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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Doug Lindner	CEO / President
APPLICANT ORGANIZATION	**DATE SUBMITTED**
Meta House, Inc.	7/16/2013

Foster, Alania (SAMHSA)

From: Lindner, Amy [alindner@metahouse.org]
Sent: Wednesday, June 26, 2013 4:46 PM
To: Foster, Alania (SAMHSA)
Cc: Jehly, Andrea; Gollmar, Bill; Ullstrup, Christine
Subject: FW: TI024728 - TCE-TAC - Application Review - Response Requested
Attachments: Meta House TCE-TAC (TI024728) Financial Questions - Responses.pdf

Alania:

Attached please find the responses to your questions below. Please feel free to contact me with any additional questions you may have. Thank you!

Amy Lindner

Amy Lindner ▪ President and CEO
Meta House, Inc. ▪ 2625 N. Weil Street ▪ Milwaukee, WI 53212
Direct: 414-977-5808 ▪ Main: 414-962-1200 ▪ Fax: 414-962-2305
Email: alindner@metahouse.org ▪ Visit us at: www.metahouse.org
Facebook: www.facebook.com/MetaHouse ▪ Twitter: twitter.com/MetaHouse

Reclaiming Women's Lives ▪ Rebuilding Families

Save the Date! Friday, September 20th is our 50th Anniversary Event.

From: Foster, Alania (SAMHSA) [mailto:Alania.Foster@samhsa.hhs.gov]
Sent: Wednesday, June 26, 2013 9:14 AM
To: Jehly, Andrea
Cc: Lindner, Amy; Ullstrup, Christine
Subject: RE: TI024728 - TCE-TAC - Application Review - Response Requested

Dear Andrea,

I just spoke with Lisa the subcontractor under your TCE-TAC application. I cleared up an error I made regarding the subcontractor having to fill out the rent questionnaire. They do not have to fill out the questionnaire, the questionnaire only applies if the grantee is requesting rent costs. Therefore, the following are the only items that need addressed:

1. It was noted that your organization does not provide an adequate description of existing resources and other support it expects to receive for the proposed project. Provide a detailed description of existing resources and other support you expect to receive for the proposed project.
2. It was noted that your organization does not clearly indicate it plans to dedicate no more than 20% of the total grant award for data collection, performance measurement, and performance assessment (e.g., activities required in Sections I-2.1 and 2.2 of the RFA), including incentives for participating in the required data collection follow-up. Specifically identify the items in the budget associated with these costs.
3. It was noted that your organization did not provide an adequate breakdown and calculations for the 'additional expenses' costs listed under Planning Council contract. Provide a detailed breakdown of the $3,562. How much is for telephone and internet, how much for rent, how much for insurance, etc.

4. Provide a copy of your organizations Indirect Cost Rate Agreement, that shows a 15.1% rate.

Thank you and sorry for the confusion.

Alania Foster

Alania Foster, M.S.
Grants Management Specialist
U.S. Department of Health and Human Resources (DHHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Office of Financial Resources (OFR), Division of Grants Management (DGM)
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857
(240) 276-1409 (phone)
(240) 276-1430 (fax)
alania.foster@samhsa.hhs.gov
www.samhsa.gov

From: Foster, Alania (SAMHSA)
Sent: Friday, June 21, 2013 10:05 AM
To: 'cullstrup@metahouse.org'
Cc: 'alindner@metahouse.org'
Subject: TI024728 - TCE-TAC - Application Review - Response Requested

Dear Christine,

My name is Alania Foster from the Division of Grants Management at SAMHSA.

Your organization recently applied to the FY 2013 Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need announcement, RFA # TI-13-008. I have started the financial review of your application, and the following items need to be addressed before I can complete the review:

5. It was noted that your organization does not provide an adequate description of existing resources and other support it expects to receive for the proposed project. Provide a detailed description of existing resources and other support you expect to receive for the proposed project.
6. It was noted that your organization does not clearly indicate it plans to dedicate no more than 20% of the total grant award for data collection, performance measurement, and performance assessment (e.g., activities required in Sections I-2.1 and 2.2 of the RFA), including incentives for participating in the required data collection follow-up. Specifically identify the items in the budget associated with these costs.
7. It was noted that your organization did not provide an adequate breakdown and calculations for the 'additional expenses' costs listed under Planning Council contract. Provide a detailed breakdown of the $3,562. How much is for telephone and internet, how much for rent, how much for insurance, etc.
8. For the rent cost, please fill out the attached questionnaire if applicable.
9. Provide a copy of your organizations Indirect Cost Rate Agreement, that shows a 15.1% rate.

If you make any changes to the budget you must submit a full revised detailed budget and a revised SF424A. Also, if any changes are made to the budget, please ensure that the bottom line of $280,000 does not change.

The requested items should be submitted to me via e-mail as one PDF attachment by **COB on June 26, 2013**. If you have questions regarding this request, do not hesitate to contact me.

Please be informed that funding decisions have not been made; however, these are items that needs to be addressed before your application can be further reviewed.

Please note: Any correspondence/response must be sent from the Project Director, Business Official or Authorizing Representative of your organization. If prepared by someone other than those individuals listed above, the correspondence/response must be forwarded to the Project Director, Business Official, or Authorizing Representative then sent to this office with their comments.

Thank you,

Alania Foster

Alania Foster, M.S.
Grants Management Specialist
U.S. Department of Health and Human Resources (DHHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Office of Financial Resources (OFR), Division of Grants Management (DGM)
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857
(240) 276-1409 (phone)
(240) 276-1430 (fax)
alania.foster@samhsa.hhs.gov
www.samhsa.gov

June 26, 2013

Below are Meta House's responses to the financial review questions regarding our application for the FY 2013 Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need announcement, RFA # TI-13-008. (TI024728)

1. **It was noted that your organization does not provide an adequate description of existing resources and other support it expects to receive for the proposed project. Provide a detailed description of existing resources and other support you expect to receive for the proposed project.**

   In the proposed budget, $39,668 of other resources were designated as coming from the applicant. These funds were specifically proposed to cover personnel-related costs, as follows:

Personnel	$25,750
Benefits (28.84%)	$ 7,715
Indirect Costs	$ 5,203
Total Costs	**$39,668**

   In the first year, the resources to cover these expenses would come from fundraising efforts and Meta House reserves. Currently, Meta House reserves total $1,107,870, an amount more than sufficient to cover the expenses listed.

   In future years of the grant, we anticipate that a proportion of the resources to cover these expenses would also come from additional program income received as a result of electronic billing via the electronic health records system to be implemented as proposed in the grant application.

2. **It was noted that your organization does not clearly indicate it plans to dedicate no more than 20% of the total grant award for data collection, performance measurement, and performance assessment (e.g., activities required in Sections I-2.1 and 2.2 of the RFA), including incentives for participating in the required data collection follow-up. Specifically identify the items in the budget associated with these costs.**

   The items in the proposed budget related to data collection, performance measurement, and performance assessment are detailed below:

QI Director Salary	$10,500		
Evaluation Assistant Salary	$ 8,178		
Total Salaries		$18,678	
Benefits (28.84%)		$ 5,387	
Incentives		$ 1,800	
Total MH Direct			$25,865
MH Indirect (15.1%)			$ 3,906
Planning Council			$24,390
Total Evaluation			**$54,061**

The evaluation portion of the proposed budget is $54,061, which is 19% of the proposed funding amount of $280,000.

3. **It was noted that your organization did not provide an adequate breakdown and calculations for the 'additional expenses' costs listed under Planning Council contract. Provide a detailed breakdown of the $3,562. How much is for telephone and internet, how much for rent, how much for insurance, etc.**

   Following is a breakdown of the "additional expenses" cost for the Planning Council contract:

Office & Occupancy	$1,500
Liability & Property Insurance	$ 720
Telephone	$ 576
Technology & Software	$ 378
Internet & Fax	$ 288
Office Supplies, Printing, & Postage	$ 100
Total Annual Additional Expenses	**$3,562**

4. **Provide a copy of your organization's Indirect Cost Rate Agreement, that shows a 15.1% rate.**

   A copy of our Indirect Cost Rate Agreement is attached.

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

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 04/08/2013

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Meta House, Inc.

* b. Employer/Taxpayer Identification Number (EIN/TIN): 39-1017822

* c. Organizational DUNS: 8010173930000

d. Address:

* Street1: 2625 N Weil St

Street2:

* City: Milwaukee

County/Parish:

* State: WI: Wisconsin

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 53212-3060

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix:

* First Name: Amy

Middle Name:

* Last Name: Lindner

Suffix:

Title: CEO/President

Organizational Affiliation:

* Telephone Number: 414-962-1200

Fax Number:

* Email: alindner@metahouse.org

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-13-008

* Title:

Grants to Expand the Use of Technology-Assisted Care in Targeted Areas of Need

13. Competition Identification Number:

Title:

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

Add Attachment | Delete Attachment | View Attachment

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

Meta House Healthy Connections

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: WI-004 | b. Program/Project: WI-004

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 09/30/2013 | * b. End Date: 09/29/2016

18. Estimated Funding ($):

* a. Federal	280,000.00
* b. Applicant	39,668.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	319,668.00

*** 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

Add Attachment | Delete Attachment | View Attachment

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: Amy

Middle Name:

* Last Name: Lindner

Suffix:

* Title: CEO/President

* Telephone Number: 414-962-1200 | Fax Number:

* Email: alindner@metahouse.org

* Signature of Authorized Representative: Andrea Jehly | * Date Signed: 04/08/2013

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2014

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.		$	$	$	$	$
2.						
3.						
4.						
5. Totals		$	$	$	$	$

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	N/A				
a. Personnel	$ 138,889.00	$	$	$	$ 138,889.00
b. Fringe Benefits	40,058.00				40,058.00
c. Travel	2,166.00				2,166.00
d. Equipment	0.00				
e. Supplies	4,664.00				4,664.00
f. Contractual	60,370.00				60,370.00
g. Construction	0.00				
h. Other	6,303.00				6,303.00
i. Total Direct Charges (sum of 6a-6h)	252,450.00				$ 252,450.00
j. Indirect Charges	27,550.00				$ 27,550.00
k. TOTALS (sum of 6i and 6j)	$ 280,000.00	$	$	$	$ 280,000.00
7. Program Income	$ 0.00	$	$	$	$

Authorized for Local Reproduction

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Other sources	$ 39,668.00	$	$	$ 39,668.00
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$ 39,668.00	$	$	$ 39,668.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

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

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. TCE-TAC	$ 280,000.00	$ 280,000.00	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 280,000.00	$ 280,000.00	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

Abstract

The **Healthy Connections** program will use technology, including electronic health records (EHR), text-messaging, and smartphone applications, to enhance the capacity of Meta House (MH) to serve underserved populations of racially-diverse (50% African American, 40% White), low-income women in Milwaukee with substance abuse disorders (SUDs) who have co-occurring conditions (COCs), including mental health disorders and chronic health problems. The goals of the Healthy Connections program are aligned with SAMHSA's strategic initiative for Health Information Technology and the goals of the TCE-TAC RFA: 1) implement new technology to enhance the treatment and recovery of underserved women, 2) serve **83 women** with SUDs and COCs, 3) improve client engagement in substance abuse treatment, 4) improve women's level of functioning relating to substance use and recovery, 5) improve women's mental health functioning and decrease the impact of trauma, 6) improve women's physical health and access to health care, and 7) minimize subpopulation disparities in access to, use of, and outcomes of project services. To achieve these goals, the Healthy Connections program incorporates three complementary evidence based practices: 1) Technology-Enhanced Integrated Treatment for Co-Occurring Disorders, 2) Motivational Interviewing and Stages of Change, and 3) Seeking Safety: Psychotherapy for Trauma/PTSD and SUDs. An array of 100+ possible services to support recovery and resiliency will be provided to women in the Healthy Connections program, including group and individual substance abuse and mental health treatment, comprehensive biopsychosocial assessment, psychiatrist services, case management, consumer peer services, and child and family services. For 50 years, MH has provided gender-responsive, culturally-competent substance abuse and mental health treatment and has for over a decade of used technology to support treatment and trained staff to use technology. However, MH's current system makes it nearly impossible to effectively use available information to coordinate client care among the multidisciplinary team, to provide timely evaluation and quality improvement feedback to the program, and to efficiently use staff time and organizational resources. The technology enhancements included in the Healthy Connections program will allow MH to more fully integrate care for all clients, to improve the long-term recovery and resiliency for women in the program, and to continue to do so long after the grant is over. The performance assessment for the Healthy Connections program will be conducted by the Planning Council for Health and Human Services, an evaluation agency with 20 years of experience evaluating SAMHSA grants. The performance assessment will use findings from intake and 12 month follow-up evaluation interviews, as well as qualitative and process data, to examine the extent to which the Healthy Connections program meets the goals listed above.

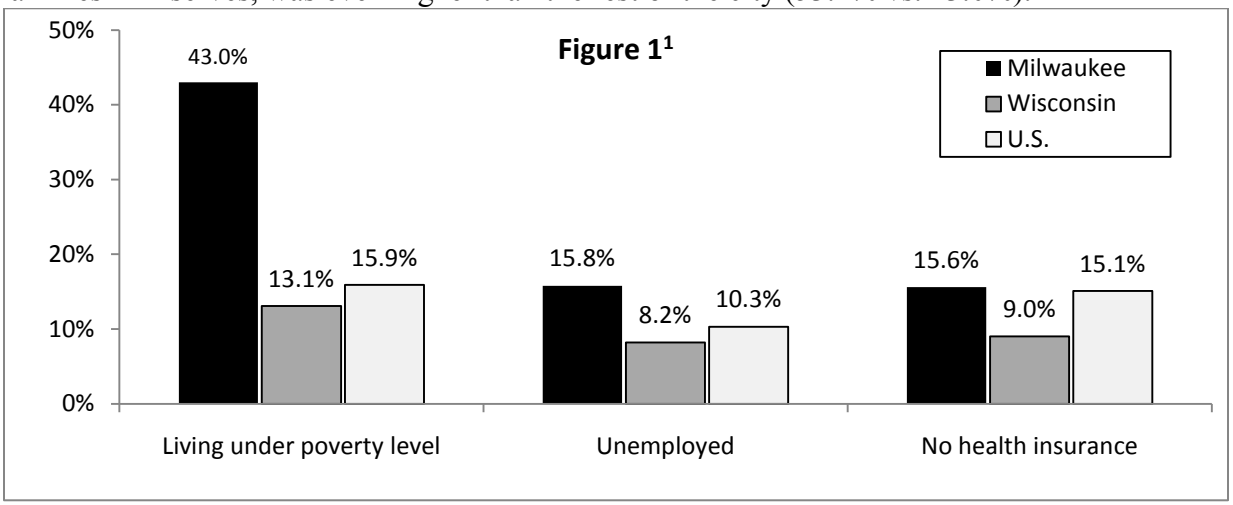
TABLE OF CONTENTS

Section A: Population of Focus and Statement of Need

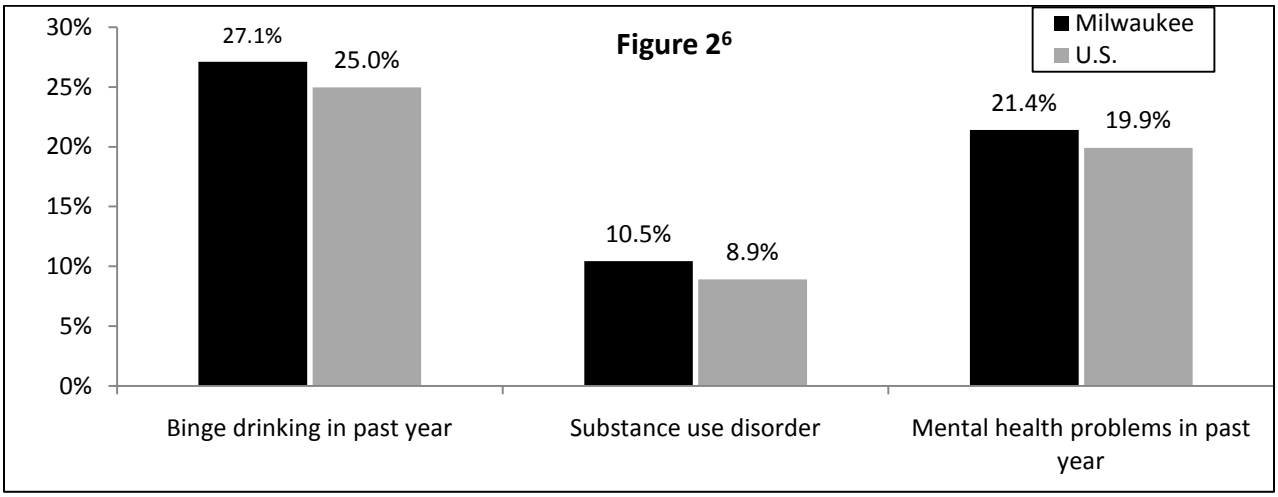
Demographic profile: Meta House's (MH) Healthy Connections program will serve some of the most highly vulnerable women in our community: women with substance use disorders (SUDs) who have co-occurring conditions (COCs), including mental health disorders and chronic health problems. Based on recent demographics, the population of focus is expected to be primarily African American (50%) and Non-Hispanic White (40%), with the majority of the remaining women being Hispanic/Latina and Native American. This demographic profile closely matches the overall demographics of the low socioeconomic status (SES) central city neighborhoods served by MH (51% African American, 36% White) per the American Community Survey estimate.[1] The average age of MH clients is 33 years old. Based on recent MH data, women served by Healthy Connections will be low-income and typically have multiple special needs in addition to their SUDs and COCs, such as trauma history, low literacy, and employability concerns (see Table 1). Almost all will be mothers, and a significant number will be actively parenting their children. Most will be involved in multiple systems, including child welfare, TANF, and criminal justice.

Table 1: MH Demographic Characteristics	
One or More Characteristics of Serious Addiction*	95%
One or More Significant Medical Conditions	48%
Co-occurring Mental Health Symptoms	76%
History of Abuse	88%
Homeless	53%
Poverty – Income Below Federal Poverty Level	93%
Unemployed or Earn Less than $1,000/mo	91%
History of Criminal Justice Involvement	80%
Average Number of Children per Woman	3.7
*More than five years of cocaine use; more than 10 years of use of a drug other than cocaine; intravenous use; and/or regular use of more than one substance on the same day.	

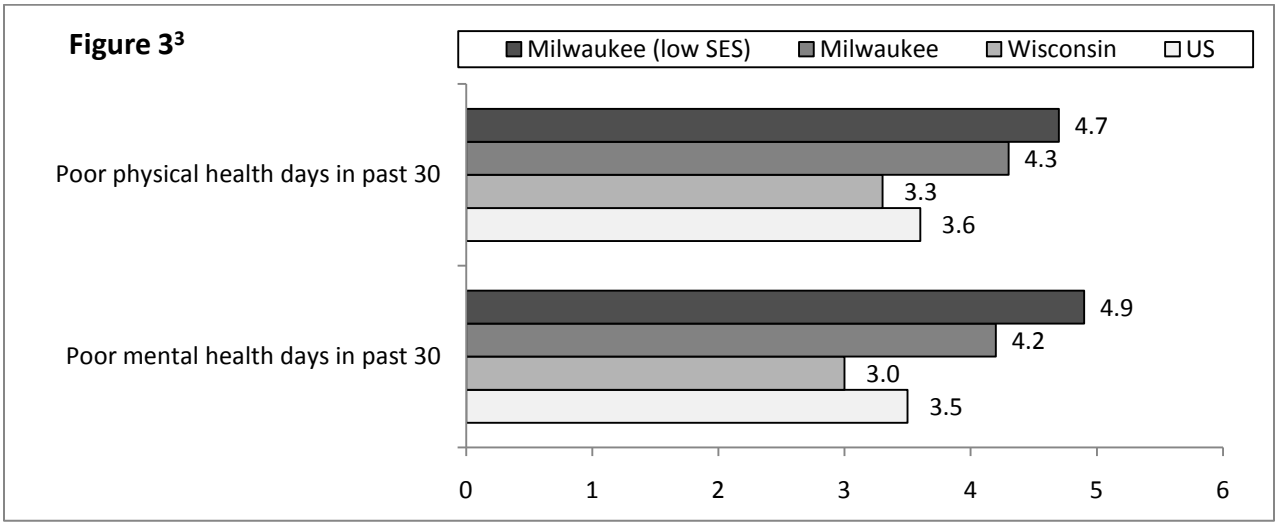
Relationship to overall population: The geographic area to be served will be the City of Milwaukee, WI. Milwaukee has a population of 594,833, making it similar in size to Washington, DC, and Baltimore, MD.[2] The vast majority of MH clients come from the 10 zip codes that make up the neighborhoods with the lowest socioeconomic status (SES) in the city.[3] These neighborhoods were designated as a distressed urban community by HUD, known as the Milwaukee Renewal Community.[4] According to the most recent American Community Survey data (2011 1-year estimates),1 Milwaukee has higher rates of unemployment, poverty, and individuals without health insurance than the rest of Wisconsin and the nation (see Figure 1). The poverty rate for Milwaukee families headed by single women, which is the majority of the families MH serves, was even higher than the rest of the city (53.1% vs. 43.0%).

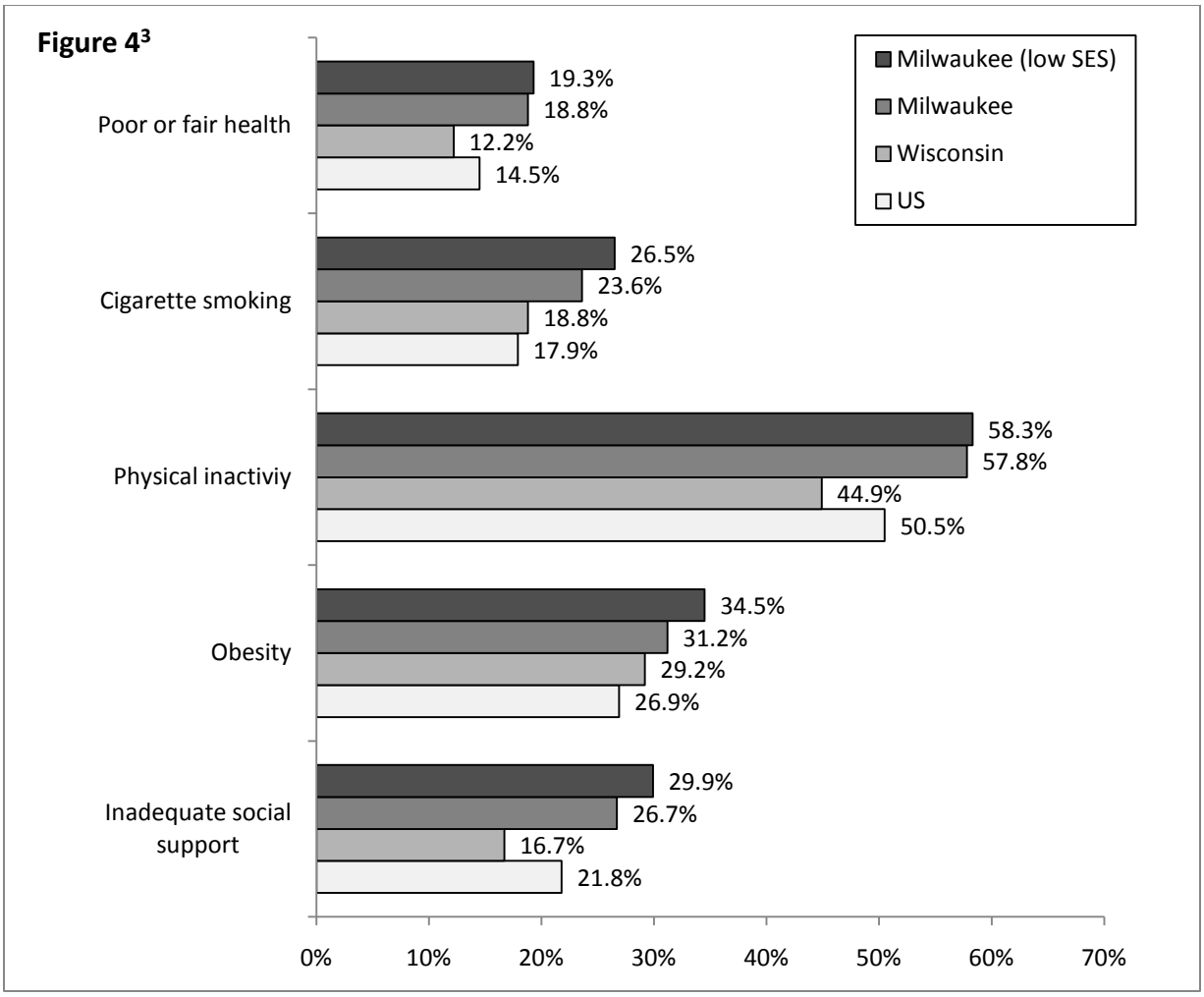


The area served by MH is not only in significant economic distress, but has significant substance use, mental health, and physical health concerns. Since 2002, Wisconsin has had the highest rates of adult binge drinking in the nation.[5] The National Survey on Drug Use and Health (NSDUH) reports that Milwaukee has higher rates of substance abuse and dependence, binge drinking, and mental illness than the national average,[6] as shown in Figure 2.



As seen in Figures 3 and 4, Milwaukee has a greater prevalence of several other measures of mental health concerns (e.g., poor mental health days, inadequate social support) and physical health concerns (e.g., poor physical health days, poor or fair health, cigarette smoking, physical inactivity, obesity) than Wisconsin and the nation.[3] In many of these areas, the low SES areas of Milwaukee served by MH have even higher rates of these problems than the city as a whole. The women and children in Milwaukee, especially those in the low SES areas of the city, also have a high risk of exposure to violence and trauma. Milwaukee was ranked #7 in crime rate when compared to other cities with populations over 500,000.[7] In addition, those living in low SES areas were more likely to have experienced a violent assault than those living in higher SES areas of Milwaukee (7.3% vs. 4.9%).[3]





Nature of the problem: The National Survey on Drug Use and Health (NSDUH) reports that 10.47% of Milwaukee adults have a SUD.[6] Based on NSDUH data for Wisconsin from 2010-2011, adult women constitute approximately 37% of all adults with SUDs.[8] If these figures are applied to Milwaukee's adult population (439,544), it is estimated that there are **18,021 women in Milwaukee with SUDs**. NSDUH data also indicates that women with SUDs are much more likely to have a co-occurring mental health disorder than men. Specifically, 59% of women with SUDs had a co-occurring mental health disorder, compared to 36% of men with SUDs.[8] Based on these prevalence rates, there are an estimated **10,632 women** in Milwaukee with a co-occurring SUD and mental health disorder. Considering chronic health problems, NSDUH data from 2010-2011 indicates that the most prevalent chronic health problems for women with SUDs are asthma (24%) and hypertension (18%).[8] Based on those prevalence rates, there are an estimated **4,325** women in Milwaukee with a SUD who have asthma and **3,064** women with a SUD who have hypertension.

The availability of SUD treatment services responsive to the needs of women is a pressing issue. Women face tremendous barriers when attempting to access, initiate, and sustain treatment.[9] Over the years, research has identified the need for specialized integrated treatment for women. To serve women appropriately there must be an integration of services that address their health,

employment, parenting, mental health, trauma, housing, and child care needs.[9] The Milwaukee County Behavioral Health Division (BHD) operates a public sector substance abuse services delivery system with 35 treatment providers in its network.[10] However, in contrast to the **over 18,000** women with SUDs in Milwaukee who could benefit from treatment, only an estimated **717** women received substance abuse treatment through the WIser Choice network in 2012**.**[*]

For women with SUDs and COCs, there are treatment barriers beyond the availability of treatment. Individuals with COCs have been found to have poorer retention and treatment outcomes.[11,12,13,14,15,16] Although there is support in the literature that integrated treatment for those with COCs leads to better retention and outcomes,[17,18,19,20,21] MH is one of few agencies that provide integrated treatment for the **over 10,000** women in Milwaukee with COCs.[10] Even at MH, an experienced and integrated treatment facility, the high demand for services, the complexity of the needs of women with COCs, and changing levels of care can make it challenging for the staff to communicate as well as needed across levels of care, departments, and agencies and to respond quickly to continually evolving client needs. The goal of the Healthy Connections program, as described below, is to use technology to increase the engagement, retention, and coordination of care to improve the long-term recovery, health, and resilience of a substantial subpopulation of our clients.

Section B: Proposed Evidence-Based Service/Practice

Purpose, Goals, and Objectives: The purpose of the Healthy Connections program is to use technology to enhance the capacity of MH to serve an underserved population of low-income women in Milwaukee with SUDs and COCs. These technology enhancements will involve improving the quality and functionality of our electronic system by fully implementing an EHR system and integrating text-messaging and smartphone applications to support the recovery of women in treatment. The goals and objectives of the program (listed in Table 2 below) are focused on the implementation of the proposed technology and improving the long-term recovery and health care of women with SUDs and COCs.

Table 2: Healthy Connections Goals and Objectives	
Technology Enhancement	
Goal 01:	**Implement new technology to enhance the treatment and recovery of underserved women**
Objective 01.1	Fully implement an ONC-ATCB certified electronic health record (EHR) system throughout the agency.
Objective 01.2	Train 100% of the women enrolled in treatment to access and utilize the EHR system's patient portal.
Objective 01.3	Implement a text messaging and/or email reminder system to support substance abuse treatment attendance.
Objective 01.4	Review smartphone applications and create a menu of recommended apps to serve as an adjunct to substance abuse treatment.
Objective 01.5	Engage and train 40 women in piloting the use of smartphone applications to support relapse prevention and/or health status monitoring.
Objective 01.6	Women enrolled in treatment will describe the benefits and limitations of using technology enhancements to support their recovery.

[*] Nunley, M. Milwaukee County BHD. Personal communication, April 5, 2013.

Table 2: Healthy Connections Goals and Objectives	
Client Numbers	
Goal 02:	**Serve women with substance use disorders who have co-occurring conditions, including mental and/or physical health conditions**
Objective 02.1	Serve 83 women in the Health Connections program over the three-year grant period.
Client Engagement	
Goal 03:	**Improve client engagement in substance abuse treatment**
Objective 03.1	The proportion of women who remain in treatment for 30 days or longer will increase as compared to the year prior to implementation.
Objective 03.2	There will be an increase in the number of treatment hours received by women in the first 30 days as compared with the year prior to implementation.
Recovery and Resiliency	
Goal 04:	**Improve women's level of functioning relating to substance use and recovery**
Objective 04.1	Women will demonstrate a statistically significant pre-post decrease in their substance use and/or abuse.
Objective 04.2	70% of women will demonstrate a commitment to recovery at follow-up.
Goal 05:	**Improve women's mental health functioning and decrease impact of trauma**
Objective 05.1	Women will demonstrate a statistically significant pre-post decrease in their overall mental health symptoms.
Objective 05.2	Women will demonstrate a statistically significant pre-post decrease in their trauma-specific symptoms.
Goal 06:	**Improve women's physical health status and access to health care**
Objective 06.1	70% of women will have access to health care at follow-up, including health insurance and/or an identified health care provider.
Objective 06.2	Women will report a statistically significant pre-post decrease in the degree to which physical health problems interfere with their lives.
Objective 06.3	Women will demonstrate a statistically significant pre-post decrease in their use of tobacco products.
Health Disparities	
Goal 07:	**Minimize subpopulation disparities in access to, use of, and outcomes of project services.**
Objective 07.1	Achieve the targets to be established in the Health Disparities Impact Statement to be submitted post-award.

.

Evidence based practices (EBPs):

The technology-enhanced program to improve retention, engagement, and outcomes for women with SUDs and COCs will incorporate three complementary evidence based practices: 1) Technology-Enhanced Integrated Treatment for Co-Occurring Disorders, 2) Motivational Interviewing and Stages of Change, and 3) Seeking Safety: Psychotherapy for Trauma/PTSD and SUDs. Details of the three EBPs, including justification for choosing them for this program and proposed modifications, are described below, followed by a discussion of how the Healthy Connections program will address specific issues in the population of focus and subpopulation disparities.

1) Technology-Enhanced Integrated Treatment for Co-Occurring Disorders: The Healthy Connections program will use the model for integrated treatment that is described in the SAMHSA Evidence-Based Practices KIT *Integrated Treatment for Co-Occurring Disorders* [17] and TIP #42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*.[18] The Institute of Medicine (IOM), in its 2006 report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*,[21] recommends that quality integrated care requires compatible administrative infrastructures, including informational technology systems and EHR. Technology enhancements, including an ONC-ATCB certified EHR system, text messaging, and

smartphone applications, will be used to improve and support the integration of the program, as described in Table 3 below.

Table 3: Characteristics of Integrated Treatment and Related Technology Enhancements [17,22,23]	
Characteristic	**Technology enhancement**
1. Multidisciplinary team	EHR will facilitate close communication and coordination among multidisciplinary team members.
2. Integrated treatment specialists	
3. Stage-wise interventions (treatment matched to client's stage of change for each problem)	The EHR system allows for continuity between assessments, treatment plans, and progress notes, allowing providers to identify a stage of change for each co-occurring condition and for goals appropriate to each condition and stage to be brought forward into progress notes to ensure they are being addressed at all points of contact.
4. Access to comprehensive services	EHR system allows more efficient monitoring of what services are needed and have been provided so that client needs can be fully met. The EHR's patient portal allows clients to see upcoming appointments and contact their providers. Text-message/email reminders can be set to remind clients of their upcoming appointments.
5. Time-unlimited services (length of stay and level of care based on client needs)	The EHR system allows staff to systematically monitor progress and match length of stay and level of care to client needs.
6. Outreach	EHR allows staff to monitor client attendance in real-time so they can actively re-engage clients more effectively. Text-message/email reminders can be used to re-engage clients in treatment.
7. Motivational interventions	EHR allows motivational interventions to be applied more effectively when staff has access to the appropriate stage of change for each problem (see #3 above).
8. Substance abuse counseling	The EHR patient portal allows clients to send confidential messages to their counselors. Smartphone apps can be used to assist clients with relapse prevention strategies and coping skills.
9. Group treatment for co-occurring disorders	The EHR system allows staff to monitor client attendance and respond in a timely way with text message/email reminders to support group attendance.
10. Family interventions for co-occurring disorders	
11. Alcohol and drug self-help (*e.g.*, 12-step meetings)	Smartphone apps can be used to help clients locate self-help meetings and track their own attendance.
12. Pharmacological treatment	EHR allows MH psychiatrist to e-prescribe medications, to improve communication between psychiatrist and other staff regarding medication, and to monitor effectiveness.
13. Interventions to promote health	EHR allows for improved tracking of chronic health conditions. Smartphone apps can be used to promote health (e.g., smoking cessation, improve nutrition, increase activity, ongoing monitoring of mental and physical health symptoms)
14. Secondary intervention for nonresponders	EHR and smartphone apps can be used to monitor client progress in order to determine if clients require additional services.

MH staff members routinely participate in trainings related to effectively providing integrated treatment for co-occurring disorders. Additional staff training will be required to fully implement the EHR system, which is included in the budget for the Healthy Connections program.
Justification: Integrated Treatment for Co-Occurring Disorders improves treatment and recovery outcomes for people with COCs,[17,18,19,20,21] which is consistent with the population of focus and goal for the Healthy Connections program. With the technology enhancements listed above, this EBP is especially suited to the intent of this RFA. This treatment methodology will

enhance the ability of program staff to effectively communicate with clients and keep them engaged in treatment, to provide better client-centered care, and to empower clients to take an active part in their treatment. **Modifications:** The only modification planned for Integrated Treatment for Co-Occurring Disorders is the addition of technology elements. As detailed above, the technology will serve as an enhancement to the original EBP that is supported by current literature and will not affect implementation fidelity.

2) Motivational Interviewing and Stages of Change: MH will use Motivational Interviewing techniques and the Stages of Change framework that is well-described in TIP #35, *Enhancing Motivation for Change in Substance Abuse Treatment*[24] and the *Motivational Enhancement Therapy Manual* from Project MATCH.[25] Motivational Interviewing is registered in NREPP as an EBP.[26] MH staff was first trained on Motivational Interviewing and Stages of Change in 2008, and MH has maintained ongoing training and supervision for staff. The style and approach has been incorporated into individual and group treatment at MH, as well as supervision and staffing processes. **Justification:** Motivational Interviewing has demonstrated effectiveness in reducing substance use and negative health consequences associated with substance use and in retaining clients in treatment,[27,28,29,30,31] which is consistent with the goals of the Healthy Connections program and the RFA. The use of Motivational Interviewing and interventions based on the client's stage of change is highly supported for treating people with co-occurring disorders by SAMSHA in TIP 42,[18] the *Integrated Treatment for Co-Occurring Disorders* KIT,[17] and by a recent review of evidence-based treatments effective with clients who have SUDs and COCs.[19] Based on these recommendations, Motivational Interviewing is applicable for the population of focus and the Healthy Connections program, as well as the RFA's focus on providing patient-centered care to clients with special needs and supporting their ongoing recovery and resilience. **Modifications:** No modifications are planned for this EBP.

3) Seeking Safety Therapy for Posttraumatic Stress Disorder and Substance Abuse: To simultaneously address early recovery from symptoms of SUD and PTSD, Dr. Lisa Najavits has developed an integrated treatment program called Seeking Safety[32,33,34] which is registered in NREPP as an EBP. [35] Seeking Safety is a manual-based, structured treatment grounded in cognitive behavior therapy that has abstinence from substances, stabilization, and personal safety as its primary goals.[36] Staff at MH have received substantial training in the model. **Justification:** SAMHSA's TIP 42[18] recommends implementing a trauma-informed treatment program for women with COCs, an important part of which is teaching clients the interaction between trauma and substance use. TIP 42 lists Seeking Safety as a promising curriculum for that purpose. Meta House selected the Seeking Safety curriculum over other trauma-focused programs because of the considerable evidence of its success with women in SUD treatment, including both positive outcomes and positive reviews from participating clients and clinicians. The International Society for Traumatic Stress Studies Practice Guidelines currently identifies Seeking Safety as the only effective intervention for co-occurring PTSD and SUD.[37] The effectiveness of Seeking Safety for women in SUD treatment has been rigorously tested through the NIDA Clinical Trials Network's "Women and Trauma Study,"[38] as well as through several secondary analyses of the study's data.[39] [40] [41] Fourteen studies have further evaluated the efficacy of Seeking Safety.[42,43,44,45,46,47,48,49,50,51,52,53,54,55] Consistently positive outcomes have been found for both the group and individual modalities of Seeking Safety, including with women, men, and adolescents and with challenging populations such as homeless women, incarcerated women, and public

sector clients. Outcome findings have included a decrease in drug and alcohol use at the end of treatment[56] and at follow-up.[57] Studies have also found a decrease in PTSD symptoms at the end of treatment,[58,59] at three-month follow-up,[60] at six-month follow-up,[61] and at 12-month follow-up.[62] In addition, clients who participated in Seeking Safety have been highly satisfied and found it to be uniquely helpful in their recovery.[63,64,65,66,67] Eleven studies evaluating Seeking Safety specifically found positive results with adult women either seeking or engaged in SUD treatment.[68,69,70,71,72,73,74,75,76,77,78,79,80,81] Seeking Safety is appropriate for this population of focus and the Healthy Connection program because it has been shown to have positive outcomes for recovery from SUDs and COCs, including many studies which have specifically documented its effectiveness with a population very similar to the Healthy Connections population of focus.[82,83,84,85,86,87,88] Seeking Safety is consistent with the intent of the RFA to improve the quality of treatment and improve recovery and resiliency for underserved special needs populations.
Modifications: Since it was first implemented, MH has made some minor modifications to the Seeking Safety program, such as rolling group admissions, open group format, and the addition of concrete examples and activities, to more effectively work within the outpatient setting and meet the needs of MH clients. MH's evaluation team conducted a qualitative evaluation of the fidelity and impact of the Seeking Safety implementation. The evaluation team noted that the minor modifications made by the program were "adaptations within the model" rather than "adaptations outside the model", as specified by Najavits.[89] As a result, it is anticipated that no significant modifications to Seeking Safety will be needed.

How EBPs will address issues in the population of focus: <u>Demographic issues</u>:
<u>Race/ethnicity</u>: Studies have found that African American people with SUDs and COCs are less likely to receive treatment for their COCs than White people, while they are equally likely to receive substance abuse treatment.[90] Therefore, one of the goals of providing an integrated treatment program like Healthy Connections is that minority women receive needed treatment for their COCs in conjunction with their substance abuse treatment to reduce this disparity. Additionally, both Motivational Interviewing and Seeking Safety have proven to be effective practices for minority women.[82,83,84,85,86,87,88,91] As a result, none of the EBPs specified will require adaptation to meet the needs of minority clients. As a program, MH maintains a commitment to providing culturally-competent treatment to the African American and other minority women we serve and the Healthy Connections program has an experienced staff who are trained to provide all services in a culturally-competent manner. <u>Religion</u>: While religion is not expected to present a barrier for providing integrated treatment, MH staff recognizes the importance of religion and spirituality in the lives of many of our clients and has experience in incorporating and accommodating religious traditions as needed in our treatment setting. <u>Gender</u>: As stated in Section A, women are more likely to have COCs, hence our desire to provide integrated treatment in our gender-responsive program. As a gender-responsive treatment program, MH has 50 years of experience in meeting the specialized needs of women with SUDs and COCs. As noted in TIP 42,[18] women with COCs have better treatment outcomes in single-gender groups, when child care needs are attended to, and when trauma is addressed in conjunction with SUDs. All of these conditions will be present in the Healthy Connections program. Additionally, MH and our consulting psychiatrist have extensive experience with COCs and psychopharmacology as it relates to pregnant and postpartum women, as well as the ability to offer family-centered residential treatment if needed, with a full-time R.N. on staff. Motivational Interviewing and Seeking Safety also have proven effectiveness for women.

[82,83,84,85,86,87,88,91] MH anticipates that implementing integrated treatment, including Motivational Interviewing and Seeking Safety, will serve the needs of women without adaptation. Age: The vast majority (97%) of MH clients are between the ages of 18 and 54; thus, there is no reason to expect that the EBP will not be appropriate based on age. Geography/Socioeconomic Status: The clients served will be from the low-SES inner city neighborhoods surrounding MH. As such, integrated treatment will better meet their needs, as more efficient coordination of care will provide fewer barriers to clients who may be using public transportation and have a variety of case management needs. The technology chosen for the intervention was selected due to its availability for low-income clients. Although many of our clients do not have easy access to a computer or email, all of our clients have cell phones capable of text messaging. Approximately half of our clients have smartphones, and we expect that proportion to increase over time. Additionally, as part of this program, MH has budgeted money to be available to pay for smartphone apps for clients so that finances will not be a barrier in implementing the technology enhancements. **Language:** While the Healthy Connections population of focus will be primarily English-speaking women, MH does have Spanish speaking bicultural staff, the only other non-English speaking culture historically served. **Literacy:** The average MH client reads at an 8th grade level, and 17% are functionally illiterate. To be sensitive to the shame commonly experienced by people who are unable to read and to assure comprehension, forms and curriculum materials are read out loud to each person. MH also offers literacy services to all clients. **Sexual Identity (Orientation and Gender Identity):** Informed by the CSAT publication on treatment of LGBT clients,[92] all sexual orientations and gender identities are accepted at Meta House and are seen as non-pathological variation in human behavior. MH uses approaches that incorporate an understanding of the issues and stressors that impact lesbian and bisexual women and individuals with non-traditional gender identity, so that treatment plans can address these factors.[93] MH can also refer women and family members to LGBT groups conducted by several individual therapists in the community. **Disability:** MH has historically served some clients with physical and cognitive disabilities. The agency is able to accommodate or find alternatives for women and family members with disabilities and keep staff well-trained and informed about the barriers that are commonly encountered. Our psychiatrist and Master's level therapists ensure that the MH programs are able to serve people with cognitive disabilities. Community-based services are coordinated for women and family members with disabilities after a thorough assessment of their specific needs.

Section C: Proposed Implementation Approach

Support for SAMHSA's Health Information Technology Initiative (HIT): SAMHSA's Strategic Initiative #6 calls for:

> *Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).*

The Healthy Connections program supports this initiative primarily by fully implementing an ONC-ATCB certified EHR system throughout all levels of care for all clients in treatment. MH is planning to implement the Epitomax EHR system from Psytech Solutions, Inc., which was specifically designed to accommodate the needs of behavioral health care organizations. Currently, MH maintains client information via a relatively disconnected system of databases,

spreadsheets, and paper charts. When the EHR system is fully implemented, all of this client information will be incorporated into one system, including but not limited to client demographics, treatment episode information, assessments, diagnoses, treatment plans, services provided, progress notes, medication information, insurance information, and releases of information. Fully implementing the system will allow MH to much more completely integrate care for clients, especially for those with COCs, as necessary information will be more readily available to all staff working with a client and will improve communication between staff, including our consulting psychiatrist, on-staff R.N., counselors, case managers, consumer peer specialists, and transportation staff. This EHR-assisted coordination of care will be further enhanced by providing smartphones to staff who are out in the community with clients (e.g., case managers, consumer peer specialists, and transportation staff), so they can access provider information and client schedules as needed. Additionally, the ability to generate and receive a Continuity of Care Record (CCR) and immediate access to releases of information and contact information for client's other providers (e.g. external health care providers, psychiatrists, psychologists) will allow MH staff to more effectively communicate and coordinate care with outside providers. Clients will be trained in the use of the EHR system's patient portal, which allows clients to communicate confidentially with staff, complete assessments, view appointments, and opt in or out of appointment reminders. The implementation of the EHR system will also improve business practices that support effective client treatment. Specifically, staff time can be used more efficiently when the current collection of databases, spreadsheets, and paper charts are integrated into one electronic system, which can be accessed securely both on-site and off-site, and reimbursement from insurance and other funders for billable services will be vastly improved. MH is planning to begin partial implementation of the Epitomax EHR system in 2013, with full implementation planned after receipt of grant funds.

Experience using technology: For over a decade, MH has used technology to assist in the treatment of substance-using populations. The central piece of the MH information systems has been MetaCare, a custom-designed database developed in 2001 and used to track clients, demographic information, treatment episodes, service provision, and funding information across all levels of care. Staff use the system to access a variety of information and reports, including service usage, demographic trends, funding authorizations, and billing reports. In 2011, MetaServices was developed, which functions as an extension of the MetaCare system allowing staff to submit individual services electronically to increase efficiency and accuracy in reporting. Electronic versions of progress note forms and assessments have been developed in Microsoft Word, which many clinicians complete and store on a HIPAA-compliant network drive, although the records are then printed and stored in paper charts. Many program evaluation forms are also completed electronically. Program evaluation databases have been developed for all evaluation data and have been in use for several years. The program has been using online data systems designed for specific federal grants for years (e.g., SAMHSA's SAIS-GPRA website, the HUD HMIS system ServicePoint) to data enter client level data and run reports for analysis. A combination of Microsoft Outlook and spreadsheets are used to coordinate staff and client schedules electronically. As we prepare to move into EHR implementation, MH has designated two members of its management team with extensive technology experience to lead the implementation of the technology enhancements. The Director of Management Information Systems and Communication (DMIS) has been with MH for over 20 years, with responsibility for network administration, computer maintenance, database administration, and communication.

The Director of Quality Improvement (DQI) was trained as a computer programmer and employed as a programmer/analyst for six years before coming to MH. During the past 10 years of employment at MH, the DQI has been responsible for making updates and improvements to the MetaCare system as well as developing the MetaServices system and a variety of other databases for clinical and program evaluation purposes. Because of the DQI's technological experience and expertise, she has been responsible for leading the search for an EHR system and will act as MH's liaison with the EHR vendor for MH. Please see Section H for more detailed biographical sketches and job descriptions for both the DMIS and DQI.

Successes, challenges and outcomes: Over the years, the primary challenge for the use of technology to support treatment at MH has been staff and technological limitations, including outdated computer equipment and the resistance of some staff to using information technology. However, these challenges have been progressively resolved over the years. Currently, we have staff using technology in multiple ways, as detailed above. Computer hardware/software and internet bandwidth have been upgraded to accommodate the growing needs of the agency. These changes have been largely facilitated by having two experienced IT professionals as long-standing MH employees (as described above). The technological sophistication of MH staff has increased substantially over the past several years, and many MH staff members have expressed enthusiasm for the implementation of the EHR system and other technological enhancements and, indeed, have been asking for MH to implement EHR via employee satisfaction surveys and focus groups. Beyond overcoming these challenges, another success of the program in using technology to support treatment was the pilot of a clinical outcomes monitoring project in 2011. The project was sponsored by a state NIATx initiative and involved the monthly administration of a standardized outcome measure (the Brief Addiction Monitor/BAM). A database was developed to administer and monitor the results of the BAM so the clinician and client could see ongoing treatment progress and challenges in a user friendly graphical format. Feedback from this project suggested both clinician and client satisfaction with the pilot project. This success with clinical outcome monitoring will be extended into the current project by offering smartphone applications to clients that can be used to monitor substance use and by mental and physical health symptoms on an ongoing basis as well as providing incentives for participating in such monitoring. With the smartphone applications, the program anticipates that clients can continue to self-monitor symptoms to aid long-term recovery and resilience after program completion.

Current capacity: Currently, MH has computer hardware, software, and an internet connection sufficient to meet the requirements of the Epitomax EHR system. As described above, we currently have the ability to view and/or report on client demographics, treatment episodes, services received, funding information, scheduling, and evaluation outcomes. Having this level of technology available enhances quality of care and organizational efficiency in some ways, as we are able to monitor service provision and usage, generate reports to use for billing purposes, and use some of the available program evaluation data for feedback to the program. However, the disconnection and variety of different recordkeeping systems makes it difficult or impossible to effectively use this information to truly coordinate client care among the multidisciplinary team, to provide timely evaluation and quality improvement feedback to the program, and to efficiently use staff time and organizational resources. For example, because group services are manually entered into the MetaCare system from a client sign-in sheet that is sent to clerical staff

for data entry, there is a long turnaround time for a counselor to see their clients' attendance information. This makes it impossible to take immediate action to actively re-engage clients or resolve problems when engagement or retention problems arise. Because progress notes are kept in paper charts, it is difficult for staff to see notes from other members of the multidisciplinary team, which inhibits integration of care, especially across multiple levels of care. Similarly, it is time-consuming to determine what releases of information are on file for a client and/or contact information for other providers, which can negatively impact coordination of care by making it more difficult for staff to contact providers and/or know what information the client has authorized them to share. From the client perspective, the current system has almost no ability to allow clients to engage in their own care from a technological perspective. From the organizational perspective, the current system makes it difficult for supervisors to audit the quality and completeness of staff documentation. The current system has multiple efficiency limitations. Redundancy in data collection for clinical and evaluation purposes, writing progress notes for group services in multiple paper charts for many clients, and reporting services provided separately from entering progress notes all mean that direct service staff spend a lot of time on redundant administrative tasks that could be better spent providing services to clients. Additionally, administrative staff spend an inordinate amount of time tracking authorizations for various funders, billing funders manually, determining whether claims have been paid and reasons for denials, and manually consolidating data from multiple disconnected sources for reporting purposes. Audits and quality assurance in the current system are limited in their comprehensiveness and are extremely time-consuming.

Factors influencing technology enhancement:

Organizational factors: While MH believes that the implementation of EHR and other technological enhancements will greatly improve organizational efficiency and processes in the long-term, the management team is well-aware that there are many organizational factors to consider when implementing such a comprehensive system. MH has a great deal of experience with process improvement through NIATx initiatives sponsored by the state and previous SAMHSA grants, including initiating walkthroughs of various processes in the agency and implementing and evaluating rapid-cycle changes. As a result, many changes have already been made to improve the admission process and other organizational processes, and the agency culture is one that fully supports process improvement. Currently, the EHR implementation team is beginning to plan for procedural changes to best take advantage of the potential efficiencies of the EHR system. As a first step, a team of managers is meeting to draft assessments to be incorporated into the EHR system that reduce redundancy for ongoing clinical assessments and evaluation data collection. Leadership support has been found to be an important facilitator in implementing health IT systems in substance abuse treatment agencies.[22] MH has a CEO/President who is committed to the technological enhancements included in the Healthy Connections program and who has been successful in moving MH staff to adopt other electronic tools (e.g.,transitioning staff from paper calendars to Microsoft Outlook, use of smartphones), so we anticipate that her support of this project, as well as the full support of the management team, will enable a successful implementation of the EHR system. Additionally, the EHR implementation team has included members from all departments and programs at MH to help ensure that the system will meet staff needs and be easy for them to use. MH is planning to implement the EHR system progressively, one department at a time, to make as smooth a transition as possible and to minimize organizational barriers.

Provider training and competence factors: As described above, the MH staff as a whole has progressed significantly in their comfort with and ability to use technology over the past several years. However, the implementation of a new system always has the potential to present new challenges. MH will utilize multiple resources to make the implementation of these technological enhancements a success. The first is our experienced DMIS who has spent 20 years successfully training MH staff to use technology, including many with limited IT dexterity, and also has experience teaching computer skills to adults at a local technical college. MH's DQI has also had significant professional experience as a computer programmer and during her 10-year tenure at MH training users with a vast range of computer expertise to use technology. In preparation for EHR implementation, on-site training on the Epitomax EHR system from Psytech Solutions, Inc., will be scheduled during the startup period for the Healthy Connections program and is included in the budget. The Epitomax EHR system also has a library of free online training webinars and other training materials that MH will use to train staff and provide refresher training. To accommodate ongoing training and support needs, MH staff members with a high level of IT skill and comfort have been designated to be trained as EHR system "super users," and they will be responsible for ongoing training of staff in using the EHR system and answering questions as staff learn to use the system. To support the super users, the DMIS will research and implement helpdesk software that will allow for efficient and timely response to staff questions and for the compilation of a Frequently Asked Questions list that staff will be able to access to help with common problems. The Epitomax system also has a responsive helpdesk system of its own that can be used to request support as needed. In reality, once the EHR system has reached the mature implementation stage, we expect the training needs to be somewhat lower for the EHR system with its user-friendly and consistent interface than they currently are for staff to use the current system with its multiple interfaces and disconnected systems. Regarding the smartphone apps that will be piloted with clients to support their recovery and health, MH is planning to recruit a few of the most interested and tech-savvy staff members to form a committee to research and test appropriate smartphone apps for the Healthy Connections program. The committee will develop a menu of smartphone apps that are suitable for clients and will be available to train clients on using the apps as needed.

Relationship factors between provider and persons in treatment: In considering how to implement the technology enhancements that are part of the Healthy Connections program, MH has considered how best to minimize negative impacts on clients and the relationship between clients and providers. We expect the long-term impact on clients to be overwhelmingly positive, as we more successfully coordinate care to improve treatment for clients with SUDs and COCs and help keep them more engaged in treatment. Although we expect some adjustment period, the immediate impact will also be largely positive. As data collection redundancy is reduced, the client burden for assessments will be reduced. As noted in Section B, forms and assessment are typically read to clients to accommodate lower literacy levels, so clients will not be expected to fill out forms themselves online. This lower client burden extends to the group sign-in process, as staff will be marking clients present via a tablet computer rather than clients having to sign themselves in for group and have their paper tracking sheets signed. Clients will be asked to sign some forms electronically; however, the hardware used to accomplish electronic signatures is very similar to technology clients currently use to sign for purchases at the store. If clients are uncomfortable with electronic signatures, forms can easily be printed, signed, and then scanned

into the system by staff. Receiving text-message or email appointment reminders may be a new experience for clients; however, the majority of our clients are already experienced with texting, and many of the younger clients prefer texting to calls, so we expect this to be a positive change for many. Clients are also able to opt out of appointment reminders via the EHR system patient portal if desired. Clients will be trained to use the EHR patient portal; however, use of the patient portal will be an optional adjunct to their treatment, not required. A tablet computer will be available at the front desk for clients to access the patient portal via a touch screen, as many clients may find that interface more intuitive to use than a traditional mouse and/or keyboard. A stylus will be available to accommodate clients who have difficulty using a touch screen with their fingers alone. Smartphone apps will be implemented with clients who already have smartphones and are thus at least minimally familiar with using the touch screen interface. As discussed above, a committee of staff members will be responsible for testing the apps for ease of use and will help clients learn to use them. Additionally, a list of links to the appropriate apps will be emailed to clients so that they can access them easily, MH will pay the cost of any apps that are not free, and staff will assist with the purchase of the apps. Typically, MH's community of clients have also served as an important resource for one another, with more experienced clients providing assistance to their peers; we expect this dynamic to be helpful during the transition to using the technology enhancement. MH also plans to incorporate feedback from clients as part of the implementation process; this is described more fully in Section E.

Technical factors requiring additional staff or consultants: As described earlier, MH has developed a plan for training and support that involves the initial training of super users and ongoing training and support by MH staff, with the support of helpdesk software. We expect to have the additional capacity for staff members to provide training and support due to a reduction in staff workload related to the implementation of the EHR system (e.g., reduction in redundancy of tasks, lower data entry requirements, less paper and thus less filing time). Staff will be trained to provide technical support and assistance, make modifications to forms and reports, and scan paper documents in to the EHR system as needed. The current MIS department is equipped to handle ongoing maintenance of the current computer equipment. Minimal new hardware and software are being added to the system because the EHR system will be hosted offsite and accessed via the internet; as such, MH's current MIS staff is capable of handling any ongoing maintenance needs to keep the system operating.

Financial factors: As part of the EHR system selection process, MH was thoughtful about choosing an EHR system that would be sustainable for us in the long-term. The Epitomax EHR system has a very reasonable annual cost for the functionality provided, and the off-site hosting allows us to avoid substantial ongoing hardware maintenance costs and software upgrades and to avoid adding additional MIS staff. Additionally, the Epitomax system allows us to bill payers directly rather than requiring us to use a billing clearinghouse as many other systems do, thus allowing us to experience the benefits of electronic billing without the ongoing transaction costs incurred through using many of the popular clearinghouses. Preliminary review of the implementation leads us to expect that no computer hardware or software upgrades will be required beyond what is normally budgeted for the organization; the maintenance and replacement for other equipment such as the tablets and signature pads is expected to fall within normal operating costs for the agency. As described earlier, refresher training will primarily be handled via online webinars and using current staff (the super users or other staff) to train new

staff members. The ongoing costs of maintaining reimbursement for smartphone apps for clients will be relatively minor and sustainable, especially considering the number of free apps continually being developed. If significant additional unexpected costs arise related to the technological enhancements, MH will find the lowest-cost solution to the problem and pursue private funding to support this. However, overall, MH expects to be able to recoup some of the expense of the technology enhancements in the long-term in the following ways: 1) less redundancy and increased efficiency from implementing the EHR system will reduce the administrative workload for direct service staff, resulting in a higher ratio of billable time; 2) increase in client attendance and retention reduces staff time spent in the "revolving door" of discharging and readmitting client and increases total billable services; and 3) improved monitoring of authorization status, potential billing errors, improved capturing of all services provided, and a shorter turnaround time for insurance claims and other billing leads to a higher rate of reimbursement for services already being provided.[22]

Effective consent: Section I details the procedures to obtain and track effective consent consistent with State law and 42 CFR Part 2.

Impact on community: The goals for the Healthy Connections program include enhancing MH's treatment program with technology, serving women with SUDs and COCs (including both mental and physical health conditions), improving client engagement and retention, decreasing substance use, improving mental health and reducing the impact of trauma, improving physical health and engagement in health care, and minimizing subpopulation disparities (see Table 2). These goals are expected to have meaningful and relevant results in the community by improving the effectiveness of treatment and interventions for women with SUDs and COCs, who are a traditionally underserved population. As discussed in Section A, individuals with SUDs and COCs typically have poorer treatment retention, engagement, and outcomes. By achieving the program goals, the Healthy Connections program will improve the long-term recovery of women with SUDs and COCs, thereby improving the physical and mental health of the low-income communities in Milwaukee that are served by MH. Because a substantial proportion of the women served by MH are minority women, achieving program goals will also reduce racial disparities in mental health treatment in the community. The majority of women served by MH are single mothers of minor children; thus, by achieving the goals of the program, the quality of life for their children will also be improved. By improving the health care for women and their connection to health insurance and health care providers, the Healthy Connections program will also reduce the reliance on emergency room care by the families in the program and reduce the public health burden. The long-term impact of reducing substance use and improving mental health can also include reduced criminal activity, homelessness, and child abuse and neglect; this not only contributes to a better quality of life in the community but also can help contribute to reducing the burden on the criminal justice system, child welfare system, and shelters and other housing resources.

Support for SAMHSA's goals: The first goal for the Healthy Connections program (described in Table 2) is to implement technology enhancements, including EHR, text-messaging, and smartphone applications, that support recovery, which aligns with SAMHSA's strategic initiative #6 (Health Information Technology) and the goals of the RFA. The Healthy Connections goals overall are designed to improve treatment opportunities (including engagement, retention, and

outcomes) and communication with women in treatment who have difficulty engaging in and fully accessing treatment and health services due to the impact of their SUDs and COCs and other socioeconomic barriers (poverty, lack of health insurance, family needs). The goals of the Healthy Connections program also align with the expected outcomes listed in the RFA. Although sharing of effective treatment models and results (RFA Outcome #1) is not a stated objective of the program, the Healthy Connections program will be exploring the effectiveness of technology enhancements in conjunction with integrated treatment for co-occurring disorders and the evaluation will identify lessons learned. The results will be shared with SAMHSA via regular performance reports and with other grantees via SAMHSA grantee meeting. The goals of the program support increased engagement of persons in treatment in their health care (RFA Outcome #2) in multiple ways, such as increasing client engagement in treatment, training women to use the patient portal of the EHR system, helping women access health insurance, and helping women connect with a primary health care provider. The implementation of technology and coordination of care support increased monitoring and tracking of individual health status (RFA Outcome #3) for the women in the program. All of the Healthy Connection program goals support improving recovery and resiliency rates (RFA Outcome #4), as the overall goal of the program is to improve long-term recovery from SUDs and COCs (both physical and mental health conditions) for the women we serve, which in turn improves the resiliency of women, their families, and the community as a whole.

Screening/assessment for co-occurring disorders: As described in Section B, the Healthy Connections program model is based on technology-enhanced integrated treatment for co-occurring disorders. A fundamental requirement for implementing integrated treatment for co-occurring disorders is screening/assessment of co-occurring disorders and interventions matched to the stage of change for each co-occurring condition.[17,18] Before admission to MH, all women are evaluated for substance use disorders and co-occurring mental health disorders using a comprehensive biopsychosocial assessment. Because of the prevalence of trauma for women in SUD treatment, women are also assessed for PTSD symptoms using the Modified PTSD Scale (MPSS-SR).[94] MH contracts with a female psychiatrist (see Section H for biographical sketch and job description) who evaluates and diagnoses women as requested. Medications and medical conditions, as well as SUD or withdrawal, can mimic the symptoms of a mental disorder.[95] For clarification and confirmation of diagnoses, women are re-evaluated periodically as acute symptoms related to SUD subside. All assessments and psychiatrist notes will be incorporated into the EHR system, allowing substance use and mental health diagnoses to be linked to the woman's treatment plan so that stage of change for each condition can be established by the clinician and allowing appropriate goals and matched interventions to be established based on diagnosis and stage of change. Through the EHR system, these treatment plan goals are also linked to service activity and progress notes so that treatment can be matched directly to co-occurring conditions identified in the assessment. Some MH counselors are dually-certified to provide both substance abuse treatment and mental health treatment, and all MH counselors are trained to identify and treat co-occurring conditions. Seeking Safety (as described in Section B) is provided for all women due to the prevalence of trauma exposure. Additionally, MH employs a therapist certified in EMDR and art therapy to provide additional services for co-occurring disorders. MH's psychiatrist prescribes medication for clients with co-occurring disorders as appropriate and has experience with prescribing medications appropriately for pregnant and postpartum women. With the implementation of the EHR system, information about the

medications prescribed will be more accessible to other staff working with the clients, and monitoring the effectiveness of medications based on the observations of the entire multidisciplinary team can be conducted more easily. For client needs that cannot be met within the Healthy Connections program, referrals will be made to the many mental health providers in the city based on payment structure, geographic location, and availability for family members, and communication for the purposes of coordinating care will be facilitated by the EHR system.

Project timeline: Table 4 below shows the proposed timeline for Healthy Connections.

Table 4: Healthy Connections Timeline

Staff	Activity/Milestone Month:	1	2	3	4	5	6	7	8	9	10	11	12	18	24	30	36
IT	Ensure that system requirements for EHR system are met																
IT	Purchase signature pads/tablets																
IT	Purchase smartphones for staff and train them to use																
IT	Purchase limited use cell phones and distribute to transportation																
PD/QI/ IT	Fully implement EHR system																
PD/QI	Train staff on EHR system																
PD/QI	Establish smartphone app committee																
PD/QI	Research/test smartphone apps and develop list for clients/staff																
PD	Admit clients to program																
PD	Train clients to use patient portal																
PD	Use text-message appointment reminders																
PD	Help clients with smartphones install and use appropriate apps																
EV/QI	Assist project team in developing Disparities Impact Statement																
EV/QI	Train evaluation staff on GPRA/local evaluation protocol																
EV/QI	Establish local evaluation data entry forms																
EV/QI	GPRA/ local evaluation data collection																
EV/QI	Qualitative interviews/focus groups with staff																
EV/QI	Qualitative interviews/focus groups with clients																
EV/QI	Study Team reviews of NOMS																
EV/QI	Biannual review of program & performance assessment																
PD/QI	Submit progress reports																
EV	Analysis of baseline & 12 month follow-up data																
EV/QI	Final report*																

Staff Key: PD = Project Director, IT = MIS Director, QI = Quality Improvement Director, EV = Evaluator

* Work on the final report will begin in Month 36 and will be submitted in Month 39 as specified by SAMHSA.

Population of Focus Beliefs, Norms, Values: Women and SUDs: As described by TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women*,[9] the central factor to understanding women and SUDs is the importance of relationships. Romantic relationships and family play an important role in the initiation of substance use and development of SUDs for women. Women often begin using substances through a romantic relationship, and women with SUDs are more likely to report a family history of substance problems. The involvement of significant others and family also has a strong influence on women's engagement and retention in treatment as well as potential recovery and relapse. For women who are mothers, their parenting role often affects their substance use and treatment. Many women stop or reduce their use while pregnant; although, for women who become pregnant while in treatment, pregnancy can interrupt the recovery process, particularly for women who have COCs and/or are on medication. The desire to retain custody of their children is a strong motivator for women to seek treatment for SUDs; however, the fear of having their children detained is also a serious barrier to seeking treatment for other women. Once engaged in treatment, women value an accepting, warm, and collaborative relationship with their counselor and other staff and being able to maintain a consistent connection with their providers throughout the continuum of care. While women generally enter treatment with more serious SUDs, mental/physical health problems, trauma histories, economic barriers, and social problems, they also are more likely to seek help, to participate in mental and physical health care services when offered to them, and to benefit from integrated and coordinated services which address these complex needs. [96,97,98,99,100,101,102,103,104,105,106,107,108,109]

African American Women and SUDs: Effective treatment of African American women requires an appreciation of the impact of the history of slavery, racism, poverty and oppression on women's present experience. [110,111,112,113,114,115] As one of the lingering effects of having families torn apart by slavery, relationships are even more important for African American women, often including connections to extended family and the larger community.[9] More than White women, African American women are especially influenced by an expectation to always be strong, sacrifice themselves to care for others, and not to seek help or discuss private issues with others. Although a variety of environmental stresses (e.g., lack of financial resources, inadequate medical care and housing, higher stress levels) make African American women more vulnerable to SUDs and other health conditions, these cultural expectations can interfere with seeking treatment when it is needed. Alienation and depression caused by persistent oppression and lack of opportunity is a factor in influencing some African Americans to turn to alcohol and drugs. Additionally, African American women with SUDs experience more negative consequences of their substance use than White women. They are particularly more likely to have their children removed by child welfare or experience other legal ramifications; fear of these consequences is a substantial barrier to entering treatment.[9] Spirituality and church is an important part of life for many African American women, which can be a significant factor in recovery for African American women in recovery. Given the effects of the long history of oppression and racism on African American women, a strengths-based approach is more suitable than a problem-based approach.

Identification, recruitment, and retention of the population of focus: Clients from the population of focus for Healthy Connections will come to MH in one of two ways. One potential point of access is through the Milwaukee WIser Choice program, a County-wide system for the funding and provision of treatment and other recovery support services for people without

insurance. Women can access one of Milwaukee County's Central Intake Units (CIUs) where they are screened for substance use and mental health problems and the appropriate level of care is determined. Milwaukee County operates a voucher program and allows consumers their choice of treatment facility. Because MH is state-licensed as a substance abuse treatment facility and as a mental health clinic and because we participate in WIser Choice's Mental Health Outpatient Program, a large proportion of these referrals are for women with COCs. The other point of access is that clients with insurance can contact MH directly to schedule an intake appointment. MH also conducts outreach through educational seminars and direct contact to the shelters, privatized child welfare and TANF agencies, family courts, churches, hospitals, other AODA agencies, the District Attorneys, Public Defenders and other institutions that are likely to serve women with SUDs and COCs. Conscious of the barriers that fear of losing their children can present for treatment, MH has worked on a series of collaborative projects with child welfare to help women engaging in treatment retain custody of their children and receive services that better support their families and treatment needs. Children can live with their mothers in residential treatment, and child care and assistance with finding appropriate outside child care is provided. MH is well known among women in Milwaukee and in the African American community for successful outcomes and cultural and gender competence. MH consistently has a wait list for its services, so we do not anticipate difficulties with identification and recruitment of clients. As described above, MH assesses all clients for COCs, so identification of clients who fit the population of focus for Healthy Connections will be incorporated into the current assessment process. Better engagement and retention of clients from the population of focus is one of the goals of the Healthy Connections program. The technology enhancements proposed will be used to improve client retention as described in detail in Section B, and retention and engagement of clients will be continually monitored by the DQI and evaluation team and reported to project staff so any adjustments can be made. In addition, MH is always working to better engage and retain clients. For example, MH management is currently working with Robert Spector Consulting to learn about improving customer service based on the principles of Nordstrom department stores. In addition, the program recently conducted agency assessments for co-occurring capability (the COMPASS-EZ, as part of Milwaukee County's Co-Occurring Capability initiative) and cultural competence (Cultural Competence Assessment Scale) in order to work toward continuing to make the program as culturally sensitive and welcoming as possible to women with COCs and extensive trauma histories. The physical and emotional environment first encountered by those seeking services is sensitive to the traumatic histories and needs of women. This includes a waiting room that is very comfortable, homelike, and includes pictures that represent diverse families, child care, a secluded waiting area, and a staff that is trauma-informed. During the intake process, the needs of the woman and her family are assessed and coordination of care to meet those needs is provided by her counselor, case manager, and other members of the multidisciplinary team.

Input of Clients: MH is always conscious of ways to include client input into all aspects of programming and program evaluation. As part of the evaluation for the Healthy Connections program, feedback from clients will be incorporated via regular qualitative data collection regarding the successes and challenges of the enhancements and suggestions for improvement. MH frequently conducts focus groups and client surveys on an ad hoc basis to provide input into management decisions and program changes, and this will continue as needed for the project. Feedback is solicited regularly from MH clients via client satisfaction surveys. This feedback is

provided to staff, program management, the CEO/President, and the Board of Directors on a regular basis so that program changes can be made accordingly. A proportion of MH staff and management has always consisted of program graduates, including our current Project Director (see biographical sketch in Section H), and a MH graduate recently joined the Board of Directors. Over the past three years, MH has added four Consumer Peer Specialist positions. These individuals help ensure that a perspective representing the population of focus is provided daily.

Other organizations participating in the project: Two other organizations will be committed to the Healthy Connections program. The Planning Council for Health and Human Services will fill the role of external evaluator (please see Section E for more details). Psytech Solutions will provide Epitomax, the ONC-ATCB certified EHR system. A description of the roles and responsibilities of each of these organizations and signed memoranda of agreement (MOAs) can be found in Attachment 1.

Number to be served: Over the three-year grant period, the Healthy Connections program proposes to provide enhanced services to **83** women (unduplicated count). Table 5 shows the number to be served each year of the program (please note that fewer women will be served the first year to account for the three-month startup period). 100% of the number served will be female. Based on past demographics, MH expects 50% of clients to be African American, 40% of clients to be White Non-Hispanic, and the remaining 10% of clients to be Hispanic or Native American.

Table 5, Clients Served by Year and Subpopulation

Year	1	2	3	TOTAL
Women	**23**	**30**	**30**	**83**
African American	12	15	15	**42**
White Non-Hispanic	9	12	12	**33**
Other	2	3	3	**8**

Services offered**:** A comprehensive array of services to support recovery and resiliency will be provided as part of the Healthy Connections program. All clients will receive technology-enhanced integrated treatment for co-occurring disorders, which includes over 100 possible services. All clients will be offered the following core services:

Group Services	Individual Services
Seeking Safety	Biopsychosocial assessment
Relapse Prevention	Trauma assessment
Helping Women Recover	Individual counseling
A Woman's Way through the 12 Steps	Psychiatrist services
Stages of change process groups	Crisis intervention
Educational workshops	Wraparound/ coordinated care meetings with client's multidisciplinary team along with support system, and/or other providers
Anger/stress management	Case management, including assistance with financial, legal, medical, and housing needs
Women's health education	Consumer peer services
Living skills	Child and family services, including child care
Case management group	Transportation
Art therapy	
Nurturing and parenting	
Vocational/educational groups	
Open houses/education for family members	

Anticipated outcomes**:** Anticipated outcomes for the Healthy Connections program are detailed in Section B, Table 2. Details about how these outcomes will be measured can be found in Section E, Table 8.

Per-Person Costs: As previously discussed, low-income women with SUDs and COCs tend to have more and different risk factors than their male counterparts, requiring services that are extensive and therefore more costly. Programs responsive to women tend to be more complex, requiring specialized roles and high level of care coordination.[9] This is especially true for African American women, as they are likely to experience more health and social consequences as a result of their SUD than White women.[9] Due to the complexity of the demands, intensive coordination efforts among various systems are required. This program will provide a continuum of Outpatient, Intensive Outpatient, Day Treatment, and Residential treatment (as determined by the ASAM criteria), with many integrated services to each woman that must be coordinated by a multidisciplinary team. Although the program makes every effort to connect women with health insurance, many of the comprehensive services required to support the long-term recovery of low-income women with SUDs and COCs, most of whom are mothers, are not covered by insurance or other funding sources. Additionally, technological enhancements to support integrated treatment will be implemented across all levels of care. Therefore, the cost per woman for this program is **$8,096**. Plan for maintaining and/or improving the provision of high quality cost-effective services: As described above, fully implementing the EHR system will improve the efficiency, quality, and cost-effectiveness of services. The ability to monitor the quality and cost-effectiveness of services provided will also be improved when medical records, service records, and reimbursement are integrated into one electronic system. The Project Director and DQI will be responsible for ongoing monitoring of services, and progress toward program outcomes will be reviewed regularly as described in Section E. MH expects the implementation of the EHR system and other technology enhancements included in the Healthy Connections program will have a positive impact on the quality and cost-effectiveness of services provided that will last far beyond the end of the three-year grant period.

Section D: Staff and Organizational Experience

Capability and Experience: Meta House (MH) has been providing gender-appropriate SUD treatment services for women since 1963. In 1988 it opened one of the first residential women and children's treatment programs in the country. Currently, it offers a continuum of care that includes outpatient, intensive outpatient, day treatment, and residential treatment. At each level of care, MH provides a comprehensive array of services targeted to women, children and families. With a budget of $5.5 million, MH served 472 women in 2012 and has a multi-disciplinary staff of 81 people. Over the years, MH has successfully implemented nine SAMHSA grants serving women similar to the Healthy Connections population of focus. MH currently administers three HUD supportive housing grants, two Administration for Children and Families (ACF) grants, and one SAMHSA Pregnant and Postpartum Women grant. The agency has received numerous awards and recognitions on a national and local level, including an Outstanding Program Award from the Wisconsin Association on Alcohol and Other Drug Abuse as a program that significantly impacted on its clients and community. Evaluations consistently indicate a high degree of success for a racially diverse population of women with SUDs and COCs. The external evaluator will be the **Planning Council for Health and Human Services**

(PC), a private, nonprofit organization in Milwaukee. The PC manages over 25 different planning, research, and evaluation projects, engaging more than 80 different area nonprofits, government entities, educational institutions, and foundations. The PC has extensive experience in multi-year, federally funded evaluations in the areas of AODA treatment and prevention, including external evaluation of nine previous MH SAMHSA grants. The EHR system will be provided by **Psytech Solutions**. Psytech Solutions has 12 years of experience providing and supporting EHR for behavioral health organizations. **Linkages to the Target Population and Grassroots/Community-Based Organizations:** MH's program staff reflects the population to be served: 94% female, 52% people of color, of whom 84% are African American. MH is one of 75 community and faith-based providers linked together through the County public sector AODA delivery system and serves on the Core Values Committee for WIser Choice for Families, the CoC for the Homeless, the Child Welfare Partnership Council, and the Families Moving Forward Coalition (the Milwaukee team developed in response to the SAMHSA Community Leaders & Interfaith Summit). MH has linkages with hundreds of grassroots and community-based organizations serving the target population.

Staffing plan:

Table 6: Key Project Staff

Staff Member, Title, FTE	Qualifications	Experience/Familiarity with Population of Focus (POF)	JD/ Bio pg. #
Christine Ullstrup., MSW, LCSW, Project Director, 0.1 FTE	Director of Programs, Project Director – SAMHSA PPW Grant Oversees all Meta House programs Trained in trauma-informed education	15 years managing treatment for POF; 18 years working with POF; **Meta House Graduate**	46
Cathy Perkins, MD, Psychiatric Consultant, 15 hrs/week	Meta House Medical Director ASAM Fellow Asst. Professor, U. of WI Med. School	14 years treating POF at MH, 23 years as psychiatrist, Past liaison, neonatal ICU, Aurora Sinai Hospital	49
Andrea Jehly, MS, Director of Quality Improvement, 0.15 FTE	Oversees quality improvement, internal evaluation functions, and EHR system M.S. Ed. Psych, Research & Evaluation, A.A.S. in MIS	10 years evaluating programs with POF, evaluation of 9 SAMHSA grants	52
Lisa Larson, PhD, External Evaluator, Contract	Oversees project evaluation Ph.D., Clinical Psychology	20 years evaluating programs with POF, evaluation of 11 SAMHSA grants	55
Ruth O'Donnell, BS, Medical Records Coordinator, 0.6 FTE	Oversees medical records department B.S. Psychology	13 years working with POF, involved in 9 SAMHSA grants	58
Karen Rheault, MS, Director of MIS/ Communications, 0.15 FTE	Oversees information technology M.S. Computer Information Systems	20 years working with information technology at MH	61
Stacey Yonkoski, MSW, LCSW, CSAC, Manager of Clinical Services, 0.1 FTE	Oversees substance use and mental health treatment, supervises counselors	15 years treating SUDs and COCs with POF; involved in 4 SAMHSA grants	64

Table 7: Additional Project Staff					
Position (Role)	**Name**	**FTE**	**Qualifications**	**Yrs. Exp. with POF**	**JD p. #**
Medical Records Administrative Assistant	Tonya Henry	1.0	A.A.S. Human Services, coursework in office technology	8	67
Receptionist	Kimberly Ousley	0.25	A.A. Liberal Arts, working toward Health Information Tech. certificate	7	68
Admissions/Client Benefits Coordinator	Sandra Fenninger	0.25	H.S. diploma, **Meta House graduate**	16	69
Research & Evaluation Assistant	Sidnee Smith	0.2	B.A. Sociology/Communications	9	70
AODA Counselor Tech.	Lynne Rosenberg	0.1	B.A. Psychology, Substance Abuse Counselor in Training (SAC-IT), B.A. Business Administration	5	71
AODA Counselors	Various	0.75	Certified Substance Abuse Counselor (CSAC)	5 – 10	72
Case Managers	Various	0.05	Bachelor's degree	n/a	73
Transportation	Various	0.1	H.S. diploma or equivalent	n/a	74
Consumer Peer Specialists	Various	0.25	H.S. diploma or equivalent, consumer peer certification	n/a	75

Staff Experience in Serving the Population of Focus: See Tables 6 and 7 above. (See Section H for Job Descriptions for all project positions and Biographical Sketches for all key positions.)

Section E: Data Collection and Performance Measurement

Ability to Collect and Report on Required Performance Measures: The evaluation will be conducted by the Planning Council for Health and Human Services (PC) in partnership with MH's internal Research and Evaluation department. PC staff will provide training, supervision, and monitoring for data collection; conduct data analysis; and write the interim and final reports. Meta House evaluation staff will collect reliable and consistent data from clients; provide regular evaluation feedback to the program; and write biannual progress reports. The PC is a community-based, nonprofit organization that has been operating in southeastern Wisconsin since 1965 with a mission of advancing community health and human services through objective planning, evaluation, and research. Meta House has an established internal evaluation department, with staff specifically dedicated to collecting data to inform program improvement and meet funder requirements. The external and internal evaluation partners have worked together on 12 previous federal grants to date, including 9 SAMHSA grants. Each of these evaluations has involved extensive qualitative and quantitative data collection and has successfully met SAMHSA's 80% benchmark for GPRA follow-up interviews.

The goals of the Healthy Connections performance assessment are to: 1) successfully meet or exceed benchmarks for the required Performance Measures (GPRA); 2) describe the implementation and utilization of the technology enhancements; 3) document treatment outcomes for women; 4) describe the strategies used and outcomes achieved for addressing subpopulation disparities; and 5) provide formative feedback to assure continuous quality improvement.

Meta House's internal evaluation department has a long-standing, effective approach for conducting and entering baseline and follow-up interviews to meet GPRA requirements. The department is comprised of four experienced evaluation staff members who represent the gender and cultural diversity of the target population (all staff are women and two of the four are African American). In addition, the internal evaluation staff members meet weekly with the PC external evaluator to monitor all data collection, including GPRA requirements. This internal/external evaluation team has extensive experience in administering the GPRA tool and successfully tracking clients for follow-up, having met the 80% six month follow-up requirement for multiple residential and outpatient CSAT grants. In addition, the team has successfully achieved a high 12 month interview follow-up rate for the purpose of local evaluation of these grants. The successful follow-up rate is attributable to an approach that is informed by best practices in longitudinal research and is grounded in the program's trauma-informed, relational model. Being on-site, the internal evaluation staff establish relationships with clients through routine informal contacts and participation in the program's social activities. Frequent contact and systematic tracking compliant with client confidentiality rights continue after clients leave treatment, allowing evaluation staff to regularly update client contact information and maintain a positive relationship with former clients. In addition, clients are provided with a modest monetary incentive for completed interviews. This combination of facilitating factors will continue for the proposed project, and it is anticipated that the team will readily meet or exceed the 80% reassessment requirement.

Data Collection: The on-site evaluation staff will conduct face-to-face interviews with women at intake, discharge, 6 months post-intake, and 12 months post-intake. GPRA and local evaluation questions will be integrated into the intake and follow-up interviews for all clients. All measures will be administered as interviews to accommodate varying literacy levels and to ensure cultural sensitivity. All evaluation interviews will begin with an oral informed consent process (see Attachment 3 for sample consent forms). In addition to the GPRA and local evaluation interviews, data collection will include program-level information on the technology-related performance measures. Specifically, the program will routinely track the number of enhanced technologies that are integrated into the infrastructure of the program, the number of women who are trained in the use of technology-related tools, and the number who have access to and ultimately use those tools. Finally, to address process evaluation questions related to the technology enhancements (see pg. 30), focus groups and key informant interviews with staff and clients will also be conducted.

Data Management: GPRA data will be submitted to SAMHSA's web-based SAIS system within seven business days of the interview. Evaluation staff has extensive experience systematically entering GPRA data into SAIS in a timely and accurate manner. It is anticipated that the local evaluation's client-level data will be entered into Meta House's EHR system (supplemented by a customized Access database for evaluation purposes if needed). The EHR system will be capable of managing and storing: 1) basic demographic characteristics used in the evaluation; 2) service utilization data; 3) retention data on client engagement and length of stay; 4) discharge data on program completion status; and 5) local evaluation data. On-site, internal evaluation staff will enter, systematically check, and maintain all evaluation data, following procedures to assure privacy and confidentiality (see Section I, Confidentiality and Participant Protection). In

addition, the evaluation staff will also ensure the integrity of the EHR system's service data, coordinating and reviewing the system's clinician and administrative data. In order to track the project's program-level technology enhancements, a customized database will be developed and will include the number and types of technologies implemented, the trainings conducted with staff and clients, and the use of technology-related tools. The external evaluation team will meet weekly with internal evaluation staff to assure adherence to the evaluation design, the integrity of the data, and the data entry procedures.

Data Analysis: Using descriptive statistics, the evaluation team will analyze the GPRA data to describe the characteristics of the population served, assess service access by the project's subpopulations, summarize the technology-related performance measures, and document progress towards National Outcome Measures (NOMS). Qualitative data to support the process evaluation regarding the implementation of the technology enhancements will be analyzed through a systematic data reduction and coding process. The extent to which the project accomplishes its goals and objectives will be analyzed using local evaluation data, focusing on identifying statistically significant pre-post changes (using paired t-tests and chi-square statistics) and on describing levels of meaningful client success at the 12-month follow-up. The final data interpretation will include input from program staff and program participants.

Data Reporting: On a monthly basis, program staff and administration will receive preliminary information on target numbers, technology-related accomplishments, demographic characteristics of the participants served (including subpopulations), and progress towards meeting NOMS. A biannual report will be provided to CSAT on progress achieved, any barriers encountered, efforts made to overcome these barriers, and any deviations from the proposed implementation plan. Interim reports will be developed to describe the implementation of the technology enhancements, including the benefits and limitations of those enhancements. A final report will be organized around the process and outcome questions including: the implementation of the project plan; any deviations from the plan and the context surrounding those deviations; the number and characteristics of the women and subpopulations served; the treatment services provided; and the extent to which the outcomes reflected in the goals and objectives were achieved.

Specification/Justification of Additional Measures: Table 8 specifies measures to be used to collect data for each of the objectives listed in Section B, Table 2.

Table 8 – Data Collection Measures

Goal	Objective	Measure and Outcome(s) Being Measured
1	**1.1**	Technology enhancement tracking database: • EHR system is implemented at all levels of care; clinical and administrative staff are trained.
1	**1.2**	Technology enhancement tracking database: • Number of clients trained in utilizing the EHR patient portal.
1	**1.3**	Technology enhancement tracking database: • Text messaging and/or email reminder system is implemented and utilized.
1	**1.4**	Document review: • Menu of smartphone applications is developed and revised.
1	**1.5**	Technology enhancement tracking database: • Number of clients trained in piloting the use of smartphone applications.

Table 8 – Data Collection Measures		
Goal	**Objective**	**Measure and Outcome(s) Being Measured**
1	**1.6**	Focus groups and key informant interviews: • Clients and staff describe the benefits and limitations of technology enhancements.
2	**2.1**	Initial Evaluation Interview: • 83 women who meet target population criteria are enrolled and served.
3	**3.1**	EHR system: • 30 day retention rate (as measured by % of Healthy Connections women vs. pre-implementation women retained in treatment for 30 days or longer).
3	**3.2**	EHR system: • Treatment hours (as measured by number of treatment hours attended in first 30 days for Healthy Connections women vs. pre-implementation women).
4	**4.1**	GPRA and Modified Addiction Severity Index (ASI): • Alcohol and drug use (as measured by pre-post change in days of use).
4	**4.2**	GPRA and Modified ASI: • Commitment to recovery (as measured by no use or, if use, involvement in treatment at follow-up).
5	**5.1**	GPRA and Modified ASI: • Mental health status (as measured by pre-post change in days of symptoms).
5	**5.2**	Trauma Symptom Checklist (TSC-40): • PTSD symptoms (as measured by pre-post change in TSC-40 Total Score).
6	**6.1**	GPRA and Modified ASI: • Access to health care (as measured by having health insurance and/or an identified health care provider at follow-up).
6	**6.2**	GPRA and Modified ASI: • Physical health status (as measured by pre-post change in degree of interference from physical health problems).
6	**6.3**	GPRA and Modified ASI: • Tobacco use (as measured by pre-post change in use of tobacco products).
7	**7.1**	GPRA, EHR, document review: • Targets established in the Health Disparities Impact Statement are achieved.
Process Evaluation		Intake/Discharge Interviews; EHR service tracking: • Client characteristics, time in program, program completion status, level of care and service utilization. Key Informant Interviews and Focus Groups with Clients and Staff: • Experience with and lessons learned from implementation of EHR, automated appointment reminders, and smartphone applications.

The Healthy Connections population of focus is a diverse group of women (primarily African American and White, English-speaking) with SUDs who have COCs. The population includes low income women from central-city Milwaukee, many of whom have substantial trauma histories, limited educational backgrounds, and a low level of literacy. All measures will be administered in an interview format to accommodate varying literacy levels and to support cultural sensitivity.

Addiction Severity Index (ASI): In addition to the GPRA questions, the local evaluation interviews at intake and follow-up will include selected questions from the ASI to document progress towards the project's goals and objectives related to substance use, mental health, and criminal involvement at intake and follow-up (see Attachment 2). The ASI is a structured interview that describes problem severity across multiple areas: family and social relationships, employment and financial support, medical issues, psychiatric symptoms, alcohol and drug use,

and legal status.[116] Extensive data from over 30 years of widespread use suggests excellent inter-rater reliability; test-retest reliability; and concurrent, convergent, and discriminant validity.[117,118,119,120,121,122] In addition, reliability and validity results have demonstrated consistency across age, gender, race/ethnicity, and primary drug problem and with women with SUDs.[123,124] The ASI (or adaptations of it) has been used successfully in studies with participants similar to the Healthy Connections population focus including: women with complex traumas and SUDs;[125] African American and Hispanic clients in substance abuse treatment;[126] pregnant substance using women;[127] incarcerated women with substance addictions;[128] and in the Women, Co-occurring Disorders, and Violence Study.[129] The ASI developers emphasize adapting and developing supplemental questions to meet a program's informational needs and to be culturally sensitive to specific regional and ethnic populations.[130,131] In 1999, the PC external evaluators developed a modified form of the ASI for use with Meta House clients. This modified ASI included items identified as most appropriate for a population comprised of a diverse group of women in Milwaukee County and for Meta House's program context and evaluation needs. For the Healthy Connections program, supplemental questions derived from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) Questionnaire will be added to document women's access to health care and physical health challenges.[132] For over 10 years, Meta House has administered the modified version of the ASI to women enrolled in their outpatient and residential treatment programs, i.e. women who represent the Healthy Connections population of focus (adult, racially diverse, low income women with co-occurring conditions). Meta House's evaluation data has supported the sensitivity of this measure to improvements among women who participated in residential or outpatient treatment, with pre-post changes documented in substance use, mental health symptoms, and other key indicators of treatment progress.

Trauma Symptom Checklist (TSC-40): In addition to the trauma-related questions on the GPRA interview, the TSC-40 will be administered at the intake and follow-up interviews to provide an in-depth assessment of the impact of integrated treatment for co-occurring disorders, Seeking Safety, and other trauma-related interventions (see Attachment 2). A revision of the earlier TSC-33, the TSC-40 is a research measure for adults that evaluates symptoms associated with traumatic experiences.[133,134] Studies using the TSC-40 indicate that it is a reliable measure, with Cronbach's alpha for the full scale averaging between .89 and .91.[135] Studies have also demonstrated convergent and discriminant validity of the TSC-40 in clinical and nonclinical adult samples.[136,137,138] The TSC-40 has been used successfully in studies of: women in substance abuse and domestic violence treatment programs,[139,140,141,142] adult survivors of sexual abuse who met diagnostic criteria for SUDs,[143] female survivors of childhood sexual abuse,[144,145,146,147] women and men seeking treatment for PTSD,[148,149,150,151,152] and community samples of women and men.[153] Also, studies of the effectiveness of Seeking Safety have found significant program impacts using the TSC-40 with women who experienced both PTSD symptoms and substance dependence.[154,155,156] For approximately eight years, Meta House has successfully administered the TSC-40 to women who represent the Healthy Connections population of focus. Meta House's evaluation data has supported the sensitivity of the TSC-40 to pre-post improvements for women who attended Seeking Safety and received trauma-informed care in their treatment programs, with statistically significant pre-post changes noted for TSC-40 Total Scores and for each subscale score.

Process for Tracking Subpopulation Disparities: At the outset of the project, the evaluation team will work with the Healthy Connections program's staff and administration to develop a health disparities impact statement and to develop a plan to address potential subpopulation differences in access to program services, service use, and outcomes. The impact statement and the targets set for the plan will be informed by local Milwaukee data and by Meta House's own data on the demographic characteristics of the population served in the past. Over time, the evaluation will track on the extent to which the project achieves the targets established in the plan.

The evaluation team will also work with the program to ensure that data on each participant's gender, race, ethnicity, and spoken and written language is routinely collected and integrated into the program's management information system (as specified in the Culturally and Linguistically Appropriate Services in Health Care or CLAS standards). This tracking, along with the GPRA and local performance assessment data, will enable the evaluation team to create detailed snapshots of the needs and status of the subpopulations served by the project. These snapshots will be reviewed with the project's Study Team on a quarterly basis to ensure that the project is aware of and responding to the unique needs of the subpopulations being served.

As the project reflects on and responds to the data related to subpopulations, the process evaluation will document any changes made to address disparities in access and service use. In addition, the evaluation will document program changes that incorporate any of the original CLAS standards (related to culturally competent care; language access services; and/or organizational supports) and/or adopt any of the enhanced CLAS standards (related to the principal standard; governance, leadership, and workforce; communications and language assistance; and/or engagement, continuous improvement, and accountability).
Overall, this plan will enable the project to use a data-driven quality improvement process to ultimately reduce subpopulation disparities within the population of women who have substance use disorders and co-occurring conditions. The final evaluation report will document the strategies used to respond to the needs and culture of all individuals. In addition, the final report will (to the extent possible given sample size limitations) analyze the outcomes achieved to determine whether the subpopulations served experienced similar outcomes (and therefore reduced behavioral health disparities).

Plan for Conducting Performance Assessment: The evaluation team is comprised of PC external evaluation staff and Meta House's internal evaluation department. This team has a long-standing collaborative relationship, having successfully implemented performance assessments for nine previous SAMHSA grants. These performance assessments have been implemented smoothly and as planned, have met the required performance measures, have been well-received by clients and staff, have prompted program adjustments, and have produced useful information for the program and for SAMHSA. The evaluation team will use this base of experience to conduct a process and outcome evaluation for the Healthy Connections program.

Process Assessment: The process assessment will address technology enhancements and program implementation, including: the number and type of technology enhancements implemented; the number and characteristics of the women served, including the targeted subpopulations; specific strategies utilized to address disparities in access, service use, and

outcomes across subpopulations; any deviations from the original implementation plan, the context surrounding those deviations, and the implications of deviations for project success; and any barriers encountered as well as efforts made to overcome those barriers. The process assessment will draw from descriptive data gathered through the baseline and follow-up interviews with clients. In addition, key informant interviews and focus groups will be conducted with staff and clients, supplemented by document review and program data.

Process questions. *Technology Implementation:* Is the EHR system fully implemented throughout the agency, with staff and clients trained in its use? Does the program adopt a technology-based reminder system, is it utilized by staff and clients, and to what extent is this system seen as supporting client attendance? What types of smartphone applications are identified as potential adjuncts to treatment, which applications are piloted, and to what extent are they viewed as helpful? Overall, what are the successes, challenges, and lessons learned from implementing technology enhancements to support women's recovery? (Data sources: Technology Enhancement Tracking Database, key informant interviews, focus groups.) *Demographics and Subpopulations:* Do the client characteristics match the intended population of focus? Do the characteristics and needs of clients change over time, and does the program modify its services to meet those needs? What strategies does the program use to engage and serve subpopulations? Are approaches to technology implementation customized for different subpopulations? Are CLAS standards incorporated into the program's structure and services? (Data sources: GPRA/Modified ASI, document review, staff interviews.)

Outcome Assessment: The outcome assessment will include documentation of progress towards meeting the project's goals/objectives; an evaluation of pre-post changes, client outcomes at follow-up, and the durability of those outcomes; and the program factors and participant characteristics (e.g., race/ethnicity) that may be associated with achieving those outcomes. The outcome evaluation will draw from EHR data on client attendance as well as pre-post data gathered through baseline and 12 month follow-up interviews with clients.

Outcome questions. *Client Engagement:* When retention rates prior to implementation of Healthy Connections are compared with rates following project implementation, is there an increase in the proportion of women retained in treatment for 30 days or longer? Following implementation, is there an increase in the average number of treatment hours received in the first 30 days? (Data source: EHR system.) *Substance Use:* Is there a significant pre-post decrease in women's use of alcohol and illegal drugs from baseline to the 12 month follow-up? At follow-up, do women demonstrate a commitment to recovery? (Data source: GPRA/Modified ASI.) *Mental Health:* Is there a significant pre-post decrease in women's mental health symptoms and trauma-specific symptoms? (Data sources: GPRA/Modified ASI, TSC-40.) *Physical Health:* At follow-up, do women have health insurance and an identified health care provider? Is there a significant pre-post decrease in the extent to which women view physical health problems as interfering with their lives? Is there a significant pre-post decrease in women's use of tobacco products? (Data source: GPRA/Modified ASI.) *Health Disparities:* Does the project meet its targets for access to services, service use, and outcomes for identified subpopulations? (Data sources: GPRA/Modified ASI, EHR system).

Overall, the data from the process and outcome performance assessment, combined with the performance measurement data, will serve as the basis for regular evaluation feedback to the program. The evaluation team has a long history of routinely communicating evaluation data to program staff and facilitating the use of that data. Relying upon existing evaluation feedback procedures, the internal evaluation staff will hold monthly Study Team meetings with program administration and staff to ensure timely access to information about technology enhancements, clients served, and progress toward outcomes. The consistent exchange of information between the evaluation team and the program will provide context for the evaluation findings, enhance project management, support continuous quality improvement, and provide direction for any needed program adjustments.

Section F: Electronic Health Record (EHR) Technology

After an exhaustive review of available systems, MH has identified an ONC-ATCB certified EHR system, the Epitomax system from Psytech Solutions, Inc. MH is currently negotiating a contract for the Epitomax system and plans to begin partial implementation of the system in July, 2013. The system will be hosted by Psytech Solutions at a site that maintains complete HIPAA-compliant security, including a firewall and a secure backup system. (The MOA between MH and Psytech Solutions is included in Attachment 1.)

The annual cost for licensing and hosting the system will be $35,980. The startup cost for the system from Psytech will be $5,989 (not included in the budget as it will be incurred before grant funding begins). After the Healthy Connections program begins, the program is planning a one day onsite training by Psytech, which will cost an estimated $2,000. Additional training will be conducted online for no charge. The program will purchase signature pads to allow for electronic signatures and tablet computers to assist with client sign-in for groups and allow clients to access the EHR patient portal at the front desk, as specified in the budget. Because Epitomax will be implemented as a hosted system, there will be no need for additional computer hardware or software. The internet connection was recently upgraded and currently has sufficient bandwidth to support the number of users who will need to access the hosted EHR system.

The DQI will maintain overall responsibility for the EHR system and will act as the liaison between MH and Psytech Solutions. The DMIS will continue to support the computer system and internet connection. No additional staff will be hired to support the implementation of the EHR system. While staff time will be devoted to the EHR system, MH anticipates that multiple experienced, technology-proficient staff members will have a reduced workload after the transition to the EHR system from our current system due to reduced redundancy, data entry needs, and other needs associated with paper client charts (e.g., filing, copying), and these staff members will be assigned new duties based on the needs of the EHR system. Specifically, the Medical Records Coordinator, the Medical Records Administrative Assistant, the Evaluation Assistants, the Receptionist, and other clerical support staff (see Section H for job descriptions) will be assigned new job duties, including providing training and technical support for staff, creating and modifying data entry screens and reports, and scanning in paper documents to the electronic system as needed. The current billing staff will continue to be responsible for billing insurance and other funders via the EHR system; due to the increased efficiency of the integrated EHR system, MH does not anticipate a need to add staff to the billing department.

Budget and Justification – TCE-TAC Year 1

A. Personnel:

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
(1) Project Director	Christine Ullstrup	$83,221	10%	$8,322
(2) Director of Quality Improvement	Andrea Jehly	$70,000	15%	$10,500
(3) Medical Records Coordinator	Ruth O'Donnell	$43,285	60%	$25,971
(4) Director of MIS/Communications	Karen Rheault	$79,581	15%	$11,937
(5) Manager of Clinical Services	Stacey Yonkoski	$68,000	10%	$6,800
(6) Medical Records Administrative Assistant	Tonya Henry	$32,467	100%	$32,467
(7) Receptionist	Kimberly Ousley	$34,632	25%	$8,658
(8) Admissions/Client Benefits Coordinator	Sandra Fenninger	$37,877	25%	$9,469
(9) Research & Evaluation Assistant	Sidnee Smith	$40,893	20%	$8,178
(10) AODA Counselor Tech.	Lynne Rosenberg	$29,120	10%	$2,912
(11) AODA Counselors	Various	$40,000	75%	$9,000
(12) Case Managers	Various	$39,500	5%	$1,975
(13) Transportation	Various	$27,000	10%	$2,700
(14) Consumer Peers	Various	$23,000	~~25%~~	$0
			TOTAL	**$138,889**

JUSTIFICATION: Describe the role and responsibilities of each position.

(1) The Project Director will provide daily oversight of the grant and will be considered key staff.

(2) The Director of Quality Improvement will a) collaborate with external evaluator from the Planning Council to conduct program evaluation and b) oversee implementation of the EHR system.

(3) The Medical Records Coordinator will a) monitor the use of the EHR system, b) monitor compliance with client confidentiality procedures, c) and perform quality assurance audits.

(4) The Director of MIS will oversee the integration of the technology enhancements into our current information systems.

(5) The Manager of Clinical Services oversees AODA and mental health treatment services.

(6) The Medical Records Administrative Assistant is responsible for a) internal staff training on the EHR system, b) modifying and updating data entry screens and reports, c) and providing ongoing technical support to staff.

(7) The Receptionist schedules clients via the system and assist clients in accessing the patient portal.

(8) The Admissions/Client Benefits Coordinator conducts intakes with clients and coordinates benefits including their insurance coverage.

(9) The Research & Evaluation Assistant collects GPRA and local evaluation data and track clients for follow-up interviews.

(10) The AODA Counselor Technician will monitor and obtain insurance and other funder authorization for client treatment.

(11) The AODA Counselors provide substance abuse and mental health treatment services.

(12) The Case Managers coordinate the other services clients need including legal, medical, housing, family services, and financial needs.

(13) Transportation staff provide transportation for clients to and from appointments in the community.

(14) Consumer Peer Specialists assist with client engagement and retention, meeting client needs as appropriate.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form S-424A) **$138,889**

B. Fringe Benefits: List all components that make up the fringe benefits rate

FEDERAL REQUEST

Component	Rate	Wage	Cost
FICA	7.65%	$138,889	$10,625
Workers Compensation	1.21%	$138,889	$ 1,681
Medical Insurance	12.74%	$138,889	$17,694
Life & Disability Insurance	1.26%	$138,889	$ 1,751
Unemployment Insurance	1.98%	$138,889	$ 2,751
Retirement	4.00%	$138,889	$ 5,556
		TOTAL	**$40,058**

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF-424A) **$40,058**

C. Travel:

FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
(1) Grantee Conference	Washington, DC	Airfare	$300/flight x 2 persons	$600
		Hotel	$211/night x 2 persons x 3 nights	$1,266
		Per Diem (meals and incidentals)	$50/day x 2 persons x 3 days	$300
			TOTAL	**$2,166**

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

(1) Two staff (Project Director and Evaluator) to attend mandatory grantee meeting in Washington, DC.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF-424A) **$2,166**

D. Equipment: none

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF-424A) **$ 0**

E. Supplies:

FEDERAL REQUEST

Item(s)	Rate	Cost
(1) General office supplies	$164/FTE times 4.05 project FTE	$664
(2) Signature Pads (20)	$90	$1,800
(3) Tablet computers (4)	$500	$2,000
(4) Limited Use Cell Phones (10)	$20	$200
	TOTAL	**$4,664**

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

(1) Office supplies are used by staff assigned to the project.

(2) The signature pads are used for clients to sign electronic forms.

(3) The tablet computers are used to manage attendance in program and groups.

(4) Limited use cell phones are provided to clients that we transport to appointments so they can call for the return ride.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF-424A) **$4,664**

F. Contract:

1) Agreement with the Planning Council

Personnel	
Director of Research & Evaluation (0.10 FTE)	$7,900
Evaluation Manager (0.15 FTE)	$6,750
Project Staff (0.05 FTE)	$1,750
Total Salary	$16,400
Benefits	$4,428
(Health, Life, & Disability Insurance; FICA; Unemployment & Worker's Compensation; Retirement)	
Total Salary + Benefits	$20,828
Additional Expenses	$3,562
(Office & Occupancy; Liability Insurance; Technology & Software; Office Supplies; Telephone & Internet; Printing; Postage)	
Total Subcontract with Planning Council	**$24,390**

Narrative budget justification

The **Director of Research & Evaluation** is the lead evaluator, responsible for: working in partnership with the internal Director of Quality Improvement and the internal evaluation team; providing evaluation technical assistance & capacity building; designing quantitative & qualitative data collection; leading & conducting quantitative & qualitative data analysis; and serving as lead author on external evaluation reports.

The **Evaluation Manager** is responsible for: working in partnership with the internal evaluation team and the PC Director of Research & Evaluation; insuring integrity and reliability of evaluation interview data; reviewing formative feedback to program; conducting qualitative data collection & analysis; conducting quantitative data analysis; and serving as co-author on external evaluation reports.

The **Project Staff** are responsible for: assisting with qualitative data collection & coding; performing data clean-up; and for assisting with the ongoing compilation of data & supporting materials.

2) Agreement with Psytech Solutions for Epitomax EHR system.

Epitomax Electronic Health Record system will be installed at Meta House. Once installed there will be an ongoing fee paid to Epitomax to host the Meta House Electronic Health Record. The annual fee is **$35,980**

FEDERAL REQUEST

JUSTIFICATION: Explain the need for each contractual agreement and how it relates to the overall project.

(1) The Planning Council provides the expertise and manpower necessary to complete the program evaluation.
(2) Epitomax is the Electronic Health Record system to be operated by Meta House Monthly cost is $2,940 for the basic system--$35,280 annually and $700 annually for e-prescribe for contract total of $35,980

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF-424A) **$60,370**

G. Construction: None – Leave Section B columns 1& 2 line 6g on SF-424A blank.

H. Other: expenses not covered in any of the previous budget categories

FEDERAL REQUEST

Item	Rate	Cost
(1) Training	$1,500/day plus $300 travel and $200 hotel	$2,000
(2) Telephone	$467/FTE X 4.05 FTE	$1,891
(3) Client Incentives	$20/client follow up x 30 clients x 3	$1,800
(4) Printing and Duplicating	$40/FTE X 4.05 FTE	$162
(5) Smart Phone Apps	15 clients X $10 per apps	$150
(6) Client Incentive Gift Cards	Anticipate 30 given at $10 each/year	$300
	TOTAL	**$6,303**

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

(1) The cost for one full day onsite training in EHR through Epitomax including travel and accommodation.

(2) The monthly telephone costs reflect the % of effort for the personnel listed in this application for the SAMHSA project only.

(3) The $20 incentive is provided to encourage attendance to meet program goals for 30 client

for three evaluation interviews/follow-ups.

(4) Allocated by FTE at $40/FTE and the number of FTEs in this project.

(5) Clients with Smart Phones will be encouraged to download apps that Meta House pays for enabling reminders and other information sharing with the client.

(6) Gift card incentives provided to clients to encourage attaining goals of use of Smart Phones

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF-424A) **$6,303**
Indirect Cost Rate: Approved Rate 15.1%
FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF-424A) **$27,550**
==========
TOTAL DIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF-424A) $252,450

INDIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6j of form SF-424A) $27,550

TOTALS: (sum of 6i and 6j)

FEDERAL REQUEST – (enter in Section B column 1 line 6k of form SF-424A) **$280,000**

==========

Other Funding Required

Proposed Project Period

a. Start Date:	**09/30/2013**	b. End Date:	**09/29/2016**

BUDGET SUMMARY (should include future years and projected total)

Category	**Year 1**	**Year 2***	**Year 3***	**Total Project Costs**
Personnel	$138,889	$138,889	$138,889	$416,667
Fringe	$ 40,058	$ 40,058	$ 40,058	$120,174
Travel	$ 2,166	$ 2,166	$ 2,166	$ 6,498
Equipment	$ 0	$ 0	$ 0	$ 0
Supplies	$ 4,664	$ 4,664	$ 4,664	$ 13,992
Contractual	$ 60,370	$ 60,370	$ 60,370	$181,110
Other	$ 6,303	$ 6,303	$ 6,303	$ 18,909
Total Direct Charges	$252,450	$252,450	$252,450	$757,350
Indirect Charges	$ 27,550	$ 27,550	$ 27,550	$ 82,650

Category	Year 1	Year 2*	Year 3*	Total Project Costs
Total Project Costs	**$280,000**	**$280,000**	**$280,000**	**$840,000**

TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF-424A) **$840,000**

Section G: Literature Citations

[1] U.S. Census Bureau. (2011). DP-03 Selected Economic Characteristics: 2011 [Data]. 2011 ACS 1-Year Estimates. Retrieved from http://factfinder2.census.gov on 3/23/2013.

[2] U.S. Census Bureau. (2010). DP-01 Profile of General Population and Housing Characteristics: 2010 [Data]. 2010 Demographic Profile Data. Retrieved from http://factfinder2.census.gov on 3/23/2013.

[3] Chen, H-Y., Baumgardner, D.J., Galvao, L.W., Rice, J.P., Swain, G.R., & Cisler, R.A. (2011). *Milwaukee Health Report 2011: Health Disparities in Milwaukee by Socioeconomic Status.* Center for Urban Population Health: Milwaukee, WI.

[4] Department of Housing and Urban Development (2007). *Milwaukee Urban Renewal Community*. Retrieved March 18, 2013, at http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/economicdevelopment/programs/rc/tour/wi/milwaukee

[5] Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services. (2012). *Wisconsin Epidemiological Profile on Alcohol and Other Drug Use, 2012 (P-45718-12).* Prepared by the Office of Health Informatics, Division of Public Health, in consultation with the Division of Mental Health and Substance Abuse Services and the University of Wisconsin Population Health Institute. September 2012.

[6] Substance Abuse and Mental Health Services Administration. (2012). *2008-2010 National Survey on Drug Use and Health Substate Age Group Tables.* Rockville, MD: Office of Applied Studies. Retrieved March 23, 201 from http://www.oas.samhsa.gov/substate2k10/toc.cfm

[7] O'Leary Morgan, K., & Morgan, Scott. (2013). *City Crime Rankings 2013.* Thousand Oaks, CA: CQ Press.

[8] National Survey on Drug Use and Health. 2-Year R-DAS (2002 to 2003, 2004 to 2005, 2006 to 2007, 2008 to 2009, and 2010 to 2011). Analysis ran on 3/23/2013 using SDA 3.5: Tables, accessed at http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/34482/datasets/1/sda.

[9] Center for Substance Abuse Treatment. (2009). *Substance Abuse Treatment: Addressing the Specific Needs of Women*. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[10] Milwaukee County Behavioral Health Division. (2012). *Milwaukee Wiser Choice Provider Network Directory.* Revised February 4). Retrieved May 23, 2012 at http://county.milwaukee.gov/WIserChoiceProviderN10742.htm

[11] Mangrum, L.F. (2009). Client and service characteristics associated with addiction treatment completion of clients with co-occurring disorders. *Addictive Behaviors, 24*, 898-904.

[12] Weisner, C., Matzger, H., & Kaskutas, L.A. (2003). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. *Addiction, 98,* 901-911.

[13] Compton, W.M., Cottler, L.B., Jacobs, J.L., Ben-Abdallah, A., & Spitznagel, E.L. (2003). The role of psychiatric disorders in predicting drug dependence treatment outcomes. *American Journal of Psychiatry, 160*, 890-895.

[14] Weinstock, J., Alessi, S.M., & Petry, N.M. (2007). Regardless of psychiatric severity the addition of contingency management to standard treatment improves retention and drug use outcomes. *Drug and Alcohol Dependence*, *87,* 288-296.

[15] Demarce, J.M., Lash, S.J., Stephens, R.S., Grambow, S.C., & Burden, J.L. (2008). Promoting continuing care adherence among substance abusers with co-occurring psychiatric disorders following residential treatment. *Addictive Behaviors, 33*, 1104-1112.

[16] Brown, C.H., Bennett, M.E., Li, L., & Bellack, A.S. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors, 36,* 439-447.

[17] Substance Abuse and Mental Health Services Administration. (2009). *Integrated Treatment for Co-Occurring Disorders.* DHHS Pub. No. SMA-08-4366. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

[18] Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons with Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. DHHS Pub. No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[19] Kelly, T.M., Daley, D.C., & Douaihy, A.B. (2012). Treatment of substance abusing patients with comorbid psychiatric disorders. *Addictive Behaviors, 37*, 11-24.

[20] Sterling, S., Chi, F., & Hinman, A. (2011). Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions. *Alcohol Research & Health, 33*(4), 338-349.

[21] Institute of Medicine. (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

[22] Wisdom, J.P., Ford, J.H., Wise, M., Mackey, D., & Green, C.A. (2011). Substance abuse treatment programs' data management capacity: an exploratory study. *The Journal of Behavioral Health Services & Research, 38*(2), 249-264.

[23] Tai, B., Wu, L-T., & Clark, H.W. (2012). Electronic health records: Essential tools in integrating substance abuse treatment with primary care. *Substance Abuse and Rehabilitation, 3,* 1-8.

[24] Center for Substance Abuse Treatment. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, No. 35. HHS Publication No. (SMA) 08-4212. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[25] National Institute on Health (1994). *Motivational Enhancement Therapy Manual.* Project MATCH Series, Vol. 2 (1994) NIH Pub. No. 94-3723.

[26] Substance Abuse and Mental Health Services Administration. (2007). *Motivational Interviewing.* Retrieved March 30, 2013, from the National Registry of Evidence-based Programs and Practices Web site, http://nrepp.samhsa.gov/viewintervention.aspx?id=130

[27] Senft, R. A., Polen, M. R., Freeborn, D. K., & Hollis, J. F. (1997). Brief intervention in a

primary care setting for hazardous drinkers. *American Journal of Preventive Medicine, 13*(6), 464-470.

[28] Baer, J. S., Kivlahan, D. R., Blume, A. W., McKnight, P., & Marlatt, G. A. (2001). Brief intervention for heavy-drinking college students: Four-year follow-up and natural history. *American Journal of Public Health, 91*(8), 1310-1316.

[29] Monti, P. M., Colby, S. M., Barnett, N. P., Spirito, A., Rohsenow, D. J., Myers, M., et al. (1999). Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *Journal of Consulting and Clinical Psychology, 67*(6), 989-994.

[30] Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*(1), 49-59.

[31] Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., et al. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3), 301-312.

[32] Najavits, L.M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford.

[33] Najavits, L.M. (2004). Treatment of posttraumatic stress disorder and substance abuse: Clinical guidelines for implementing Seeking Safety therapy. *Alcoholism Treatment Quarterly, 22,* 43-62.

[34] Najavits, L.M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD. In K.A. Witkiewitz & G.A. Marlatt (Eds.). *Therapist's guide to evidence based relapse prevention: Practical resources for the mental health professional* (pp. 141-167). San Diego: Elsevier Press.

[35] Substance Abuse and Mental Health Services Administration. (2006, October). Seeking Safety. Retrieved March 30, 2013, from the National Registry of Evidence-based Programs and Practices Web site, http://nrepp.samhsa.gov/ViewIntervention.aspx?id=139.

[36] Najavits, L.M. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford.

[37] International Society for Traumatic Stress Studies Practice Guidelines (2009). Treatment of PTSD with comorbid disorders: guideline 18. In Foa, E.B., Keane, T.M., Friedman, M.J., Cohen, J.A. (Eds.). *Effective Treatments for PTSD.* Guilford: New York, 606-613.

[38] Hien, D.A., Wells E.A., Jiang H., Suarez-Morales L., Campbell A.N., Cohen L.R., Miele G.M., Killeen T., Brigham G.S., Zhang Y., Hansen C., Hodgkins C., Hatch-Maillette M., Brown C., Kulaga A., Kristman-Valente A., Chu M., Sage R.,Robinson J.A., Liu D., Nunes E.V. (2009). Multisite randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. *Journal of Counseling and Clinical Psychology, 77*(4), 607-619.

[39] Hien, D.A., Campbell, A.N.C., Killeen, T., Hu, M., Hansen, C., Jiang, H., Hatch-Maillette, M.,

Milele, G.M., Cohen, L.R., Gan, W., Resko, S.M., DiBono, M., Wells, E.A., and Nunes, E.V. (2010a). The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA clinical trials network "Women and Trauma" multi-site study. *AIDS Behavior, 14*(2), 421-430.

[40] Hien, D.A., Jiang, H., Campbell, A.N.C., Hu, M., Miele, G.M., Cohen, L.R., Brigham, G.S., Kulaga, A., Robindon, J., Suarez-Morales, L., Nunes, E.V. (2010b). Do treatment improvements in PTSD severity affect substance abuse outcomes? A secondary analysis from a randomized clinical trial in NIDA's clinical trials network. *American Journal of Psychiatry, 167,* 95-101.

[41] Hien, D.A.. Campbell. A.N.C, Ruglass, L.M., Hu, M. & Killeen, T. (2010c). The role of alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's women and trauma study. *Drug and Alcohol Dependence, 111*, 114-119.

[42] Najavits, L.M., Gallop, R.J., & Weiss, R.D. (2006). Seeking Safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial. *Journal of Behavioral Health Services & Research, 33,* 453-463.

[43] Ghee, A.C., Bolling, L.C & Johnson, C.S. (2009). Adult survivors of child sexual abuse: The efficacy of a condensed *Seeking Safety* intervention for women in residential chemical dependence treatment at 30 days posttreatment. *Journal of Child Sexual Abuse, 18,* 475-488.

[44] Zlotnick, C., Johnson, J. & Najavits, L.M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavioral Therapy, 40(4),* 325-336.

[45] Desai, R.A., Harpaz-Rotem, I., Najavits, L.M. & Rosenheck, R.A. (2008). Impact of the Seeking Safety program on clinical outcomes among homeless female veterans with psychiatric disorders. *Psychiatric Services, 59*(9), 996-1003.

[46] Desai, R.A. & Rosenheck, R.A. (January, 2006). Effectiveness of Treatment for Homeless Female Veterans with Psychiatric and/or Substance Abuse Disorders: Impact of "Seeking Safety" and Residential Treatment on One-year Clinical Outcomes. West Haven, CT: Northeast Program Evaluation Center, unpublished manuscript.

[47] Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience. *Journal of Community Psychology, 35*, 863-878.

[48] Hien, D.A., Cohen, L.R., Caren-Litt, L., Miele, G.M., & Capstick, C. (2004). Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426-1432.

[49] Cook, J.M., Walser, R.D., Lane, V., Ruzek, J.I., & Woody, G. (2006). Dissemination and feasibility of a cognitive-behavioral treatment for substance use disorders and posttraumatic stress disorder in the Veterans Administration. *Journal of Psychoactive Drugs, 38*, 89-92.

[50] Holdcraft, L.C. & Comtois, K.A. (2002). Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health, 21*, 91-109.

[51] Najavits, L.M., Schmitz, M., Gotthardt, S., & Weiss, R.D. (2005). *Seeking Safety* plus exposure therapy for dual diagnosis men. *Journal of Psychoactive Drugs, 27*, 425-435.

[52] Najavits, L.M., Weiss, R.D, Shaw, S.R., & Muenz, L. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

[53] Young, M.S., Hills, H.A., Rugs, D., Peters, R., Moore, K., Woods-Brown, L., & Pape, L. (2004, July). *Integrating Seeking Safety into substance abuse treatment programs.* Paper presented at the 112th annual meeting of the American Psychological Association, Honolulu, HI.

[54] Zlotnick, C., Najavits, L.M., Rohsenow, D.J., & Johnson, D.M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99-105.

[55] Searcy, V., & Lipps, A. (2012). The effectiveness of Seeking Safety on reducing PTSD symptoms in clients receiving substance dependence treatment. *Alcoholism Treatment Quarterly, 30*, 238-255.

[56] Hien, D.A., Cohen, L.R., Caren-Litt, L., Miele, G.M., & Capstick, C. (2004). Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426-1432.

[57] Najavits, L.M., Weiss, R.D, Shaw, S.R., & Muenz, L. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

[58] Zlotnick, C., Najavits, L.M., Rohsenow, D.J., & Johnson, D.M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99-105.

[59] Searcy, V., & Lipps, A. (2012). The effectiveness of Seeking Safety on reducing PTSD symptoms in clients receiving substance dependence treatment. *Alcoholism Treatment Quarterly, 30*, 238-255.

[60] Najavits, L.M., Weiss, R.D, Shaw, S.R., & Muenz, L. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

[61] Hien, D.A., Cohen, L.R., Caren-Litt, L., Miele, G.M., & Capstick, C. (2004). Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426-1432.

[62] Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience. *Journal of Community Psychology, 35*, 863-878.

[63] Brown, V.B., Najavits, L.M., Cadiz, S., Finkelstein, N., Heckman, J.P., & Rechberger, E. (2007). Implementing an evidence-based practice: Seeking safety group. *Journal of Psychoactive Drugs, 39*, 231-240.

[64] Cook, J.M., Walser, R.D., Lane, V., Ruzek, J.I., & Woody, G. (2006). Dissemination and feasibility of a cognitive-behavioral treatment for substance use disorders and posttraumatic stress disorder in the Veterans Administration. *Journal of Psychoactive Drugs, 38,* 89-92.

[65] Holdcraft, L.C. & Comtois, K.A. (2002). Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health, 21*, 91-109.

[66] Najavits, L.M., Schmitz, M., Gotthardt, S., & Weiss, R.D. (2005). *Seeking Safety* plus exposure therapy for dual diagnosis men. *Journal of Psychoactive Drugs, 27,* 425-435.

[67] Zlotnick, C., Johnson, J. & Najavits, L.M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavioral Therapy, 40*(4), 325-336.

[68] Desai, R.A., Harpaz-Rotem, I., Najavits, L.M. & Rosenheck, R.A. (2008). Impact of the Seeking Safety program on clinical outcomes among homeless female veterans with psychiatric disorders. *Psychiatric Services, 59*(9), 996-1003.

[69] Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience. *Journal of Community Psychology, 35, 863*-878.

[70] Ghee, A.C., Bolling, L.C. & Johnson, C.S. (2009). Adult survivors of child sexual abuse: The efficacy of a condensed Seeking Safety intervention for women in residential chemical dependence treatment at 30 days posttreatment. *Journal of Child Sexual Abuse, 18,* 475-488.

[71] Hien, D.A., Cohen, L.R., Caren-Litt, L., Miele, G.M., & Capstick, C. (2004). Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426-1432.

[72] Hien, D.A., Wells E.A., Jiang H., Suarez-Morales L., Campbell A.N., Cohen L.R., Miele G.M., Killeen T., Brigham G.S., Zhang Y., Hansen C., Hodgkins C., Hatch-Maillette M., Brown C., Kulaga A., Kristman-Valente A., Chu M., Sage R.,Robinson J.A., Liu D., Nunes E.V., et al. (2009). Multisite randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. *Journal of Counseling and Clinical Psychology, 77*(4), 607-619.

[73] Hien, D.A., Campbell, A.N.C., Killeen, T., Hu, M., Hansen, C., Jiang, H., Hatch-Maillette, M., Milele, G.M., Cohen, L.R., Gan, W., Resko, S.M., DiBono, M., Wells, E.A., and Nunes, E.V. (2010a). The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA clinical trials network "Women and Trauma" multi-site study. *AIDS Behavior, 14*(2), 421-430.

[74] Hien, D.A., Jiang, H., Campbell, A.N.C., Hu, M., Miele, G.M., Cohen, L.R., Brigham, G.S., Kulaga, A., Robindon, J., Suarez-Morales, L., Nunes, E.V. (2010b). Do treatment improvements in PTSD severity affect substance abuse outcomes? A secondary analysis from a randomized clinical trial in NIDA's clinical trials network. *American Journal of Psychiatry, 167,* 95-101.

[75] Hien, D.A., Campbell, A.N.C., Ruglass, L.M., Hu, M. & Killeen, T. (2010c). The role of

alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's women and trauma study. *Drug and Alcohol Dependence, 111,* 114-119.

[76] Holdcraft, L.C. & Comtois, K.A. (2002). Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health, 21,* 91-109.

[77] Najavits, L.M., Weiss, R.D, Shaw, S.R., & Muenz, L. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11,* 437-456.

[78] Young, M.S., Hills, H.A., Rugs, D., Peters, R., Moore, K., Woods-Brown, L., & Pape, L. (2004, July). *Integrating Seeking Safety into substance abuse treatment programs.* Paper presented at the 112th annual meeting of the American Psychological Association, Honolulu, HI.

[79] Zlotnick, C., Najavits, L.M., Rohsenow, D.J., & Johnson, D.M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99-105.

[80] Ibid

[81] Searcy, V., & Lipps, A. (2012). The effectiveness of Seeking Safety on reducing PTSD symptoms in clients receiving substance dependence treatment. *Alcoholism Treatment Quarterly, 30*, 238-255.

[82] Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience**.** *Journal of Community Psychology, 35*, 863-878.

[83] Ghee, A.C., Bolling, L.C., & Johnson, C.S. (2009). Adult survivors of child sexual abuse: The efficacy of a condensed *Seeking Safety* intervention for women in residential chemical dependence treatment at 30 days posttreatment. *Journal of Child Sexual Abuse, 18,* 475-488.

[84] Hien, D.A., Cohen, L.R., Caren-Litt, L., Miele, G.M., & Capstick, C. (2004). Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426-1432.

[85] Hien, D.A., Campbell, A.N.C., Killeen, T., Hu, M., Hansen, C., Jiang, H., Hatch-Maillette, M., Milele, G.M., Cohen, L.R., Gan, W., Resko, S.M., DiBono, M., Wells, E.A., and Nunes, E.V. (2010a). The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA clinical trials network "Women and Trauma" multi-site study. *AIDS Behavior, 14*(2), 421-430.

[86] Hien, D.A., Jiang, H., Campbell, A.N.C., Hu, M., Miele, G.M., Cohen, L.R., Brigham, G.S., Kulaga, A., Robindon, J., Suarez-Morales, L., Nunes, E.V. (2010b). Do treatment improvements in PTSD severity affect substance abuse outcomes? A secondary analysis from a randomized clinical trial in NIDA's clinical trials network. *American Journal of Psychiatry, 167*, 95-101.

[87] Hien, D.A.. Campbell. A.N.C, Ruglass, L.M., Hu, M. & Killeen, T. (2010c). The role of

alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's women and trauma study. *Drug and Alcohol Dependence, 111*, 114-119.

[88] Young, M.S., Hills, H.A., Rugs, D., Peters, R., Moore, K., Woods-Brown, L., & Pape, L. (2004, July). *Integrating Seeking Safety into substance abuse treatment programs.* Paper presented at the 112th annual meeting of the American Psychological Association, Honolulu, HI.

[89] Najavits, L.M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD. In K.A. Witkiewitz & G.A. Marlatt (Eds.). *Therapist's guide to evidence based relapse prevention: Practical resources for the mental health professional* (pp. 141-167). San Diego: Elsevier Press.

[90] Hatzenbuehler M.L., Keyes K.M., Narrow W.E., Grant B.F., & Hasin D.S. (2008). Racial/ethnic disparities in service utilization for individuals with co-occurring mental health and substance use disorders in the general population: results from the national epidemiologic survey on alcohol and related conditions. *Journal of Clinical Psychiatry,* 69(7), 1112-21.

[91] Hettema, J., Steele, J., & Miller, W.R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91-111.

[92] Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, (2001). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* HHS Publication NO. (SMA) 09-4104). Washington, DC, US Government Printing Office.

[93] Finnegan, D., and McNally. (1996). Chemically dependent lesbians and bisexual women: recovery from many traumas. In B. L. Underhill, and D. G. Finnegan (Eds.), *Chemical Dependency: Women at Risk* (pp. 87–107). New York: Harrington Park Press/Haworth Press.

[94] Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of posttraumatic stress disorder. *The Behavioral Therapist, 16,* 161-162.

[95] Cramer, M. (2001) "Welfare Reform: A Holistic Approach to Improving Service Integration and Responding to the Needs of Women and Families Receiving TANF." Presentation to SAMHSA Third National Conference on Women, Orlando, FL.

[96] Blume, S.B. (1990). Chemical dependency in women: Important issues. *American Journal of Drug and Alcohol and Alcohol Abuse, 16*, 297-307.

[97] Boyd, C.J., & Mieczkowski, T. (1990). Drug use, health, family and social support in "crack" cocaine users. *Addictive Behaviors, 15*(5), 481-485.

[98] Johnson, S. (1991). Recent research: Alcohol and women's bodies. In P. Roth (Ed.), *Alcohol and Drugs are Women's Issues: Volume One – A Review of the Issues* (pp. 32-42). Metuchen, NJ: The Scarecrow Press, Inc.

[99] Kosten, T. A., Gawin, F.H., Kosten, T.R., & Rounsaville, B.J. (1993). Gender differences in cocaine use and treatment response. *Journal of Substance Abuse Treatment, 10,* 63-66.

[100] Hanlinkas, J.A., Crosby, R.D., Pearson, V.L., & Nugent, S.M.(1994). Psychiatric co-morbidity in treatment-seeking cocaine abusers. *The American Journal of Addictions, 3*(1), 25-35.

[101] Greenfield, S.F. (1996). Women and substance use disorders. In M.F. Jensvold and U. Halbreich (Eds.), *Psychopharmacology and Women: Sex, Gender, and Hormones* (pp. 299–321). Washington, DC: American Psychiatric Press.

[102] Najavits, L.M., Weiss, R.D., and Liese, B.S. (1996). Group cognitive–behavioral therapy for women with PTSD and substance use disorder. *Journal of Substance Abuse Treatment, 13*(1):13–22.

[103] Davis, R.E. (1997). Trauma and addiction experiences of African American women. *Western Journal of Nursing Research, 19*(4), 442-465

[104] Coletti, S. (1998). Service providers and treatment access issues. In C. L. Wetherington & A.B. Roman (Eds.), *Drug addiction research and the health of women* (NIH Publication No. 98-4290, pp. 237-243). Washington, DC: U.S. Department of Health and Human Services.

[105] Kilpatrick, D.G, Resnick, H.S., Saunders, B.C. and Best, C.L. (1998). Victimization, post-traumatic stress disorder, and substance use and abuse among women. In C. L. Wetherington and A. B. Roman (Eds.), Drug Addiction Research and the Health of Women. (NIH Publication No. 98-4290, pp. 285-307). Rockville, MD: U.S. Department of Health and Human Services.

[106] Wechsberg, W.M., Craddock, S.G., & Hubbard R.L. (1998). How are women who enter substance abuse treatment different than men? A gender comparison from the Drug Abuse Treatment Outcome Study. *Drugs and Society, 13*(1/2), 97-115.

[107] Brady, K.T. and Randall, C.L. (1999). Gender differences in substance use disorders. *Addictive Disorders*, 22(2), 241–252

[108] Morgenstern, J. & Bux, D.A. (2003). Examining the effect of sex and ethnicity on substance abuse treatment and meditational pathways. *Alcoholism: Clinical and Experimental Research, 27*(8), 1330-1332.

[109] Health Resources and Services Administration (2005). A Guide to the Clinical Care of Women with HIV/AIDS, 2005 edition. HIV/AIDS Bureau: Rockville, MD. Retrieved May 13, 2011 at ftp://ftp.hrsa.gov/hab/WG05.pdf

[110] Black, L. (1996). Families of African origin: An overview. In M. McGoldrick, J. Giordano and J.K. Pearce (Eds.), *Ethnicity and Family Therapy* (Second Edition) (pp. 57-65). New York: The Guilford Press.

[111] Boyd-Franklin, N. (1989). *Black Families in Therapy: A Multisystems Approach.* New York: Guilford Press.

[112] Boyd-Franklin, N. (1993, July/August). Pulling out the arrows. Family Therapy Networker, 54-56.

[113] Hardy, K.V. (1993, July/August). War of the worlds. *Family Therapy Networker*, pp.50-57.

[114] Mayo, J.A. (2004). Psychotherapy with African American populations: Modification of traditional approaches. *Annals of the American Psychotherapy Association,* 7.

[115] Peterson, S. (2000). Multicultural perspective on middle-class women's identity development. *Journal of Counseling and Development, 78*, 63-71.

[116] McLellan, A.T. Luborsky, L., Woody, G.E., & O'Brien, C.P. (1980). An improved evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disease, 168*(1), 26-33.

[117] Hodgins, E., & El-Guebaly, N. (1992). More data on the Addiction Severity Index: Reliability and validity with the mentally ill substance abuser. *Journal of Nervous and Mental Disease, 180*(3), 197-201.

[118] Kosten. T.R., Rounsaville, B.J., & Kleber, H.D. (1983). Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disease, 171*(1), 606-610.

[119] McLellan, A.T., Cacciola, J.C., Alterman, A.I., Rikoon, S.H., & Carise, D. (2006). The Addiction Severity Index at 25: Origins, contributions and transitions. *The American Journal on Addictions, 15*(2), 113–124.

[120] McLellan, A.T., Luborsky, L., Cacciola, J., Griffith, J.E., Evans, F., Barr, H., & O'Brien, C.P. (1985b). New data from the Addiction Severity index: Reliability and validity in three centers. *The Journal of Nervous and Mental Disease, 173*(7), 412-423.

[121] Murphy, D.A., Hser, Y.I., Huang, D., Brecht, M.L., & Herbeck, D.M. (2010). Self-report of longitudinal substance use: A comparison of the UCLA Natural History Interview and the Addiction Severity Index. *Journal of Drug Issues, 40*(2), 495-516.

[122] Rogalski, C.J. (1987). Factor structure of the Addiction Severity Index in an inpatient detoxification sample. *International Journal of Addictions, 22*(10), 981-992.

[123] McLellan, A.T., Luborsky, L., Cacciola, J., & Griffith, J.E. (1985a). The psychiatrically severe drug abuse patient: Methadone maintenance or therapeutic community? *American Journal of Drug and Alcohol Abuse, 10*(1), 77-95.

[124] Drake, R.E. (1995). The test-retest reliability of standardized instruments among homeless persons with substance use disorders. *Journal of Studies on Alcohol, 56*(2), 161-167.

[125] Cohen, L.R. & Hein, D.A. (2006). Treatment outcomes for women with substance abuse and PTSD who have experienced complex trauma. *Psychiatric Services, 57*(1), 100-106.

[126] Winiarski, M.G., Greene, L.I., Miller, A.L., Palmer, N.B., Salcedo, J., & Villanueva, M. (2005). Psychiatric diagnoses in a sample of HIV-infected people of color in methadone treatment. *Community Mental Health Journal, 41*(4), 379-391.

[127] Chaudhury, R., Jones, H.E., Wechsberg, W., O'Grady, K.E., Tuten, M., & Chisolm, M.S. (2010). Addiction Severity Index composite scores as predictors for sexual-risk behaviors and drug-use behaviors in drug-using pregnant patients. *The American Journal of Drug and Alcohol Abuse, 36*(1), 25-30.

[128] Guyon, L., Brochu, S., Parent, I., & Desjardins, L. (1999). At-risk behaviors with regard to HIV and addiction among women in prison. *Women and Health: A Mutidisciplinary Journal of Women's Health Issues, 29*(3), 49-66.

[129] Morrissey, J.P., Jackson, E.W., Ellis, A.R., Amaro, H., Brown, V.B., & Najavits, L.M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56*(10), 1213-1222.

[130] McLellan, A.T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment, 9*(3), 199-213.

[131] Carise, D. & McLellan, A.T. (1999). *Increasing Cultural Sensitivity of the Addiction Severity Index (ASI): An example with Native Americans in North Dakota*. Special Report. DHHS. Rockville, MD.

[132] Centers for Disease Control and Prevention (CDC). (2011). *Behavioral Risk Factor Surveillance System Survey Questionnaire*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

[133] Briere, J. (1996). Psychometric review of the Trauma Symptom Checklist – 40. In Stramm, B.H. (Ed.), *Measurement of Stress, Trauma and Adaptation.* Lutherville, M.D., Sidan Press.

[134] Briere, J. N., & Runtz, M.G. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*(2), 151-163.

[135] Briere, J. (1996). Psychometric review of the Trauma Symptom Checklist – 40. In Stramm, B.H. (Ed.). *Measurement of Stress, Trauma and Adaptation.* Lutherville, M.D., Sidan Press.

[136] Elliott, D. & Briere, J. (1992). Sexual abuse trauma among professional women: Validating the Trauma Symptom Checklist-40 (TSC-40). *Child Abuse and Neglect, 16*(3), 391-398.

[137] Whiffen, V.E., Benazon, N.R., & Bradshaw, C. (1997). Discriminant validity of the TSC-40 in an outpatient setting. *Child Abuse and Neglect, 21*(1), 107-115.

[138] Zlotnick, C., Shea, M.T., Begin, A., Pearlstein, T., Simpson, E., & Costello, E. (1996). The validation of the Trauma Symptom Checklist-40 (TSC-40) in a sample of inpatients. *Child Abuse and Neglect, 20*(6), 503-510.

[139] Downs, W.R., Capshew, T. & Rindels, B. (2006). Relationships between adult women's mental health problems and their childhood experiences of parental violence and psychological aggression. *Journal of Family Violence, 21*(7), 439-447.

[140] Ghee, A.C., Johnson, C.S., Burlew, A.K. (2010). Measurement equivalence of the Trauma Symptom Checklist-40 for chemically dependent African American and Caucasian women: A preliminary study. *Journal of Aggression, Maltreatment & Trauma, 19*(8), 820-838.

[141] Ghee, A.C., Bolling, L.C., & Johnson, C.S. (2009) The efficacy of a condensed Seeking Safety intervention for women in residential chemical dependence treatment at 30 days posttreatment. *Journal of Child Sexual Abuse, 18*(5), 475 – 488.

[142] Tracy, E.M., Laudet, A.B., Min, M.O., Kim, H., Brown, S., Jun, M.K., & Singer, L. (2012). Prospective patterns and correlates of quality of life among women in substance abuse treatment. *Drug and Alcohol Dependence*, *124*, 242-249.

[143] Roesler, T.A., & Dafler, C.E. (1993). Chemical dissociation in adults sexually victimized as children: Alcohol and drug use in adult survivors. *Journal of Substance Abuse Treatment, 10*(6), 537-543.

[144] Banyard, V.L., Williams, L.M., & Siegal, J. A. (2002). Retraumatization among adult women sexually abused in childhood explorative analysis in a prospective study. *Journal of Child Sexual Abuse, 11*(3), 19-48.

[145] Binder, R.L, McNiel, D.E, & Goldstone, R.L. (1996). Is adaptive coping possible for adult survivors of childhood sexual abuse? *Psychiatric Services, 47*(2), 186-188.

[146] Roesler, T.A., & McKenzie, N. (1994). Effects of childhood trauma on psychological functioning in adults sexually abused as children. *Journal of Nervous and Mental Disease, 182*(3), 145-150.

[147] Sikkema, K.J., Hansen, N.B., Tarakeshwar, N., Kochman, A., Tate, D.C., & Lee, R.S. (2004). The clinical significance of change in trauma-related symptoms following a pilot group intervention for coping with HIV-AIDS and childhood sexual trauma. *AIDS and Behavior, 8*(3), 277-291.

[148] Classen, C.C., Nevo, R., Koopman, C., Nevill-Manning, K., Felton, C., Rose, D.S. & Spiegel, D. (2002). Recent stressful life events, sexual revictimization, and their relationship with stress symptoms among women sexually abused in childhood. *Journal of Interpersonal Violence, 17*(12), 1274-1290.

[149] Koopman, C., Gore-Felton, C., Classen, C.C., Kim, P., & Spiegel, D. (2001). Acute stress disorder reactions to everyday stressful life events among sexual abuse survivors with PTSD. *Journal of Child Sexual Abuse, 10*(2), 83-99.

[150] Koopman, C., Gore-Felton, C., & Spiegel, D. (1997). Acute stress disorder symptoms among female sexual abuse survivors seeking treatment. *Journal of Child Sexual Abuse, 6*(3), 65-85.

[151] O'Brien, C., Gaher, R.M., Pope, C., & Smiley, P. (2008). Difficulty identifying feelings predicts the persistence of trauma symptoms in a sample of veterans who experienced military sexual trauma. *Journal of Nervous & Mental Disease, 196*(3), 252-255.

[152] Zlotnick, C., Johnson, J., & Najavits, L.M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavioral Therapy, 40*(4), 325–336.

[153] Higgins, D.J., & Mcabel, M. P. (2000). Relationships between different types of maltreatment during childhood and adjustment in adulthood. *Child Maltreatment, 5*(3), 261-272.

[154] Ghee, A.C., Bolling, L.C., & Johnson, C.S. (2009). The efficacy of a condensed Seeking Safety Intervention for women in residential chemical dependence treatment at 30 days posttreatment. *Journal of Child Sexual Abuse, 18*(5), 475 – 488.

[155] Najavits, L.M., Weiss, R.D, Shaw, S.R., & Muenz, L. (1998). Seeking Safety: Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*(3), 437-456.

[156] Zlotnick, C., Johnson, J., & Najavits, L.M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavioral Therapy, 40*(4), 325–336.

Section H: Biographical Sketches and Job Descriptions

- Key Project Staff –Biographical Sketches and Job Descriptions
    - Project Director
    - Psychiatrist (Consulting)
    - Director of Quality Improvement
    - External Evaluator
    - Medical Records Coordinator
    - Director of MIS and Communication
    - Manager of Clinical Services

- Additional Project Staff – Job Descriptions
    - Medical Records Administrative Assistant
    - Receptionist
    - Admissions/Client Benefits Coordinator
    - Research & Evaluation Assistant
    - AODA Counselor Technician
    - AODA Counselor
    - Case Manager
    - Transportation
    - Consumer Peer Specialist

JOB DESCRIPTION **PROJECT DIRECTOR**

Description of Duties and Responsibilities

- Responsible for the administrative oversight of the grant-funded project
- Oversee all administrative and programmatic aspects of the concept, planning, implementation, contracts, consultants, and evaluation of the project
- Monitor adherence to the project implementation plan
- Ensure proper use of funds
- Provide administrative supervision to staff according to the treatment goals and objectives
- Act as primary contact with *SAMHSA* staff to ensure timely reporting to *SAMHSA* and its contract associates
- Oversee the relationship with any project subcontractors
- Serve as project's public representative to the community
- Responsible for scheduling and maintaining a high quality of content in the programming; assuring integration of evidence based and gender-responsive principles
- Work with Service Managers to ensure coverage of all services & program documentation
- Work with Quality Improvement and Evaluation to meet outcome and reporting requirements
- Assure that teams work together to benefit the women and children in the program
- Develop and maintain close working relationships with community resources
- Ensure that the Core Values are the guiding principles for service delivery

Qualifications for Position

- Master's Degree in human services-related field
- AODA certification and Clinical Supervisor Certification

Supervisory Relationships

- Supervised by President/CEO

Skills and Knowledge Required

- Proven leadership ability, good communication, documentation and problem-solving skills
- Ability to work with women and families from a variety of cultural backgrounds
- Demonstrates initiative, maturity and professionalism

Prior Experience Required

- Five or more years in a leadership capacity
- Five or more years of clinical supervisory experience in AODA and mental health treatment
- Five or more years of experience working with co-occurring disorders
- Experience working with women, including pregnant/postpartum in substance abuse treatment

Personal Qualities

- Must be flexible, patient, and have a good sense of humor

Amount of Travel and any Other Special Conditions or Requirements

- Must have a valid driver's license and proof of insurance

Salary Range

- $60,000 – $85,000

Hours

- 40 hours/week, Monday – Friday - some evenings and weekends, on-call.

BIOGRAPHICAL SKETCH

CHRISTINE ULLSTRUP, LCSW, CSAC, ICS **PROJECT DIRECTOR**

EDUCATION:

University of Wisconsin – Milwaukee, MSW, 2001
University of Wisconsin – Milwaukee, BSW, 1999
Milwaukee Area Technical College – Associate's Degree, Sign Language Interpretation, 1998

DIRECT PROFESSIONAL EXPERIENCE:

Ms. Ullstrup has over seventeen years of experience in substance abuse treatment. She joined the Meta House staff in 1995 as a House Manager in Residential Services. In 1998, while working on her BSW, she became a Case Manager and Counselor in Training. Ms. Ullstrup earned her BSW in 1999 and obtained certifications in Alcohol and Drug Abuse Treatment. In 2000, Christine was promoted to Child and Family Services Manager and served in that position until April of 2003. She obtained her MSW in May of 2001 and was promoted to Manager of Residential Services in 2003. In 2011, Ms. Ullstrup was promoted to Director of Programs. In this new position she provides oversight and leadership for all three Meta House Programs: Residential, Outpatient and Transitional Housing. She is responsible for the vision and goals and coordination of services across a continuum of care. She develops policies and procedures to implement grant, certification, and licensing requirements. She also develops and maintains relationships with community resources.

Ms. Ullstrup has trained Community System personnel on "Risking Connection," a training curriculum for working with survivors of childhood abuse. She has made presentations to graduate students on Motivational Interviewing and how to engage people in substance abuse treatment. Most Recently in July of 2010, she presented at the 4th National Conference on Women Addiction and Recovery on a program that was developed and implemented at Meta House Residential Program. RIPLE (Rewards in Positive Living Environment) is a growth-based contingency management system for women's residential treatment. She frequently speaks at public forums on the need for gender-specific treatment, reducing the stigma of substance abuse, and the need for more treatment options.

In 2009, Ms. Ullstrup completed a leadership program called Women's Addiction Services Leadership Institute (WASLI). WASLI was established by The Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT) to meet the need to strengthen the capacity to serve women with substance use disorders. SAMHSA and CSAT recognized the urgent need to accelerate leadership in women's services to address current challenges such as a changing and aging workforce, financial shortages, service improvement goals, and collaborative opportunities. WASLI has roots in the Partners for Recovery-Addiction Technology Transfer Center Leadership Institute; it was customized to specifically meet the needs of professionals working in the women's substance abuse treatment field. Topics covered included: leadership practices, conflict resolution, negotiation, presentation

skills, facilitating change, women's leadership strengths, and mitigating women's leadership challenges.

Licensure and Certificates

- Internationally Certified Alcohol and Drug Counselor (ICRC) 6/2002
- LCSW 8/2009
- CSAC 2/2007
- ICS 2/2007
- Certificate in Addiction and People with Co-Existing Disabilities, UWM, 8/2004
- Certificate in The Nurturing Program 2/2000
- Risking Connections Train the Trainer (A training curriculum for working with survivors of childhood abuse)

JOB DESCRIPTION PSYCHIATRIST (CONSULTANT)

Description of Duties and Responsibilities

- Serve as Medical Director for the agency
- Provide psychiatric evaluation and differential diagnosis for project participants
- Review and approve all admissions, treatment plans and discharge plans upon completion of the clinical supervisor's review
- Provide integrated mental health services for the treatment of the dually diagnosed
- Review medications and make appropriate recommendations regarding psychotropic medications and their appropriate use during pregnancy
- Participate in staffing of clients as necessary
- Confer and direct medical screenings with clinical supervisor
- Complete all necessary client medical and treatment records
- Provide Medical Supervision and Clinical Consultation

Qualifications for Position

- Medical Degree and Board Certification in Psychiatry
- American Society of Addiction Medicine (ASAM) Fellow preferred

Supervisory Relationships

- Works with clinical staff as a consultant

Skills and Knowledge Required

- Certified in addiction medicine or knowledgeable in the practice of addiction medicine
- Familiar with interactions of psychotropic and antiretroviral medications
- Understanding of state regulations pertaining to HFS
- Understanding of cultural competencies and gender issues for women in recovery from substance use and mental health disorders
- Experience with women, AODA issues and trauma

Prior Experience Required

- At least five years of clinical experience

Personal Qualities

- Must be flexible, nurturing and personable

Amount of Travel and any Other Special Conditions or Requirements

- N/A

Salary Range

- $70,000/yr. Part-time on contractual basis.

Hours

- Hours as Needed; On Call (Approximately 15 hrs/week).

BIOGRAPHICAL SKETCH

CATHY PERKINS, M.D. **PSYCHIATRIST (CONSULTANT)**

EDUCATION:
St. Lawrence University, Canton, NY, 1984
Bachelor of Science Degree, Biology
President's Scholarship

State University of New York, School of Medicine and Biomedical Sciences,
Buffalo, NY, 1988
Medical Degree

POSTGRADUATE EDUCATION:
Resident in Psychiatry, Department of Psychiatry, State University of New York,
Buffalo, NY, 1988-1992

Chief Resident in Psychiatry, Medical-Dental Consortium, Buffalo, NY, 1991-1992

Psychiatry Fellowship, Brigham & Women's Hospital, Boston, MA, 1992-1993
Primary liaison to Lung Transplantation Team

American Society of Addiction Medicine (ASAM) Fellow, 2002

DIRECT PROFESSIONAL EXPERIENCE:
Dr. Perkins has provided psychiatric consultation to Meta House since 1999. As the prescribing onsite psychiatrist, her role is to evaluate individual clients identified as having psychiatric symptoms. Dr. Perkins interviews at-risk clients, and a working differential diagnosis is made in order to suggest treatment. Dr. Perkins prescribes the required medication for clients whose disorders require medication. She also provides the clients their follow-up care while they remain in treatment at Meta House. Dr. Perkins is present for weekly staffings to strategize in clients' care. She also runs a weekly group, "Ask the Doctor," which is an educational group for the women at Meta House, covering various topics relevant to dual-diagnosis treatment. She has led an adolescent group held for the children of the women who attend the quarterly family meetings.

Prior to working with Meta House, Dr. Perkins worked extensively in hospital settings as a psychiatric consultant to medical-surgical units. Following her residency at SUNY Buffalo, she completed a year-long fellowship (1992-1993) in psychiatric consultation-liaison at Brigham and Women's Hospital in Boston. In 1993, she then worked as a consulting psychiatrist on the medical units and in the emergency department at Boston City Hospital, as well as at Massachusetts General Hospital, where she worked extensively with people infected with HIV/AIDS.

In 1994, Dr. Perkins chose to focus her work solely at Boston City Hospital, as her commitment to working with an inner-city population grew. In 1995 she was appointed director of the Psychiatric Emergency Department at Boston City Hospital. Dr. Perkins accepted a position as

director for Consultation-Liaison Psychiatry at Aurora Sinai-Samaritan Medical Center in Milwaukee in 1996. At Aurora Sinai-Samaritan she continued her focus on the inner-city population, while teaching medicine residents and psychology interns. She provided a strong liaison to the neonatal intensive care unit at Sinai-Samaritan by assessing mothers in crisis. In 2002, Dr. Perkins became an American Society of Addiction Medicine Fellow.

Her prior hospital and emergency room work have prepared her for the challenging population that Meta House serves. She feels comfortable assessing complicated medical issues, assessing withdrawal potential and treating acute psychiatric symptoms in the dually-diagnosed women.

FACULTY APPOINTMENTS:
Assistant Professor of Psychiatry, University of Wisconsin Medical School, Milwaukee Clinical Campus, 1996-Present

Clinical Instructor of Psychiatry, Boston University Medical School, Boston, MA, 1993-1996

Clinical Instructor of Psychiatry, Harvard University Medical School, Boston, MA, 1993-1994

RELEVANT PUBLICATIONS/PRESENTATIONS:
Perkins C., Mueller R., Longo L. "Selecting Psychotropic Medications for HIV Positive Patients: A Clinical Challenge." Primary Psychiatry, December 2000: Vol. 7, #12.

Ob-Gyn Grand Rounds: "Depression in Women: Evaluation and Treatment for Primary Care Providers." Sinai Samaritan Medical Center, Milwaukee, Wisconsin, 1997.

Internal Medicine Teaching Seminar: "Evaluating and Managing Depression." Sinai Samaritan Medical Center, Milwaukee, Wisconsin, 1996.

Community Mental Health and Crisis Intervention Inservice: "Assessment and Management of Aggressive or Violent Clients in a Community Setting." Lexington, Massachusetts, 1996.

Pristach, C., Smith C., Perkins C. "Reliability of the Self-Administered Alcoholism Screening Test (SAAST) in Psychiatric In-patients." Journal of Addictive Diseases, 1993: 12(4).

LICENSURE AND CERTIFICATIONS:
Board Certified in Psychiatry, 1993, Wisconsin #37916

JOB DESCRIPTION **DIRECTOR OF QUALITY IMPROVEMENT**

Description of Duties and Responsibilities

- Develop, implement and monitor all quality improvement activities for project
- Ensure compliance with requirements of contract with SAMHSA, including submission of biannual reports, GPRA data collection and data entry
- Work with External Evaluator to design, implement, and supervise internal evaluation activities, including qualitative and quantitative data collection, client tracking and locating procedures, and outcome reporting
- Provide regular feedback to Meta House staff and board based on evaluation findings
- Ensure that client confidentiality, safety, and well-being are maintained in the context of program evaluation activities
- Act as primary liaison with the electronic health records system provider
- Coordinate implementation and maintenance of the electronic health records system, including staff training and technical support

Qualifications for Position

- Masters Degree in social science, Ph.D. preferred
- Minimum two years experience directly related to AODA and/or mental health issues

Supervisory Relationships

- Works under supervision of the President/CEO
- Supervises Evaluation Assistant

Skills and Knowledge Required

- Computer skills including familiarity with major database programs
- Understand and stay current on all federal, state and county regulations regarding outcome measurement requirements
- Understands data collection instruments and procedures, develops modifications as required
- Excellent personal and professional boundaries and problem-solving skills
- Understanding of cultural competencies and gender issues for women

Prior Experience Required

- One year of research design and implementation experience
- Two or more years of experience directly related to AODA or mental health

Personal Qualities

- Must be flexible, have a good sense of humor, and possess strong leadership qualities

Amount of Travel and any Other Special Conditions or Requirements

- Travel out of state to grantee meetings

Salary Range

- $60,000 - $75,000/yr., full-time

Hours

- 40 hours/week, full-time; Monday-Friday; weekends and evenings as needed; on call

BIOGRAPHICAL SKETCH

ANDREA JEHLY, M.S. **DIRECTOR OF QUALITY IMPROVEMENT**

EDUCATION:
M.S. – Educational Psychology, Research & Evaluation, UW-Milwaukee (May, 2010)
B.A. – Psychology, UW-Milwaukee (May, 2003)
A.A.S. – Computer Information Systems – Programmer/Analyst, MATC, Milwaukee (May, 1995)

DIRECT PROFESSIONAL EXPERIENCE:

Andrea Jehly has ten years of program evaluation experience at Meta House. She began her tenure at Meta House in 2003 as an Evaluation Assistant, served as Research & Evaluation Coordinator from 2008 to 2013, and was recently promoted to Director of Quality Improvement. In her current position, she is responsible for supervising internal program evaluation activities; collaborating with the Planning Council for Health and Human Services (an external evaluation agency) on the implementation of evaluation processes and the analysis of outcome data; monitoring compliance with SAMHSA contracts, including biannual reporting and GPRA data collection; and providing feedback to the agency for quality improvement purposes. Ms. Jehly has been involved with conducting program evaluation for seven SAMHSA grants: three Pregnant and Postpartum Women grants, two Treatment for the Homeless grants, one TCE grant, and one TCE/HIV grant. She has also planned and implemented processes for cross-site data collection required by a SAMHSA Pregnant and Postpartum Women grant (in collaboration with the external evaluator), assisted with projects as part of the SAMHSA Treatment for the Homeless Women & Families evaluator workgroup (including a review of parenting measures and a review of evidence based practices), and developed and implemented databases used for collecting and reporting agency outcome data. Additionally, Ms. Jehly has been a presenter at SAMHSA Treatment for the Homeless, TCE/HIV, and Pregnant and Postpartum Women grantee meetings on evaluation-related topics, including service tracking and reporting, choosing evaluation instruments, and implementing the NIATx model.

Ms. Jehly received her M.S. in Educational Psychology from the University of Wisconsin – Milwaukee. She has also completed graduate level coursework (including fieldwork in a substance abuse treatment program at the Guest House, a shelter for homeless men) at Marquette University in Milwaukee, Wisconsin, in a Community Counseling master's program with a specialization in Substance Abuse Counseling. Additionally, Ms. Jehly has participated in numerous training programs (including participation in SAMHSA grantee meetings) on a variety of topics including: trauma-informed treatment, women's treatment, co-occurring disorders, HIV prevention, and cultural competence. She has also received extensive training in the collection, presentation and interpretation of GPRA data and client outcomes.

Before starting her career in research and evaluation, Ms. Jehly spent seven years as a computer programmer at MSI Data Systems where she designed, wrote, and maintained computer applications for clients. She has continued to use those skills by developing databases and reports used for service tracking, GPRA interview tracking, and other data collection within the agency. While working as a computer programmer, she completed her B.A. in Psychology at the University of Wisconsin - Milwaukee. In the process of completing her degree, she gained experience (both paid and unpaid) in a variety of settings including: working as a research

assistant in the Drug Neuroimaging Laboratory at the Medical College of Wisconsin studying the effects of aging on cognition, conducting behavioral therapy with autistic children as a Line Therapist with Autism and Behavioral Consultants, assisting with a meta-analysis of the effects of community violence on children and adolescents at UW-Milwaukee, and volunteering as a rape crisis counselor at Project HELP in Naples, Florida.

PROFESSIONAL AFFILIATIONS

- American Evaluation Association (AEA)
- Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA)
- American Psychological Association Division 50 (Society of Addiction Psychology)

JOB DESCRIPTION **EXTERNAL EVALUATOR**

Description of Duties and Responsibilities:

- Provide training, supervision, and monitoring for GPRA, cross-site evaluation, and local evaluation data collection
- Together with the Director of Quality Improvement, provide consulting on issues of evaluation implementation as they arise
- Conduct data analysis and author the interim and final performance assessment reports, in consultation with the Meta House internal evaluation team
- Together with the Project Director and Meta House internal evaluation team, assure an objective representation of the findings

Qualifications for Position

- Minimum of Master's Degree in a social science, Ph.D. preferred

Supervisory Relationships

- All Planning Council Staff report to the Executive Director of the Planning Council
- Work closely with Meta House internal evaluation team and the Project Director

Skills and Knowledge Required

- Expert knowledge of program evaluation
- Computer skills, including familiarity with major database programs and statistical packages
- Understand and stay current on Federal, State and County regulations regarding outcome measurement requirements
- Understand current data collection instruments and procedures; able to develop modifications when required
- Understanding of cultural competencies and gender issues for women

Prior Experience Required

- Minimum of five years research and evaluation experience, to include related areas such as substance abuse treatment and women
- Clinical or research experience with AODA and/or mental health populations

Personal Qualities

- Excellent personal and professional boundaries and problem-solving skills
- Must be flexible, have a good sense of humor, and possess strong leadership qualities

Amount of Travel and any Other Special Conditions or Requirements

- Travel out of state to grantee meetings as needed

Salary Range

- $45,000 - $75,000/yr., full-time

Hours

- Hours as needed to fulfill contract

BIOGRAPHICAL SKETCH

LISA LARSON, Ph.D. **EXTERNAL EVALUATOR**

EDUCATION:
Ph.D. - 1996 - Southern Illinois University, Carbondale, IL, Clinical Child Psychology
M.A. - 1987 - Southern Illinois University, Carbondale, IL, Clinical Child Psychology
B.A. - 1984 - Wesleyan University, Middletown, CT, Psychology

DIRECT PROFESSIONAL EXPERIENCE:
Lisa (Elisabeth) Larson has 20 years of experience in applied research and program evaluation. She is currently the Director of Research and Evaluation for the Planning Council for Health and Human Services, Inc. The Planning Council is a non-profit organization whose mission is to advance community health and human services in Southeastern Wisconsin through objective planning, evaluation, and research. In her present position, Dr. Larson is responsible for working collaboratively with stakeholders in evaluation design and in the collection, analysis, and interpretation of data. Dr. Larson has served as the lead evaluator for numerous federal grants, including 11 SAMHSA grants (nine of which also involved Meta House). Dr. Larson is a long-time member of the American Evaluation Association.

Recent projects include:

Evaluation of the Meta House Recovery and Health Program – a five-year evaluation of a SAMHSA-funded outpatient treatment program for women at risk for HIV/AIDS. The evaluation documented the extent to which the program was successful in assisting women in their recovery, decreasing their risk of HIV infection, and improving the stability of the family environment.

Evaluation of the Families Come First pilot project – a three-year evaluation of an ACF Children's Bureau-funded collaboration between child welfare and substance abuse treatment designed to provide collaborative assessments and treatment for women who are pregnant and using substances or who give birth to a substance-affected infant. The evaluation documented the development of the collaboration, as well as child safety outcomes and child and family well-being outcomes.

Evaluation of the Meta House Preserving and Reuniting Families in Recovery Program – a three-year evaluation of a SAMHSA-funded residential, gender-responsive treatment program for pregnant and postpartum women. The evaluation documented the program's ability to move women into recovery and to improve mental health, physical health functioning, family functioning, quality of life, and birth outcomes.

Evaluation of the Band of Brothers and Sisters Program – a three-year evaluation of a SAMHSA-funded peer-to-peer recovery support program for veterans. The process evaluation describes the peer-to-peer model, its value for veterans and peer mentors, and the collaboration between a facilitating organization and a recovery community organization. The outcome evaluation assesses the extent to which the program is successful in meeting its goals and objectives.

Evaluation of the *Un Nuevo Amanecer* Program – a three-year evaluation of a SAMHSA-funded program designed to assist elderly Latinos in managing symptoms of depression through a culturally appropriate, evidence-based intervention. The evaluation assessed the

extent to which the program was successful in decreasing depression symptoms, improving levels of physical functioning, and improving quality of life among elderly participants.
Evaluation of the Meta House Pregnant-Postpartum Women Program – a four-year evaluation of a SAMHSA-funded residential, gender-responsive treatment program for pregnant, postpartum, and parenting women. The evaluation assessed the program's ability to effectively address the substance use, mental health, trauma, medical, and parenting needs of participants.
Evaluation of the Meta House FamilyWorks Program – a four-year evaluation of a SAMHSA-funded intensive outpatient substance abuse treatment program for women in TANF Wisconsin Works (W-2) and/or the child welfare system. The evaluation documented the effectiveness of this program, while providing technical assistance and training as the program developed its own internal evaluation capacity.

Dr. Larson also has ten years of experience in the area of clinical psychology. Prior to her current position, she provided psychotherapy and conducted assessments with adults, children, and families. She specialized in working with children and families who were dealing with issues related to childhood sexual abuse.

SELECTED PRESENTATIONS:

Larson, L., Malcolm, E., and Jehly, A. (2012, October). Evaluation capacity 4.0: Taking the long view. American Evaluation Association, Minneapolis, MN.

Larson, L., Malcolm, E., and Whelan Capell, J. (2011, June). Analyzing outcomes data. Beyond Accountability: Measuring Nonprofit Performance to Improve Practice, Milwaukee, WI.

Larson, L. (2010, November). External data sets: Working with WiSACWIS. Webinar for Family Connection Discretionary Grants, sponsored by James Bell Associates, Inc., National Webinar.

Larson, L. and Malcolm, E. (2010, September). Evaluating your wellness program: A practical approach. 20th Annual Worksite Wellness Conference: Improving Health to Empower Business, Wisconsin Dells, WI.

Lapine, L., Larson, E., and Aniakudo, P. (2006, November). The external evaluation team contribution to a partnership model of evaluation capacity building: Lessons learned. American Evaluation Association, Portland, OR.

Aniakudo, P., Larson, E., and Lapine, L. (2006, November). The internal evaluation department contribution to a partnership model of evaluation capacity building: Lessons learned. American Evaluation Association, Portland, OR.

Larson, E. and Lapine, L. (1998, November). Levels of outcomes for women's residential AODA treatment: Making the most of the ASI. American Evaluation Association, Chicago, IL.

JOB DESCRIPTION **MEDICAL RECORDS COORDINATOR**

Description of Duties and Responsibilities

- Implementation and Coordination of the agency-wide medical records system
- Assure quality of documentation that meets the standards and requirements of Federal and State regulations, grant expectations, inter-agency data collection and referral funding reports
- Maintain up-to-date knowledge of State and Federal regulations pertaining to licensing and apply these standards to an agency-wide medical records system according to agency policy
- Conduct agency-wide Quarterly Assurance audits to identify systemic problems and recommend/implement training and other corrective action as appropriate
- Collect, distribute and enter data into an agency-wide data base, recording established outcomes as required by various grant requirements
- Generate timely lists, schedules and reminders of various record keeping and report writing deadlines to case management and counseling staff
- Oversee and delegate transcription of bio-psycho-social reports, progress reports and discharge summaries to meet the agency standards and policies established
- Monitor all components of client files from admission to discharge, closeout charts within designated timeframes and archive closed charts
- Works with Privacy Officer to assure operations are in compliance with agency policies/ procedures and federal and state regulations pertaining to the privacy of client information

Qualifications for Position

- Bachelor's degree in Human Service related field preferred

Supervisory Relationships

- Works under the direct supervision of the Operations Director

Skills and Knowledge Required

- Knowledge and experience working with mental health and/or alcohol and drug terminology and diagnoses
- Excellent written communication skills, ability to work independently and within the confines of deadlines

Prior Experience Required

- Three to five years experience in medical records and data entry

Personal Qualities

- Demonstrated initiative, maturity, professionalism and attention to detail

Amount of Travel and any Other Special Conditions or Requirements

- Required driving to various locations; must have a valid driver's license and insurance

Salary Range

- $33,000 - $47,000/yr., full-time

Hours

- 40 hours/week; Monday-Friday, weekends and evenings as needed

BIOGRAPHICAL SKETCH
RUTH O'DONNELL **MEDICAL RECORDS COORDINATOR**

EDUCATION:
Coe College, BA, 1979

DIRECT PROFESSIONAL EXPERIENCE:

Ms. O'Donnell joined the Meta House staff as their Medical Records Coordinator in 2000. In this capacity, her primary responsibilities are to implement and coordinate the agency-wide medical records system assuring documentation meets the standards and requirements of federal and state regulations, grant expectations, inter-agency data collection and referral funding reports. She also maintains up-to-date knowledge of state and federal regulations pertaining to licensing and applies theses standards to Meta House's medical records system according to agency policy. She is responsible for conducting agency-wide Quarterly Assurance audits to identify systemic problems, and recommends and implements training and other corrective action as appropriate; collecting, distributing and entering data into an agency-wide database, recording established outcomes as required by various grant requirements; and oversees and delegates transcription of bio-psycho-social reports, progress reports and discharge summaries to meet the agency standards and policies established. Ms. O'Donnell is also responsible for generating timely lists, schedules and reminders of various record keeping and report writing deadlines to case management and counseling staff. Further, she monitors all components of client files from admission to discharge, closes out charts within designated timeframes and archives closed charts. And finally, Ms. O'Donnell works with the Privacy Officer of Meta House to assure operations are in compliance with agency policies and procedures, along with federal and state regulations, pertaining to the privacy of client information.

Prior to her employment at Meta House, Ms. O'Donnell was a Resident Coordinator at Creative Living Environments in Milwaukee, Wisconsin, from 1998 to 2000. In this position, she was responsible for all aspects of the management of an eight-bed group home for the elderly, including ensuring adherence to state regulations, care planning, medication management, appointment scheduling, personal care, activity planning and implementation, caregiver supervision, staff meetings and house maintenance and repair.

From 1992 to 1995, Ms. O'Donnell worked first as the Director of Wakeeney Youth Programs and then later as the Director of Training and Quality Assurance at The Farm, Inc. in Wakeeney, Kansas. As the Director of Wakeeney Youth Programs, she was responsible for the start up of and overseeing the operations and programs, including the Greater Western Regional Juvenile Detention Center, the Odessa/Terry Emergency Shelter and the Trego County Level V group home. Her duties included ensuring compliance with licensing regulations, preparing and articulating yearly budget requirements and interpreting programs to community groups, legislative bodies and other agencies. She directly supervised five managers who, in turn, supervised 50 employees, including interviewing, hiring, training, planning and directing work, appraising performance, disciplining and addressing grievances. In her role as the Director of Training and Quality Assurance at The Farm, Inc., Ms. O'Donnell's duties included the development and maintenance of the agency-wide orientation training program, probationary and continuing training programs and ensuring compliance with state regulations. She also planned,

coordinated and conducted periodic internal audits of residential and foster care programs, prepared timely written reports summarizing audit results, monitored program corrective action plans and ensured audit results were implemented during follow-up audits.

From 1988 to 1992, Ms. O'Donnell was employed by the Kansas Department of Social and Rehabilitation Services in Topeka. As the Jail Alternatives Coordinator, her duties included coordination of the plan, policies and implementation strategies to bring Kansas into compliance with the Juvenile Justice and Delinquency Prevention Act. She provided technical assistance to local sheriffs, judges, court service officers, SRS personnel and county commissioners on planning and implementing jail alternatives; organized and conducted training sessions for over 1,000 volunteers; acted as liaison between the Justice Department and their contractors and state and local officials; developed and provided informational materials to local units of government; and monitored and assessed the jail alternatives programs.

Prior to her employment with the State of Kansas, Ms. O'Donnell served as a Guidance Counselor at the Excelsior Springs Job Corps Center in Excelsior Springs, Missouri from 1986 to 1988. She provided monthly and individual counseling sessions for a caseload of 90-100 corps members to monitor progress in the program, discussed problems and concerns and assisted in vocational or employment plans after completion of the program.

From 1980 to 1986, Ms. O'Donnell was a Youth Services Supervisor at the Linn County Juvenile Detention Center in Marion, Iowa. While there, she supervised activities and child care staff, which included directing and supervising youth counselors, youth workers, interns and volunteers. She also assisted in developing management goals and implementing plans to achieve those goals, along with planning daily activities, evaluating staff performance and ensuring that staff potential was effectively utilized.

In 1980, Ms. O'Donnell was a Youth Service Worker at the Heartwood Treatment Center in Cedar Rapids, Iowa, where she supervised daily activities of emotionally disturbed and delinquent adolescents in a residential setting.

Ms. O'Donnell received her Bachelor of Arts degree in 1979 from Coe College in Cedar Rapids, Iowa, majoring in Psychology.

Workshops Presented:
Youth Attendant Care Training, Salina, KS – 1988-1995
OJJDP Regional Juvenile Justice Workshop, Seattle, WA – March 1989
OJJDP Regional Juvenile Justice Workshop, Tampa, FL – April 1989
Kansas Conference on Social Welfare, Wichita, KS – May 1989
Council for Exceptional Children, Salina, KS – November 1989
Status Offenders Conference, St. Louis, MO – December 1989
Non-Secure Attendant Care Training, Anchorage, AK – January 1990
Training of Trainers: Non-Secure Attendant Care Training, Anchorage, AK – June 1990
Kids Conference, Topeka, KS – March 1993

JOB DESCRIPTION **DIRECTOR OF MIS AND COMMUNICATION**

Description of Duties and Responsibilities

- Network Administration – Develop, plan and implement the overall strategic goals of Meta House's network system; evaluate and recommend changes to current and future network requirements to meet Meta House's needs within the confines of a limited budget; monitor, test and troubleshoot hardware and software problems pertaining to the Local Area Network (LAN); detect, diagnose and repair problems on both the server and the workstations; recommend and schedule repairs and improvements to the network; provide end-user support for all LAN-based applications; install and configure workstations; support and maintain user account information including rights, security and systems groups
- Computer Maintenance – Install new software releases, system upgrades, evaluate and install patches and resolve software related programs; monitor system configuration to ensure data integrity; maintain, analyze, troubleshoot and repair or replace hardware, software and computer peripherals; perform routine tasks to maintain computer equipment; manage the deployment, maintenance, support and upgrade of servers, desktop PCs, hardware, software, operating systems and peripheral devices
- Communication – Develop, plan and implement Meta House's communication system; troubleshoot and coordinate communication service needs; evaluate need, research and recommend personal communication solutions (e.g. smart phones and cell phones)
- Database – Review, administer, evaluate, implement and maintain Meta House's database; develop and implement policies and procedures for ensuring the security and integrity of Meta House's database

Qualifications for Position

- Bachelor's degree in computers or related field

Supervisory Relationships

- Reports to Operations Director

Skills and Knowledge Required

- Thorough knowledge of personal computer hardware, including being able to remove and replace components
- Familiarity with standard computer concepts, practices and procedures
- Ability to juggle a variety of tasks, investigate needs/problems and follow through to solution
- Superior written and verbal communications; excellent organizational and problem-solving skills

Prior Experience Required

- Four or more years of experience working with Windows (server and workstation) operating systems

Personal Qualities

- Be a self-starting, take-charge individual

Amount of Travel and any Other Special Conditions or Requirements:

N/A

Salary Range

- $70,000 to $80,000/yr.

Hours

- 40 hours/week, weekdays

BIOGRAPHICAL SKETCH

KAREN RHEAULT, MS **DIRECTOR OF MIS AND COMMUNICATION**

EDUCATION:
Cardinal Stritch University, MS, 2000
Ottawa University, BS, 1998
Milwaukee Area Technical College, AS, 1995

DIRECT PROFESSIONAL EXPERIENCE:

Ms. Rheault is a degreed professional with over 20 years of experience in the information systems field. She joined Meta House in 1992 as the Executive Assistant/Microcomputer Specialist to the Executive Director and transitioned through the years to the Director of MIS and Communication. In this capacity, her primary responsibilities are to establish, plan and administer the overall policies and goals for the information and communication technology of Meta House. She determines the organization's long-term needs, recommends improvements in current standards, and implements system changes. As Director of MIS and Communication, Ms. Rheault's job duties are broken down into four different components:

- Network Administration – Develop, plan and implement the overall strategic goals of Meta House's network system; evaluate and recommend changes to current and future network requirements to meet Meta House's needs within the confines of a limited budget; monitor, test and troubleshoot hardware and software problems pertaining to the Local Area Network (LAN); detect, diagnose and repair problems on both the servers and the workstations; recommend and schedule repairs and improvements to the network; provide end-user support for all LAN-based applications; install and configure workstations; support and maintain user account information including rights, security and systems groups
- Computer Maintenance – Install new software releases, system upgrades, evaluate and install patches and resolve software related programs; monitor system configuration to ensure data integrity; maintain, analyze, troubleshoot and repair or replace hardware, software and computer peripherals; perform routine tasks to maintain computer equipment; manage the deployment, maintenance, support and upgrade of servers, desktop PCs, hardware, software, operating systems and peripheral devices
- Communication – Develop, plan and implement Meta House's communication system; troubleshoot and coordinate communication service needs; evaluate need, research and recommend personal communication solutions (e.g. smart phones and cell phones)
- Database – Review, administer, evaluate, implement and maintain Meta House's database; develop and implement policies and procedures for ensuring the security and integrity of Meta House's database

Along with working full-time at Meta House, Ms. Rheault worked part-time as an instructor at Milwaukee Area Technical College in the evenings teaching computer-related courses and had a part-time desktop publishing business from 1996 until 2005.

Prior to her employment at Meta House, Ms. Rheault worked as an Administrative Assistant in the Legal Department at United Health, Inc. in Milwaukee, Wisconsin, from 1989 to 1992. In this position, her responsibilities included transcription of legal documents, briefs, contracts and

confidential correspondence. She prioritized and processed all incoming items, identified documents and issues requiring immediate attention, made sure all deadlines, response dates, hearing appearances, arbitrations and conferences were recorded and met, and maintained the department library.

Prior to United Health, Inc., Ms. Rheault worked part-time at InvestAmerica Venture Group, Inc. and Growth Financial Services, Inc., both located in Milwaukee, Wisconsin, as an Administrative Assistant, preparing correspondence, reports, proposals and performing general office duties.

From 1976 to 1989, Ms. Rheault was employed by D&N Savings Bank, FSB, in Hancock, Michigan. She started at D&N Savings as an Administrative Aide-Purchasing in the Office Services Department. Her duties included purchasing equipment, supplies, forms, negotiable instruments and inventory maintenance. Among her achievements in this position, she implemented and tested a computer inventory program, set up a system to track equipment, service contracts and rentals by branch and equipment type and established library/inventory forms procedures. As a result of her accomplishments, Ms. Rheault was ultimately promoted to Forms Controls Specialist in the Methods & Procedures Department at D&N Savings. In this capacity, her responsibilities included design, composition, proofing, printing, purchasing and inventory control of approximately 1,500 forms used throughout the organization. This involved report analysis detailing usage by individual departments and branches and determining lead times needed to revise and produce forms for optimum inventory levels. She had extensive contact with all levels of management and outside vendors regarding use and production of forms and new products. While in this position, Ms. Rheault was cited for excellent performance, saved $30,000 per year in forms expense and reduced the number of backorders.

Licensure and Certificates

- Certificate of Achievement and Diploma of Merit-General Banking from the Institute of Financial Education in Chicago, Illinois
- Certificate of Achievement in the Desktop Publishing Certificate Program
- State of Wisconsin Technical College System Board – Certified to teach 106 Office Systems/Technology and 107 Computer Information Systems and 103 Computer Software

JOB DESCRIPTION **MANAGER OF CLINICAL SERVICES**

Description of Duties and Responsibilities

- Provide clinical supervision of Substance Abuse/Mental Health counselors
- Provide clinical insight to Living Support Staff
- Provide supervision of AODA Authorization Specialist
- Directly manage the day-to-day responsibilities of the Substance Abuse Counselors
- Work directly with the Program Director and other Service Managers to ensure quality team functioning
- Work with Program Director and Program Administrator to develop and maintain policies and procedures for Substance Abuse Counseling staff as indicated by regulations, funding sources, financial accounting, professional ethics, etc.
- Ensure that the agency Core values are the guiding principles for service delivery
- Develop working relationships with the community that enhance delivery of services
- Work with Program Quality Assurance Coordinator to ensure credentialing of clinical staff and enrollment in appropriate insurance carriers
- Monitor systems for insurance authorizations and billing
- Monitor Core Competencies program to assess LSS staff development

Qualifications for Position

- Masters Degree in Counseling or MSW
- LPC or LCSW
- CSAC
- Independent Clinical Supervisor

Supervisory Relationships

- Supervised by the Director of Programs
- Supervises Substance Abuse Counselors and Living Support Staff Supervisor

Skills and Knowledge Required

- Ability to work effectively with people, supervisory skills
- Ability to demonstrate a mature approach to problem solving
- Organization and planning skills
- Computer skills including proficiency in Word, Excel and other applications

Prior Experience Required

- Minimum of five years supervisory experience in AODA services

Personal Qualities

- Good communication, documentation and problem-solving skills
- Must be flexible, patient, have a good sense of humor, and have a nurturing personality
- Ability to work with women from a variety of cultural backgrounds

Amount of Travel and any Other Special Conditions of Requirements:

- N/A

Salary Range

- $50,000 - $65,000/year, full-time

Hours

- 40 hours/week, full-time; Monday-Friday, 8:00 a.m. to 4:30 p.m.; weekends and evenings as needed; on call.

BIOGRAPHICAL SKETCH

STACEY YONKOSKI, LCSW, CSAC — **MANAGER OF CLINICAL SERVICES**

EDUCATION:

University of Wisconsin – Milwaukee, MSW, 1994
University of Wisconsin – Parkside, BS, 1990

DIRECT PROFESSIONAL EXPERIENCE:

Ms. Yonkoski is a degreed professional with over 15 years of experience in the behavioral health field, as well as implementing and organizing programs with successful project management. Beginning her career in the mid 1990's, she built and maintained a client base in private practice as a psychotherapist while concurrently serving as the Clinical Director at the United Community Center (UCC) where she was responsible for daily administration and clinical management of behavioral health outpatient, day treatment and residential programs.

She later joined Meta House in 2001 as its Outpatient Program Manager where she managed all aspects of the behavioral health intensive outpatient and day treatment programs for women, serving 200 people annually. She also was responsible for the implementation and administrative oversight of two, three-year SAMHSA/CSAT federal grants totaling $4 million, along with developing policies, procedures and quality assurance methods while maintaining compliance with clinical, ethical, state and federal regulatory standards.

Following her five-year tenure at Meta House, Ms. Yonkoski became employed by Ceridian-Lifeworks in Eagan, Minnesota where she managed an Employee Assistance Program, was the subject matter expert for Substance Abuse Case Management and Management Line products, and acted as a resource to Account Executives.

Returning to the Milwaukee metropolitan area in 2006, she managed three behavioral health programs as the Manager of Outpatient Behavioral Health Programs at a Milwaukee-area medical center; and in 2007 was named the Manager of Clinical Services at the Milwaukee Women's Center where she provided daily leadership and administration of behavioral health residential and outpatient programs.

In 2012, Ms. Yonkoski returned to Meta House, accepting a position as its Manager of Clinical Services. In this capacity, her primary responsibilities are to provide overall substance abuse and mental health expertise to the entire agency. She is directly responsible for ensuring that the Substance Abuse Counselors and Living Support Staff have needed clinical knowledge to perform their job duties. She also works with the Program Director and Program Administrator to develop and maintain policies and procedures for the Meta House Substance Abuse Counseling staff as indicated by regulations, funding sources, financial accounting and professional ethics. Further, Ms. Yonkoski works with the Program Quality Assurance Coordinator at Meta House to ensure credentialing of clinical staff and enrollment in appropriate insurance carrier. And finally, she develops working relationships with the community that enhance delivery of services through good communication, documentation and problem-solving skills.

In 2011, Ms. Yonkoski completed a leadership program called Women's Addiction Services Leadership Institute (WASLI). WASLI was established by The Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT) to meet the need to strengthen the capacity to serve women with substance use disorders. SAMHSA and CSAT recognized the urgent need to accelerate leadership in women's services to address current challenges such as a changing and aging workforce, financial shortages, service improvement goals, and collaborative opportunities. WASLI has roots in the Partners for Recovery-Addiction Technology Transfer Center Leadership Institute; it was customized to specifically meet the needs of professionals working in the women's substance abuse treatment field. Topics covered included: leadership practices, conflict resolution, negotiation, presentation skills, facilitating change, women's leadership strengths, and mitigating women's leadership challenges.

Ms. Yonkoski received her Bachelor of Science degree from the University of Wisconsin-Parkside in 1990, majoring in Sociology, and she received her Master of Social Work degree from the University of Wisconsin-Milwaukee in 1994.

Licensure & Certification

- LCSW - 1998
- CSAC - 1997

JOB DESCRIPTION MEDICAL RECORDS ADMINISTRATIVE ASSISTANT

Description of Duties and Responsibilities

- Establish and maintain the residential level of care client charts from admission through discharge/transfer
- Maintain the residential client chart archives, destroying records as scheduled
- Monitor residential client charts regularly by performing audits on new client charts within 72 hours of admission, monthly group progress note audits, quarterly quality assurance audits and other audits as requested
- Accurately bill Milwaukee County funded residential clients on a weekly basis
- Distribute client mail daily, accurately recording benefit letters and checks, distributing receipts to clients and forwarding mail as requested
- Provide training and technical support to staff related to the electronic health records system and maintain forms and reports in the EHR system

Qualifications for Position

High school degree or equivalent

Supervisory Relationships

Supervised by the Medical Records Coordinator

Skills and Knowledge Required

- Good written and verbal skills
- Good organizational skills and ability to meet specified deadlines
- Attention to detail
- Able to work in a multi-cultural setting
- Computer skills including proficiency in Word, Excel, and other applications

Prior Experience Required

- Two years experience as an administrative assistant or equivalent position

Personal Qualities

- Must be flexible, patient, and have a good sense of humor

Amount of Travel and any Other Special Conditions or Requirements: N/A

Salary Range

- $30,000 to $40,000/yr.

Hours

- 40 hours/week, weekdays

JOB DESCRIPTION **RECEPTIONIST**

Description of Duties and Responsibilities

- Answer the telephone; provide information regarding Meta House and its services; direct calls to appropriate personnel; return calls as necessary; overhead paging as needed
- Greet visitors, ascertain the nature of their business, assist and/or direct visitors to appropriate person
- Greet new clients and explain attendance sign-in sheets
- Create/maintain intake calendar; schedule appointments for Day Treatment and Outpatient intake clients
- Create attendance sheets for Day Treatment and Outpatient clients and track clients' schedules
- Receive the mail, open and distribute as necessary
- Log money received through mail or dropped off at reception desk and distribute to appropriate person; collect rental and miscellaneous payments from transitional housing clients
- Sign for and accept special deliveries

Qualifications for Position

High school degree or equivalent

Supervisory Relationships

Supervised by the Program Administrator

Skills and Knowledge Required

- Able to work cooperatively with other team members
- General computer literacy and word processing experience
- Good written and verbal skills
- Good organizational skills with attention to detail
- Able to work in a multi-cultural setting
- Courteous and professional attitude and appearance

Prior Experience Required

- Two years experience as a receptionist or equivalent position

Personal Qualities

- Must be flexible, patient, and have a good sense of humor

Amount of Travel and any Other Special Conditions or Requirements: N/A

Salary Range

- $30,000 to $40,000/yr.

Hours

- 40 hours/week, weekdays

JOB DESCRIPTION ADMISSION/CLIENT BENEFITS COORDINATOR

Description of Duties and Responsibilities

- Responsible for the initial and ongoing contact with the potential Residential clients either via the Milwaukee County waitlist, private pay, or grant-eligible women
- Conduct thorough intake admissions for Residential Program
- Complete Intake forms for Outpatient clients
- Facilitate transfer admission from one level of care to another
- Utilize motivational interviewing techniques to prepare client for residential program
- Meet with all Residential clients and connect eligible residents to Quest, W2 and insurance programs.
- Be responsible for all related paperwork and record keeping

Qualifications for Position

- Bachelor's degree in Social Work or related field
- Minimum two years experience with AODA and family issues
- Outstanding documentation, communication and customer service skills

Supervisory Relationships

Supervised by the Director of Programs

Skills and Knowledge Required

- Knowledge of chemical dependency issues
- Ability to effectively communicate, both orally and in writing
- Ability to relate to culturally diverse populations, displaying compassion and understanding

Prior Experience Required

- Minimum two years experience working with women and families in the AODA field
- Familiarity with Milwaukee AODA treatment community
- Extensive computer experience, with attention to detail

Personal Qualities

- Must be flexible, patient, and have a good sense of humor

Amount of Travel and any Other Special Conditions or Requirements: N/A

Salary Range

- $35,000 to $45,000/yr.

Hours

- 40 hours/week, weekdays

JOB DESCRIPTION **RESEARCH & EVALUATION ASSISTANT**

Description of Duties and Responsibilities

- Data collection for GPRA (80% follow-up rate) and local evaluation; as well as data entry into SAIS website and local evaluation databases
- Maintain confidentiality of information collected through the research and evaluation process
- Complete data entry for evaluation data, admit and follow-up data & outcomes management
- Screen patient charts following acceptance into program and track admission status of clients
- Assist in enrolling and following clients who agree to participate in the program evaluation
- Tracking and locating of clients for follow-up interviews
- Conduct intake, discharge, and follow-up interviews with present and former clients
- Track client participation in the evaluation
- Record variations on evaluation protocols and follow-up for clarification as necessary
- Assist the Director of Quality Improvement in gathering qualitative and quantitative evaluation information
- Facilitate activities with clients for program feedback
- Maintain open communication with staff to ensure reliable and valid data collection
- Participate in training with External Evaluator to develop data management and report skills
-

Qualifications for Position

- Bachelor's degree, including course work in social science research

Supervisory Relationships

- Supervised by Director of Quality Improvement

Skills and Knowledge Required

- Ability to work in a multi-cultural setting
- Good communication and organizational skills
- Computer literate and familiar with major database programs

Prior Experience Required

- Data management and report writing
- Experience with the AODA/Mental Health population

Personal Qualities

- Must be detail-oriented, flexible, have good interpersonal skills and awareness of boundaries

Amount of Travel and any Other Special Conditions or Requirements

- Local travel between Meta House facilities and to Planning Council

Salary Range

- $35,000 - $45,000/yr., full-time

Hours

- 40 hours/week

JOB DESCRIPTION **AODA COUNSELOR TECHNICIAN**

Description of Duties and Responsibilities

- Responsible for monitoring and tracking of clients' insurance or funding source on funding spreadsheet
- Check insurance validity monthly and update funding spreadsheet
- Responsible for getting initial authorizations and linking with appropriate counselor for intake
- Work with counselor to ensure initial authorization was approved and get additional authorizations for services for each client
- Monitor session use of each client and authorization expiration dates
- Manage Recovery Support Services for all clients at intake and throughout treatment stay; work collaboratively with Milwaukee County, CIU's and Recovery Support Coordinators
- Work closely with Meta House Accounting staff regarding funding and billing issues
- Assist and train counselors with completing authorizations

Qualifications for Position

- Bachelor's degree in social work or related field

Supervisory Relationships

- Reports to Manager of Clinical Services

Skills and Knowledge Required

- Outstanding documentation skills with special attention to accuracy and detail
- Outstanding communication and customer services skills
- Able to work in a multi-cultural setting
- Computer skills including proficiency in Word, Excel, and other applications

Prior Experience Required

- Minimum two years experience in AODA and family issues

Personal Qualities

- Must be flexible, patient, and have a good sense of humor

Amount of Travel and any Other Special Conditions or Requirements: N/A

Salary Range

- $27,000 to $33,000/yr.

Hours

- 40 hours/week, weekdays

JOB DESCRIPTION **AODA COUNSELOR**

Description of Duties and Responsibilities

- Provide mothers and pregnant women with gender and culturally appropriate interventions and programming.
- Work in concert with the multidisciplinary team members to ensure continuity of care, treatment plan development and implementation
- Provide direct and coordinated services to mothers with substance use disorders, their children and families, utilizing internal program modalities and external linkages
- Facilitate group therapy sessions
- Conduct one-to-one therapy sessions
- Provide family and couples therapy sessions
- Provide Substance Abuse education and relapse prevention
- Monitor random drug testing to inform and support the therapeutic process
- Attend interdisciplinary/inter-organizational staffings
- Be responsible for all related paperwork and record-keeping
- Work with mental health provider to coordinate treatment interventions

Qualifications for Position

- Masters degree preferred in human services or related field and/or five years experience
- State of Wisconsin Licensure in Alcohol and Other Drug Abuse (CSAC)

Supervisory Relationships

- Reports to the Manager of Clinical Services

Skills and Knowledge Required

- Strong knowledge of Women, Families, Pregnant Women and Substance Abuse issues
- Knowledge of DSM IV
- Ability to integrate mental health treatment into Substance Abuse treatment
- Understanding of cultural competencies and gender issues for women
- Good communication and organizational skills

Prior Experience Required

- A minimum of two years' experience working in the Substance Abuse field

Personal Qualities

- Must be flexible, have a good sense of humor, and possess strong leadership qualities

Amount of Travel and any Other Special Conditions or Requirements

- Must have a valid driver's license and proof of insurance

Salary Range

- $35,000 - $45,000/yr., full-time

Hours

- 40 hours/week, Monday – Friday, evenings and weekends as needed

JOB DESCRIPTION **CASE MANAGER**

Description of Duties and Responsibilities

- Implement the Plan of Care (SCCP) developed by the Care Coordinator and client's team members
- Act as advocate for client within existing system
- Coordinate services needed by Meta House transitional housing clients including: medical, social services, housing, legal, financial and any other service identified
- Triage the medical, housing, legal, etc. needs of clients not involved with our transitional housing program and give the appropriate referrals
- Develop a service plan to meet the client's goals
- Help the client learn to access services independently and make referrals when appropriate
- Perform all required record keeping and paperwork related to treatment and work at Meta House
- Attend staffing, wraps and do home visits at transitional housing
- Facilitate Case Management Group

Qualifications for Position

- Bachelor's Degree in human services or related field, or related experience

Supervisory Relationships

- Reports to the Program Administrator

Skills and Knowledge Required

- Thorough knowledge of the TANF and Child Welfare systems and community resources
- Knowledge of AODA issues as they relate to women and families
- Thorough working knowledge of community resources

Prior Experience Required

- Minimum of two years of experience working in the case management/AODA field

Personal Qualities

- Must be flexible, maintain composure and have a sense of humor
- Ability to adapt to diverse environments and possess strong leadership skills
- Ability to relate to individuals from diverse cultural backgrounds

Amount of Travel and any Other Special Conditions or Requirements

- Will be visiting clients in their homes, usually within a 10-mile radius of the facility
- Must have a valid driver's license and proof of insurance

Salary Range

- $35,000 – $45,000/yr., full-time

Hours

- 40 hours/week, Monday – Friday; weekends and evenings as needed; on call

JOB DESCRIPTION **TRANSPORTATION: VAN DRIVER**

Description of Duties and Responsibilities

- Provides transportation services for clients and their children
- Provides transportation to doctor's appointments, Children's Court Center, and other appointments as necessary
- Responsible for ensuring safety (use of car seats according to children's ages, maintain appropriate adult/child ratio, and seat belts)
- Responsible for the maintenance of agency vehicles (gas, fill up tires, trash pickup and cleaning)
- Responsible for processing transportation requests and scheduling as necessary in the absence of lead driver
- Collect mail from post-office and boxes at various facilities, sort and distribute as needed
- Distribute paychecks to employees at the various facilities on payday
- Make bank deposits and cash petty cash checks as requested
- Perform other duties as assigned

Qualifications for Position

- High school diploma or equivalent

Supervisory Relationships

- Reports to the Grant and Special Projects Coordinator

Skills and Knowledge Required

- Familiar with the functions, responsibilities, and staff of the program
- Familiar with AODA issues
- Good organizational skills with attention to detail and must demonstrate initiative and maturity
- Ability to work with a culturally diverse client population and understand the family dynamics from many cultural viewpoints

Prior Experience Required

- Minimum of two years of transporting experience

Personal Qualities

- Must be flexible, have a good sense of humor and common sense

Amount of Travel and any Other Special Conditions or Requirements

- Must have a valid driver's license, good driving record and able to operate a 15-passenger van

Salary Range

- $20,000 - $30,000/yr., full-time

Hours

- 40 hours/week

JOB DESCRIPTION **CONSUMER PEER SPECIALIST**

Description of Duties and Responsibilities

- Assist Meta House clients to make healthy decisions that directly affect their own lives; encourage individuals to take responsibility for themselves and others; assure women/mothers that they will be treated with respect and dignity; and foster the understanding that the families are valued and do have skills and strengths
- Model/mentor recovery process and demonstrate coping skills
- Safe, timely, organized client transport
- Accompany clients to appropriate community appointments and advocate as needed
- Communication with coworkers and collaborative staff via phone and email
- Document all participant contact as required
- Uphold, understand, and review all policies, procedures as outlined by Employee Handbook
- Engage in, attend, and complete all required supervision, staff meetings, training, in-service, and health regulations deemed necessary by policies and regulations
- Obtain Certification as a Peer Specialist

Qualifications for Position

- High school degree or equivalent
- Driver's license, safe driving record, safe vehicle and proof of vehicle insurance

Supervisory Relationships

Reports to the Grant and Special Projects Coordinator

Skills and Knowledge Required

- Good written and verbal skills
- Good organizational skills and ability to meet specified deadlines
- Attention to detail
- Able to work in a multi-cultural setting
- Computer skills including proficiency in Word, Excel, and other applications

Prior Experience Required

- A self-identified current or former user of AODA, mental health or co-occurring services who can relate to others who are now using those services

Personal Qualities

- Must be flexible, patient, and have a good sense of humor

Amount of Travel and any Other Special Conditions or Requirements: N/A

Salary Range

- $20,000 to $25,000/yr.

Hours

- 40 hours/week, weekdays

Section I: Confidentiality/SAMHSA Participant Protection/Human Subjects

1. Protect Clients and Staff from Potential Risks

Risks Associated with Participation in the Project

Given the stigma associated with substance abuse and mental health disorders, there is a risk that individuals participating in treatment may be subjected to discrimination in their places of employment, by family members, or in the community. These risks will be minimized for participants as much as possible by strictly following federal regulations which require that the program protect client confidentiality. Meta House has extensive privacy policies and procedures that adhere to HIPAA, Title 42 of the Code of Federal Regulations Part 2 (42 CFR Part 2), and Wisconsin State law. Meta House staff will not disclose protected health information, including the woman's status as a substance abuse treatment client, without her written consent or under a few narrowly defined exceptions under state and federal law. (See Section 5 for more detail.)

Additionally, the substance use treatment process engages individuals in self-reflection in the context of abstinence, which may contribute to participants experiencing uncomfortable emotions or temporary exacerbation of mental health symptoms. The treatment facility is staffed whenever clients are present, with a counselor always on call, so participants who experience difficulty with emotions and/or mental health symptoms always have a staff member and a counselor available to assist them. In the interest of the safety of all participants, staff have been also been trained in the procedures for appropriately handling suicidal and violent participants if such situations arise. Meta House counselors are aware of the risks for individuals participating in treatment, and as part of routine practice they check in with their clients to see how interactions in individual or group sessions may be affecting them. In addition, clients will be assessed for mental health issues, and the program will address these issues through its consultants or through referrals to other service providers.

Risks Associated with Participation in the Evaluation.

Individuals participating in the evaluation will be asked to answer questions from the GPRA tool, the modified Addiction Severity Index (ASI), and other local evaluation measures. These interviews involve many personal questions which may bring up uncomfortable feelings. If the client experiences serious emotional stress at the time of the interview, she will have access to a Meta House counselor. All interviews are conducted at the treatment site to ensure the availability of counselor assistance if needed. The informed consent procedures clearly state that clients who express intent to harm themselves or others will be reported to program staff or others as appropriate to protect the safety of all participants.

2. Fair Selection of Participants

The Population of Focus

The population of focus for this SAMHSA grant is women with substance use disorders (SUDs) and co-occurring mental and physical health conditions (COCs). Based on recent demographics, the population of focus is expected to be primarily African American (50%) and Non-Hispanic White (40%), with the majority of the remaining women being

Hispanic/Latina and Native American. It is anticipated that the overall average age of the women will be 33 years. Along with severe and chronic substance use disorders and co-occurring physical/mental health disorders, the women served under this grant are likely to have been exposed to trauma, such as childhood abuse and/or other violence. While the population of focus for grant purposes will be women with COCs, women with SUDs who come to treatment at Meta House but do not fall into this category will still have access to the same treatment services and will only be excluded from grant funding.

Recruitment and Selection

Clients from the population of focus for Healthy Connections will be recruited in one of two ways. One potential point of access is through the Milwaukee WIser Choice program, a County-wide system for the funding and provision of treatment and other recovery support services for people without insurance. Women can access one of Milwaukee County's Central Intake Units (CIUs) where they are screened for substance use and mental health problems and the appropriate level of care is determined. Milwaukee County operates a voucher program and allows consumers their choice of treatment facility. Because Meta House is state-licensed as a substance abuse treatment facility and as a mental health clinic and because we participate in WIser Choice's Mental Health Outpatient Program, a large proportion of these referrals are for women with COCs. The other point of access is that clients with insurance can contact Meta House directly to schedule an intake appointment. Meta House also conducts outreach through educational seminars and direct contact to the shelters, privatized child welfare and TANF agencies, family courts, churches, hospitals, other AODA agencies, the District Attorneys, Public Defenders and other institutions that are likely to serve women with SUDs and COCs. All women who enter the project will be offered the opportunity to participate in the evaluation unless they are currently participating in the evaluation for a different CSAT grant.

Neither the treatment program nor the evaluation will exclude women due to pregnancy, mental health disorders, disabilities, or vulnerability to HIV/AIDS. The program provides sufficient mental health and medical resources (*e.g.,* a full time R.N. and an onsite psychiatrist) and additional access to mental health and medical services through coordinated care and case management services to accommodate the expected incidence of these complications in the population of focus. Additionally, the evaluation staff has experience modifying evaluation requirements to meet any unique needs of women experiencing these complications.

3. Absence of Coercion

Participation in treatment will be voluntary. However, child welfare agencies have the responsibility to protect children and may initiate court actions on behalf of the children of clients in the project. The court may set conditions for mothers wishing to retain or regain custody of their children. One of these conditions may be satisfactory participation in substance use treatment. Similar situations may occur when women are referred from the TANF agencies and the correctional system. Although participation in treatment will remain voluntary under these circumstances, clients will be aware that a decision to decline treatment may have consequences in other systems.

Participation in the evaluation interviews will also be voluntary. The informed consent materials for participation in the evaluation and in the personal interviews that are part of the evaluation all clearly state that participation is voluntary. Participants in the evaluation interviews are informed that the evaluation is completely independent of treatment and that not participating or withdrawing from participation in the evaluation will not affect the services they and their families will receive from the treatment program. Participants are not penalized for choosing not to provide any of the information requested. Also, clients are informed that they are free to decline to answer any specific question, to ask questions at any time during interviews, and to withdraw from interviews at any time.

Remuneration

Participants are paid $20.00 for each evaluation follow-up interview. Women in the program are encouraged to recognize that their time is valuable; therefore, it is reasonable to reflect that understanding in the evaluation process. However, the amount of the incentive is consistent with SAMHSA guidelines and is not considered to be an excessive amount that would provide undue inducement to participate. The program has used this incentive in the past and has found that it is the minimum amount that will provide the participation necessary to achieve the SAMHSA mandated 80% follow-up target.

4. Data Collection

Data Collection Procedures

Program staff will collect basic client demographic information from the referral sources and from the client herself. Meta House will use the electronic health records (EHR) system for the collection of the following information: client demographics, contact information, treatment episodes, assessments, treatment plans, services provided, progress notes, funding sources, billing authorizations, and releases of information/consents. The GPRA tool, the ASI questions, and the Trauma Symptom Checklist (TSC-40) will be included in interviews conducted by the evaluation staff with clients at program entry, at discharge, at 6 months post-intake, and at 12 months post-intake. All interview data collection is conducted in a one-on-one setting where privacy can be ensured. Program evaluation data is collected with only evaluation staff present.

Urine specimens (and alcohol swabs if appropriate) are routinely collected from clients by the program so that the results can be used by clinical staff to monitor treatment progress. Results from specimen analysis are not used as part of the evaluation.

Data Collection Instruments/Interview Protocols

Attachment 2 includes the in-person evaluation interview that integrates both the GPRA required questions, as presently understood, and the additional ASI questions selected for the local evaluation. A link to the TSC-40 is also provided in Attachment 2.

5. Privacy and Confidentiality

Collection of Data

Meta House clinical and/or evaluation staff will collect all client information for use in the treatment program and the evaluation, following the policies and procedures described below:

- Meta House agrees to maintain alcohol and drug abuse client records in accordance with the provisions of HIPAA, 42 CFR Part 2, and Wisconsin state law.
- Meta House policies and procedures follow these provisions:
  a) The confidentiality of alcohol and drug abuse client records maintained by Meta House is protected by Federal law and regulations.
  b) Generally, employees and volunteers may not disclose to any person that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser unless:
     1) the client consents in writing;
     2) the disclosure is allowed by court order;
     3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation;
     4) the client commits or threatens to commit a crime either at the program or against any person who works for the program.
  c) Employee's signatures indicate that they are aware that the violation of the Federal law and regulations by a program is a crime and that violations may be reported to the United States Attorney.
  d) Employees are also aware that Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Signed releases of information will be stored electronically in the EHR system, along with expiration or revocation dates, so this information is easily accessible to Meta House staff to ensure protection of client confidentiality.

The consent forms described under #6 (Adequate Consent Procedures) assure clients that the information they provide as part of the program evaluation is entirely confidential, *i.e.*, no one other than evaluation team members will ever see identifiable individual responses, including Meta House clinical staff. Individual responses are supplied to SAMHSA via the GPRA website and to the Planning Council external evaluators, but all of these responses are coded with a client identification number rather than with client names or other identifiable data. All information from the evaluation interviews will be grouped when used to report to SAMHSA, staff, the Board of Directors, and any other entity. Grouped information will not identify which women participated in the personal interviews and which did not. The purpose of the grouped data is to describe client perceptions of Meta House's treatment and services, client progress in key areas of their lives, and what changes or additions clients would like to see in the treatment program and services.

Access to and Maintenance of Data
Confidentiality and privacy will be maintained for all treatment program and program evaluation data, in accordance with the policies described above. The treatment program will maintain client records in an ONC-ATCB certified EHR system, hosted at a secure HIPAA-compliant facility on servers that are protected by a firewall. Access to the EHR system will require a password and is controlled by role-based security, ensuring that users of the system can access only the information appropriate for the provision of treatment. Meta House will maintain any paper client records in secure offices on site.

Only the evaluation staff at Meta House and the Planning Council will have access to any data collected for program evaluation purposes. The raw data collected as part of the evaluation will be stored at Meta House in physical files which are only accessible to evaluation staff and will be data-entered in a secure database only accessible to evaluation staff. All individual data entry screens will only have client code numbers (no client names, dates of birth, ages, entry dates, or exit dates). All GPRA data will be entered on the SAIS website provided by SAMHSA, which is accessed only by evaluation staff. The analyzed data will reside at the Planning Council in a secure computer system that is protected from the internet by a firewall and is in a directory secured through password protection.

Client-specific data will include an identifying code number, and the identity of the individual's code number will be known only to the evaluation staff at Meta House. Evaluation data provided to the Planning Council will be identified with the code number only and will not include other identifying information such as client names or social security numbers. Clients will not know their own code numbers. Code numbers will be stored separately from the data. All summaries of data will combine any categories of responses that would include less than 10 individuals to protect the clients from identification through their answers to personal questions. Program feedback data obtained from client focus groups and other surveys will not contain any client information or identifying code numbers and will only be shared with the Planning Council, staff, and the Board of Directors in aggregate form.

All information that is collected solely for evaluation purposes (as opposed to assessments done for clinical purposes) will be identified to the client as part of Meta House's evaluation and will be collected by evaluation staff. Data that is collected for use by clinical staff which will also be included in the program evaluation will be identified to the clients so the client is aware that this information will also be in their clinical chart. Evaluation staff will be able to access some program data about clients (the minimum necessary to perform their duties), but non-evaluation program staff will not be able to access any individual program evaluation data. Only evaluation staff will have access to the evaluation data at the individual level. The data will be provided to non-evaluation program staff in aggregate form only.

6. Adequate Consent Procedures

As required by state law, all clients in substance use treatment at Meta House receive information about their rights, the voluntary nature of their participation, their right to leave

the project at any time without repercussion, possible risks from participation, procedures in place to protect them from any identified risks, program expectations, and confidentiality matters. In addition, women who have been referred to Meta House will be informed that they are receiving treatment that is funded through SAMHSA. Women will fully participate in their treatment planning and will sign and regularly review their service plans in accordance with state regulations.

Additional release of information forms in accordance with the provisions of HIPAA, 42 CFR Part 2, and Wisconsin state law will be used to determine what information will be shared between Meta House and any outside agencies. These release forms will be developed in cooperation with the outside agencies and will specify what specific information they will release to Meta House, what specific information Meta House will release to them, and the dates for which the release is in effect. As described earlier, signed releases of information will be stored electronically in the EHR system, along with expiration or revocation dates, so this information is easily accessible to Meta House staff to ensure protection of client confidentiality.

All participants in the evaluation will receive a description of the Meta House program evaluation, which details the reasons for the program evaluation, the potential risks, the follow-up interview schedule and incentives, participants' rights, how the information will be used, and contact information for the Clients Rights Specialist so that they can express any concerns or ask any questions about the evaluation. The participant rights section of the form specifically states that participation in the evaluation is completely voluntary and that a participant may choose not to participate in any activity, to leave any program evaluation activity before it has been completed, to refuse to answer any given question in the personal interviews, and that whether they choose to participate in the program evaluation will not affect any services they are to receive at Meta House. This information is reiterated in the consent form that participants sign if they do agree to participate in the evaluation. Participants are also asked to provide consent to being contacted for further follow-up interviews. Clinical staff will also provide clients with information about the program evaluation when asking clients to complete forms that will be used both by clinical and evaluation staff.

Any clients who decline to participate in the program evaluation will still be able participate in the treatment program, although they will not be counted as grant-funded clients for evaluation purposes.

Low Literacy/Informed Consent

In consideration of varying levels of literacy among clients, treatment program materials and release forms will be reviewed verbally with all clients to ensure an understanding of the material. Additionally, evaluation and clinical staff will read the description of the Meta House program evaluation, participant rights, and all consent forms to the participants in the program evaluation. The description and consent forms have been specifically developed to be easily understandable to participants with a low literacy level. Additionally, a written copy of the description of the program evaluation will be given to the participants to keep and evaluation staff will solicit and respond to questions about evaluation participation.

Separate Consents

Separate consents will be obtained for participation in the treatment program, release of information to outside agencies, and participation in the program evaluation. Sample consent forms are provided in Attachment 3. Additionally, separate consents will be obtained for the collection of evaluation data at program entry and each follow-up data collection point (discharge, 6 months post-intake, and 12 months post-intake). Each consent process includes providing the participant with the description of the program and asking for signed consent, as noted above.

7. Risk/Benefit Discussion

The benefits of integrated substance use and mental health treatment are well documented. Meta House's success in the area of substance use treatment has also been well documented by previous participation in nine SAMHSA grants. Most of the risks are associated with not participating in treatment. However, during treatment it is not unusual to have disturbing feelings, especially when issues of sexual abuse and other forms of violence are discussed. In addition, if medication is being taken, there may be side effects.

The involvement of other systems (e.g., child welfare) and the commitment to coordinate treatment with the needs of those participating in these systems is not expected to involve any intrinsic risk. Moreover, involvement with these systems, in a way that does not take into account women's substance use treatment needs, may be detrimental to women and their families.

Involvement in the evaluation portion of the project has few risks. Women who experience emotional stress during the interviews will have counselors available to work with them. Long-standing experience with the program evaluation interviews suggests that, for most women, they are a welcome opportunity for self-reflection, recognition of personal progress, and rededication to self-improvement. In addition, the knowledge gained through use of the collection of similar evaluation data has proven useful for program planning, program improvement, funding allocation decisions, and public policy.

Attachment 1: Providers, Assurances, Letters of Commitment

1) Identification of Treatment Provider

The experienced, licensed mental health/substance abuse treatment provider organization for the Healthy Connections program is **Meta House, Inc.,** in Milwaukee, WI. Meta House has been providing substance abuse treatment to women for 50 years, and is state-licensed as a substance abuse treatment facility and a mental health clinic. MH has successfully implemented nine SAMHSA grants serving women similar to the Healthy Connections population of focus.

2) List of All Direct Service Providers

Provider Name	Service
Meta House, Inc. (Applicant)	Experienced, licensed substance abuse and mental health treatment provider. Responsible for providing all treatment services as specified in Sections B and C of
The Planning Council for Health and Human Services, Inc.	External evaluation (MOA can be found on page 85)
Psytech Solutions, Inc.	Electronic health records system vendor (MOA can be found on page 86)

3) Statement of Assurance

Please see page 84 for the statement of assurance.

4) Letters of Commitment/Memoranda of Agreement

Please see pages 85 – 86 for memoranda of agreement from **The Planning Council for Health and Human Services** and **Psytech Solutions**.

Statement of Assurance

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

- a letter of commitment 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.[2] (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.

Signature of Authorized Representative

4/8/2013
Date

[2] Tribes and tribal organizations are exempt from these requirements.

Memorandum of Agreement

Meta House, Inc., the *potential* grant recipient for a SAMHSA funding opportunity entitled "Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need", and the Planning Council for Health and Human Services, Inc., the *potential* sub-recipient evaluator, hereby enter into a memorandum of agreement upon notice of award and contract completion.

Whereby, Meta House, Inc., agrees to:

- Provide oversight of the sub-recipient to meet the goals and outcomes described in the grant-funded program;
- Provide the legal, administrative and fiscal responsibility for the grant;
- Provide the fiscal management of the grant funds;
- Provide the programming as committed in the grant application
- Be the reporting recipient of the evaluation process and outcomes.

Whereby Planning Council for Health and Human Services, Inc. agrees to work with the Meta House, Inc., Project Director and the Director of Quality Improvement to conduct an evaluation that will:

- Address service implementation and outcomes specific to the purpose of the grant application;
- Provide support for the collection of required GPRA performance measures; and
- Provide data analysis and reporting for the local performance assessment of program goals and objectives.

Executed this 4th day of April, 2013.

Signatures:

Amy Lindner
CEO/President
Meta House
2625 N. Weil St.
Milwaukee, WI 53212

Kathleen Pritchard
President and CEO
Planning Council for Health and Human Services, Inc.
1243 N 10th St., Suite 200
Milwaukee, WI 53205

Memorandum of Agreement

Meta House, Inc., the *potential* grant recipient for a SAMHSA funding opportunity entitled "Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need", and Psytech Solutions, Inc., the *potential* sub-recipient provider of an electronic health records system, hereby enter into a memorandum of agreement upon notice of award, contract completion, and completion of software agreement.

Whereby, Meta House, Inc., agrees to:

- Provide oversight of the sub-recipient to meet the goals and outcomes described in the grant-funded program;
- Provide the legal, administrative and fiscal responsibility for the grant;
- Provide the fiscal management of the grant funds;
- Provide the programming as committed in the grant application;
- Be the reporting recipient of the evaluation process and outcomes; and
- Fulfill obligations specified in the software agreement.

Whereby Psytech Solutions, Inc., agrees to provide the following (as specified in the software agreement):

- Licenses for the ONC-ATCB certified EHR system (Epitomax);
- Off-site, secure, HIPAA-compliant hosting of the EHR system; and
- Training, support, and maintenance as specified in the contract.

Executed this 3rd day of April, 2013.

Signatures:

Amy Lindner
CEO/President
Meta House, Inc.
2625 N. Weil St.
Milwaukee, WI 53212

Michael Kreamer
President
Psytech Solutions, Inc.
1138 Stone Creek Drive
Hummelstown, PA 17036

Attachment 2: Data Collection Instruments/Interview Protocols

- **Modified Addiction Severity Index (ASI)**

  The modified form of the ASI developed by the external evaluator for use can be found on pages 88 - 107

- **Trauma Symptom Checklist (TSC-40)**

  The TSC-40 can be found at the following website: http://www.johnbriere.com/tsc.htm

Assignment # _____ Client Initials _____ Client ID #_____

INITIAL ASSESSMENT INSTRUMENT

Admit Date ____/____/____

Interview Date ____/____/____

Client Birth Date ____/____/____

Interviewer _____

Grant:

- ☐ MATR/OFFSPRG
- ☐ Healthy Connections
- ☐ Other: _____

Notes _____

_____

_____

_____

_____

_____

_____

GPRA Data Entry Date ____/____/____

Local Data Entry Date ____/____/____

Data Checking Date ____/____/____

Demographics

(Please remember to mark RF for any question that the client refuses to answer.)

1. Are you Hispanic or Latina?

☐ Yes ☐ No

1a. If yes, what ethnic group do you consider yourself?

Please answer yes or no for each of the following. You may say yes to more than one.

☐ Central American ☐ Dominican ☐ Puerto Rican
☐ Cuban ☐ Mexican ☐ South American
☐ Other (Specify) _____

2. What is your race?

Please answer yes or no for each of the following. You may say yes to more than one.

☐ Black or African American ☐ Native Hawaiian/other Pacific Islander ☐ White
☐ Asian ☐ Alaska Native ☐ American Indian

3. How many children do you have? _____ (if children, use individual Child Information Sheets)

3b. Are you currently pregnant?

☐ Yes ☐ No ☐ Don't Know

4. What forms of assistance do you receive? ☐ None

☐ W-2 (TANF) ☐ Social Security Disability ☐ Health Insurance for self
☐ Food Stamps/Quest Card ☐ SSI ☐ Health Insurance for child
☐ WIC ☐ SSI for child's disability ☐ Rent assistance/voucher
☐ Other (Specify) _____

4a. (If client receives SSI / SSD) How did you become eligible for SSI or SSD?

☐ Developmental Disability/Learning Disability
☐ Physical Disability
☐ Psychiatric Diagnosis/Mental Health
☐ Don't Know
☐ Other (Specify) _____
☐ SSI / SSD for Child (Specify)_____

5. What is your relationship status?

☐ Living with a partner/married
☐ In a relationship
☐ Not in a relationship

6. Have you ever served in the Armed Forces, Reserves, or National Guard? (If no, go to question 9)

☐ Yes ☐ No

6a. (If yes) Which area did you serve?

☐ Armed Forces ☐ Reserves ☐ National Guard

7. Are you currently on active duty in the Armed Forces, Reserves, or National Guard?

☐ Yes ☐ No

7a. (If yes) Which area?

☐ Armed Forces ☐ Reserves ☐ National Guard

8. Have you ever been deployed to a combat zone?

☐ Yes, specify where: _____

☐ No

9. Has anyone in your family or someone close to you ever been on active duty in the Armed Forces, Reserves, or National Guard? (If yes, complete grid below. If no, skip to next section)

☐ Yes, only one person

☐ Yes, more than one person

☐ No

Relationship (specify)						
Were any of them deployed in support of combat operations?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Were any of them physically injured during combat operations?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any of them develop combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression or suicidal thoughts?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any of them die during combat operations?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Family and Living Conditions

(Please remember to mark RF for any question that the client refuses to answer.)

1. In the past 30 days, did you stay overnight in a controlled environment?

☐ Yes ☐ No

1a. If yes, where did you stay? (check all that apply)

☐ Jail ☐ Alcohol or drug treatment ☐ Psychiatric treatment
☐ Medical Treatment ☐ Other (specify) _____

1b. If yes, for how many nights? _____

2. In your lifetime have you ever stayed (spent the night) in any of the following places?

☐ Yes	☐ No	a. A shelter
☐ Yes	☐ No	b. A rented room (hotel, motel, not an apartment) with no place else to stay
☐ Yes	☐ No	c. Your parents' home (without paying rent) since the age of 18
☐ Yes	☐ No	d. Someone else's home (extended family, friends, etc.) without paying rent and with no place else to stay
☐ Yes	☐ No	e. A halfway house, residential treatment, or institution with no other place you were paying rent for at the time
☐ Yes	☐ No	f. A car
☐ Yes	☐ No	g. An empty/vacant building
☐ Yes	☐ No	h. A drug (crack) house
☐ Yes	☐ No	i. The streets or a park
☐ Yes	☐ No	j. A library, bus station, all night movie, airport or some other public place

3. In the past 30 days, where have you been living **most** of the time (check only <u>one</u>).

☐ a. Shelter

☐ b. Street/outdoors (sidewalk, doorway, park, public or abandoned building)

☐ c. Institution (hospital, nursing home, jail/prison)

☐ d. Housed

- ☐ Own/rent apartment, room, house
- ☐ Someone else's apartment, room, house – contributing money for rent
- ☐ Someone else's apartment, room, house – **not** contributing money for rent
- ☐ Residential Treatment
- ☐ Meta Housing
- ☐ Other transitional living (specify) _____
- ☐ Other housed (specify) _____

☐ f. Don't Know

3a. If client is housed or in transitional living: In the past 30 days what were your living arrangements most of the time? (check all that apply).

- ☐ Spouse/Significant other
- ☐ Children
- ☐ Parents
- ☐ Roommate/suite mate
- ☐ Siblings/Other Family
- ☐ Friends
- ☐ Alone
- ☐ With Non-relatives in Controlled Environment
- ☐ No Stable Arrangement
- ☐ Drug House
- ☐ Other (Specify) _____

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery? That is, in the past 30 days have you spent time with people who are supportive of your recovery, including family and friends?

☐ Yes ☐ No ☐ Don't Know

5. To whom do you turn when you are having trouble? That is, who is the one person you turn to most commonly for support?

- ☐ No one
- ☐ Clergy Member
- ☐ Family Member
- ☐ Friends
- ☐ Don't Know
- ☐ Other (specify)_____

The next few questions are very personal. I'd like to remind you that you can choose to skip any question that makes you feel uncomfortable.

First I'm going to ask you about your sexual activity. Is that ok with you? (If yes, continue. If no, skip to question #8 and ask about criminal activity.)

7. During the past 30 days, did you engage in sexual activity (with another person)?

☐ Yes ☐ No

(If yes) Next I'm going to ask you about the number of sexual contacts you've had in the past 30 days. Is that ok with you? (If yes, continue.)

7a. How many sexual contacts did you have? _____

By that I mean vaginal, oral, or anal sexual contacts.

Next I'm going to ask you about how many of these sexual contacts were unprotected. Is that ok with you? (If yes, continue.)

7b. How many unprotected sexual contacts did you have? _____

By "unprotected", I mean without a condom or other latex barrier.

(If answer to 7b is more than 0, continue.)

7c. How many of these unprotected sexual contacts were with an individual who was:

HIV positive or has AIDS? _____

An injection drug user? _____

High on some substance? _____

(If any of #7 answered …) Thank you for going through these very personal questions with me. You'll be pleased to know we are done with this type of very personal question.

(If none of #7 answered …) As I said, it's fine to skip any questions that make you feel uncomfortable. You'll be pleased to know we are done with this type of very personal question. But as we go through, if there's anything else you'd want to skip please let me know.

Legal Issues

(Please remember to mark RF for any question that the client refuses to answer.)

The next question asks you about any criminal activity that you may have engaged in recently.

8. In the past 30 days, how many times have you committed a crime? _____

(Note on GPRA data entry: Check Page 11, question #2 for number of days illegal drug use. Any answer here must be equal to or greater than the number of days of illegal drug use.)

Next, I have just a few more questions about legal issues.

In the past 30 days …

1. How many times have you been arrested? # of times _____

2. How many times have you been arrested for drug-related offenses? # of times _____

3. How many nights have you spent in jail/prison? # of nights _____

4. How many days did you engage in illegal activities for profit? # of days _____

5. Are you currently awaiting charges, trial, or sentencing? ☐ Yes ☐ No

6. Are you currently on parole or probation? ☐ Yes ☐ No

7. Are you involved with any of these other legal services?

☐ Adult drug court (not family drug court)

☐ Deferred prosecution (Justice 2000)

☐ Other: _____

Employment and Income

(Please remember to mark RF for any question that the client refuses to answer.)

1. In your lifetime, have you had a full-time job?

☐ Yes ☐ No

1a. If yes, how long was your longest full-time job? _____years _____months _____weeks

1b. What is your usual occupation? _____

2. Are you currently employed?

(Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work.)

☐ Unemployed, looking for work
☐ Unemployed, disabled
☐ Unemployed, volunteer work
☐ Unemployed, retired
☐ Unemployed, not looking for work
☐ Unemployed, Other (specify) _____

☐ Employed full time (35+ hours a week or would have been)
☐ Employed part time
☐ Employed Other (Specify)_____

3. Approximately, how much money did YOU receive (pretax individual income) in the past 30 days from: (Please enter dollar amount.)

$_____ Wages (also include occasional work)

$_____ Public assistance (W-2, Food Stamps) W2_____ Food Stamps _____

$_____ Retirement

$_____ Disability (Social Security)

$_____ Disability (SSI) for child/children

$_____ Non-legal income

$_____ Child Support (GPRA entry: add into "other")

$_____.Family and/or friends

$_____ Other (specify)_____

$_____ Total Monthly Income

4. How many people depend on you for most of their food, shelter, etc.? _____
(for example, children, unemployed partner, extended family)

Education

(Please remember to mark RF for any question that the client refuses to answer.)

1. What is the highest level of education you have finished, whether or not you received a degree?

Last grade _____

- ☐ 12th Grade/High School Diploma/Equivalent (GED or HSED)
- ☐ College or University/ 1st Year Completed
- ☐ College or University/ 2nd Year Completed/Associates Degree (AA,AS)
- ☐ College or University/ 3rd Year Completed
- ☐ Bachelor's Degree (BA/BS) or Higher
- ☐ Voc/Tech Program After High School but No Voc/Tech Diploma
- ☐ Voc/Tech Program After High School (program completed)

2. Are you currently in school or a job training program?

- ☐ Not Enrolled
- ☐ Enrolled full time
- ☐ Enrolled part time
- ☐ Enrolled, literacy or GED program (Meta House or other)
- ☐ Enrolled Other (specify) _____

2a. If enrolled, how long have you been attending? _____ years _____ months _____ weeks

3. Have you had any (other) training or technical education courses? ☐ Yes ☐ No

3a. How many? _____

3b. How many trainings did you complete? _____

3c. How long was the longest training you attended? _____ years _____ months _____ weeks

Drug and Alcohol Use

(Please remember to mark RF for any question that the client refuses to answer.)

1. In your lifetime have you used any of the following?

If yes, record lifetime use if consumption was "regular". Check "P" if use was always as prescribed.

Also, if yes in the last 30 days, how many days did you use this substance? Check "P" if use in the past 30 days was always as prescribed.

Note re: the usual route: for more than one route, choose the most severe (highest number).

Route of admission: 1=Oral, 2=Nasal, 3= Smoking, 4= Non-IV injection, 5= IV	**Lifetime Use**	**Lifetime Regular Use**	**In last 30 days, # of days**	**1**	**2**	**3**	**4**	**5**
a. Cocaine/Crack	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
b. Marijuana/Hashish (Weed, Pot, Joints, Blunts)	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
c1.Heroin (Smack, H, Junk Skag)	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
c2. Morphine	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c3. Diluadid	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c4. Demerol	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c5. Percocet	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c6. Darvon	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c7. Codeine	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c8. Tylenol 2,3,4	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
c9. Oxycontin/Oxycodone	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
d. Methadone	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
e. Hallucinogens/psychedelics, PCP (Angel Dust), Ecstasy, Acid, Mushrooms (Peyote), Mescaline	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
f. Methamphetamine/ amphetamine, (Meth, Speed, Crank), ADD Medication (Ritalin, dexadrine)	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV

Reminder: **1=Oral, 2=Nasal, 3= Smoking, 4= Non-IV injection, 5= IV**	**Lifetime Use**	**Lifetime Regular Use**	**In last 30 days, # of days**	**1**	**2**	**3**	**4**	**5**
g1. Benzodiazepines: Diazepam(Valium), Alprazolam (Xanax), Lorazepam (Ativan), Triazolam (Halcion) Rohypnol (roofies), Librium	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
g2. Barbiturates: Mephobarbital, Nembutal, Amytal, Seconal, Phenobarbital, downers	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
g3. Non-prescription GHB (G, Liquid Ecstasy, soap)	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
g4. Ketamine (Special K, jet)	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
g5. Other tranquilizers, downers, sedatives, hypnotics (Ambien, Haldol, Quaaludes)	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
h. Inhalants (poppers, snappers, rush, whippets, nitrous oxide, glue, aerosols**)**	☐ Yes ☐ No	_____years _____months	_____	Oral	Nasal	Smoking	Non IV	IV
i. Other Illegal Drugs (Vicodin) Specify_____	☐ Yes ☐ No ☐ P	_____years _____months	☐ P _____	Oral	Nasal	Smoking	Non IV	IV
j. Any alcohol	☐ Yes ☐ No	_____years _____months	_____					
j1. Alcohol to intoxication (**5+** drinks in one sitting)	☐ Yes ☐ No	_____years _____months	_____					
j2. Alcohol to intoxication (**4 or <** drinks in one sitting)	☐ Yes ☐ No	_____years _____months	_____					
k. Both alcohol and drugs on the same day	☐ Yes ☐ No	_____years _____months	_____					
l. More than 1 substance per day (include alcohol)	☐ Yes ☐ No	_____years _____months	_____					
m. Tobacco products	☐ Yes ☐ No	_____years _____months	_____	Number per day _____				

2. Think about the last 30 days, how many of these days did you use illegal drugs? _____

3. In the past 30 days, have you injected any drugs? ☐ Yes ☐ No

3a. If yes, in the past 30 days, how often did you use a syringe, cooker, cotton, or water that someone else used?

☐ Always ☐ More than half the time ☐ Half the time ☐ Less than half the time ☐ Never ☐ Don't Know

4. In the last 30 days, how many days were you completely drug and alcohol free? _____

5. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? (GPRA data entry: if question #4=30 and answer here is "not at all", code=N/A)

☐ Not at all ☐ Somewhat ☐ Considerably ☐ Extremely

6. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? (GPRA data entry: if question #4=30 and answer here is "not at all", code=N/A)

☐ Not at all ☐ Somewhat ☐ Considerably ☐ Extremely

7. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? (GPRA data entry: if question #4=30 and answer here is "not at all", code=N/A)

☐ Not at all ☐ Somewhat ☐ Considerably ☐ Extremely

8. In the past 30 days, were you living with anyone who:

8a. has a current alcohol problem? ☐ Yes ☐ No

8b. has a current drug abuse problem? ☐ Yes ☐ No

9. In the past 30 days, did you attend any voluntary non-religious self-help groups for recovery such as Alcoholics Anonymous or Narcotics Anonymous? ☐ Yes ☐ No

9a. If yes, how many times in the past 30 days? _____ ☐ Don't know

10. In the past 30 days, did you attend any other recovery self-help groups, specifically any church, faith or religiously affiliated groups? ☐ Yes ☐ No

10a. If yes, how many times in the past 30 days? _____ ☐ Don't know

11. In the past 30 days, did you attend any meetings of organizations that support recovery other than the organizations described above? (Church attendance, clubs, women's support group, etc.) ☐ Yes ☐ No

11a. If yes, how many times in the past 30 days? _____ ☐ Don't know

Mental Health

(Please remember to mark RF for any question that the client refuses to answer.)

In the past 30 days, have you had any of the following problems (not due to alcohol or drugs)?

If yes, how many total days did you experience this?

If yes, have you had **5 days or more** in a row in which you have experienced this?

	Have you?	In last 30 days, # of days	5 days or more?
a. Experienced serious depression	☐ Yes ☐ No		☐ Yes ☐ No
b. Experienced serious anxiety, tension, or nervousness.	☐ Yes ☐ No		☐ Yes ☐ No
c. Experienced trouble understanding, concentrating, or remembering	☐ Yes ☐ No		☐ Yes ☐ No
d. Experienced serious problems with sleeping or eating.	☐ Yes ☐ No		☐ Yes ☐ No
e. Experienced hallucinations	☐ Yes ☐ No		☐ Yes ☐ No
f. Experienced trouble controlling violent behavior.	☐ Yes ☐ No		☐ Yes ☐ No
g Experienced serious thoughts of suicide	☐ Yes ☐ No		☐ Yes ☐ No
h. Attempted suicide	☐ Yes ☐ No		☐ Yes ☐ No
i. Taken prescribed medication for psychological/emotional problems.	☐ Yes ☐ No		☐ Yes ☐ No

In the past 30 days, how many total days did you experience the psychological or emotional problems that we just discussed? _____

How much have you been bothered by these psychological or emotional problems in the past 30 days?

☐ Not at All ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

The next few questions could bring up some uncomfortable feelings. I'd like to remind you that you can choose to skip any question that makes you feel uncomfortable.

Have you ever experienced violence or trauma in any setting? (If no, go to question 5)

☐ Yes ☐ No

(If yes) Did any of these experiences feel so upsetting that, in the past or in the present, you:

4a. Have had nightmares about it or thought about it when you did not want to?

☐ Yes ☐ No

4b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

☐ Yes ☐ No

4c. Were constantly on guard, watchful, or easily startled?

☐ Yes ☐ No

4d. Felt numb and detached from others, activities, or your surroundings?

☐ Yes ☐ No

In the past 30 days, how often have you been physically hurt by someone (for example, being hit, kicked, or slapped)? You don't need to tell me any details. All I need to know is if it happened.

☐ Never ☐ A few times ☐ More than a few times

Overall Health and Treatment

1. How would you rate your overall health right now?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Do you have any chronic medical problems which continue to interfere with your life? ☐ Yes ☐ No

2a. If yes, please specify: _____

3. In the past 30 days, how many days did you experience any medical problems (include serious medical problems as well as colds, flu, etc.)? _____

4. During the past 30 days, how much did medical problems keep you from doing your usual activities (e.g., self-care, work, or recreation)?

☐ Not at All ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

The next few questions are also about your health care, but they're a bit more personal. I'd like to remind you that you can choose to skip any question that makes you feel uncomfortable.

5. Have you ever been tested for HIV? (If no, skip question 3).

☐ Yes ☐ No

I'm not going to ask you about what the results of the test were. I only need to know if you were informed about the test results afterwards.

6. Do you know the results of your HIV testing?

☐ Yes ☐ No

7. During the past 30 days did you receive Inpatient treatment for:

	If yes, altogether for how many nights?			**# of Nights**
Pregnancy or childbirth	☐ Yes	☐ No	☐ Don't Know	_____
Physical complaint	☐ Yes	☐ No	☐ Don't Know	_____
Mental or emotional difficulties	☐ Yes	☐ No	☐ Don't Know	_____
Inpatient AODA	☐ Yes	☐ No	☐ Don't Know	_____
Residential AODA	☐ Yes	☐ No	☐ Don't Know	_____

8. During the past 30 days did you receive Outpatient treatment for:

	If yes, altogether for how many times?			**# of Times**
Pregnancy or childbirth	☐ Yes	☐ No	☐ Don't Know	_____
Physical complaint	☐ Yes	☐ No	☐ Don't Know	_____
Mental or emotional difficulties	☐ Yes	☐ No	☐ Don't Know	_____
Alcohol or substance abuse	☐ Yes	☐ No	☐ Don't Know	_____

9. During the past 30 days did you receive Emergency Room treatment for:

	If yes, altogether for how many times?			**# of Times**
Pregnancy or childbirth	☐ Yes	☐ No	☐ Don't Know	_____
Physical complaint	☐ Yes	☐ No	☐ Don't Know	_____
Mental or emotional difficulties	☐ Yes	☐ No	☐ Don't Know	_____
Alcohol or substance abuse	☐ Yes	☐ No	☐ Don't Know	_____

10. Do you have one person you think of as your personal doctor or health care provider?

☐ Yes ☐ No

7a. [If no:] Is there more than one person you think of, or is there no one you think of as your personal doctor or health care provider?

☐ More than one ☐ No one ☐ Don't Know/Unsure ☐ Refused

Child Information Sheet

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

***** *Any placement due to child welfare or a family/children's court order, including transfer of guardianship*

Child Information Sheet

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): ___________________________	☐ Overnights, nights/wk: ________

***** *Any placement due to child welfare or a family/children's court order, including transfer of guardianship*

Child Information Sheet

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): __________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): __________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): __________________________	☐ Overnights, nights/wk: ________

Child # _ **Name** ________________________ **Gender** _ **Age** ___________

WHERE IS THIS CHILD LIVING NOW? ☐ Don't know

If not formal placement:	If formal placement*:
☐ Living with you	☐ Living with family/friends
☐ Living with father	☐ Living with someone other than family/friends
☐ Joint custody with father	
☐ Living independently	If formal placement, level of contact:
☐ Living with family/friends	☐ No visits
☐ Adopted/TPR	☐ Supervised visits, hrs/wk: ________
☐ Deceased	☐ Unsupervised visits, hrs/wk: ________
☐ Other (specify): __________________________	☐ Overnights, nights/wk: ________

***** *Any placement due to child welfare or a family/children's court order, including transfer of guardianship*

Child Information Summary Sheet

For all living children:

Number of children _____

Number of children over 18 years of age _____

Number of children under 18 years of age _____

For minor children (under 18):

Number living with client _____

Number living with father _____

Number living informally with family, friends, etc. _____

Number for whom parental rights have been terminated _____

Number living with someone else due to a child protective court order _____

Number living in another arrangement _____

For deceased children:

Number of children who are deceased _____

Attachment 3: Sample Consent Forms

The following sample consent forms are included in this attachment:

- Informed Consent for Treatment (pp. 109 - 110)
- Release of Information (pg. 111)
- Consent for Program Evaluation (pp. 112 - 117)

Meta House, Inc.

INFORMED CONSENT

You have taken a very important step in your life by considering treatment at Meta House!

Allow us now to provide you with some information about our professional services and our policies. We believe it is important for you to understand more about being in treatment. Please read the following carefully. If you have any questions, please feel free to discuss them with our staff.

BENEFITS OF TREATMENT AND SERVICES

Treatment has had many benefits for the women in the Meta House programs. Generally, it helps with the feelings of distress, problems in relationships, parenting difficulties and understanding chemical addiction and how it has affected your life. During treatment you will learn the necessary tools to live a drug free life. The staff will help you understand how to use those tools.

ADMINISTRATION OF TREATMENT AND SERVICES

Once you are admitted, our staff will do an initial evaluation. During this evaluation you and your counselor will talk about different areas in your life and how we can best serve you. At the end of the evaluation, your counselor will be able to share with you some initial impressions of what your treatment will include. This will lead to the development of an initial treatment plan. The initial treatment plan will be reviewed on a regular basis, and if necessary updated to meet your needs. The services available at Meta House include individual counseling, group therapy, drug and alcohol education, family programs, parenting sessions, job placement and/or help with W-2.

SIDE EFFECTS OR RISKS OF TREATMENT

During treatment it is not unusual to feel sad, guilty, angry, frustrated, helpless and sometimes lonely. Issues of sexual abuse and other forms of violence are discussed. This may bring up painful memories. Also, if you are on medication, you may experience side effects. At those times, share your concerns with our staff!

ALTERNATIVES TO TREATMENT

Under section 51.61 of Wisconsin Statutes, you have the right to refuse medications and any treatment. If you believe that Meta House is not right for you, please let us make a referral.

CONSEQUENCES OF NOT RECEIVING TREATMENT

If you chose to not receive treatment, you need to be aware of some of the consequences. Chemical dependency may be seen as a progressive disease: without treatment the situation and your symptoms may get worse. Some people do get better without treatment, however there is no way to know if you are one of those people.

TIME PERIOD OF INFORMED CONSENT

This consent is effective from today until 15 months from today. If you change your mind and decide to withdraw the informed consent, you may do so at any time in writing.

****

AGREEMENT:

I understand that this agreement is effective for 15 months from the time at which I have signed it. I also understand that I have the right to withdraw the informed consent at any time, however it needs to be done in writing.

_____ _____

(Client) *(Witness)*

_____ _____

(Date) *(Date)*

META HOUSE
CONSENT FOR RELEASE OF INFORMATION

I, _____ authorize
(Client Name)

Meta House _____ and _____
(recipient of information)

to use and/or disclose to one another the following information:

(initial each category that applies)
___ my name and other identifying information;
___ that I am a participant in (alcohol and/or drug) treatment;
___ initial screening;
___ date of admission;
___ assessment results and treatment history;
___ summary of treatment plan, progress and compliance;
___ attendance;
___ urinalysis results;
___ date of discharge and discharge status;
___ discharge plan;
___ other: _____

The information identified above will be used and/or disclosed for the following purposes:_____

_____

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I have the right to inspect and receive a copy of the material disclosed under Wis. Adm. Code section HFS 92.05 and 92.06 (pursuant to HFS 92.03(3)(d)). I also understand that, by notifying my case manager or the program director verbally or in writing, I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

_____

_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Signature of client: _____ Date: _____

Signature of Personal Representative: _____ Date: _____
Nature of authority (e.g., parent, guardian): _____

Revoked: Signature of client: _____ Date: _____

Program Evaluation Consent
Description of the Meta House Family Study

What is the Meta House Family Study?

Meta House wants to offer the best programs it can to the women who come here and to their children. A grant from SAMHSA (the Substance Abuse and Mental Health Services Administration) is providing some of the funding for your participation in Meta House programs. Because they provide this funding, SAMHSA requires Meta House to enroll the women funded by the grant into the Meta House Family Study. This study will help Meta House know what works best for women in treatment. Also, it will help professionals across the country who want to learn how to provide the best programs to women and their families.

What will I be asked to do in the Meta House Family Study?

Today we will do an interview together that will get you started with the Meta House Family Study. This interview includes questions about your experiences with alcohol, drugs, and substance abuse treatment. It also includes some personal questions about your life. Some of these questions may bring up uncomfortable feelings. Your AODA counselor or case manager will be happy to talk with you about any uncomfortable feelings you may have.

You will also be asked to meet with me for what we call follow-up interviews. There are three follow-up interviews, and they have similar questions to the interview today. One interview will be about 6 months from today, another will be around the time that you complete or leave Meta House treatment, and the last interview will be about 12 months from today. Each of these follow-up interviews will take about 1½ hours. At the end of each follow-up interview, you will receive $20. You will receive a total of $60 if you participate in all three follow-up interviews. Your participation in the study should last no more than 14 months.

What are my rights?

We are required to complete this first interview today because your program participation is partially funded by SAMHSA. However, you may skip any questions you'd rather not answer. Please let me know if you feel uncomfortable with a particular question or set of questions, and we can skip them. You may ask me questions at any time during the interview.

Your participation in your follow-up interview and the study questions about your children are voluntary. This means that you don't have to schedule a follow-up interview. You can make a decision about that when the time is closer.

Will my decision about participating affect my treatment?

Your decision about whether to participate in the follow-up interviews is completely separate from your treatment. If you do not wish to participate, your decision will not affect the services you receive from Meta House or any other treatment program. You can withdraw from the follow up interviews at any time.

What happens if I leave treatment?

If you decide to leave Meta House for any reason, you will still be asked to participate in the three follow-up interviews with me (one 6 months from now, one around the time you complete treatment, and one 12 months from now). We will schedule these interviews at my office. At the end of our time today, I will ask you how you would like to be contacted to schedule the follow-up interviews. Also, I'll give you my contact information.

What will happen to the information I give?

All answers that you give in our interviews here will be kept strictly confidential. No individual responses from your interviews or meetings with me will be shared with any staff

member at Meta House. Only the study interviewers will see what anyone has answered to a question. For most purposes, your identity is protected by your answers being combined with answers from other people so that you cannot be identified. SAMHSA does receive answers from individual interviews, but they receive no information that would actually identify who you are. We also have an outside agency called the Planning Council that helps us with the study. They may also see information from the interviews. Again, the interview information will not include your name or any other information that would identify who you are.

There is some information we cannot keep confidential. If you threaten to harm yourself or others, we cannot keep this information confidential. We are also required to report actual or suspected child abuse or neglect. If you tell us this kind of information, we need to stop the interview and talk with you about what to do next.

What if I have questions or problems about the Meta House Family Study?

Before we go on, please ask any questions you may have about your participation in the Meta House Family Study. If you have any further questions or concerns please contact:

Andrea Jehly
Clients Rights Specialist
Phone: (414) 977-5818
Meta House
2625 N. Weil St.
Milwaukee, WI 53212

Consent for Program Evaluation

I, _____, have been informed of the purpose of the Meta House Family Study.

I consent to be interviewed about my experiences with alcohol, drugs, substance abuse treatment, and some personal questions about my life. I understand that some of these questions may bring up uncomfortable feelings and I can choose to talk with an AODA counselor or case manager to deal with any feelings I may have.

I understand that no individual responses I give in this interview will be shared with any Meta House staff members other than the study interviewers. The information that I provide during this interview will be combined with answers from other people so that I cannot be identified. The one exception to this confidentiality is that individual answers I give will be reported to SAMHSA and the Planning Council. When the information is used in this way, there will be no identifying information such as my name. I have also been informed of whom I might contact if I feel my right to confidentiality has been violated.

I will not be penalized for not providing any part or all of the information requested, in this first interview or any follow-up interviews. I understand that my participation in the Meta House Family Study is voluntary. My treatment at any program and my receipt of any service will not be affected by my choice of whether or not to participate in the Meta House Family Study follow-up interview. Also, I am free to withdraw from the follow-up interview at any time.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Consent for Contact with Meta House

I, _____, authorize Meta House to contact me to conduct program evaluation activities while I am in the program and after I have left. I may be contacted by telephone, in person or by mail. The purpose of these contacts is to collect information that is helpful to the program and to collect information required by a funder of the program (SAMHSA). This information will be only be used for program evaluation purposes. However, my confidentiality is protected as defined under federal regulations (42 CFR Part 2 - the CEO has a copy of the regulations).

I understand that I can change my mind about allowing Meta House to contact me at any time by contacting Meta House's Clients Rights Specialist. However, I understand that I can't change my mind about study information I've already given to Meta House.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Attachment 4: Letter to the SSA

- **Letter to the Wisconsin SSA**

  The letter to the SSA can be found on page 119.

- **PHSIS**

  The PHSIS description of the project that was sent to the SSA along with the letter and a copy of the face page (SF 424) can be found on page 120.

April 8, 2013

Joyce Allen
Director
Bureau of Prevention Treatment and Recovery
Wisconsin Division of Mental Health and Substance Abuse Services
1 West Wilson St.
Madison, WI 53707-7851

Dear Ms. Allen:

Meta House has submitted a grant application for funding from the **Substance Abuse and Mental Health Services Administration** in response to a funding opportunity entitled "Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need" (TCE-TAC, TI-13-008). The grant will enable Meta House to enhance its services to women with substance use disorders and co-occurring conditions, including mental health disorders and chronic health conditions. Attached is a Public Health Impact Statement (PHSIS) which consists of a copy of the face page form SF 424 and a summary of the project including a description of the population to be served, a summary of the services, and a description of the coordination planned with your Division.

A copy of the grant application is also enclosed for your review. As part of the application process, you are invited to comment on the proposal. Comments must be sent to SAMHSA no later than 60 days after the grant deadline, which is April 10, 2013. Therefore, **any comments must be received by SAMHSA no later than June 9, 2013.** Comments should be sent to:

For United States Postal Service:
Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**
Attn: SSA: - Funding Announcement No. TI-13-008

For other delivery service:
Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20850**
Attn: SSA: - Funding Announcement No. TI-13-008

I believe that this grant will help Meta House meet a significant need in Milwaukee. If we are awarded this grant, I will inform you within 30 days of the notice. Thank you for your support.

Very truly yours,

Amy Lindner
CEO/President

PUBLIC HEALTH SYSTEM IMPACT STATEMENT
Meta House, Inc. Grant Proposal for the
Substance Abuse and Mental Health Services Administration Funding Opportunity:
Grants to Expand Care Coordination through the Use of Technology-Assisted Care
in Targeted Areas of Need (TCE-TAC, TI-13-008)

1) Description of the population to be served: The Meta House Healthy Connections program will provide treatment for women in Milwaukee with substance use disorders and co-occurring conditions, including mental health disorders and chronic health conditions. The program will serve **83** women over the three-year grant period. The women served will be low-income and typically have multiple special needs in addition to their substance use disorders and co-occurring conditions, such as trauma history, low literacy, and employability concerns. Almost all will be mothers, and a significant number will be actively parenting their children. Most will be involved in multiple systems, including child welfare, TANF, and criminal justice.

2) Summary of the services to be provided: The Healthy Connections program will enhance Meta House's treatment program through the implementation of technology, including fully implementing an ONC-ATCB certified electronic health records (EHR) system and integrating text-messaging and smartphone applications to support the recovery of women in treatment. The goals of the program are focused on the implementation of the proposed technology, improving treatment retention and engagement, and improving the long-term recovery and health care of women with substance use disorders and co-occurring conditions. Women will receive technology-enhanced integrated treatment for co-occurring disorders, including a comprehensive array of over 100 possible services. All clients will be offered the following core services:

Group Services	Individual Services
Seeking Safety	Biopsychsocial assessment
Relapse Prevention	Trauma assessment
Helping Women Recover	Individual counseling
A Woman's Way through the 12 Steps	Psychiatrist services
Stages of change process groups	Crisis intervention
Educational workshops	Wraparound/Single Coordinated Care Plan meetings
Anger/stress management	Case management, including assistance with financial, legal, medical, and housing needs
Women's health education	Consumer peer services
Living skills	Child and family services, including child care
Case management group	Transportation
Art therapy	
Nurturing and parenting	
Vocational/educational groups	
Open houses/education for family members	

3) Coordination with the Bureau of Mental Health and Substance Abuse Services: Meta House and DMHSAS have a long history of collaboration in providing care for women and children. Meta House will serve these families using the theories, principles and core values that the State has recommended for all its gender-responsive programs for women. In addition, Meta House will continue to partner with the Milwaukee County WIser Choice program in providing services to women in the Healthy Connections program.

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

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: Meta House, Inc.

DUNS Number: 8010173930000

* Street1: 2625 N Weil St

Street2:

* City: Milwaukee County:

* State: WI: Wisconsin

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 53212-3060 * Project/ Performance Site Congressional District: WI-004

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:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

DISCLOSURE OF LOBBYING ACTIVITIES

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

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name* Meta House, Inc.

** Street 1* 2625 N Weil St *Street 2*

** City* Milwaukee *State* WI: Wisconsin *Zip* 53212

Congressional District, if known:

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

6. * Federal Department/Agency:
Department of Health and Human Services

7. * Federal Program Name/Description:
Substance Abuse and Mental Health Services_Projects of Regional and National Significance

CFDA Number, *if applicable:* 93.243

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*
$

10. a. Name and Address of Lobbying Registrant:

Prefix ** First Name* None *Middle Name*

** Last Name* None *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

b. Individual Performing Services (including address if different from No. 10a)

Prefix ** First Name* None *Middle Name*

** Last Name* None *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when 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:** Andrea Jehly

***Name:** *Prefix* ** First Name* Amy *Middle Name*

** Last Name* Lindner *Suffix*

Title: CEO/President **Telephone No.:** 414-962-1200 **Date:** 04/08/2013

Federal Use Only:

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

OMB Approval No. 0990-0317
Expiration Date: 8/31/2010

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)	06/10/1993	
☒ Assurance Concerning the Handicapped (45 CFR 84)	06/10/1993	
☒ Assurance Concerning Sex Discrimination (45 CFR 86)	06/10/1993	
☒ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)	06/10/1993	
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: | First Name: Amy | Middle Name:
Last Name: Lindner | Suffix:
Title: CEO/President
Organization: Meta House, Inc.
Street1: 2625 N Weil St
Street2:
City: Milwaukee
State: WI: Wisconsin | ZIP / Postal Code: 53212 | ZIP / Postal Code4:
E-mail Address: alindner@metahouse.org
Telephone Number: 414-962-1200 | Fax Number:

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

Prefix: | First Name: Christine | Middle Name:
Last Name: Ullstrup | Suffix:
Title: Director of Programs
Organization: Meta House, Inc.
Street1: 2625 N Weil St
Street2:
City: Milwaukee
State: WI: Wisconsin | ZIP / Postal Code: 53212 | ZIP / Postal Code4:
E-mail Address: cullstrup@metahouse.org
Telephone Number: 414-962-1200 | Fax Number:

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)* SAMHSA

on *(Date)* 06/14/2002

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)