Zip: _____		
<b>b. Individual Performing Services</b> (including address if different from No. 10a) Prefix:      * First Name: none      Middle Name: _____ * Last Name: none      Suffix: _____ * Street 1: _____      Street 2: _____ * City: _____      State: _____      Zip: _____		
<b>11.</b> 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 the 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: David Loveland * Name: Prefix:      * First Name: Fred      Middle Name: _____ * Last Name: Nirde      Suffix: _____		
Title: President and CEO Human Service Center      Telephone No.: 3096718025      Date: 06/15/2011		
Federal Use Only		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

### Project/Performance Site Location(s)

Project/Performance Site Primary Location  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.

Organization Name: Human Service Center

DUNS Number: 0608608630000

\* Street1: 600 Fayette Street

Street2: PO Box 1346

\* City: Peoria

County:

\* State: IL: Illinois

Province:

\* Country: USA: UNITED STATES

\* ZIP / Postal Code: 61654-1346

\* Project/ Performance Site Congressional District: IL-018

Project/Performance Site Location 1  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.

Organization Name: North Central Behavioral Health Services, Inc

DUNS Number: 9378365750000

\* Street1: 2960 Chartres Street

Street2:

\* City: LaSalle

County:

\* State: IL: Illinois

Province:

\* Country: USA: UNITED STATES

\* ZIP / Postal Code: 61301-1097

\* Project/ Performance Site Congressional District: IL-011

Additional Location(s)

Add Attachment

Delete Attachment

View Attachment

**CHECKLIST**

**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 & 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: <input type="text"/>	First Name: <input type="text" value="Clark"/>	Middle Name: <input type="text"/>
Last Name: <input type="text" value="Schuh"/>	Suffix: <input type="text"/>	
Title: <input type="text" value="Director of Finance"/>		
Organization: <input type="text" value="Human Service Center"/>		
Street1: <input type="text" value="600 Fayette Street"/>		
Street2: <input type="text" value="PO Box 1346"/>		
City: <input type="text" value="Peoria"/>		
State: <input type="text" value="IL: Illinois"/>	ZIP / Postal Code: <input type="text" value="61654"/>	ZIP / Postal Code4: <input type="text" value="1346"/>
E-mail Address: <input type="text" value="cschuh@fayettecompanies.org"/>		
Telephone Number: <input type="text" value="3096718019"/>	Fax Number: <input type="text" value="3096718010"/>	

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

Prefix: <input type="text"/>	First Name: <input type="text" value="Dana"/>	Middle Name: <input type="text"/>
Last Name: <input type="text" value="Figlock"/>	Suffix: <input type="text" value="Ph.D"/>	
Title: <input type="text" value="Director of Training"/>		
Organization: <input type="text" value="Human Service Center"/>		
Street1: <input type="text" value="600 Fayette Street"/>		
Street2: <input type="text" value="PO Box 1346"/>		
City: <input type="text" value="Peoria"/>		
State: <input type="text" value="IL: Illinois"/>	ZIP / Postal Code: <input type="text" value="61654"/>	ZIP / Postal Code4: <input type="text" value="1346"/>
E-mail Address: <input type="text" value="dfiglock@fayettecompanies.org"/>		
Telephone Number: <input type="text" value="3096718065"/>	Fax Number: <input type="text" value="3096718010"/>	

HHS Checklist (08-2007)

**PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.**

- (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: (Agency)

on (Date)

## INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

## EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the

Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

**BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.**

**THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:**

**Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).**

**Handicapped Individuals – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).**

**Sex Discrimination – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).**

**Age Discrimination – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).**

**Debarment and Suspension – Title 2 CFR part 376.**

**Certification Regarding Drug-Free Workplace Requirements – Title 45 CFR part 82.**

**Certification Regarding Lobbying – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).**

**Environmental Tobacco Smoke – Public Law 103-227.**

**Program Fraud Civil Remedies Act (PFCRA)**

Internal Revenue Service

Department of the Treasury

District  
Director

Person to Contact: EO:TPA

Telephone Number: 1-800-424-1040  
312-435-1040

Refer Reply to: 89-3327

Human Service Center  
600 Fayette Street  
Peoria, IL 61603

Date: 9-7-89

RE: Human Service Center  
EIN: 37-1004882

This is in response to the letter dated September 1, 1989 regarding your status as an organization exempt from Federal income tax.

Our records indicate that a ruling letter was issued in September, 1977, granting your organization an exemption from Federal income tax under the provisions of Section 501(c)(3) of the Internal Revenue Code of 1954. Our records also indicate that your organization is not a private foundation but one that is described in 509(a)(1) & 170(b)(1)(A)(vi).

Contributions made to you are deductible by donors in computing their taxable income in the manner and to the extent provided in Section 170 of the Internal Revenue Code.

If your gross receipts each year are normally \$25,000.00 or more, you are required to file Form 990, Return of Organizations Exempt from Income Tax by the fifteenth day of the fifth month after the end of your annual accounting period.

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under Section 511 of the Code. If you are subject to this tax, you must file an income tax return on F-990-T.

If any question arises with respect to your status for Federal income tax purposes, you may use this letter as evidence of your exemption.

This is an advisory letter.

Sincerely yours,



R. S. Wintrode Jr.  
District Director

**Table 1: Demographics of the 10-County Region in central Illinois**

County	Total Census	Rural/ Urban	%White Non- Hispanic	% Black	% Hispanic	Median Age	% Female	% below poverty level
Bureau	34,699	Rural/ micropolitan	90.4	0.8	7.1	42	51	9.9
Fulton	36,652	Rural/ micropolitan	93.3	4.0	1.5	41.3	48	15.1
LaSalle	112,498	Rural/ micropolitan	88.8	1.8	7.6	40.3	51	10.4
Marshall	12,702	Rural	94.9	1.1	2.7	43.4	50	8.8
McDonough	32,770	Rural/ micropolitan	88.9	5.0	2.0	24.7	51	20.8
Peoria	185,816	Medium metro	75	17.4	3.1	35.9	52	15
Putnam	6009	Rural/ micropolitan	93.4	0.8	4.7	44.2	50	7.4
Stark	6019	Rural	97	0.3	1.6	43.5	51	10.8
Tazewell	132,466	Medium metro	95.3	1.4	1.6	39.7	51	7.8
Woodford	38,862	Medium metro	96.3	1.1	1.4	39.1	50	5.9

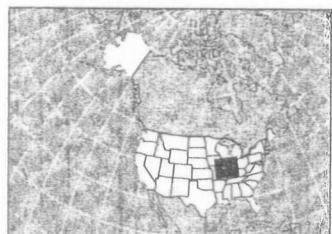


**CONGRESSIONAL DISTRICTS**  
112th Congress (January 2011–January 2013)

The Constitution prescribes Congressional apportionment based on decennial census population data. Each state has at least one Representative, no matter how small its population. Since 1941, distribution of Representatives has been based on total U.S. population, so that the average population per Representative has the least possible variation between one state and any other. Congress fixes the number of voting Representatives at each apportionment. States delineate the district boundaries. The first House of Representatives in 1789 had 65 members; currently there are 435. There are non-voting delegates from American Samoa, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

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MILES  
0 25 50 75 100  
Albers equal area projection



# ILLINOIS

