

TI11-02

Application #: 1 H79 TI023830-01

Bus Off: Risner, Jerry

Council: 08/2011

Receipt Date: 06/16/2011

Application for Federal Assistance SF-424

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * Other (Specify): <input type="text"/>
* 3. Date Received: <input type="text" value="06/16/2011"/>		4. Applicant Identifier: <input type="text"/>
5a. Federal Entity Identifier: <input type="text"/>		5b. Federal Award Identifier: <input type="text"/>
State Use Only:		
6. Date Received by State: <input type="text"/>		7. State Application Identifier: <input type="text"/>
8. APPLICANT INFORMATION:		
* a. Legal Name: <input type="text" value="Buffalo Valley, Inc."/>		
* b. Employer/Taxpayer Identification Number (EIN/TIN): <input type="text" value="58-1374964"/>		* c. Organizational DUNS: <input type="text" value="8307462360000"/>
d. Address:		
* Street1: <input type="text" value="501 Park Ave. S. P.O. Box 879"/>	Street2: <input type="text"/>	
* City: <input type="text" value="Hohenwald"/>	County/Parish: <input type="text" value="Lewis"/>	
* State: <input type="text" value="TN: Tennessee"/>	Province: <input type="text"/>	
* Country: <input type="text" value="USA: UNITED STATES"/>		
* Zip / Postal Code: <input type="text" value="38462-0879"/>		
e. Organizational Unit:		
Department Name: <input type="text"/>	Division Name: <input type="text"/>	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: <input type="text" value="Ms."/>	* First Name: <input type="text" value="Deborah"/>	
Middle Name: <input type="text" value="Ann"/>		
* Last Name: <input type="text" value="Hillin"/>		
Suffix: <input type="text"/>		
Title: <input type="text" value="Vice President - Principle Investigator"/>		
Organizational Affiliation: <input type="text"/>		
* Telephone Number: <input type="text" value="615-975-0196"/>	Fax Number: <input type="text" value="931-796-5124"/>	
* Email: <input type="text" value="debbiehillin@buffalovalley.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-11-002

* Title:

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

13. Competition Identification Number:

Title:

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

* 15. Descriptive Title of Applicant's Project:

BVI's Connect Program

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

b. Program/Project

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

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="280,000.00"/>
* b. Applicant	<input type="text" value="91,392.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="371,392.00"/>

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

a. This application was made available to the State under the Executive Order 12372 Process for review on

b. Program is subject to E.O. 12372 but has not been selected by the State for review.

c. Program is not covered by E.O. 12372.

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

Yes No

If "Yes", provide explanation and attach

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

** I AGREE

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

Authorized Representative:

Prefix:

* First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number:

Fax Number:

* Email:

* Signature of Authorized Representative:

* Date Signed:

ABSTRACT

Expanding Technology Assisted Services for Substance Use and Co-Occurring Disorders in Rural Tennessee: The Buffalo Valley Connect Project

Buffalo Valley Inc. will use new electronic technology services to help almost 900 residents of its primarily rural 19-county geographic area to address their substance abuse and co-occurring substance use and mental health disorders, beginning October 1, 2011. Initiated as part of ongoing local, state and federal efforts to use emerging health information technology to provide more effective health care, staff of the new *BVI Connect* program will use web-based outreach, smart phones and other emerging electronic applications to treat and support 230 residents in its first year, 290 in its second year, and an additional 360 in its third year. Funded over three years by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the *BVI Connect* will be able to reach many rural residents who would not otherwise be able to come into one of Buffalo Valley's Middle Tennessee service sites, located in Hohenwald, Clarksville and Lewisburg. Lack of public transportation, scheduling problems, geographic distance, lack of treatment resources and the stigma related to alcohol and drug use and treatment present overwhelming barriers to many individuals who are struggling with serious alcohol and drug problems. Prior to Buffalo Valley's new program, these residents have had few treatment and support options, sometimes placed on a waiting list for future care. *BVI Connect* makes it possible for individuals with alcohol and drug problems to immediately communicate over the Internet with staff about substance abuse, discussing and exploring their concerns on line, by telephone and through other electronic avenues, working closely with staff trained to deliver effective care through the web. This format is proving increasingly practical and effective for substance use and mental health care across the country, especially with agencies like Buffalo Valley, who receive over 5,000 new calls for treatment assistance and support services each year. Anyone who chooses to can complete a self-assessment of their drug and/or alcohol use to determine how serious a problem they have. Outpatient treatment services will be delivered on-line to both individuals and groups in a structured format over a set period of time, using the same techniques that work in face to face sessions. For those who have successfully completed their treatment, *BVI Connect* staff will provide the ongoing on-line and telephone support that most individuals need to maintain their sobriety over time. *BVI Connect* services will be offered in conjunction with AA meetings, NA meetings and other peer support groups. As part of supporting area residents to track and manage their own health, providing support and information when and where they are needed, *BVI Connect* will develop a number of useful educational tools related to alcohol, drug use and mental health disorders for the general public, including a educational presentations on recognizing alcohol and drug addictions 12-step programs; managing stress and anger; developing a personal plan for recovery from addictions; Substance abuse 101 for Families, and others.

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Mandatory Documents for submission included in application:

SF 424

Project/performance Site Location

Project Narrative Attachment Form

HHS Checklist

SF-LLL

Budget Narrative Attachment Form

Budget Information for Non-Construction Program

Optional Documents

Based EEO Survey

Other Attachments Form

BUDGET INFORMATION - Non-Construction ProgramsOMB Approval No. 4040-0006
Expiration Date 07/30/2010**SECTION A - BUDGET SUMMARY**

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need	93.243	\$ [redacted] 0.00	\$ [redacted]	\$ [redacted] 280,000.00	\$ [redacted] 91,932.00	\$ [redacted] 371,932.00
2.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
4.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
5. Totals		\$ [redacted]	\$ [redacted]	\$ [redacted] 280,000.00	\$ [redacted] 91,932.00	\$ [redacted] 371,932.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	(1)	GRANT PROGRAM, FUNCTION OR ACTIVITY			Total (5)
		(2)	(3)	(4)	
	Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need			\$ 98,372.00	\$ 98,372.00
a. Personnel	\$ 98,372.00	\$	\$	\$	\$ 98,372.00
b. Fringe Benefits	27,544.00				27,544.00
c. Travel	8,500.00				8,500.00
d. Equipment					
e. Supplies	11,400.00				11,400.00
f. Contractual	38,884.00				38,884.00
g. Construction					
h. Other	8,500.00				8,500.00
i. Total Direct Charges (sum of 6a-6h)	193,200.00				193,200.00
j. Indirect Charges	86,800.00				86,800.00
k. TOTALS (sum of 6i and 6j)	\$ 280,000.00	\$	\$	\$	\$ 280,000.00
7. Program Income	\$	\$	\$	\$	\$

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SECTION C - NON-FEDERAL RESOURCES					
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS	
8. Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need	\$ 91,392.00	\$ 0.00	\$ 0.00	\$ 91,392.00	
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)	\$ 91,392.00	\$ 0.00	\$ 0.00	\$ 91,392.00	
SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 280,000.00	\$ 70,000.00	\$ 70,000.00	\$ 70,000.00	\$ 70,000.00
14. Non-Federal	\$ 91,392.00	\$ 22,848.00	\$ 22,848.00	\$ 22,848.00	\$ 22,848.00
15. TOTAL (sum of lines 13 and 14)	\$ 371,392.00	\$ 92,848.00	\$ 92,848.00	\$ 92,848.00	\$ 92,848.00
SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT					
(a) Grant Program	(b) First	(c) Second	(d) Third	(e) Fourth	
16. Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need	\$ 280,000.00	\$ 280,000.00	\$ 280,000.00	\$ 280,000.00	
17.					
18.					
19.					
20. TOTAL (sum of lines 16 - 19)	\$ 280,000.00	\$ 280,000.00	\$ 280,000.00	\$ 280,000.00	
SECTION F - OTHER BUDGET INFORMATION					
21. Direct Charges:	22. Indirect Charges:				
23. Remarks:					

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PROJECT NARRATIVE

Section A. Statement of Need

A.1. Population to be Served. Tennessee is located in the Southeastern portion of the United States and is the 16th most populous state in the nation with an estimated 6.1 million (2008 projection) residents. The population is predominantly White and African American, with persons of other races comprising a small portion of the total. Buffalo Valley, Inc. is the largest single provider of addictions services in the State, whose primarily rural 19-county geographic service area extends throughout Middle Tennessee. We know these counties to be among the most disadvantaged in Tennessee, including: Bedford, Cheatham, Coffee, Dickson, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Montgomery, Moore, Perry, Robertson, Sumner, Trousdale, Wayne, and Williamson. *BVI Connect* will serve all residents of our service area, where lack of public transportation, scheduling problems, geographic distance and the stigma associated with alcohol and drug use and treatment present overwhelming barriers to many individuals and their families seeking better behavioral health. *BVI Connect's* population of focus represent a cross-section of all State and county residents. Special care will be taken to reach out to elderly residents, rural areas, mobile military personnel and families, caretakers and people with limited time to seek services during traditional hours, individuals whose working hours do not correspond with traditional times for treatment. Table 1 provides socio-economic, demographic data and baseline data for *BVI Connect's* focus population. **Population.** Tennessee's population is increasing at a brisk rate: between 2000 and 2009, the State's population increased by 10.7%, almost 18% higher than the national average (<http://quickfacts.census.gov/qfd/states/47000.html>). The population of our target area comprises just over 15% of the State's total population. **Race/Ethnicity.** 88.2% of the State's population are white a figure that is comparable to the national average. However, just 16.8% are African American, a rate that is 30% lower than the national average. Latino and Hispanic individuals comprise 4.2% of the State's population, a figure that is 27% lower than the national average. Individuals of other ethnic origin are at 1.8%. **Gender.** Tennessee's gender distribution and that of the target counties are roughly equal and comparable to national statistics at approximately 51% female and 49% male. **Income/Poverty Level.** Tennessee citizens make less money and are poorer than the nation as a whole: at \$19,393 annually, per capita income falls 10% below the national average, while the State's rate of 15.5% of persons living below poverty is more than 17% over the national average. Within the target geographic area, the Wayne County poverty rate is the highest at 20.7%, followed by Hickman at 19.4%, Lewis at 18.6% and Perry at 18.1%. At 4.9%, Williamson County had the lowest rate. **Unemployment Rate.** At 9.6%, Tennessee's rate of unemployment is significantly higher than the national average of 8.7%, as of April 2011 (US Bureau of Labor Statistics, 2011). **Drop-Out Rate.** Educational attainment is key to maintaining a satisfactory lifestyle. Unfortunately, at 30% Tennessee's high school drop-out and the drop-out rate of our target area are significantly higher than the national average of 25% (Alliance for Excellence in Education, 2009).

Table 1. Demographic and Socioeconomic Data for BVI Connect Focus Population

	Population	Race/Eth	Gender	Income/ Poverty/%	Unemp Rate	Drop Out rate	Health Status	Home- lessness
19 Cty Target Area	967,877 (15%)	W 85% ¹ B 13% H 1% O 1%	M 49% F 51%	17,300/ 17%	17%	35%		7,798
State	6,296,254 (100%)	W ² 80% B 16.8 H 4.2 O 1.8	M 49% F 51%	\$19,393/ 15.5%	9.6%	30%		55,706

Health Status. BVI's experience is well supported by research that individuals with substance use & mental health disorders have comparatively poor health. The health status of Tennesseans & residents of our target area is comparatively poor & trending downward, a fact which presents serious issues for our target population, individuals who are chronically homeless with substance use or co-occurring substance use & mental disorders (CDC, 2011). The State's current smoking prevalence of 22 % is almost twice that of the *Healthy People 2010 Objective* of 12 %, 31% prevalence rate of no physical activity, & overweight & obesity prevalence rate of 69%. These individuals have complex medical problems, such as hypertension, kidney disease, diabetes, alcohol & drug addictions, & mental illness & often cycle between homelessness & institutional care & use more than 50% of the services. Applying cluster analysis to test of a typology of homelessness: Results from the analysis of administrative data. 45% have co-occurring disorders; 51% have substance use disorders with the primary drugs of choice being Cocaine/Crack (35%), prescription drugs (15%), alcohol (10%), marijuana (10%) & poly drug use (30%). **Behavioral Health.** From >10% to >40% of homeless men & women have been violently victimized at some time in their lives (North, Smith, Spitzagel, 1994). Battery is a risk factor for depression, alcoholism & drug abuse (Brown, et.al.,1999). Historically, prevalence has been associated with trauma such as natural disasters, rape/assault, terrorism, & violence (Guess, 2006). On the five-year anniversary of the deployment of troops to Iraq, it was estimated that 18% returned with PTSD (Neason, 2006). In the War on Terrorism in Iraq, an increased number of guard members & reservists were deployed, returned home, & had to return to combat a second time. With regard to mental health treatment, returning veterans have presented with depression, hostility, poor coping skills, anxiety disorders, eating disorders, & substance abuse disorders (Treatments of PTSD, 2008).

A.2. Geographic Area to be Served. Buffalo Valley's geographic service area is largely without public transportation, making access to services an almost insurmountable barrier for many residents. Even when buses are available, individuals with limited or no income cannot afford to purchase the tokens required to use them, effectively making transportation inaccessible. This lack of transportation lies at the heart of the myriad challenges which this population and community service agencies face in meeting their needs for health, behavioral health and housing services and supports. It also justifies the great need for BVI to employ health information technologies through *BVI Connect* that can help us overcome issues related to distance, geography, resources constraints, and stigma.

¹ White, Black, Hispanic, Other

² Census permits Hispanic individuals to report in more than one ethnic category.

A.3. Nature of the Problem and Extent of the Need. Substance use disorders are a major societal problem. Collectively, they not only bring personal challenges to individuals and families, but also are responsible for enormous economic costs to American society. Health-related costs include acute hospital stays specifically for alcohol and other drugs (AOD) related diagnoses, exacerbating the length of stay for non-AOD related diagnoses, outpatient treatment, co-morbidity with psychiatric disorders, and fetal alcohol syndrome. Substance use disorders dramatically impact societal costs such as employee productivity, accident rates and mortality. Crime-related costs are more heavily weighted toward drug abuse, and include expenditures for law enforcement, legal and adjudication costs, probation services, correction and detention costs, and property destruction costs. Society bears many of the costs of victims of crime and from the need to incarcerate criminals.

Alcohol and Drug Service Needs. Understanding the nature and extent of the substance abuse problem in Tennessee includes examining the number of people at risk of or now suffering from substance use, abuse and addiction or co-occurring mental health disorders. A recent draft needs assessment (EMT, 2011) reflects a number of critical findings:

- Two-fifths (40.2 percent) or two-plus million Tennesseans 12 years and older consumed alcohol in the past month.
- 20 percent or 967,000 Tennesseans 12 years and older engaged in binge drinking in the prior month.
- 18 to 25 year-olds use illicit drugs 2.5 times more than any other group of Tennesseans.
- Approximately nine percent, or 458,000 Tennesseans 12 years and older suffer from alcohol dependence or illicit drug dependence or abuse.
- Over seven percent or 356,000 Tennesseans 12 years or older need, but are not receiving treatment for alcohol use.
- Approximately one-fifth (21 percent) of all public school have experimented with alcohol before they reached age 13.
- About 35 percent of youth who initiated alcohol use before age 13 engaged in binge drinking by the time they reached high school.

Table 2 classifies individuals seeking treatment services throughout the State, including the BVI Middle Tennessee geographic area. It combines two separate indicators – one on treatment setting, specifically inpatient and outpatient, and by type of disorder, including the possibility of a poly-drug issue (both alcohol and drug use disorder).

Table 2. Number of Admissions for Treatment by Type of Disorder, Tennessee 2008

Type of Disorder	Inpatient #	Inpatient %	Outpatient #	Outpatient %	Total #
Alcohol Disorder	1,311	20.5	478	14.0	1,789
Drug Disorder	3,149	49.2	2,054	60.3	5,203
Both Alcohol and Drug Disorder	1,941	30.3	858	25.2	2,799
Total	6,401		3,390		9,791

Source: 2008 Tennessee Treatment Episode Data Sets (TEDS)

Individuals age 18 to 25 years have the highest percentage of past month *binge alcohol use* compared to other age groups at 37.1 percent. Almost one in four (23.0 percent) 12 to 20 year olds or 168,000 consumed alcohol in the past month, and 15.4 percent or 112,000 binge drank in

the past month. Alcohol use, particularly excessive consumption, remains the top priority in substances used by Tennessee residents.

Table 3. Illicit Drug Use, Tennessee (NSDUH)

	Age 12+	Age 12-17	Age 18-25	Age 26+	Age 18+
Past Month Illicit Drug Use	# 444,000 % 8.79	49,000 9.77	133,000 21.41	262,000 6.69	395,000 8.69
Past Year Marijuana Use	# 503,000 % 9.96	62,000 12.51	165,000 26.67	275,000 7.02	441,000 9.68
Past Month Marijuana Use	# 288,000 % 5.71	31,000 6.20	100,000 16.13	158,000 4.02	258,000 5.66
Past Month Use of Illicit Drugs Other Than Marijuana	# 262,000 % 5.19	29,000 5.74	68,000 10.94	166,000 4.22	233,000 5.13
Past Year Cocaine Use	# 139,000 % 2.75	8,000 1.51	51,000 8.24	80,000 2.04	131,000 2.88
Past Year Nonmedical Pain Reliever Use	# 351,000 % 6.94	45,000 9.09	98,000 15.79	207,000 5.29	305,000 6.71
Average Annual Number of Marijuana Initiates	# 45,000 % 1.49	24,000 5.56	18,000 5.78	3,000 0.11	21,000 0.81

Source: National Survey of Drug Use and Health (NSDUH), Nation and State of Tennessee Reports, 2008 results

According to the NSDUH, in Tennessee about one in five (21.4 percent) of 18 to 25 year olds used illicit drugs in the past month; that is almost 2.5 times higher than the prevalence of past month illicit drug use for all people ages 12 and older (8.8 percent). The prevalence of past year marijuana use is largest when compared to all other drug prevalence rates. The prevalence of drug and alcohol use among 18 to 25 year olds is largest when compared to all other drug and alcohol use prevalence. The prevalence of cocaine use among 18 to 25 year olds (8.2 percent) is almost three times higher than the prevalence of cocaine use for all people ages 12 and older (2.8 percent). The prevalence of nonmedical pain reliever use among 12 to 17 year olds (9.1 percent) is second only to marijuana use prevalence (12.5 percent). In general, there is a peak of illicit drug use among individuals between 18 to 25 years olds compared to other years.

Table 4. Past Year Dependence, Abuse and Treatment (NSDUH)

	Age 12+	Age 12-17	Age 18-25	Age 26+	Age 18+
Illicit Drug Dependence	104,000 2.07	13,000 2.53	38,000 6.09	54,000 1.38	92,000 2.02
Illicit Drug Dependence or Abuse	151,000 2.98	22,000 4.53	55,000 8.90	73,000 1.86	128,000 2.82
Alcohol Dependence	160,000 3.18	10,000 1.98	48,000 7.66	103,000 2.63	151,000 3.31
Alcohol Dependence or Abuse	377,000 7.47	27,000 5.44	111,000 17.91	239,000 6.09	350,000 7.69
Alcohol or Illicit Drug Dependence or Abuse	458,000 9.08	41,000 8.21	136,000 21.98	281,000 7.17	418,000 9.18
Needing But Not Receiving Treatment for Illicit Drug Use	129,000 2.55	21,000 4.22	50,000 8.06	58,000 1.47	108,000 2.37
Needing But Not Receiving Treatment for Alcohol Use	356,000 7.06	26,000 5.22	107,000 17.32	223,000 5.69	330,000 7.26

Source: National Survey of Drug Use and Health (NSDUH), Nation and State of Tennessee Reports, 2008 results

The prevalence of past year illicit drug dependence or abuse (8.9 percent) or past year alcohol dependence or abuse (17.9 percent) of 18 to 25 year olds is larger than any other age group. This subpopulation has the highest treatment service needs for both alcohol and illicit drug use than any other age group tracked by NSDUH. During the past year, 8.1 percent of 18 to 25 year olds needed, but did receive treatment for illicit drug use, almost double every other age group. Over 17 percent (17.3) of this population (107,000 individuals) also needed treatment services for their alcohol consumption patterns. In summary, over seven percent (7.1 percent) or 356,000 individuals, of people ages 12 or older needed, but did not receive treatment for alcohol during the past year. This number of nearly one-third of a million individuals dwarfs the actual number of Tennessee residents who sought treatment services during 2008. According to the Treatment Episode Data Set (TEDS) for Tennessee, 9,791 individuals were provided treatment services in 2008 compared to the approximately 485,000 individuals needing alcohol (356,000) or illicit drug (129,000) related treatment services in that time period.³ It has been estimated that approximately 40% of all patients admitted for chemical dependency treatment in the U.S. are relapsers who have been previously treated. Additionally, 47% of patients treated in private treatment programs return to chemical use within the first year following treatment. Most relapses occur within the first 18 months of recovery, and most of these occur within just the first six months of recovery. The dramatic gap between need and resources available to meet the need forces Buffalo Valley to maintain waiting list in virtually all services, although the organization works diligently to decrease waiting times through various means, now including *BVI Connect*. More than 5,000 calls requesting services of all types are recorded annually through BVI's management information system, providing a very clear picture of service gaps in the system of care.

Alcohol and Drug Costs. Substance use disorders impose substantial costs on society in the form of both direct expenditures (e.g., treatment and criminal justice system costs) and indirect costs associated with reduced quality of life (e.g., loss of productivity due to AOD-related illnesses and mortality). An as-yet incomplete study commissioned by the Tennessee Department of Mental Health (EMT, 2011) examines a broad range of consequences of alcohol and drug use and estimates associated costs. Findings include:

- Total cost of alcohol and drug abuse in Tennessee in 2008 was nearly **\$4.8 billion**, \$767 for each man, woman and child.
- Costs related to the negative health consequences of alcohol and drug use (e.g., hospitalization, treatment, morbidity, mortality) totaled \$2.5 billion, slightly more than 50 percent of all economic costs associated with substance use in the State.
- Costs related to crime and its consequences attributable to alcohol and drug use totaled \$1.5 billion, nearly one-third of the total economic costs associated with substance use in the State.
- Nearly three-fourths (72.8 percent) of the total economic cost of alcohol and drug abuse in Tennessee in 2008 was indirect, totaling \$3.5 billion. The single largest source of indirect costs was reduced productivity of substance-impaired workers, including those who died as a result of their substance use behavior.

³ The National Survey of Substance Abuse Treatment Services (N-SSATS) indicates a patient count of nearly 13,000 in their Tennessee prevalence survey conducted March 31, 2008.

- Other losses in productivity included AOD impairments in the general work force (\$795 million) and lost work force participation due to AOD related hospitalization (\$14.3 million). Victimization costs due to the crime categories with an attributable AOD rate accounted for \$628.5 million.
- Alcohol abuse generates greater costs to the state of Tennessee (\$2.4 billion) than drug abuse (\$1.3 billion). The cost of alcohol abuse is largely through health-related impairments, while drug abuse generates more criminal justice costs. Another 23 percent (\$1.1 billion) of the total costs involved both alcohol and drug costs.

The magnitude of the costs identified here clearly indicates the need for Tennessee to treat or prevent abuse of alcohol and drugs before their full negative consequences develop. The great majority of the cost of alcohol and drug use to Tennessee is clearly avoidable if substance abuse were reduced. Successful reduction of abuse will reduce the economic burden of alcohol and drug use to society, permit scarce resources to be used more effectively and ultimately improve the quality of life for the citizens of Tennessee.

A.4. Existing Gaps in Service. BVI is a highly experienced provider of substance abuse services, co-occurring substance use and mental health services and Tennessee's largest single provider of housing services to individuals with these disorders. Our team is acutely aware of the complex challenges this population faces in working toward recovery. In fact, BVI believes that recovery from substance misuse, abuse & co-occurring disorders is virtually impossible without the full range of treatment, recovery services & supports, along with stable & appropriate housing, to meet client needs in all stages of their recovery process. Our long-term experience in these counties and recent statistics indicate that significant gaps exist between behavioral health service needs and the services available to meet them. Tennessee's substance abuse service system has experienced a budget reduction of more than 30% in recent years. Substance Abuse Prevention & Treatment (SAPT) Block Grant funds services for indigent populations, but as in other states, but it meets only a small portion of the need. More than 5,000 calls requesting services of all types are recorded annually through BVI's management information system, giving us a very clear picture of the service gaps in our system. In 2009, BVI served 1,599 individuals in all levels of clinical care, representing a 31 percent admission rate. Fully 72% of these individuals had no access to either SSI/SSDI, Medicaid (TennCare), or other third party insurance benefits or mainstream resources to support treatment & recovery services. We are forced to maintain a waiting list in virtually all services, although we are working to decrease waiting times through various means. Unfortunately, waiting list times extend to weeks and sometimes months, by which time the best opportunity to engage them in care has long passed.

A.5. Consistency with Tennessee State Needs Assessment and Plan. Although the State of Tennessee has commissioned a Statewide Needs Assessment, it is in draft form and not yet published. Selected draft findings are included in this proposal. In addition, a letter from the Tennessee Department of Mental Health, Division of Alcohol and Drug Abuse Services, confirming that expanded and enhanced use of health information technologies to provide substance abuse treatment and recovery services is attached.

Section B: Proposed Evidence-Based Services and Practices

B.1. Project Purpose, Goals and Objectives. Buffalo Valley and its partners have carefully conceptualized the purpose of the *BVI Connect* program, designing its goals, objectives and strategies to meet and exceed SAMHSA's expectations. The overall purpose of the project is to use existing and emerging health information technology to deliver an array of evidence-based services to un-served and underserved residents of rural Middle Tennessee with substance use and co-occurring substance use and mental health disorders. Our team believes that the evolution of health care reform offers an unmatched opportunity to efficiently and effectively implement health information technologies that improve the behavioral and physical health of the residents of our 19-county geographic service area. In addition to the Electronic Health Record (EHR) that BVI will purchase and implement as an adjunct to *BVI Connect* (funding is not being requested through TCE-Health IT for the EHR), we will use various e-applications in all phases of the program, including web-based services, smart phones, messaging systems and other e-tools, to reach beyond existing physical facilities and throughout our 19-county service area to establish and maintain the therapeutic relationships that are needed to guide and monitor outreach, treatment and recovery aftercare services in ways that more traditional service models simply do not permit. We have organized *BVI Connect* services around four key goals and their corresponding objectives and strategies as reflected in Chart 1.

Chart 1. *BVI Connect* Goals, Objectives and Strategies

Goal 1: Expand, strengthen and maintain BVI technology-based access to substance abuse and co-occurring disorder services.
<p><i>Objective 1</i> Assess the existing <i>BVI Connect</i> program and develop plan to enhance its capabilities, efficiency and effectiveness by 12/15/11.</p> <p><i>Strategy 1:1</i> Review <i>BVI Connect</i> utilization statistics, including costs and outcomes to date.</p> <p><i>Strategy 1:2</i> Analyze the effectiveness, timeliness and "reach" of BVI's current web site to determine ways that it can be improved and expanded to host traffic and activities related to <i>BVI Connect</i>.</p> <p><i>Strategy 1:3</i> Implement improvements to strengthen and expand the capacity of BVI web-site.</p>
<p><i>Objective 2</i> Implement an Electronic Health Record that is client-centered, comprehensive and interoperable to support substance abuse and co-occurring outreach, treatment and aftercare services delivered by BVI, its partners and other providers of health care, by 1/1/12.</p> <p><i>Strategy 2:1</i> Identify the specifications necessary for a fully-functional, inter-operable and flexible EHR.</p> <p><i>Strategy 2:2</i> Solicit bids from vendors of EHR's that have been fully certified by the Office of the National Coordinator for Health Information Technology- Authorized Testing and Certification Bodies (ONC-ATCBs).</p> <p><i>Strategy 2:3</i> Select and purchase the EHR system of choice.</p> <p><i>Strategy 2:4</i> Install the new EHR, create a training manual, train all staff on its use and continuously monitor its implementation and functionality.</p>
<p><i>Objective 3</i> Build sustainable funding into <i>BVI Connect</i> by 9/30/14.</p> <p><i>Strategy 3:1</i> Utilize 3 year SAMHSA funding to establish effectiveness & efficiency of electronic-based E-therapy services to aid in establishing protocols to be considered for 3rd party and State payment for services.</p> <p><i>Strategy 3:2</i> Negotiate with TennCare/Medicaid and the three managed care organizations with whom BVI contracts for substance abuse and co-occurring services to develop system of payment for <i>BVI Connect</i> services.</p> <p><i>Strategy 3:3</i> Develop a system of self payment for <i>BVI Connect</i>.</p> <p><i>Strategy 3:4</i> Educate and train colleagues in other Tennessee agencies on the use of health information technology applications to serve residents of their service areas.</p>
Goal 2: Use multiple health information technologies to reach out to develop a therapeutic relationship with individuals who have requested substance abuse services but have been placed on a wait list because of agency resource constraints, individual time constraints and/or geographic remoteness (Phase 1: Outreach).
<p><i>Objective 1</i> Reach out to residents who have special difficulty accessing traditional "face to face" services because of their age, their occupation, their schedules, and/or their remote locations: 100 residents by 9/30/12; 120 residents by 9/30/13; 140 residents by 9/30/14.</p> <p><i>Strategy 1:1</i> Target services to elderly, individuals living in rural areas, mobile military personnel and their families, and individuals with limited time to seek services during traditional hours by developing and placing</p>

<p>special messages to them on the BVI website.</p> <p><i>Strategy 1:2</i> Disseminate information to key community partners about BVI services and the website information available to address the needs of county residents.</p>
<p><i>Objective 2</i> Decrease the average time that individuals seeking treatment are on wait list status by 40% by 3/1/12.</p> <p><i>Strategy 2:1</i> Purchase and install tracking software to identify and assess characteristics and needs of individuals on BVI Services Waiting List.</p>
<p><i>Strategy 2:2</i> Provide on-line self-screening through <i>BVI Connect</i> to help individuals seeking information regarding whether their substance use should/could be considered a problem.</p>
<p><i>Strategy 2:3</i> Provide on-line tutorials on topics of significant interest to persons seeking assistance with substance use and COD issues to help educate and support them prior to program admission.</p>
<p><i>Strategy 2:4</i> Provide on-line and/or telephone contact with a <i>BVI Connect</i> counselor < 24 hours of initial contact.</p>
<p><i>Objective 3</i> Create 3 general video presentations for web viewing by individuals on waiting list or other interested parties seeking educational information about substance use and co-occurring mental health disorders by December 31, 2011 and an additional 3 presentations by 6/30/12.</p> <p><i>Strategy 3:1</i> Solicit from BVI clients and individuals on the waiting list topics of special interest to them as they move forward in their unique recovery process.</p>
<p><i>Strategy 3:2</i> Create brief presentations on highest priority topics, such as General Orientation to BVI; Introduction to Substance Use Disorders; Managing Your Self-Care; Stress and Anger Management; Family Assistance; Basic Recovery; Using 12-step Groups; Facts About Drugs.</p>
<p><i>Objective 4</i> Provide GAIN and ASI evidence-based assessment capability through <i>BVI Connect</i> by 12/1/11.</p> <p><i>Strategy 4:1</i> Certify all <i>BVI Connect</i> counselors as ASI proficient and GAIN local administrators.</p> <p><i>Strategy 4:2</i> Maintain ongoing quality assurance for ASI and GAIN administration.</p>
<p>Goal 3: Provide evidence-based services to individuals seeking substance abuse treatment and services who have been placed on the BVI waiting list (Phase 2: Outpatient Treatment).</p>
<p><i>Objective 1</i> Identify appropriate candidates from the Outreach component of <i>BVI Connect</i> for admission into the Outpatient Treatment component.</p> <p><i>Objective 2</i> Use Motivational Interviewing and Illness Management and Recovery to deliver technology assisted evidence-based outpatient treatment to individuals needing services who were on the wait list and then engaged in Outreach (Phase 1) of <i>BVI Connect</i>: Yr. 1: 40 individuals; Yr 2: 60 individuals; Yr 3: 70 individuals.</p> <p><i>Strategy 1:1</i> Use MI and IMR to provide electronically based outpatient services to 170 clients by the end of the project funding period.</p> <p><i>Strategy 1:2</i> Continue to build <i>BVI Connect</i> and agency-wide capacity in new evidence-based treatment protocols as they become available.</p> <p><i>Strategy 1:3</i> Make 50 smart phones available annually to Active Treatment (Phase 2) and Recovery Aftercare clients (Phase 3) for Relapse Prevention.</p>
<p>Goal 4: Maintain healthy, functional and informative relationships with individuals who participated in all phases of <i>BVI Connect</i> to support the individual's recovery process. (Phase 3: Recovery Aftercare).</p>
<p><i>Objective 1</i> Provide ongoing substance abuse relapse prevention services to help sustain recovery to 350 individuals throughout the project (Yr 1: 90; Yr 2: 110; Yr 3: 150).</p> <p><i>Strategy 1:1</i>: Develop and disseminate prevention information on-line, including the capacity to e-mail a BVI prevention counselor with questions.</p> <p><i>Strategy 1:2</i> Maintain lists of peer led recovery support services in BVI communities, including 12-Step programs, faith-based programs and programs offered through other community human service agencies.</p> <p><i>Objective 2</i> Develop and disseminate a series of five rotating on-line messages and web-based materials clients in Recovery Aftercare that support client involvement in healthy relationships and activities and potential obstacles to recovery, beginning <24 hours of transition from Active Treatment into Recovery Aftercare by 3/15/12.</p> <p><i>Strategy 2:1</i> Contact individuals in Recovery Aftercare at least twice per month annually through automatic phone messages, on-line messages, smart phone messages, personal telephone calls or other e-modalities.</p> <p><i>Strategy 2:2</i> Provide psycho-educational, interactive Webinars at least twice a month.</p>

Ensure Availability and Adequacy of *BVI Connect* Platform (Goal 1) is technologically oriented, where the electronic underpinnings of *BVI Connect* will be established, enhanced and expanded to ensure that the program's "mechanics" all work properly and that Internet connections are sufficiently available; individuals can use the website to access educational and support materials; statistics are collected and reported appropriately; Smartphone and other e-

technologies are properly understood and applied, and so on. This is also the point at which BVI will purchase and implement a fully-compliant Electronic Health Record, with all of its associated advantages and capacities to enhance and expand the agency's behavioral health care excellence. Achieving this foundation goal provides the solid health information electronic platform on which Goals 2, 3 and 4 and their associated objectives and strategies will be accomplished. Individuals will enroll in the **Outreach (Goal 2)**, phase of *BVI Connect* either because they have already contacted the agency and been placed on a wait list for services due to space and resources constraints, or through new contacts they make through the *BVI Connect* section of the agency's website or through phone requests for service. We will begin *BVI Connect* by reaching out to individuals on the wait list and inviting them into the e-service program. In **Active Treatment (Goal 3)**, clients will participate in outpatient services that are appropriate to their individual circumstances and needs. Individual and group sessions, educational seminars, client to client "chats" and other electronic services and formats will be offered in support of creating and implementing a client-developed *BVI Connect* Treatment Plan. Finally, **Recovery Aftercare (Goal 4)** helps individuals maintain sobriety over time by staying connected with the agency and its staff once outpatient treatment has been completed, with continuing Internet contacts, Smartphones, and telephone calls to check in on continued progress and recovery. Former clients who have dropped out of treatment can also "tap into" BVI Connect aftercare resources. Individuals can move from Outreach to Aftercare without passing through Outpatient Treatment, although we expect that the majority of clients will move through all three phases, at some point. There are no time limits on any phase of *BVI Connect*. Unlike a "bricks and mortar" approach to behavioral health care, the electronic format allows much more latitude for the growth and maintenance of a therapeutic relationship between client and agency staff over time. Participation in the program need not be sequential. Individuals with substance abuse and co-occurring mental health disorders will find opportunities, support and assistance at all phases of *BVI Connect*.

B.2. Evidence-Based Practices Selected and How they Address *BVI Connect's* Goals, Purposes and Objectives. Buffalo Valley incorporates a variety of evidence based practice models into our service approach. We believe that evidence-based therapeutic tools present staff and clients with greater opportunities for and likelihood of successful partnerships between client and staff in managing the individual's health and behavioral health. Two separate and complementary EBPs have been chosen for *BVI Connect*, each with demonstrated effectiveness in helping clients with substance use disorders and co-occurring mental health disorders manage their illnesses, develop their own goals for recovery and make well informed choices about their treatment. Motivational Interviewing (MI) and Illness Management and Recovery (IMR) are well known and accepted, appropriately documented and straightforward for staff to implement (Miller, 2000; Skinner and Latchford, 2006; Stofle, 2002). As importantly, with respect to the purpose, goals and objectives of *BVI Connect*, we propose MI and IMR specifically because: (1) they are both responsive to the needs of individuals at any of the three phases of the *BVI Connect* experience; and (2) they can both be realistically applied and expected to help clients achieve their personal health goals within the electronic environment. It should be noted that in addition to these two EBPs, staff will also draw on their knowledge of other relevant EBPs as needed (CSAT, 2006; CSAT, 2005; CSAT, 1999).

Responsiveness to the Individual Needs of *BVI Connect* Clients. We will work with clients wherever they are in *BVI Connect's* three phases: Outreach, Active Treatment or Recovery

Aftercare. In each phase of care, individuals face common concerns, questions and decisions: *How do I understand my problem? Do I even have a problem? What can I do about my drug and alcohol use? How should I involve my friends and families in my care, if at all? Am I making progress? What situations and people should I avoid? Will I ever be "cured?" How do I maintain sobriety through my life?* These and other questions reflect a continuous process of self-discovery, awareness and commitment to self-care that is not necessarily sequential; reflects an evolving personal understanding of the nature of behavioral health disorders in general and in particular; and position individuals to take their next steps forward in their own recovery. While structured and guided, both Motivational Interviewing and Illness Management and Recovery are client-centered, practical, and flexible, meeting and supporting clients where they are, including the Internet environment (CSAT, 2009; .

Realistic Application in the Electronic Environment. Motivational Interviewing and Illness Management and Recovery actually lend themselves well to electronically based care. The Internet is a personally directed experience: we choose to go to certain sites, click where our curiosity takes us, move at our own pace. Without taking anything away from the face to face experience, both EBPs invite individuals into a similar person-centered and person-directed experience. These approaches allow, and even guide, individuals to find sympathetic listeners who empathize with their problems; open them up to observations about discrepancies between their goals for self-care and their behavior within a safe and non-threatening environment; teach them how to recognize stressors and cope with them appropriately; and invite them to find other individuals and resources to help manage substance use and co-occurring related issues (Alleman, 2002; SAMHSA, 2009; Burke, et al., 2003, Darkins, 2000; Maheu, 2003; Mallen, 2005)). The ease and flexibility of Motivational Interviewing and Illness Management and Recovery through *BVI Connect* will help individuals achieve their own goals and objectives for their personal health care.

B.3. Evidence of EBP's Effectiveness. Our focus population consists of individuals with substance abuse and co-occurring substance use and mental health disorders, a number of whom have experienced lifetimes of trauma, legal and criminal justice involvement, strained and broken relationships and repeated failures to alter their substance abusing behaviors. Others are relatively young, with unrecognized or barely recognized problems who have not yet faced the years of losses and disappointments that abuse of drugs and alcohol so often bring. According to the BVI BLIS information system (2010 data), 60 to 70 percent of those who seek care with the agency have co-occurring substance use and mental health disorders. We selected evidence-based practices for *BVI Connect* based on their broad applicability to and success with BVI clients with these needs and experiences. Motivational Interviewing was originally developed for the treatment of alcohol abuse (Miller, 1983). Overall, MI has been found to be effective. An analysis of 30 controlled clinical trials of motivational interviewing found small to moderate but significant gains for both alcohol and drug use, in addition to notable progress in work life and personal relationships (Burke, Arkowitz and Menchola (2003). Illness Management and Recovery has equally broad-based evidence substantiating its effectiveness with individuals with psychiatric, substance use and co-occurring substance use and mental health problems. An authoritative research review included in the Illness Management and Recovery Toolkit produced by SAMHSA (2009) indicates that IMR is professional and peer intervention designed for individuals to collaborate in managing their behavioral health disorders, reduce their susceptibility to relapse (including through the use of alcohol or drugs) and develop ways to cope

more effectively with illness. BVI has been certified by the State of Tennessee Department of Mental Health as a COD-Capable agency, in part because we depend on these two EBPS as well as others to treat and support our clients.

B.4. Evidence that EBP's Produce Desired Outcomes. Our population of persons with alcohol and drug disorders includes all ages, ethnicities, experiences with substance use, and capacity to address it. We expect that *BVI Connect* will produce the outcomes we desire from the program, including identifying the impact of alcohol and drug use on all elements of the individual's life; assuming responsibility for one's own behavioral health care; seeking assistance and support when and where it is needed; preventing relapses through understanding triggers and applying healthy coping mechanisms. Both Motivational Interviewing and Illness Management and Recovery are tailor made to produce these client-oriented outcomes. Evidence demonstrates even brief use of MI with a co-occurring population are more likely to participate and stay in treatment longer than those without any exposure to MI (Martino, et al., 2000). Brief motivational intervention has proven effective in an outpatient setting (Swanson, et al., 1999). Drake (2004) found that MI produced improvements in treatment engagement, substance abuse, symptoms, among other measures. Illness Management and Recovery is again self-directed, practical and oriented to helping individuals manage their own health care process through application of motivational strategies, educational strategies and cognitive behavioral strategies (SAMHSA, 2009). An IMR approach to substance use and co-occurring mental health disorders depends on individuals to understand the triggers for substance misuse and then employ coping mechanisms of their own choosing that prevent relapse behaviors. Of particular interest to BVI, is the effectiveness of IMR in randomized controlled trials in supportive housing (Levitt, et al., 2009). Employing IMR techniques in our many hundreds of housing units has helped persuade us of the effectiveness of IMR for *BVI Connect*.

B.5. Modifications and/or Adaptations to Our Selected EBPs. E-therapy is a new service modality to help people resolve life and relationship issues. It utilizes the power and convenience of the Internet to allow simultaneous (synchronous) and time-delayed (asynchronous) communication between an individual and a professional. The goal of this project is to use MI and IMR EBPs adjusted for on-line use. Any material adjustments made in EBP protocols to accommodate the on-line medium will be addressed in the evaluation to ensure the effectiveness of treatment is not jeopardized.

B.6. Why We Chose these EBPs. We chose these EBPs for five specific reasons, which have been discussed earlier in Section B: (1) MI and IMR work well with our target population; (2) MI and IMR are practical in an electronic environment; (3) Staff are skilled and comfortable in using MI and IMR; (4) MI and IMR are flexible and client-centered, empowering individuals to be responsible for their own care; and, (5) MI and IMR lend themselves to partnering to produce greater effectiveness (SAMHSA, 2009; CSAT, 1998;).

B.7. Impact on Sub-Groups and Retaining Fidelity to the EBPs. Motivational Interviewing and Illness Management and Recovery are client-centered EBPs that allow individuals to move through their own care at their own pace in a safe, non-threatening environment. These characteristics are very responsive to the needs and concerns of individuals who might otherwise avoid acknowledging the need for services and not seek it out in traditional locations that reveal both their need and identity. The Internet presents vast opportunities for individuals to explore their unique circumstances and to work with *BVI Connect* staff to consider information and

guidance that found on-line. We believe that combining MI and IMR in an electronic environment addresses issues of stigma, shame and safety that often prevent individuals from different culture and languages; with disabilities; racial, ethnic and sexual minorities; and individuals with limited means from recognizing the need for and seeking out the care they need to address their substance use and COD issues and concerns. We anticipate no difficulties implementing MI and IMR with minority clients. We are completely committed to creating culturally and linguistically competent materials and activities, including military and LGBT culture; that take into account geographic differences inherent in rural services delivery; that are sensitive and specific to age, gender and ethnicity. We will reach out to experts, primarily on-line, to develop and disseminate culturally competent services through *BVI Connect*. We have built attention to fidelity measures into our logic model and our performance assessment plan.

BVI CONNECT LOGIC MODEL

Resources (Inputs)	Program Components (Activities)	Outputs (Objectives)	Outcomes (Goals)
<ul style="list-style-type: none"> •Dedicated Staff •Possible Grant Funds •Experience & expertise in implementing Evidence-based Programs •Existing Comprehensive Continuum of Substance Abuse & COD Services •Positioned in 3 Key locations in Middle Tennessee •Willingness to expend resources to prepare agency for health care reform 	<p>Staff Development and Capacity Building: Train staff on <i>BVI Connect</i> project & svc design, GAIN, GPRA</p> <ul style="list-style-type: none"> • Assess & identify clients for admission (GAIN, GPRA, ASI); PSAs and other community announcements • promote program through ads on website • United Way 211 <p>Train and certify staff to implement MI and IMR using technology.</p> <p>Program Support: Summary of baseline data • evaluate process and outcomes of treatment for continual QI • seek additional resources & funding opportunities • attend SAMHSA TA conf• evaluate community indicators for success •</p>	<ol style="list-style-type: none"> 1) Assess existing <i>BVI Connect</i> program & enhance its efficiency & effectiveness. 2) Implement interoperable EHR. 3) Build sustainable funding into <i>BVI Connect</i>. <ol style="list-style-type: none"> 1) Provide outreach services through to clients and potential clients. 2) Decrease time on wait list. 3) Develop presentation, webinars, educational materials, etc. 4) Provide for on-line self-assessment. <ol style="list-style-type: none"> 1) Identify candidates for Outpatient Treatment. 2) Deliver OP treatment. <ol style="list-style-type: none"> 1) Provide recovery aftercare services. 2) Develop on-line and web-based relapse prev materials. 	<p>#1 Build and enhance capacity of substance abuse treatment providers in providing technology-assisted care.</p> <p>#2 Use <i>BVI Connect</i> to reach out & develop therapeutic relationships with clients and potential clients.</p> <p>#3 Provide more & more effective evidence-based services to individuals with SA and COD.</p> <p>#4 Maintain healthy, functional and informative relationships to support the recovery process.</p>

Section C: Proposed Implementation Approach

C.1. Experience with and Capacity for Health Information Technology. Approximately five years ago, BVI staff met with both Arapahoe House (Colorado) and Gateway Community Services (Florida) to explore the general idea of e-services for addictions treatment. Arapahoe House was just getting started and utilizing a public domain through Google. They were using this for pre & post treatment activities. All their activities were accomplished through emails and

on-line text interaction with no video conferencing. After that initial visit our IT department began working with Google, encountering concerns regarding HIPPA and confidentiality, which remain locally and at state and federal levels. We subsequently made a follow-up visit to Gateway to review a specific software product that not addresses pre and post treatment aspects of access to services, but also on-line counseling with a counselor at the treatment center and six clients at remote locations. We made a decision to move in this direction; however, after determining the cost of software, the idea was shelved. In 2009, BVI applied for and received a grant to move toward e-services from the Appalachian Regional Commission. The grant allowed purchase of needed audio equipment, computers, and a license for Vidyo, an affordable software alternative. However, we continued to experience problems and delays with e-services, related to lack of dedicated staff, extensive connection fees and limited Internet access in rural areas, which has since been addressed with high speed internet installation. We have begun asking about Internet access as we receive calls for service; approximately 60 per cent of callers have adequate access. We more recently attended the Gateway Technology Conference and met with Gateway officials to work toward use of their system. However, we have experienced problems with linkage capabilities, i.e., lag time, freezing screens, log-in difficulties, password issues, etc. Again no dedicated staff have been available to maintain the project's focus and direction. This proposal is designed to address this long-standing problem. There is currently no standard EHR and HIT system in Tennessee, nor does BVI have a system currently interoperable with Primary Care Systems. We do currently have an MIS system that is fully functional but not certified, named BLIS. All staff are completely familiar with BLIS. We are in final negotiations with NetSmart and Qualifacts to purchase a fully certified EHR system that will be fully interoperable with Primary Care Systems and will produce a CCD (continuing care document) for clients that will give us the ability to share patient information with all other agencies participating with a certified EHR. We do have in place all hardware required to service a large MIS system as well as bandwidth capacity for *BVI Connect* as well as hosting a number of several smaller agencies with an interoperable EHR system, allowing many Tennessee treatment centers to utilize the same system. Verbal commitment has been offered by the State to support our system of choice by providing a "patch" to the State system allowing real time communication. BVI is fortunate enough to have staff in place to build upon current systems, once the new certified EHR system is in place. Much of the time now devoted to managing our BLIS legacy system will be shifted to supporting *BVI Connect* and the new EHR, a far more efficient approach to client care.

C.2. Use of HIT Tools to Reach and Engage Individuals with Substance Use and Co-Occurring Substance Use and Mental Disorders. Under our agreement with Gateway, we intend to maximize use of HIT tools to reach our proposed population in a number of ways. *BVI Connect* clients will manage their personal information including e-mail and preferences. Users can update and retrieve passwords internally. Progress notes will be part of the new EHR, providing a detailed record of events during care and a digital signature on every update. The system will create and manage client surveys, providing customized pre and post surveys. *BVI Connect* will automatically bring up surveys at a designated time after scheduled sessions. The information provided becomes a part of the client permanent records (unless designated as anonymous) and has a export feature to integrate into the EHR system. The system will allow us to create and administer standard assessment tools for system-wide use. We will use GAIN and the ASI, with results attached to the electronic client record. The system allows users to schedule, record and create a session contact. Web sessions are scheduled in real-time with web

chat between client and counselor. An option exists to record and retrieve the web chat session for quality improvement. All interactions are time-stamped and can be audited. The system also allows for corporate and staff training sessions and uploading of media sessions for later viewing. BVI can pull data for live reporting purposes to: 1) determine usage; 2) review counselor/client interaction details; 3) collect and review agency demographic information; 4) allows queries to be made in real-time; and 5) export information into the EHR. The system is capable of charging users via major credit card or “other” payment options. All records and audits are provided and exportable to the EHR or managed by “billing” user. BVI expects to use the system for medical practice management, as the electronic medical record, for prescription writing and for medical billing, with features that include: 1) patient Chart Tracking and Management; 2) ePrescribing; 3) Master Scheduler; 4) Electronic Billing including Medicare/HCFA; 5) Visitation Manager; 6) Reporting-lists, referrals, receipts, services, charts, etc. and 7) Insurance. Base security and encryption standards include web based software that employs time-tested baseline encryption and exceeds all Federal and State standards for data usage and policies.

C.3. EHR Compliance with ONC-ATCBs. As stated earlier, BVI is currently in the final stages of selecting from one of two EHR systems that are fully compliant with the requirements of the Office of the National Coordinator for Health Information Technology- Authorized Testing and Certification Bodies (ONC-ATCBs).

C.4. Strategies to Address Key Factors that Influence Expansion/Enhancement of E-Treatment. *Organizational factors.* Our strategy regarding organizational factors involves not only dedicated staff to ensure continuity of services but also a dedicated department. This department will operate under the Project Director/PI, the Project Manager, e-services counselor and case manager supported by IT staff. Although not funded under this grant, the E-Services Department will have access to admissions staff and hopefully by the time the grant is funded a certified EHR. *Provider training and competence factors.* For the past 2 years BVI has been investing in staff training and competency as evident by participating in Gateway Connect Technology conferences in Jacksonville, Florida. Current clinicians and staff are skillfulness in operating computer based technology with BVI’s current MIS system “BLIS.” Last August, Gateway provided basic training in e-services and competency to current BVI staff. To ensure on-going training and competency is addressed, Gateway will provide on-going interaction and training for all of BVI staff including the staff described in this grant proposal. *Relationship factors between provider and persons in treatment.* As in any clinical interaction, relationship between the provider and persons in treatment is critical. BVI has adopted a “Welcoming” statement that reaches out to anyone no matter the Stage of Change they are in as they inquire and/or seek services. Relationships with appropriate clinical boundaries and the strength of the program support individuals in addressing the immediate concern while leaving the door open for long-term care. This interaction supports the philosophy that the longer someone is engaged in treatment at any level, their long term impact is enhanced. To address the skillfulness of individuals in the use of electronic tools, BVI has already incorporated the use of electronic tools in all levels of care through the job training program. Our current e-services is being taught in the job training program 2 times per week. In this training program, individuals are taught how to use computers, the internet, and for the past couple of years, how to log-in for continuing care e-services. This will be on-going and will be expanded on to all BVI sites. *Technical factors requiring additional staff or consultants.*

The E-Service department will be available to staff immediately rather than an afterthought in the priority of technical support. In addition to the support internally, Gateway Connect will be active consultants in the support maintenance and operation of the system to ensure the quality of services through this expansion/enhancement. *Financial factors.* BVI is assertive in seeking appropriate funds to ensure the continuation/sustainability of programs implement internally. BVI, by the time the award announcement of this grant, will have purchased a certified Electronic Health Record with its own funds. BVI has always committed to providing training cost for technology and for staff to ensure competency and quality in the services delivered.

C.5. Implementation Plan and Timeline to Expand E-Treatment of Substance Use Disorders in Rural Tennessee. Our implementation plan and timeline offers detailed plans to implement *BVI Connect* from October 1, 2011 to September 30, 2014. The *BVI Connect* implementation plan and timeline will allow us to use existing and emerging HIT to deliver evidence-based services to un-served and underserved residents of rural Middle Tennessee for those with substance use/co-occurring substance disorders. Through *BVI Connect*, we will use various e-applications in all program phases, including web-based services, smart phones, messaging systems and others to reach beyond existing physical facilities to establish and maintain the therapeutic relationships needed to guide and monitor outreach, treatment and recovery aftercare services. The groundwork has been laid with regard to the basic technology and on-going continuing care groups therefore the implementation of this project will be operational by the 4th month after the grant award. The timeline will mimic Phase I: Outreach; Phase II: Treatment; and Phase III: Recovery Activity in Section B: Goals and objectives.

TABLE 5. Implementation Plan and Timeline

BVI Connect Key Milestones & Activities	Time frame	Responsible Staff
Announce Grant Award	Day of Award	PI
Develop Specific Implementation Plan	3 weeks	BVI & Gateway
Implement evaluation plan review baseline data	4 weeks	PI & Evaluator
Begin Awareness Component-Outreach	1 wk from award	PI & Admin Assist
Implement 3-week program training. Management observes new hires as they implement tasks. Training includes assessment protocols, EBP, etc.	Completed by 4th week	PI, Evaluator
Implement Service Design	6 weeks	All
Implement Technology Design	4 weeks	IT staff & PI
Evaluate Service Design	6 weeks	Evaluator & staff
Implement e-service training program for clients	4 weeks	Team
Weekly team & clinical staff meetings	Ongoing	Counselor & Case Mgr (CM)
Initiate evaluation meeting	Monthly for 3 months Quarterly on-going	PI & Evaluator & Team
Hire and transition new staff into project	7 days from award	PI, Program Manager (PM)
Evaluator educates staff on Evaluation process	90 days from award	Evaluator
Train staff on protocols, documentation, and service design	30 days from award	PI & PM
Increase outreach efforts	30 days from award	PI & Admin Ast.
Assess and identify clients for admission into the program	60 days from award	Counselor & CM
Administer GPRA and measurement tools	60 days from award	CM
Review process to date	90-180 days from award	All
Refer clients into the program	60 days from award	CM
Make modifications if necessary in services	90-180 days from award	PI & PM
Continue program services	60 days - ongoing	Project Staff
Begin weekly individual and group staff supervision	60 days from award	Counselor & CM
Do PSAs& other announcements.	90-180 days from award	PI & PM
Administer follow-up GPRA	90-180 days from award	CM
Do PSAs and other community announcements	90-180 days from award	PI
Begin utilization management	90-180 days from award	PI,
Provide summary of baseline data	90-180 days from award	Evaluator
Attend SAMHSA technical assistance conference	90-180 days from award	PI, Evaluator
Ensure linkages for supportive services	60 days from award	CM
Continue and enhance program services	180-360 from award	PI & PM
Refine model if necessary	180-360 from award	All
Continue Individual & group sessions	180-360 from award	Counselor & CM
Continue weekly group supervision of counselors & case managers.	180-360 from award	Counselor & CM
Administer 6 month follow-up GPRA- Achieve at least 80% follow-up	180-360 from award	CM
Analyze Data and outcomes (report to staff & stakeholders)	180-360 from award	Evaluator
Report outcomes to permit ongoing improvements & assess measures of fidelity. Maintain feedback loop regarding process & outcome efforts	Quarterly, ongoing	PI, Evaluator
Quarterly/Biannual & Annual Narrative, Statistical, and Financial reports, Annual Continuation Application, & grantee meetings twice annually	Quarterly, annually, twice per year	PI, Evaluator
Ongoing meetings with state decision makers to leverage outcomes and promote project funding; applications to sustainability funders	Ongoing, beginning during 1st year	PI, BVI ED
Seek Additional resources	180-360 from award	All
Continue outreach and awareness efforts	180-360 from award	CM
Ensure linkages to ancillary services, particularly housing	180-360 from award	CM
Provide continuing care services	180-360 from award	Counselor/CM
Continue/ Refine based on Evaluation results, Research, & client feedback	Year 2 & 3	All
Report first years findings to SAMHSA, Stakeholders and Community	Year 2 & 3	PI
Seek additional funding resources	Year 2 & 3	All
Evaluate community Indicators for success	Year 2 & 3	PI
Look for emerging trends that need addressing	Year 2 & 3	All

C.6. Obtaining Effective Consent. Effective consent will be obtained during the initial intake at on-site orientation. A process of encouragement and support will be developed as part of the client's relapse prevention plan which begins at entry into outpatient services.

C.7. Automatic Screening, Assessment and Tracking of Individuals. Because we are planning to use the GAIN and the ASI for the comprehensive bio-psychosocial assessment, assessments will be administered only over the phone or using the webcam or skype. GAIN is an assessment tool used with adults with eight core sections (Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational). Each section contains questions on timing of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, timing of utilization, and frequency of recent utilization. The items are combined into over 100 scales and subscales that can be used for DSM-IV-based diagnoses, ASAM-based level-of-care placement, JCAHO-based treatment planning, and DOMS-based outcome monitoring. Operation PAR has certified regional and local trainers and Gateway has four certified local GAIN trainers who will be accessed by BVI. The Addiction Severity Index (ASI) is a measure of addiction severity in multiple problem areas and has been a required part of BVI admissions to treatment for the past two years, also serving as an evaluation mechanism as progress is made in any of its functional areas. The web-based system offers a simple process for on-line screening. If screening indicates a possible problem, the client is asked if they would like to talk to someone. If the client has web-cam ability, the assessment can be done over the secured web-based connection. If not, the initial assessment will need to be done over the phone. However for continued web-based services, an inexpensive webcam can be shipped to the client. BVI uses the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R), which identifies the intensity and level of care in a treatment continuum. The Matrix for Matching Multidimensional Risk with Type and Intensity of Service Needs allows for improved assessment and treatment for clients with co-occurring disorders. Utilizing a Multidimensional Risk Profile integrates a client's biopsychosocial information and current conditions into a comprehensive integrated summary and treatment plan. All six dimensions are used to determine a client's immediate needs based on a "rating scale" and placement in the intensity of service. Risk descriptions indicate the severity and level of functioning and helps the staff to determine the severity, immediacy and scope of the treatment plan. Utilization of the data obtained from the screening and assessment will help create a unified and comprehensive treatment strategy which is then reflected in individual client records.

C.8. Using Messaging Systems and Personal Health Records to Engage Individuals in their own Treatment and Recovery. Once the agency implements an EHR, BVI will work to allow client access to their own personal calendar, treatment plan and relapse prevention plan. Within limits, they will schedule individual sessions with counselors. We envision working with clients to determine the types of messages they respond to in their time of need and upload a menu of inspirational messages, in the format they respond to best (audio, visual or combination) allowing the client to log on to their personal space and retrieve encouragement anytime they need it. BVI Connect staff will monitor this activity for red flags that could trigger a counselor to give them a call.

C.9. Improving Individual Health Outcomes through the Use of Home-Based Monitoring. BVI is currently researching systems of home-based monitoring. We plan to work with Dr.

David Gustafson during the second year of the project to integrate the use of SMART phones into our relapse prevention protocol. SMART phones are being tested in the Clinical Trial Network of NIDA. Upon entry into services, the counselor and the client, together program the phone for places and events that are triggers for relapse for the client. A GPS system in the phone alerts the client when approaching a triggering place (favorite bar, dealers house etc..) In advance the client has discussed what would help him in such a circumstance and the phone responds in that manner such as an inspirational message, a phone call from a counselor or sponsor, a reminder of a goal etc.. Information from the phone is tracked and addressed during individual sessions with the counselor.

C.10. Numbers of Persons to be Served.

Table 6. Persons to be Served and Expected Outcomes

	YEAR 1	YEAR 2	YEAR 3	TOTAL	ANTICIPATED OUTCOMES
Outreach (Phase 1)	100	120	140	360	Develop therapeutic relationships with clients seeking treatment (Goal 2)
Treatment (Phase 2)	40	60	70	170	Provide EBP services to clients seeking treatment and reduce wait list (Goal 3)
Recovery Aftercare (Phase 3)	90	110	150	350	Maintain therapeutic relationships with clients in Aftercare (Goal 4)
Total	230	290	360	880	

C.11. Embedding E-Treatment into Our Service System. *BVI Connect* services will be offered in three phases. The first phase is primarily for those on the waiting list. A *BVI Connect* link will be added to our current web site (bufallovalley.org); directions to that web site will be given with our automated phone systems. Necessary phone systems are in place. Programming will be completed within one month of funding. The web site link to *BVI Connect* will contain information, evaluations, sample treatment groups, AA contacts, references to other BVI resources and admission paperwork that can be done on line. Phase 2 of *BVI Connect* is when clients arrive for a day of orientation, receiving needed training to utilize *BVI Connect*. Clients will then return home, receiving all services - including individual and group counseling - via *BVI Connect*. The technology hardware is now in place at BVI, including sufficient phone bandwidth to provide services. Phase 3 will be utilized by all clients and all counseling and case management staff. Clients that go through conventional treatment will be trained to use *BVI Connect*, communicating from that point on with their counselor for aftercare and case management services primarily via computer. This is the largest program component to embed in the larger system as it will involve all clinical staff. This proposal budgets for only one case manager and counselor to accomplish Phase 2 of *BVI Connect*, even though the system will be embedded throughout the agency to fully accomplish phase 3 (Recovery Aftercare). *BVI Connect* will be utilized by existing SAMHSA-funded staff to reach clients once they return home. A currently SAMHSA-funded case manager (BVI integrated treatment for the homeless) will find *BVI Connect* particularly helpful since clients from that grant are being placed in stable environments with computer access. *BVI Connect* will integrate all data with the EHR making the data flow seamless. Embedding data in this manner will permit us to avoid repetitive data entry, reduce mistakes and improve treatment.

C.12. The Key Role of our Partners in E-Treatment. Our key partner in this effort will be Gateway Community Services who will serve as the consultant for enhancing and expanding *BVI Connect*, training staff and assisting in resolving issues and concerns as they arise. Gateway

will also provide consultation in working with state funders of services, licensing and certifications. Gateway's Cowdery Addiction Research Center will serve as the evaluator for the project. During the second year of the project, we also hope to work with Dr. David Gustafson to implement his work with SMART phones as tools for relapse prevention. In addition to Gateway, we will work very closely with two other major substance abuse and COD service agencies: CADAS in Chattanooga and CAAP in Memphis, who have expressed keen interest in adopting *BVI Connect* in their own settings. Together, we three agencies cover all part of the far upper eastern portion of Tennessee.

C.13. Speedy E-Treatment Project Start-Up. The program can easily begin before the 4th month of the project, because facilities are in place, sufficient equipment is in place with adequate phone band width, planning has been ongoing for more than 3 years with initial training of much of the staff, staff currently utilize an EHR system and are proficient, Vidyo systems have been in place for 3 yrs., A client waiting list exist and clients can begin treatment the moment *BVI Connect* goes operational. Agreements are in place with Gateway Connect to provide further system training we need. The evaluation MOU is in place. All the Key Staff are in place.

C.14. Identifying and Overcoming Potential Barriers. We understand that barriers will inevitably arise with *BVI Connect*. We are confident that working together with our staff and Gateway, we will find positive solutions to overcome them. For example, we may discover that on-line identification data or a self-administered on-line assessment is not as accurate as an assessor working directly with the participant. Perhaps it will not sufficiently allow for clarification of inconsistencies or auditing of data accuracy. In such a case, we might follow-up on-line self-assessment by calling individuals with specific questions that have been flagged as part of the process, verifying addresses and phone numbers or sending mail to clients that requires signatures and return. Another example could relate to the limited monitoring of clinical status over the Internet, especially if the client does not have immediate access to a treating clinician/facility in case of an emergency. Possible solutions might be to discuss in advance procedures the client should follow if symptoms worsen or if they face an emergency; to inform the client of whether they should contact the counselor or if pursue a referral to an outside treatment program; to include in sessions explicit questions that inquire whether a client needs immediate crisis assistance, which can trigger direct notification of the counselor; to use adaptive questioning strategies by which screening questions for risk are followed up with more extensive questions if the response suggests problems; to develop a plan for identifying clients who experience clinical deterioration and how they will be handled; to obtain information about how they can be contacted if they are in crisis and providing an emergency contact. Special note should be made of the issue of *confidentiality* as a possible barrier to full implementation of *BVI Connect* and whichever EHR *BVI* elects to use. 42 CFR Part 2 legislation protects the release of information related to substance abuse and addictions services, yet regular reports are publicized in the field about information released without proper authorization and consent. Any lack of trust by individuals that their treatment information will be properly safeguarded is likely to adversely affect their willingness to participate in services and eliminate specialty agencies such *BVI* from being fully integrated into the evolving system of health care reform. Whatever the issue, concern or possible barrier, all Team members will be responsible for bringing their concerns to the immediate attention of the Project Director (PD). The PD will either solve the issue herself or assign it to a senior Team member (i.e. Deputy Director) and then monitor the

situation until it is resolved. Ways that we might resolve issues/barriers may range from shifting staff or resources to address an emergent need to seeking the counsel of Gateway or other experts in provision of electronic care.

C.15. Sustaining E-Treatment into the Future. Substance use disorder services are funded by three sources in Tennessee: public funds that are a combination of Federal and state government dollars; Medicaid or Medicare; and private health insurance. The TDMHDD, who administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant, and TennCare are the main sources of public Federal and state substance use disorders treatment within Tennessee. Once implemented, phases one (Outreach) and three (Recovery Aftercare) of this project will be self sustaining. When *BVI Connect* is loaded onto the BVI web site it is there to be used for future generations, allowing for needed updates and revisions going forward. Once staff are trained in *BVI Connect*, the technology becomes another mode of treatment and service. Reimbursement for Active Treatment will be negotiated with the Tennessee Department of Mental Health and the Tennessee Medicaid Authority (TennCare). In this way, continuity and ongoing funding for the program will be ensured.

Section D: Staff and Organizational Experience

D.1. Our Team's Experience and Expertise in Serving Individuals with Substance Use and Co-Occurring Substance Use and Mental Health Disorders in Rural Tennessee. Our proposed staff and partners are experts who have managed dozens of large-scale, complex projects focused on substance abuse and/or co-occurring substance use and mental health disorders. We possess evidence-based and clinical services implementation expertise as well as the administrative capacity to effectively and efficiently plan for, manage and achieve the goals, objectives and strategies of *BVI Connect*. Buffalo Valley Inc., is a JCAHO accredited, community-based, non-profit agency founded in 1979 whose mission is to provide treatment, housing, economic & community development & other supportive services for low income, homeless and other residents of rural Tennessee. BVI philosophy includes the highest practicable level of independence, choice & dignity for our clients in a drug-free environment. BVI received its first CSAT grant in 1990 to treat and provide job training for minorities in the service area, its first SAMHSA grant in 1991 to provide treatment and housing for low income & homeless in rural middle Tennessee, in 2001. BVI coordinates the HNM coalition Continuum of Care for the 19 county target areas. BVI has been the lead agency in the HMN since 1995 providing established linkages with organizations rooted in the culture homelessness. BVI staff serves on the Governor's Interagency Council on Homelessness & the Council on Service Members, Veterans, & their Families & were major contributors in designing the State's ATR grant. BVI has been awarded & successfully managed grants from SAMHSA, HUD SHP, HUD 811, HUD 202, HUD RHED, VA Homeless Providers Program, Federal Home Loan Bank, THDA HOME, USDA 523, DHS Emergency Shelter Grant Program & many others.. We work together on many projects to maximize limited resources to serve these counties most vulnerable population. BVI received an ARC Grant in 2009 to extend E-Treatment to the rural population in these counties and have some success in operating E-Treatment services. We added Gateway Connect in 2009, utilizing E-treatment technology with 70 outpatient clients last year, and with 300 more in recovery aftercare activities. We purchased most of the equipment needed to operate E-Treatment effectively 18 months ago, more recently purchasing additional T-1 band width to improve the quality of transmission. We have over five years experience with E-

Treatment and have learned a good deal about what works and what does not. This grant will permit us to expand and enhance our capacity by hiring staff and purchasing additional equipment to further refine our technology in order to serve many more rural people in need. **Gateway Community Services, Inc.** is a comprehensive; community based human services organization that has been providing services to the greater Jacksonville, FL community since 1978. Program components include: substance abuse education and prevention; non residential treatment services; residential treatment for males, females, mothers and children, and adolescents; detoxification services; continuing care services; drug court services; and juvenile justice services. Gateway is licensed under Florida Chapter 397 and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, Gateway has been selected by the *National Institute on Drug Abuse* (NIDA), as a site for clinical trials for treatment of addiction in consort with the University of Miami. As part of the Florida node of the NIDA Clinical Trials, Gateway has developed an internal research. Gateway has been an active participant in five clinical trials. In 2006/2007, the Florida Legislature provided funding that allowed Gateway to develop a toll free number and e-therapy approach to address accessibility problems for substance abuse assessment and treatment in Northeast Florida. In 2007, Gateway was awarded an e-therapy grant from SAMHSA to further develop technology integrated treatment services. In 2008, Gateway developed standards for treatment which were later adopted by the Department of Children and Families. Gateway who will serve as consultant to BVI in working out the "kinks" in the platform, training staff and helping BVI's Team work with state funders of services, licensing and certifications. Gateway's Cowdery Addiction Research Center will also serve as the evaluator for the project.

D.2 Staff Skills and Qualifications.

FIGURE 4. SKILLS AND KNOWLEDGE MATRIX

Position	Justification	Qualification
Executive Director Jerry Risner	<ul style="list-style-type: none"> • .06 FTE effort, in kind – all years) • Work in close coordination with the PI and provide oversee of project planning, design, implementation and operation. 	<ul style="list-style-type: none"> ▪ MA Psychology ▪ Extensive experience in administration of hospitals / treatment centers, of federal / state grant programs ▪ Developer of HNM and HUD 811 -202 housing programs in geographic area
Principle Investigator HIT Program Director Deborah A. Hillin	<ul style="list-style-type: none"> ▪ .28 FTE effort, in-kind-all years ▪ Responsible for programmatic leadership and quality management 	<ul style="list-style-type: none"> ▪ M.A. ▪ 20 years MH/SA experience ▪ 13 years Program Administration for HNM, Clinical Grants, Drug Courts, Clinical Oversight for 3 license sites. ▪ PD/PI for SAMHSA SSH grant
Psychologist Dr. Mark Sigler	<ul style="list-style-type: none"> ▪ 0.16 FTE in-kind-all years ▪ Provide specialty psychological services 	<ul style="list-style-type: none"> ▪ PhD – Clinical Psychology ▪ TN Licensed
Nurse Julie Maddox	<ul style="list-style-type: none"> ▪ .10 FTE in-kind ▪ Provide evaluations ▪ Provide medication management 	<ul style="list-style-type: none"> ▪ LPN/RN ▪ At least 2 years clinical experience

BVI Connect Program Manager Bruce Emery	<ul style="list-style-type: none"> ▪ .50 FTE ▪ Ensure quality internal and external customer care and service ▪ Responsible for the overall day-to-day program management ▪ Maintain program quality and consistency ▪ Provides staff supervision 	<ul style="list-style-type: none"> ▪ Min 5 years plus in a related field supervisory/ administration ▪ Exceptional knowledge of the recovery process
Adm. Asst / Outreach Amy Crowe	<ul style="list-style-type: none"> ▪ 0.20 FTE ▪ Processes referrals for services & conducts initial eligibility screenings 	<ul style="list-style-type: none"> ▪ HS diploma or equivalent ▪ 3 years clerical experience ▪ Ability to communicate in English at the HS level
HIT Counselor Anthony Yader	<ul style="list-style-type: none"> ▪ 1.0 FTE ▪ Complete/review screening assessments, psychosocials, and discharge summaries ▪ Plan and coordinate services ▪ Provide education, recovery focused and therapeutic services to clients, families and communities 	<ul style="list-style-type: none"> ▪ BA w/2 years experience working in substance abuse/mental health addiction ▪ AA w/3 years experience ▪ HS diploma w/3 years experience in legal housing and vocational linkages ▪ Technology experience
HIT Case Manager To Be Names	<ul style="list-style-type: none"> ▪ .50 FTE ▪ Complete needs assessments ▪ Link and/or refer clients to appropriate community agencies ▪ Work with local agencies to arrange for Housing / social services 	<ul style="list-style-type: none"> ▪ BA w/1 year experience working in addiction or AA w/2 years experience or HS diploma w/3 years experience in legal housing and vocational linkages.
HIT Technology IT Specialist Bob Girard	<ul style="list-style-type: none"> ▪ 0.2 FTE ▪ Provide IT services & support 	<ul style="list-style-type: none"> ▪ 3 years experience in the development/coordination of IT & treatment of substance abuse or mental health disorders technology programs
Program Evaluator Dr. Neuenfeldt	<ul style="list-style-type: none"> ▪ Provides evaluation services for all 3 years of the project. 	<ul style="list-style-type: none"> ▪ PhD ▪ Previous Principle Evaluator

Deborah A. Hillin-The Principle Investigator and HIT Program Director is Senior Vice President for BVI and services will be in-kind. She has been with BVI for the past 20 years. She has a Masters of Arts in Organizational Management & is a Licensed Alcohol & Drug Abuse Counselor in the State of Tennessee & a National Certified Addiction Counselor. Ms. Hillin has been working with rural communities in middle Tennessee with the following experience gaps & needs analysis of services, i.e., homelessness, substance abuse, co-occurring, Veterans, drug court initiatives, recovery support services, case management, housing, & job training through coalition building & most recently Access to Recovery & the Matrix program for Meth addicts. She serves on the State of Tennessee Treatment & Recovery Advisory & Appalachian Committees, Practice Improvement Task Force, Operation Iraq Freedom / Operation Enduring Freedom, appointed to the Governor's Council on Service Members, Veterans, & Their Families, the Interagency Council on Homelessness for the State of Tennessee & to the Drug Court Advisory Board for the State of Tennessee in accordance with the Drug Court Treatment Act of 2003, as well as being an active member of the Tennessee Drug Court Association, & President-elect for the Tennessee Association of Alcohol & Drug Abuse Services. **Bruce D. Emery**, M.Ed., MSW. Mr. Emery is the immediate past Assistant Commissioner of the Tennessee

Department of Mental Health who directed the State Division of Alcohol and Drug Services and will be the BVI Connect Program Manager. During his tenure as Assistant Commissioner, Mr. Emery led the successful movement toward developing Co-Occurring Capable / Enhanced Treatment programs statewide. Prior to employment with the state, he worked as a Consultant with the TDMHDD in the transition of Alcohol and Drug Abuse Services from the Department of Health to the Department of Mental Health and Developmental Disabilities and has extensive history of system change. **Dr. Christine Neuenfeldt** is Vice President of Research for Gateway's Cowdery Addiction Research Institute and will lead the evaluation team. She has twenty years of extensive experience in the fields of research, grant and program evaluation, substance abuse, education, juvenile justice, and organizational leadership and is the author of curriculum guides for the prevention of Ecstasy and Club Drug use. She represents Gateway Community Services as the Research Coordinator on the Women and Trauma, Brief Strategic Family Therapy, Adolescent ADHD, Smoking Cessation, and Exercise Clinical Trials with NIDA. Dr. Neuenfeldt also has past and current experience as an evaluator on a ten SAMHSA grants including the following areas: Drug Court (Dependency & adult), Adolescents Family Centered Treatment, Technology Assisted Care, Pregnant and Post-Partum, HIV Prevention, Child Trauma and Local Recovery Oriented System of Care. In addition, she was the evaluator for a SAMHSA HIV grant in Ohio. **Key staff's experience with the population & are familiar with their culture and language.** Staff experience is indicated by the fact that many of BVI's key staff have been involved in the development and operations of previous SAMHSA grant projects, HUD SHP CoC as well as nine drug courts in rural Tennessee. The P.I. has served as an appointment to the Drug Court Treatment Advisory Committee for past years as well as the Governor's Council on Service Members, Veterans, and Their Families and the Governor's Taskforce on Homelessness. The Project Director has most recently served as TN Mental Health Assistant Commissioner and has innumerable awards of excellence and experience in other States in all aspects of Alcohol/Drug Treatment and treatment of Mental Health issues. The counselors and case managers works directly with the clients, have relevant experience working with HIV at-risk and PTSD issues, as well as years of experience with treatment of clients with Co-Occuring issues. BVI's nursing staff has extensive training in working with clients with primary health care issues, mental health issues/A/D issues and HIV at-risk clients. The counselor's, case managers, the nursing staff has had training in the E-Treatment phase of BVI's treatment program. Current E-Treat knowledge will carry over well with this grants BVI Connect. BVI emphasizes community engagement, stakeholders' involvement, local staff recruitment, professionalism and ethnic and cultural sensitivity training on an ongoing basis. Further, all treatment protocols will include attention to specific cultural characteristics with regard to family relationships, family expectations, community ties, ethnic identity and cultural values and beliefs. The staff is trained to use negotiation approaches and to tailor service delivery best practices depending upon the client's personal situation. People of color comprise 25% of the BVI staff; 30% are members of the recovery community, either in recovery themselves (30%) or have a relative in recovery (25%); 20% are veterans and 15-20% are formerly homeless. All are trained on the use of our current EHR system BLIS. BVI provides groups and individual sessions in Spanish led by a Hispanic speaking staff. Hiring practices seek to hire persons who can relate to the target population in a manner that best facilitates their engagement in the program and recovery from substance abuse. Staff receives ongoing training and supervision to discuss any cultural issues that impact their ability to best serve the participants in the programs. Staff has been attending training in the dynamics of E-Treat services issues and issues

surrounding distance learning and virtual treatment are planned. The evaluation will include an assessment of cultural issues. Key staff has over 20 years experience in the field on average, and have held key positions in the State field of Alcohol and Drug Treatment.

D.3. Availability and Location of Project Services. Although this project is technology based and occurring in their communities/homes, BVI will not be able to ensure ADA within their homeless. However, for any part of the project services occurring physically at BVI, all four licensed sites meet all ADA requirements. BVI has been actively providing services in this rural 19 county area for many years, they bring to this project many resources which will contribute to its success including 1) Experience substance abuse treatment program with valuable experience in managing federal funding. 2) Committed, competent staff already trained in evidence-based models & culturally appropriate practices. 3) Furnished office space with phones, computers & internet access in four locations (main branch in Hohenwald & 3 satellite branches covering 19 counties in Middle Tennessee). 4) Translation services for the Hispanic population. 5) Fleet of over 60 cars/vans to help with transportation challenges. 6) Skills within the agency & partnerships with community organizations throughout the 19 county areas to be able to provide additional services include comprehensive assessments, & post-recovery services including, but not limited to, job placement assistance & life skill development & e-treatment. 7) Established partnerships with local drug courts. 8) Housing- located in scattered site locations throughout the 19 county areas with multiply housing opportunities located in proximity to employment.

Section E: Performance Assessment and Data

E.1. Our Ability to Collect and Report Performance Data. Buffalo Valley, Inc. conducts ongoing evaluations of all of its programs. Our ability to collect and report performance measures is clearly documented by evaluation activities of current state and federally funded projects. BVI has successfully managed over fifty different local, state and federal contracts, all of which had stringent requirements to collect and report performance measures, including process and outcome data. Since 1990, BVI has participated in the statewide TOADS (Tennessee Outcomes for Alcohol and Drug Services) project to capture process- and individual-level client data for individuals completing substance abuse treatment. The TOADS project is the state of Tennessee's Department of Mental Health and Developmental Disabilities' relational database system, and was developed by the Institute for Substance Abuse Research & Evaluation (I-SARE) located at The University of Memphis. BVI has previous experience in meeting GPRA and SAMHSA/CSAT requirements as a vendor to the state of Tennessee's Access to Recovery (ATR) grant and as a former SAMHSA grantee. BVI successfully followed over two thousand (2,015) individuals, and GPRA follow-up rates have consistently met the 80% threshold for GPRA interviews. BVI will contract with Gateway's Cowdery Addiction Research Institute under the direction of Christine Neuenfeldt, PhD. She has extensive experience in the fields of research, grant and program evaluation, substance abuse, education, juvenile justice, and organizational leadership. She has worked in the behavioral science field of substance abuse for twenty years. She represents Gateway Community Services as the Research Coordinator NIDA Clinical Trials and has been the evaluator on eleven SAMHSA grants including one in Ohio. Staff are regularly trained on accurate data collection. BVI's experience with grants from CSAT documents our capabilities in using the GPRA website for data collection and reporting. Our Evaluator regularly pulls reports from the GPRA website to use in staff meetings to aid in the overall quality improvement of the program. Program and research staff have experience collecting GPRA data at intake, 3 months, discharge and 6 months. A few grants require 12 month data collection, which we have accomplished. We understand and uphold the time limits on each of the collection points. The information collected through the required GPRA instrument includes the collection of client self report data relating to the client's substance abuse, family and living conditions, employment status, social connectedness, access to treatment, and criminal justice status. Training is provided to program staff which helps to clarify answers with clients to assure the most accurate information is collected.

Data collection, management, analysis and reporting BVI and Gateway have experience collecting data through personal interviews, assessment instruments, satisfaction surveys, focus groups, and record review. Input from the consumer focus groups or their advocates will be gathered at the beginning of the project as a need assessment of what should be addressed in the evaluation. These groups will persist throughout the life of the grant to collect input and ideas from our target population about the evaluation process. The consumer group will be comprised of substance abusing adult using eServices and/or their advocates from different phases of the project. Project evaluation will be accomplished by using an array of data collection methods, both quantitative and qualitative. The CSAT GPRA Client Outcome Measure will be administered to every program participant under this grant at baseline (i.e., the client's entry into the project), discharge, and 6- months post the baseline. Data will be entered into CSAT's GPRA Data Entry and Reporting System via the Internet within 7 business days of the forms being completed. Each enrolled participant will be offered a \$10.00 gift card for participating in

the 6 month evaluation follow-up contact. Although BVI and Gateway have an excellent history of exceeding the 80% follow-up standard, this incentive will increase the probability of exceeding 80%. The staff will be closely following the participants on a regular basis. This regular contact adds to the likelihood of being successful in tracking the clients. Further, during intake procedures staff ask clients to sign a consent for follow-up including permission to speak with relative and significant others in our attempts to locate them for follow-up. Data will be checked for accuracy. All data will be double entered to check the accuracy of the data entry. Statistical Package for the Social Sciences (v.11.5) and Microsoft EXCEL will be utilized to process and analyze the data. Data will be processed using various statistical procedures such as analyzing frequencies for out of range values and distributions will be checked against expectations of program implementers. Data will be shared with all stakeholders on a frequent basis in order to ascertain the effectiveness of the program. The evaluator has participated in SAMHSA grant evaluations for many years and will follow informed consent procedures for all data collection. In addition, data will be collected from program implementers and partners through personal interviews and focus groups. Primary responsibility for the actual data collection, analysis and reporting will rest with the evaluator in collaboration with the service providers. The results of the evaluation will be presented regularly to the service providers to provide formative feedback. A summative evaluation report will be prepared bi-annually. Exhibit 1 presents the analytical framework for the process evaluation. As with any evaluation, data management is imperative to the success of the reporting and interpretation ability. Gateway uses the Community Mental Health Corporation system for client information. This nationally recognized information management system is highly reliable and is an integrated data system. All data related to the client's treatment episode and demographics will be stored in the HIPAA compliant system. Client records will be securely stored and all data will be handled in a manner to protect the client's right to privacy. Prior to data collection, program participants will be asked to sign a consent form for participation in the program and will be briefed regarding the evaluation procedures designed to safeguard the privacy and confidentiality of the data.

Outcome Data Analysis: The evaluation will utilize descriptive statistics to examine the distribution of key variables, and analysis of variance to examine changes over time controlling for important independent variables. The findings of this program will be reported and disseminated to CSAT, State agencies, and stakeholders. The applicant will make available the information to National and State conferences on similar subject matter as well as ensure the findings are documented and prepared in written format for dissemination through the Federal, state and local clearinghouses. **Process Evaluation:** The process evaluation is designed to address questions regarding the development and operation of treatment capacity for the program. The following are among the questions the process evaluation seeks to answer: 1. How were the project goals and objectives identified? 2. Did the program meet its intended goals and objectives? 3. Who used the project services, including specific demographics (e.g., age, gender and ethnicity/race)? What were the characteristics of the program's participants? 4. What services did the participants receive, with what type technology and how frequently? This should also capture recidivism of participants, 5. How were services delivered and by whom? What new technologies were integrated into the BVI system of care? 6. How satisfied were the clients with the services they received? How did the clients feel about the use of technology in their treatment? 7. How closely did implementation match the plan? What types of deviation from the plan occurred? What led to the deviations? What impact did the deviations have on the

planned intervention and evaluation? 8. Who provided (program, staff) what services (modality, type, intensity, duration) to whom (client characteristics) in what context (system, community) and at what cost (facilities, personnel, dollars)? Meetings with the implementing team and advisory committee will be conducted every six months with additional meetings as needed. These meetings will focus on the process evaluation and the utilization of interim findings to improve the quality of services. Changes in the program will be monitored and incorporated into the process evaluation.

Data Collection: Exhibit 1: Analytic Framework for the Process Evaluation

Research Question	Data Elements	Data Sources
Goals and Objectives	Project Goals and Objectives <i>and</i> Participant Goals and Objectives	GPRA and Interviews
Participant Demographics	Participant Profiles	Agency Database, and GPRA
Services Received	Services Offered Services Used	Interviews, GPRA, Program Records, and Gateway's Database
Service Delivery	Service Delivery Service Delivery Agencies Service Delivery Staff	Program Records, Agency Operating Plans, Client Records, and Focus Group, and Supervision records
Program Fidelity	Implementation plan, Project proposal	Interviews, Program Records
Cost Effectiveness	Budget Expenditures Units of Service	Performance Measures, Databases, and Financial Data

Data Analysis: Analysis of the data collected to address the study questions will be accomplished by using a content analysis for the qualitative data and descriptive and inferential statistics by using SPSS for the quantitative analysis. For example, in assessing the quality of the service delivery, information collected from focus groups with the service providers will be analyzed via content analysis. Descriptive statistics will be used to identify data patterns and organize data for presentation purposes. Inferential and correlation analysis will be used to examine the relationship of program operational characteristics with program outcomes and to compare program operation before and after expansion.

Outcome Evaluation: In order to assess the effectiveness of the project, the following research effectiveness and efficiency questions will frame the outcome evaluation: 1) Did the program provide evidence-based substance abuse treatment through technology assisted care to the target population identified through outreach to rural families; 2) Where clients able to access services quicker? 3) Did participants in the program decrease symptoms of substance abuse? 4) Did their

physical and mental health improve? 5) Did the project have better outcomes for its participants? 6) Did BVI expand and strengthen its services through the use of technology? 7) How satisfied were the participants with the services they received? 8) What was the effect of treatment on service participants? What program/contextual factors were associated with positive/negative outcomes? What client factors were associated with positive/negative outcomes? How durable were the effects? 9) What evidence-based interventions were used? What changes were made to deliver the intervention with technology assisted care? What impact did that have on the protocol? What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?

Exhibit 2: Analytical Framework of the Outcome Evaluation

Research Question/ Data Element	Data Source
Comprehensive, Integrated Services	Case Records, focus groups
Reduce substance abuse symptoms	GPRA, MIS systems and Participant Records, client reports
Increase health	
Increase self-sufficiency	
Utilization, Retention & Successful Completion	GPRA, Recidivism Data, Focus Groups, Surveys and Performance Measures
Better Outcomes	Agency follow-up data
Participant Satisfaction	Participant Satisfaction Surveys

The results for the outcome objectives will be measured by using the GPRA, interviews and other sources as appropriate such as the GAIN M-90, and any other instruments that might be required. Occasionally there are additional assessments used for treatment planning such as the Beck Depression Inventory, a trauma assessment, Quality of Life Indicator etc. Those are administered when the initial assessment indicates that additional information is needed to better understand the treatment needs of the client.

E.2. How Data will be used to Manage and Ensure Project Quality. BVI has established written Quality Improvement policies and procedures which is data driven. We have experience utilizing data for continuous quality improvement in considering fidelity of the implementation, impact of the program, client satisfaction, adherence to funder requirements, effective staff utilization and effective operations of the project. As an agency, utilization review is done bi-weekly in a regularly scheduled meeting. Bi-weekly Quality Assurance meetings lead by the Compliance Officer and Quality Improvement manager with program managers give structure to evaluating the programs and identifying areas needing improvement within a timely manner. Program managers are able to use this information to purposefully plan and evaluate the effectiveness of improvement measures. In addition, for this project, within the process evaluation are plans to measure the fidelity of the project to the evidence-based practices used. Focus groups of the clients and staff will ask questions about the fidelity of the program. That is, part of the process evaluation will focus on the consistency between the program as planned and the program as implemented. Feedback from this part of the evaluation will be used by staff to make corrections in program delivery to follow evidence-based practices. Data will be broken out by racial, ethnic and gender group to analyze difference responses and outcomes for the program. This information will be presented regularly to staff and the advisory/consumer group to discuss differences which may be considered for improve program functioning to be able to provide the best quality and effective services to a diverse population.

How information related to process and outcomes will be routinely communicated to program staff. The results of the evaluation will be presented in an ongoing informal way to the service providers to provide formative feedback. This accomplished through monthly meetings where data is shared from the GPRA website and data collected for other required reporting. Plans for improvement will be established, mapped out and re-evaluated. This is an ongoing process for continuous quality improvement for the program.

E.3. Performance Assessment Plan. The plan for conducting the performance assessment as specified in Section I-28 is integrated into the full evaluation designed described above. These questions have consistently been a part of Gateway and partner's performance assessment for past grants and are reported on quarterly and annual reports to SAMHSA.

Supporting Documentation

- F. Literature Citations
- G. Budget Narrative (Mandatory Document)
- H. Bio, Sketches and Job Descriptions
- I. Section J. Confidentiality

Literature Citations

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- Center for Substance Abuse Treatment. *Considerations for the Provision of E-Therapy*. HHS Publication. No (SMA) 09-4450 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.
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Stofle, G. S. (2002). Chat room therapy. In R. C. Hsiung (Ed.), e-Therapy: Case studies, guiding principles and the clinical potential of the Internet. 92-135. New York: Norton.

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BUDGET JUSTIFICATION
Federal

Position	Level of Effort	Cost
Program Manager	0.5%	\$44,867
IT Specialist	0.2%	\$8,005
Counselor	100%	\$38,000
Adm. Asst.	0.2	\$7,500
Total		\$98,372
Fringe (FICA, Employment Security, Insurance, etc 28% x \$98,372)	.28%	\$27,544
		\$27,544
Supplies (Clerical supplies, toiletries)	\$100 per month	\$1200
Phone devices for clients (50 smart phones)	\$2500	\$2500
Computers & cameras (Computers (4) \$5400 Fisheye cameras \$2300)	\$7,700	\$7,700
Total		\$11,400
Other		
Communications		\$8500
(Telephones bills, fax lines and other devices)		
Total		\$8500
Contractual		
Evaluation Services		
Connect services	Yearly	\$20,000
Evaluation Stipends (\$10 x 110 clients)	\$10	\$1200
On site research Assistant		\$17,784
Total		\$38,884
Indirect Costs		
(31%)		\$86,800
Total		\$86,000

Personnel	Salaries	Effort	SAMSHA	Non-Federal	Total
Executive Director Jerry Risner	\$100,000	.06%	0	\$6,000	\$6,000
Principle Investigator Deborah A. Hillin	\$89,900	.28%		\$25,000	\$25,000
Program Manager Bruce Emery	\$89,734	.5%	\$44,867		\$44,867
Psychologist Dr. Mark Sigler	\$120,000	.16%		\$19,000	\$19,000
IT Bob Gerard	\$40,025	.2%	\$8,005		\$8,005
Counselor Anthony Yader	\$38,000	100%	\$38,000		\$38,000
Administrative Asst. /Outreach Amy Crowe	\$34,000	.20%	\$7,500		\$7,500
Case Manager To Be Named	\$35,000	.5%		\$17,500	\$17,500
Nurse Julie Maddox	\$39,000	.1%		\$3900	\$3900
Total Personnel			\$98,372	\$71,400	\$169,772
Fringe			\$27,544	\$19,992	\$47,536
Travel Travel will be miles traveled between the sites and to and from clients in the field $10,000 \times .45 = \$4,500$ 2 people to Washington 3 days plane fare, rooms and per diem Research assistant travel to Florida Total Travel			\$4,500 \$2,900 \$1,100 \$8,500		\$8500
Supplies: Clerical office supplies, toiletries \$100 x 12 Phone devices for clients 50 smart phone \$50 ea Computer (4) &5400 Cameras (5) \$2300 (fisheye lens) Total Supplies			\$1200 \$2500 \$7700 \$11,400		\$11,400
Other Communications Monthly telephone bills, fax and other devices Total Communications			\$8,500 \$8,500		\$8,500
Contractual: Evaluation Services Evaluation (Gateway Connect recognized & experienced in E-Treatment Technology Evaluation Stipends 10 per client 110 total On-site research assistant Total Contractual			\$20,000 \$1,100 \$17,784 \$38,884		\$38,884
Indirect Costs (31%)			\$86,800		\$86,800
Total Costs			\$280,000	\$91,392	\$371,392

CALCULATION OF FUTURE BUDGET PERIODS
12-Month Budget Periods

Personnel	First 12-Months	Second 12-Months	Third 12-Months
Program Manager	\$44,867	\$44,867	\$44,867
IT	\$8,005	\$8,005	\$8,005
Counselor	\$38,000	\$38,000	\$38,000
Adm. Asst./Outreach	\$7,500	\$7,500	\$7,500
TOTAL PERSONNEL	\$98,372	\$98,372	\$98,372
FRINGE 28%	\$27,544	\$27,544	\$27,544
TRAVEL	\$8,500	\$8,500	\$8,500
SUPPLIES	\$11,400	\$11,400	\$11,400
CONTRUACTUAL	\$38,884	\$38,884	\$38,884
OTHER	\$8,500	\$8,500	\$8,500
TOTAL DIRECT COSTS	\$193,200	\$193,200	\$193,200
INDIRECT COSTS	\$86,800	\$86,800	\$86,800
TOTAL CHARGES	\$280,000	\$280,000	\$280,000

501 PARK AVE SOUTH • HOHENWALD, TN. 38462
PHONE 931-796-5124

JERRY RISNER, MA

OBJECTIVE

To obtain a challenging position that utilizes my extensive management skills and education.

PRESENT POSITION

Buffalo Valley, Inc. Hohenwald, T N.
October 1988 - Present
Chief Executive Officer
Expanded programs, diversified business, brought revenues up from \$300,000 to more than \$3,000,000. C.E.O. of a 63-bed treatment center, three clinics, 10 safe housing projects, 3 homeless Veteran Permanent Houses, and other varied programs.

PRIOR EXPERIENCE

Whitwell Medical Center Whitwell, TN.
Chief Executive Officer
C.E.O. of Medical Center, Home Health Agencies, Sequatchie General Hospital, Grundy County Projects, Alcohol and Drug Programs, psychiatric projects, etc.

Lewis County Hospital Hohenwald, TN.
Administrator
Responsible for the entire operation of the hospital. Developed the first Swings Beds in the State of Tennessee.

EDUCATION

University of North Alabama Florence, AL.
(Bachelor of Science Degree)
Middle Tennessee State University Murfreesboro, TN.
(Master of Arts, Psychology)
University of Alabama Florence, AL.
(Certificate of Health Services, Administration Development)

REFERENCES

Available upon request

5465 VILLAGE WAY • NASHVILLE, TN. 37211
PHONE 615-333-3905 • FAX 615-333-2048 • E-MAIL DEBBIEHILLIN@BUFFALOVALLEY.ORG

DEBORAH A. HILLIN, MA

OBJECTIVE

To obtain a position that will utilize my skills and abilities in clinical counseling, development and management of programs, and grant writing

RESENT POSITION

Buffalo Valley, Inc.
July 1991 to present
Senior Vice President
Case Management and Drug Court Services
Manager of HUD Continuum of Care for Middle Tennessee
Project Manager/Principal Investigator SSH SAMHSA Grant
Manager of a Social Recovery Program for Homeless and Incarceration
Manager of Recovery Support Services
Coordinator of multiple Drug Court Programs in Tennessee
Grant Writer

ADDITIONAL INFORMATION

Develops and manages case management and transitional housing services for the homeless. Coordinates a Continuum of Care in 20 counties including interaction with county governmental officials and social service agencies in the identification of gaps and needs and the official point-in-time annual count. Develops and provides clinical oversight and supervision of two treatment sites. Implements Evidence Based Practices into the clinical program and trains staff in EBP. Develops, implements, and consults on needs relative to recovery support services. Develops data collection tools, performs statistical analysis for evaluation of services for multiple Federal Grants through H.U.D. and Office of Justice. Received training in quality assurance, attended conferences and training on American Society of Addiction Medicine, and served as co-chair for the responsibility for obtaining Joint Commission on Accreditation of Hospitals Organization in 1991, 1993, 1997, 2003 and 2006 for the respectful alcohol and drug facilities. Serves as State Liaison on treatment protocols, licensure rules, recovery support services, and EBP.

PROFESSIONAL EXPERIENCE

Tennessee Alcohol and Drug Association
Not-for Profit Association
Liaison and Consultant
September 1995 to 2000

The Harbours at Brentwood
Quality Assurance Coordinator
Clinical Counselor
September 1987 to July 1991

Alcohol Safety School for Middle Tennessee
Director
September 1980 to September 1988

Marshall County Sheriff's Office
Jail Administrator & Court Liaison
January 1983 to September 1987

LICENSURE

Tennessee Department of Health
License Alcohol and Drug Counselor, 1996-current

CERTIFICATION

Tennessee Department of Health
Certified Alcohol and Other Drug Abuse Counselor, 1991-1996
National Certified Addictions Counselor, 1991-current

SOCIETY MEMBERSHIPS

Tennessee Association of Alcohol and Drug Abuse Counselors
National Association of Alcohol and Drug Abuse Counselors
National Association of Drug Court Professionals
Tennessee Drug Court Association

APPOINTMENTS

Tennessee Alcohol and Drug Association Board Representative
1994 to present
Tennessee Assoc. of Alcohol & Drug Abuse Counselors Representative
1994 to present
Tennessee Assoc. of Mental Health Organizations
A&D Advisory Board Representative
2000 to present
A&D Advisory Board Chair
2003 to present
National Association of Drug Court Professionals Conference – Panelist
2003 and 2004
National Association of Drug Court Professionals Member

HONORS

Tennessee Alcohol and Drug Association Achievement Award
1993, 1995, 1996, 1997 and 1998
Strathmore's Who's Who, 1996 – 1997 & 1997 – 1998

EDUCATION

Lawrence County High School (Graduate 1973)
University of Tennessee-Martin (B.S. Degree – Graduate 1976)
Trevecca Nazarene University (M.A. Degree – Graduate 1997)

REFERENCES

Available upon request

161 INDIAN CREEK RD • HOHENWALD, TN. 38462
PHONE 931-796-4868

MARK SIGLER, PH.D., NCSP, NCP

OBJECTIVE

To obtain a position where I can best use my extensive experience and education to assist those with mental illness.

PRESENT POSITION

Buffalo Valley, Inc.	Hohenwald, T.N.
February 1997 – Present	
Consultant Psychologist	
Performs staff consultation, behavioral consultation and analysis. Provides clinical treatment and psychological testing. Conducts in-staff training and interdisciplinary team staff meetings.	

PRIOR EXPERIENCE

Lewis County Board of Education	Hohenwald, TN.
August 1999-Present	
School Psychologist/Licensed Professional Counselor	
Provides appraisal and referral, staff consultation, and parental consultation, including counseling services. Participates in IEP Team. Conducts psychological evaluations. Provides in-service training and prevention services, third party consultation, and quality assurance. Performs behavioral consultation and analysis.	
Highland Youth Centers	Hohenwald, TN.
January 1992-July 1999	
Executive Director	
Program and facility administration for 48 bed residential mental health and drug/alcohol programs. Clinical and administrative supervision. Clinical evaluation, counseling and psychotherapy.	

EDUCATION

University of Tennessee (Bachelor of Science-Psychology)	Knoxville, TN.
1976	
Middle TN State University (Masters of the Arts-Clinical Psychology)	Murfreesboro, TN.
1978	
Clayton University (Doctor of Philosophy-Clinical Psychology)	Atlanta, GA.
1987	

REFERENCES

Available upon request

1745 University Dr.
Columbia, TN. 38401

Robert Girard

Work experience	Buffalo Valley Inc. Systems Administrator, IT Department <ul style="list-style-type: none">• Analyzes user requirements, procedures, and problems to automate processing or to improve existing computer system.• Writes detailed description of user needs, program functions, and steps required to develop or modify computer program.• Studies existing information processing systems to evaluate effectiveness and develops new systems to improve production or workflow as required.• Upgrades system and corrects errors to maintain system after implementation.• Converts data from project specifications and statements of problems and procedures to create or modify computer programs.• Built BVI E-Treatment. JACOA Systems Administrator/A & D Counselor <ul style="list-style-type: none">• Analyzes and tests computer programs or system to identify errors and ensure conformance to standard.• Formulates and reviews plans outlining steps required to develop programs to meet staff and user requirements.• Coordinates installation of computer programs and operating systems, and tests, maintains, and monitors computer system.• Assists staff and users to solve computer related problems.• Modifies program to correct errors by correcting computer codes.• Writes and revises program and system design procedures, test procedures, and quality standards.• Over one year of service. Smartsoft Solutions Owner <ul style="list-style-type: none">• Designed and developed MIS for Automobile and Video businesses.• Designed networks and PC systems.• Over seven years in business.	Hohenwald, TN. Jackson, TN.
Education	Assabet Regional Vocational Boston College	
References	Available upon request	

1704 MASSEY AVE., LAWRENCEBURG, TN. 38464
PHONE (931)244-5597 • E-MAIL JULIEMADDOX@BUFFALOVALLEY.ORG

JULIE M. MADDOX

OBJECTIVE

To obtain a position that will utilize my skills, abilities, my education and training for the advancement of quality patient care.

RESENT POSITION

Buffalo Valley, Inc.
Director of Nursing
April 2010 to Present
Reorganized, redesigned, and expanded Detox Program
Established a new Detox Program and actively participated in the physical design of nursing unit within the facility
Developed, maintained, and monitored budget
Manage and coordinate patient care in acute withdrawal phase

PROFESSIONAL EXPERIENCE

Maury Regional Medical Center	Columbia, TN
Registered Nurse	
June 2008 to Present	
Hewitt House	Pulaski, TN.
Resident Assistant	
January 2008 to June 2008	

LICENSES AND CERTIFICATION

7/2008-2/2013: Registered Nurse, State of Tennessee, License # 166206
8/2010-8/2012: BLS certified through America Heart Association
1/2011- 1/2013: ACLS certified through America Heart Association

VOLUNTEER ACTIVITIES

Department of Health South Central TN Regional Medical Reserve Corps Point of Distribution (POD) team member

PROFESSIONAL ACTIVITIES

Sep. 2010: Preceptor for community health nursing clinical nursing students
Nov. 26, 2007: PowerPoint Presentation: Nurse's Role in Infection Control
Martin Methodist College, Pulaski, TN
Oct. 30, 2007: Poster Presentation: Childhood Obesity: Parental Education & Prevention
Martin Methodist College, Pulaski, TN

EDUCATION

Martin Methodist College (BSN)	Pulaski, TN.
Middle Tennessee State University	Murfreesboro, TN.

REFERENCES

Available upon request

605 MEADOWVIEW DR., MT. JULIET, TN. 37122
PHONE 615-491-5830 • E-MAIL AYATERNIPC

ANTHONY P. YATER

OBJECTIVE

To obtain a position that will utilize my skills and abilities

PRESENT POSITION

Buffalo Valley, Inc.
Counselor

- Interviewed clients, reviewed records, and conferred with other professionals to evaluate condition of client.
- Formulated treatment plan for client, using knowledge of drug and alcohol abuse problems and counseling and treatment techniques.
- Counseled clients individually and in-group sessions to assist client in overcoming alcohol and drug dependency. Also counseled with family members regarding same issues.
- Referred client to other support services, as needed, such as medical treatment, social services, and employment services.
- Monitored condition of client to evaluate success of therapy, and adapted treatment as needed including E-Treatment.

PROFESSIONAL EXPERIENCE

About Time Sports Bar
Assistant Manager

- Interact with guests to ensure proper customer service.
- Organize and promote activities
- Assess and modify practices with the business

National Independent Pharmacy Coalition
VP of Sales

- Develop leads for new accounts across the Southeastern United States.
- Foster relationship with current and potential accounts to ensure the highest level of customer satisfaction.
- Develop and organize proposals regarding pricing, rebates, and cost of goods.
- Research and solve problems relating to my accounts.
- Create an environment that supports teamwork.

EDUCATION

Belmont University (B.A. in Psychology)	Nashville, TN.
Trevecca Nazarene University (Graduating 2012)	Nashville, TN.

REFERENCES

Available upon request

1010 BRIGGS LANE, SPRING HILL, TN. 37174
PHONE (731)225-2044 • E-MAIL ACROWE743@YAHOO.COM

AMY CROWE

OBJECTIVE

Seeking a position that will utilize my skills and abilities in a new and challenging work environment.

RESENT POSITION

Buffalo Valley, Inc. August 2010 to Present

Administrative Assistant

Keeps official records and executes administrative policies determined by or in conjunction with other officials. Prepares memorandums outlining and explaining administrative procedures and policies to supervisory workers.

Plans conferences. Directs preparation of records, such as notices, minutes, and resolutions for meetings. Recording of company issues. Acts as custodian of documents and records. Preparation and filing of legal documents with government agencies to conform with statutes.

PROFESSIONAL EXPERIENCE

Law Offices of Kyle Crowe

Martin, TN.

Office Manager

1997. to 2009

JOB ACCOMPLISHMENTS

Successfully operate a law firm

Ability to perform any and all duties and responsibilities of a paralegal

Successfully oversee multiple paralegals to assure that all firm objectives are met

Successfully developed office policies and procedures

Improved relationships by implementing feedback process to ensure clients and employees needs are met

EDUCATION

University of Tennessee

B.S., Public Administration

REFERENCES

Available upon request

Job descriptions:

BUFFALO VALLEY, INC.

Job Description

Job Title: Executive Director

Department: Leadership/Management

SUMMARY

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned. Senior member of the management team providing technical assistance, training and coaching to clinical supervisors and specific department/area coordinators. Monitors statistical and quality of care reports as determined by company policy and payor sources. Develops working relationship with other agencies and/or programs. Monitors quality of care against preestablished indicators and criteria, i.e. JCAHO, BVI Standards of Care, third-party payor standards, etc. Monitors all company policies and procedures. Adjusts staffing patterns according to budget constraints. Works closely with grant and program personnel to ensure program goals and objectives are met. Assigns duties/or responsibilities to specific personnel as determined by company needs. Develops and implements new programs/services. Assists team members in the interviewing process for selection of new employees.

SUPERVISORY RESPONSIBILITIES

Manages subordinate supervisors who supervise employees throughout the company, including outreach locations, and various programs. Is responsible for the overall direction, coordination, and evaluation of these units. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws. Responsibilities include interviewing, hiring, planning, assigning, and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.

QUALIFICATIONS EDUCATION and/or EXPERIENCE

Master's degree (M. A.) or equivalent; or eight to ten years related experience and/or training; or equivalent combination of education and experience. Has demonstrated sufficient experience in effectively managing programs and personnel.

LANGUAGE SKILLS

Ability to read, analyze, and interpret common scientific and technical journals, financial reports, and legal documents. Ability to respond to common inquiries or complaints from customers, regulatory agencies, or members of the business community. Ability to write speeches and articles for publication

that conform to prescribed style and format. Ability to effectively present information to top management, public groups, and/or boards of directors.

MATHEMATICAL SKILLS

Ability to work with mathematical concepts such as probability and statistical inference, and fundamentals of plane and solid geometry and trigonometry. Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations.

REASONING ABILITY

Ability to define problems, collect data, establish facts, and draw valid conclusions. Ability to interpret an extensive variety of technical instructions in mathematical or diagram form and deal with several abstract and concrete variables.

SALARY RANGE: \$44,000 - \$90,000

Job Description

Title of Position: Principal Investigator

Supervisor: Executive Director

Description of duties and responsibilities: The Principal Investigator is responsible for the government level coordination and overall leadership and oversight of the project. Specific role responsibilities are as follows:

- ◆ Assure that the project is implemented according to the grant application materials.
- ◆ Participate in the development of the grant project at the government level.
- ◆ Develop a monitoring plan and schedule to evaluate project implementation.
- ◆ Supervise the researcher associated with the grant.
- ◆ Chair the Project Advisory Panel
- ◆ Gather and share information at the government level to facilitate the success of the project development.
- ◆ Complete reports specified by SAMHSA-CSAT.

Qualifications:

- ◆ The ideal candidate will hold a degree psychology, business, statistics, research, criminal justice or a closely related discipline and E-Treatment experience.

Prior Experience Required:

At least ten (10) years experience in mental health or substance abuse field. Must have experience in program design, implementation and evaluation. Supervisory experience is highly desirable. The person should be familiar with federal grants and have experience in report writing.

Skills and Knowledge Required:

- ◆ Ability to work in multi-cultural settings and with multiple agencies.
- ◆ Ability to demonstrate effective communication and listening skills.
- ◆ Competence in computer skills including E-Treatment
- ◆ Strong organizational skills
- ◆ Strong writing skills.

Personal Qualities:

Must value cultural differences and be able to utilize a strengths based approach to problem solving. Must possess energy and the desire to tackle very difficult work. Must possess a sense of humor and have the ability motivate others.

Salary Range:

Hours: Not applicable.

Job Description

Title of Position: Program Director

Supervisor: Executive Director

Description of duties and responsibilities: The Program Director is responsible for the government level coordination and overall leadership and oversight of the project. Specific role responsibilities are as follows:

- ◆ Assure that the project is implemented according to the grant application materials.
- ◆ Participate in the development of the grant project at the government level.
- ◆ Develop a monitoring plan and schedule to evaluate project implementation.
- ◆ Supervise the researcher associated with the grant.
- ◆ Chair the Project Advisory Panel
- ◆ Gather and share information at the government level to facilitate the success of the project development.
- ◆ Complete reports specified by SAMHSA-CSAT.

Qualifications:

- ◆ The ideal candidate will hold a degree psychology, business, statistics, research, criminal justice or a closely related discipline and E-Treatment experience.

Prior Experience Required:

At least ten (10) years experience in mental health or substance abuse field. Must have experience in program design, implementation and evaluation. Supervisory experience is highly desirable. The person should be familiar with federal grants and have experience in report writing.

Skills and Knowledge Required:

- ◆ Ability to work in multi-cultural settings and with multiple agencies.
- ◆ Ability to demonstrate effective communication and listening skills.
- ◆ Competence in computer skills including E-Treatment
- ◆ Strong organizational skills
- ◆ Strong writing skills.

Personal Qualities:

Must value cultural differences and be able to utilize a strengths based approach to problem solving. Must possess energy and the desire to tackle very difficult work. Must possess a sense of humor and have the ability motivate others.

Salary Range:

Hours: Not applicable.

Therapist/Counselor

Direct Supervisor: Clinical Director

Supervisory Responsibilities: None

SUMMARY

Responsible for care coordination, individual sessions, IOP groups, in addition to maintaining key role for facilitating back-up of other services and enhancement,

DUTIES/EXPECTATIONS:

1. Performs care coordination, linkage and therapy
 - a. Obtains resident history and presenting information within three business days of admission and, within that timeframe, collaboratively develops an individualized treatment plan with the resident which includes targeted discharge plan and date. Must train client on use of E-Treatment
 - b. Defines all relevant community sources affecting care and treatment of the consumer (e.g., attorney, family, case manager, etc.) and develops and follows contact plans and conjoint therapy plans to help client in an E-Treatment self help environment.
 - c. Updates referring sources on consumer progress, if/as approved by the consumer.
 - d. Conducts individual sessions no less than weekly, specifically addressing and, as indicated, modifying treatment goals and ongoing evaluating discharge plans, dates, and resource needs, scheduling on site visits as needed.
2. Utilizes agency endorsed client-centered therapeutic interventions and rapport-building practices, including Motivational Interviewing techniques, to non-confrontationally enhance consumer insight regarding diagnostic and usage patterns.
 - a. Conducts assertive outreach and coordination of services, with the majority of efforts to be conducted outside of the agency.
 - b. Coordinates comprehensive discharge plan to ensure seamless community reintegration. Utilize smart phones and other technologies that are available.

QUALIFICATIONS

Understanding of a variety of models and theories of addiction, MI, and related issues; Knowledge of philosophies, practices, policies and outcomes of models of treatment, recovery, relapse prevention, and continuing care for dually diagnosed populations; Understanding of diagnostic criteria for dual conditions and ability to conceptualize modalities and placement criteria within the continuum of care; understanding of diverse cultures and gender specific issues and ability to incorporate needs of gender and culturally diverse groups into practice setting. If in recovery, must have a minimum of two years abstinence. Must comply with drug-free workplace guidelines. Must have desire, ability and experience with computer technologies, E-Treatment preferred

EDUCATION and/or EXPERIENCE

Bachelor degree in psychology, social work, or related field and two years of education/experience regarding/with MH/SA populations -or- Master's degree and one year of experience -or- addictions credentialed/eligible with three years of experience. Must be proficient in use of IT technologies.

Signature: _____

Date: _____

BUFFALO VALLEY, INC.

Job Description

Job Title: Information Technology/Software Developer

ESSENTIAL DUTIES AND RESPONSIBILITIES Include the following. Other duties may be assigned. Knowledge of both technology and business practices. Duties will vary depending upon work environment, company size and dealing with a wide range of issues, having excellent people skills and an understanding of business management and technical expertise. Be able to convert project specifications and statement of problems and procedures to detailed logical flow charts for coding into computer language. Develop and write computer programs to store and locate and retrieve specific documents, date and information. May program web sites. Develop and modify computer applications or specialized utility programs; analyze user needs and develop software solutions. Design or customize software for client use with the aim of optimizing operational efficiency.

QUALIFICATIONS - EDUCATION and/or EXPERIENCE

Four years of computer training and software education,

LANGUAGE SKILLS

Be able to set operational specifications and formulate and analyze software requirements and apply principles and techniques of computer science, engineering and mathematical analysis.

MATHEMATICAL SKILLS

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY

Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

PHYSICAL DEMANDS The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Salary Range: \$50,000 - \$74,000

BUFFALO VALLEY, INCORPORATED
Job Description

Job Title: Staff Nurse
Department: Physical Health Services
Reports To: Nursing Supervisor

SUMMARY

Provides physical health services and first aid to clients or persons who become ill or injured on premises of treatment facility by performing the following duties.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned.

Comply with all BVI Policies & Procedures, State and Federal laws, as well as State Residential, Partial Hospitalization, Intensive Outpatient, Outpatient treatment and Joint Commission requirements as provided to me by BVI administration/Operations Department.

Takes client's vital signs, treats wounds, and evaluates physical condition of clients as needed in emergency situations. Documents these in BLIS and other data locations as needed.

Contacts Physician and hospital to arrange for further medical treatment, when needed.

Maintains record of persons treated, and prepares/follows up on Incident Reports of clients, staff and visitors.

Develops employee and client education based programs such as health, accident prevention, STD's, universal precautions, infection control and first-aid.

Prepares residential clients to be seen by the Doctor for physical examination on admission. Contacts Medical Director at 8:00am and 4pm daily regarding detox admissions and nurse practitioner as appropriate for coverage and issues related to detox.

Completes client medical, medication history to be added to the clinical record. Meets with clients regarding their prescription medications, their ability to self-medicate and history of adverse reactions with the medication. Follows up on referrals made by staff for physical and/or dietary issues.

Performs tuberculosis testing on all clients at time of admission and employees in Hohenwald makes appropriate referrals for any individuals exhibiting S/S of TB or presenting with + TB test. Documents any S/S for other communicable diseases and other Infection Control information for monthly reporting.

Is responsible for the follow-up and documentation of medical information into the client's clinical record including:

CIWA-AR/COWS for ASAM level III.2D/III.7D clients

Physical Health Assessment and/or Health & Physical/Admission Order interview

Medication Profile/Medication/Medication History and review Medication Administration Record

Referrals by Staff (Nutritional/Physical)

Tuberculosis/infection control issues

Treatment planning for Clinically Monitored Detoxification and Medically Monitored client medical issues.

Detox Progress Notes

Medical Progress Notes

Supervises the self-administering of client medications and compiles daily information in the medication log book. Counsels' clients on the overuse of Over The Counter medications/drug seeking behavior as needed.

Is responsible for the upkeep and stocking of the medicine closet (over-the-counter comfort meds) and/or Floor Stock for Detox clients.

Completes the admission process and assists in medical records department, as needed.

Is available to answer medical questions after hours as needed by on-call staff.

Performs other duties as needed.

SUPERVISORY RESPONSIBILITIES

This job has no supervisory responsibilities.

QUALIFICATIONS To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

Associate's degree (A. A.) or equivalent from two-year college or technical school; or six months to one year related experience and/or training; or equivalent combination of education and experience.

LANGUAGE SKILLS

Ability to read and interpret documents such as safety rules, operating and maintenance instructions, and procedure manuals. Ability to write routine reports and correspondence. Ability to speak effectively before groups of customers or employees of organization.

MATHEMATICAL SKILLS

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY

Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

CERTIFICATES, LICENSES, REGISTRATIONS

Registered nurse or licensed practical nurse. Must have a valid license to perform the duties assigned and must notify BVI of any Adverse Licensure Actions within 5 days of the occurrence.

PHYSICAL DEMANDS The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

WORK ENVIRONMENT The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is occasionally exposed to toxic or caustic chemicals. The noise level in the work environment is usually moderate.

Signature _____ Date _____

Supervisor _____ Date _____

BUFFALO VALLEY, INC.
Job Description

Job Title: Case Manager
Department: Case Management/Telehealth Case Manager
Reports To: HNM Grants Coordinator/Supervisor

SUMMARY

As a member of the case management team, assesses the needs of the HNM clients and coordinates community resources to assist clients in obtaining permanent housing. The case manager will hold individual and group sessions via Telehealth Communications. Case Manager will work with HNM and ESGP clients.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned. Orients new HNM clients as to goals and objectives of HNM, role of the case manager, and services that are available and accessible to the client. Completes Initial Admission Assessments and Admission packet on all HNM # clients assigned to them within 36 hours of entry. Assists clients in obtaining employment and permanent housing. Maintains up-to-date, accurate and understandable case files and records, as delineated on the Chart Order Checklist. Develops employment and housing referral network and maintains professional relationship with employers/landlords to ensure continued coalition. Coordinates transportation of clients to ensure client reaches destination by scheduled time frame. Completes all necessary requirements/documentation. Attends scheduled team meetings and training sessions. Conducts follow-up on all assigned HNM clients for a minimum of one (1) year and in the time frames outlined in the HNM grant. Documents accordingly. Prepares monthly/quarterly reports of activities and submits to supervisor on scheduled due date.

QUALIFICATIONS To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Skilled in addressing the special needs of the homeless population, while displaying a compassionate and professional approach. Able to demonstrate the ability to effectively network with other agencies and the community, through accessing services available to client population. Able to communicate verbally and by telecommunication and in writing. Strong organizational and time management skills; able to meet deadlines. Flexible in days and hours available for work. Dedicated to compliance with B.V.I. standards of care, while adhering to Staff Code of Ethics.

EDUCATION and/or EXPERIENCE

High school diploma or G.E.D. required. One year certificate from college or technical school; or 6 to 12 months related experience and/or training; or equivalent combination of education and experience. Previous experience working in chemical dependency field and telecommunication preferred. Adequate understanding of HNM clients who have A & D and/or mental health issues.

REASONING ABILITY

Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form. Ability to deal with problems involving several concrete variables in standardized situations.

CERTIFICATES, LICENSES, REGISTRATIONS

Valid Tennessee driver's license with CDL or type "F" endorsement.

SALARY RANGE: \$20,000 – \$32,000

BUFFALO VALLEY, INC.

Job Description

Job Title: Administrative Clerk/Bookkeeping

Department: Business Office

SUMMARY

The employee is responsible for keeping and maintaining pertinent records for the telehealth program. **ESSENTIAL DUTIES AND RESPONSIBILITIES** include the following. Other duties may be assigned. Clerical duties as well as trouble shoot phone/computer/equipment problems as needed for the telehealth program. Assists the Business Manager in the maintenance of the following: Grant File that contains the notification letter, executed grant agreement, approved amendments to the grant agreement, and other related documents. Monitoring File that contains copies of monitoring letters, related correspondence from the Field Office, annual reports, monitoring findings, and responses, and evidence of corrective actions. Application File that contains copies of the approved application. Copy of Financial Files relative to specific grants. Program Procedure File that contains copies of program regulations, program guidance and procedures. Will maintain up-to-date personnel files on all grant employees.

QUALIFICATIONS - EDUCATION and/or EXPERIENCE

High school education with six months to one year related experience and/or training; or equivalent combination of education and experience, knowledge in computer skills.

LANGUAGE SKILLS

Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or governmental regulations. Ability to write reports, business correspondence, and procedure manuals. Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the general public.

MATHEMATICAL SKILLS

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY

Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

PHYSICAL DEMANDS The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Salary Range: \$20,000 - \$30,000

Section J: Confidentiality and SAMHSA Participant Protection/Human Subjects

1. Protection of clients and staff from potential risk:

There are minimal physical, psychological, legal or social risks involved with participants in the proposed evaluation study. Given that the self-report measurement instruments ask pointed questions regarding participants' knowledge, behavior, and attitudes relating to alcohol and drug abuse behaviors, all participants will be instructed that they may skip any questions that may potentially cause discomfort. The results of this participation will be confidential and will not be released in any individually identifiable form. Participants will be assured of their confidentiality. No one, except the Project Director and Evaluators will have access to the data, and all data will be treated anonymously. Participants will be provided the telephone numbers of the Project Director and Evaluators and community service providers. These individuals will be available to students to assist them in the referral process should they request it.

2. Fair selection of participants/Description of the Target Population:

Participants will be substance-using adults involved in co-occurring treatment and recovery-oriented systems of care. All service recipients who have documented written parental permission will have the opportunity to participate if they choose. Recruitment will be through the intake process. The proposed research will be conducted only with individuals who participate in the Project. There will be approximately 330 individuals who will participate in the co-occurring treatment and the evaluation. To be eligible for the evaluation study an individual must (a) be defined as a client of Buffalo Valley and therefore, (b) have a history of substance use, (c) have a recent history of homelessness, (d) report needing substance abuse treatment services, (e) be at least 18 years of age, (f) be interested in participating in the evaluation interview, (h) provide written consent to participate, and (i) be able to provide verifiable locator information for follow-up interviews, and (j) have risk for Post-Traumatic Stress Syndrome due to military service or substance use-related behaviors.

Absence of Coercion/Voluntary Participation:

Participation is voluntary and participants who be encouraged to complete interviews at program exit and six-month follow-up interviews will be made. Potential participants will be informed of services available to them, whether or not they choose to participate in the data collection component.

3. Data collection, including Source of Data and Setting for Data Collection:

Data collection will include quantitative data collected through face-to-face interviews in a private setting within BVI staff offices, and process measures of participant contact with intervention staff. Data will be collected from all consenting participants in the program (n=330) at program entry, program exit, and a follow-up interview six-months post-program entry utilizing the GPRA tool. Interview topics will include Demographics, Substance Use, HIV Risks, Basic information regarding psychosocial functioning (Housing Status, Employment Status, Criminal Justice Status, Social Support), Treatment Motivation (Desire for Help, Treatment Readiness), and Psychological Functioning (Depression, and Anxiety). All questions are drawn from standardized instruments used extensively and normed for the target population. Copies of all available data collection instruments and interview protocols are contained in Appendix

3:

4. Privacy and Confidentiality:

Data will be collected via participant interviews. Only the Project Director and Evaluators will have access to data identification codes. These codes will be locked during the project and destroyed after the project. We agree to maintain the confidentiality of the alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

5. Adequate Consent Procedures:

After obtaining a verbal consent, staff will screen potential participants to determine eligibility. Eligible participants will be asked to provide informed consent for participation in the overall study. In obtaining informed consent, the consent form will be read to all potential participants, and an opportunity will be given to ask questions and have them answered to ensure fully informed consent. Before being given the opportunity to sign the consent form, participants will be asked to explain in their own words what they understand about the study. Participants will then be given the opportunity to sign each of their written consents. The consent forms will include the following: a statement explaining the purpose of the research; the expected duration of the subject's participation; a description of any reasonable foreseeable risks or discomforts to the subject; a description of benefits to the subject; a statement describing the extent to which confidentiality of records identifying the subjects will be maintained; a statement that participation is voluntary; a statement that their involvement or early termination in the study will not affect their access to any services; an explanation of whom to contact for answers to pertinent questions about the research and research subject's rights; and whom to contact in the event of a research-related adverse situation. Those who do not provide written consent for the overall study will not be enrolled. Participants will be reminded that they have the right to discontinue participation in the study at any point and to refuse to answer any question.

Risk/Benefit Discussion:

There are two potential risks for participants: (1) improper disclosure of confidential information, and (2) mental discomfort associated with issues raised during the focus groups, data collection interviews, or intervention sessions. The risk of improper disclosure of information pertaining to illegal activities is real. However, the probability of improper disclosure by staff is low because of the limited number of individuals handling sensitive data and the training that these individuals will undergo. Mental discomfort arising from questions asked during interviews is a possibility. Staff will be trained to recognize signs of mental discomfort and how to provide counseling and referrals when appropriate; interviews will take place at a service-providing agency with trained on-site clinical staff with knowledge and experience. The PI will review any adverse incident as soon as it occurs and will document the incident in a report. The report will be sent to the Institutional Review Board, the Community Advisory Board, and to the SAMHSA/CSAT Project Officer. Any unanticipated serious adverse events (e.g., death, inpatient hospitalization) will be reported within 72 hours of occurrence. No minors or prisoners will be subjects in this study. It is possible that some female respondents might be pregnant, but they are not placed at risk by their involvement in the evaluation.

Protection against Foreseeable Risks

IRB and Community Advisory Board approval for the proposed study will be obtained. Participation in the study is voluntary. All staff will review regulations regarding confidentiality, and signed agreements will be kept on file. Exceptions to these regulations include threats of imminent harm.

Potential Risk of Disclosure of Information: Although the risks associated with disclosure of information are minimal, every effort will be made to protect participants against improper

disclosure of sensitive information. Participant confidentiality will be assured at data entry, storage, retrieval, and analysis stages. The interview data will be linked to participant identifiers only through a unique study ID. Data forms with locator information will be stored separately from other data in a double locked file in a locked room, with access restricted to research staff, the PI and research assistant. These risks will be further minimized through staff training and the development of specific procedures for protecting confidential information, and reporting any adverse events that may occur. All staff will be trained on confidentiality and ethics with human subjects. Staff will also be educated on their responsibilities for securing and/or recording data, the rights of participants, and the confidentiality requirements of the project. All staff will be required to sign a Confidentiality Agreement.

Potential Risk of Mental Discomfort: To minimize the risk of mental discomfort that may arise from material covered in the interviews, participants will be informed at every interview that they can refuse to answer any questions they find disturbing. Procedures will also be established for handling distressed respondents, including making referrals and mandatory reporting procedures. Staff will be trained on the various ways that emotional distress may be expressed as well as typical verbal and nonverbal cues indicating that a respondent is about to become upset. Participants will be referred to counseling if necessary and/or requested.

Potential Benefits to the Subjects and Others

There are several benefits to participating in this project. Participants will be encouraged to complete the follow up interviews. The results of this study have the potential to have an immediate impact the local service delivery system and to improve services to similar individuals in other areas who are at health risk.

Importance of the Knowledge Gained

While there is some research on the barriers and facilitators to treatment access and engagement for homeless individuals battling post-traumatic stress symptoms, these barriers require examination. Current studies have focused primarily on internal motivation and treatment readiness without placing these concepts within an environmental context for recently housed individuals who may have competing requirements from family members, employers and parole/probation officers. The proposed evaluation is designed to provide a multi-level assessment of issues that impact the delivery and outcome of services aimed at facilitating this transition from homelessness to recovery in the community. Second, the proposed project addresses treatment access and engagement from a conceptual framework emphasizing the role of both individual level and environmental level barriers and facilitators. In order to better target potential interventions, it is important to develop a better understanding of the means by which individual service users experience their relationships with service providers and the barriers and facilitators that affect these relationships. Given the increase in knowledge to be gained from these studies, the risk to the participants is reasonable.

Inclusion of Women, Children and Minorities

The proposed studies center on issues associated with culture, specifically focused on co-occurring individuals including Veterans; therefore, all of the data from participants who participated in this study will consist of primarily individuals of which approximately 30% will be female and minorities. All of the data is limited to individuals over 18 years of age, but is inclusive of participants between 18 and 21 years of age.

Data and Safety Monitoring Plan

The study will be conducted under the Department of Health and Human Services (HHS) regulations for the protection of human subjects. The PI will provide overall project and

scientific direction and will supervise activities. With regard to the protection of human subjects, the PI will establish the data management and monitoring guidelines. Prior to beginning any analyses, approval for the Protection of Human Subjects will be obtained from the Institutional Review Board.

The data obtained will have all names and other identifying information kept confidential through an encoding process to protect the identity of participants so they cannot be traced to data. None of the collected information with participants' personal information, i.e. written informed consents, and participant locator information (e.g., full names, addresses) will be obtained will be kept in a separate locked cabinet.

Data will be linked to locator information only through the use of project-generated unique identifiers (project ID numbers). Data is backed up daily and storage media (tapes, disks, CDs) are stored in locked files. Data is transmitted weekly to data storage via e-mail as ASCII files. A link file approach is used for maintaining the confidentiality of data files. In a link file system, confidential information is separated into different files without common links. A third link file that contains identifying number pairs is used to link the data records. The advantage of this system is that either of the database files can be used directly for report generation without the use of decrypting subroutines or access to the link file. Paper copies of locator information, as well as consents linked to the data through the project-generated identification, are stored in locked files in locked rooms. Participant locator information is destroyed if no long-term follow-up is planned within one year of the conclusion of the study.

The project will be in compliance with the policy that the fewer the number of individuals handling sensitive information, the greater the protection. Therefore, project files and databases associated with this study will only be available to research personnel through the authorization of the PI, and all staff with access to the project data and participants must sign Confidentiality Agreements. In addition, the study reports (such as aggregated data in progress reports) generated by the research team will provide total anonymity because no names or identifying data will be part of such reports.

All participants and staff have been apprised of their rights and responsibilities under the Declaration of Helsinki (1964), the Belmont Report (1978), and the US Privacy Act of 1974. Participants are told that the information gathered will be used only for research before they are asked any questions. Participants received specific instruction that they have the right to refuse to participate overall, refuse to answer any individual question, and/or withdraw from the study at any time. At each data collection, a participant's rights are explained again. Since study participants are not anonymous to the research staff, procedures are modified and adapted to ensure that the data collected from or about participants cannot be associated with them by anyone other than project staff. No individual participant will be identified in any published report or oral presentation. Project staffs is required to sign a Confidentiality Agreement and are also reminded of their responsibility to maintain confidentiality once they have left the study or the study has ended. All research staff and field staff will receive training on the function, roles, and responsibilities of Institutional Review Board and on the staff's roles and responsibilities in maintaining the privacy and confidentiality of research participants.

Should a violation occur (e.g., attempts to circumvent established security, use of hacker programs, etc.), staff will report immediately to the PI; and when appropriate, to local authorities. An incident report will be filed in the project files kept by the PI and appropriate action will be taken against the violator(s). If there are any concerns regarding a breach in

confidentiality, Institutional Review Board and SAMHSA/CSAT will be notified; if need be, further action will be taken.

Assurance that Institutional Review Board Approval Will Not Delay Project Start
A community-based Institutional Review Board will review the protocols in this proposal for the Protection of Human Subjects. This should not delay the project in any way, as the IRB meets on an ad-hoc basis specifically to review community-based research/evaluation projects similar to the one proposed. The review and approval process has typically been accomplished in less than thirty days; and the IRB has a long history of working within the timeframe necessitated by SAMHSA/CSAT funded projects. The development and initiation of the forms necessary for the review will be developed as part of the proposal development process to further expedite the process. The community-based IRB, the Institutional Review Board of Dual Diagnosis Management, subscribes to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects.

Attachments

Attachment 1.

1. Identification of agency
2. List of partnering agencies
3. Statement of Assurance
4. Letters of commitment and support

Attachment 2. Data Collection Instruments

Attachment 3. Sample Consent Forms

Attachment 4 Letter to SSA

Attachment 5 Certificate of Consistency

Attachment 6 State Strategic Plans

Attachment 6 Documentation of Supportive Housing

Attachment 7 Excerpts from Exhibit 1 SHP CoC

Attachment 8 Medicaid Program Documentation

Attachment 1-4

Attachment 1:

Identification of Agency
List of Agencies
Appendix D. Statement of Assurance
Letters of Support

Attachment 2:

Data Collection Instruments (Websites)

Attachment 3:

Sample Consent Form

Attachment 4

Letter to SSA

Attachment 1

1.1 Identification of Agency

The experienced licensed service provider for this grant will be:

Buffalo Valley, Inc.

501 Park Ave. S.

P.O. Box 879

Hohenwald TN 38462

Jerry T. Risner – Executive Director

931-796-4256 – office

931-796-5124 – fax

Buffalo Valley, Inc. has been in existence since 1978 which meets the two year experience requirement as well as all applicable licensing, accreditation and certification requirements and will provide the GPO with the required documentation within the time frame specified.

1.2 List of partnering agencies

None

1.3 Appendix D – Statement of Assurance

1.4 Letter of Support

- VII Assurances – Non construction
- VIII Proof of Nonprofit status
- IX BVI Licensure and Accreditations
- X State Strategic Plan

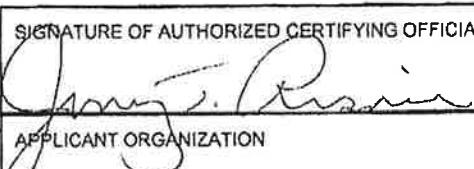
ASSURANCE
of Compliance with SAMHSA Charitable Choice
Statutes and Regulations
SMA 170

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Executive Director
APPLICANT ORGANIZATION	DATE SUBMITTED
Buffalo Valley Inc	6-15-11

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

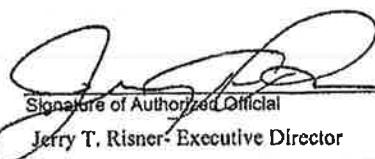
THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

6/14/11
Date


Signature of Authorized Official
Jeffry T. Risner, Executive Director

Name and Title of Authorized Official (please print or type)

Buffalo Valley, Inc.

Name of Healthcare Facility Receiving/Requesting Funding

501 Park Ave. S. P.O. Box 879

Street Address

Hohenwald, TN 38462-0879

City, State, Zip Code

Internal Revenue Service

Date: October 16, 2000

Buffalo Valley, Inc.
PO Box 879
Hohenwald, TN 38462-0879

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Person to Contact:

Judy Simonson 31-04016
Customer Service Representative

Toll Free Telephone Number:

8:00 a.m. to 8:30 p.m. EST
877-829-5500

Fax Number:

513-263-3756

Federal Identification Number:
58-1374964

Dear Sir or Madam:

This letter is in response to your request for affirmation of your organization's exempt status.

Our records indicate that a determination letter issued in September 1979 granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in section 509(a)(1) and 170(b)(1)(A)(vi).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than \$25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of \$20 a day, up to a maximum of \$10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of \$100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, estates, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Buffalo Valley, Inc.
58-1374964

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

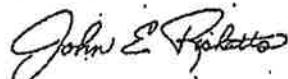
The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. You are also required to make available for public inspection a copy of your organization's exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of \$20 a day for each day you do not make these documents available for public inspection (up to a maximum of \$10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,



John E. Ricketts, Director, TE/GE
Customer Account Services



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

BUFFALO VALLEY, INC.
PO BOX 879
Hohenwald, TN 38462

February 17, 2011

Request Type: No Fee Certificate of Existence/Authorization
Request #: 0032194

Issuance Date: 02/17/2011
Copies Requested: 1

Document Receipt

Receipt #:

Filing Fee:

Regarding: BUFFALO VALLEY, INC.
Filing Type: Corporation Non-Profit - Domestic
Formation/Qualification Date: 08/09/1978
Status: Active
Duration Term: Perpetual

Control #: 55035
Date Formed: 08/09/1978
Formation Locale: Lewis County
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

BUFFALO VALLEY, INC.

- * is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;
- * has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;
- * has filed the most recent corporation annual report required with this office;
- * has appointed a registered agent and registered office in this State;
- * has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

A handwritten signature in black ink that reads "Tre Hargett".
Tre Hargett
Secretary of State

Processed By: Nichole Hambrick

Buffalo Valley, Inc.
Hohenwald, TN

Joint Commission



The Joint Commission

Healthcare Accreditation Institute

Lakeville, MN

David R. Glawson

Mark Glawson

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH
AND DEVELOPMENTAL DISABILITIES



INITIAL LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES GRANTS THIS
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO ESTABLISH A NEW FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Nashville

(Name of Facility or Service as Known to the Public)

105 Oak Valley Drive, Nashville, TN 37207

(Street Address or Location, City or Town)

THE CONDITIONS OF THE ISSUANCE OF THIS INITIAL LICENSE ARE FOUND AT RULE 0940-5-2-10(1) OF
THE RULES OF THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	vision Impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	Y	Y	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	Y	Y	Y	6	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	Y	Y	Y	6	Small Residential Board & Care
Mental Health Outpatient Facility	Y	Y	Y	n/a	Business

October 01, 2010

Date License Granted

September 30, 2011

Date License Expires

1000000007491

License Number

Virginia Carter Bass
Commissioner of Mental Health and Developmental Disabilities

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

7491

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Maple

(Name of Facility or Service as Known to the Public)

221 South Maple, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

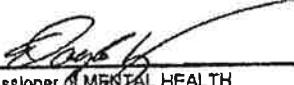
Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with hearing loss	vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	Y	N	Y	3	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	Y	N	N	13	Small Residential Board & Care
Mental Health Outpatient Facility	Y	N	N	n/a	Business

Waiver(s): 0940-5-5-.06(a)(1)&(2)

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008251
License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - 511 Park Ave S

(Name of Facility or Service as Known to the Public)

511 Park Avenue South, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

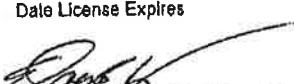
THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with hearing loss	vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Alcohol & Drug Residential Rehabilitation Treatment	N	N	N	B	Small Residential Board & Care
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008252
License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8252

BT

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - East 4th

(Name of Facility or Service as Known to the Public)

100 East 4th Street, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

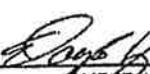
THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with			Occupancy Classification
		hearing loss	vision Impairment	Capacity	
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008253
License Number


Commissioner of MENTAL HEALTH

8253

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Lewisburg

(Name of Facility or Service as Known to the Public)

218 Martin Street, Lewisburg, TN 37091

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

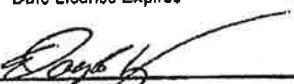
THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008254
License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8254

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Residential Rehab.

(Name of Facility or Service as Known to the Public)

554 2nd Avenue North #1, Lewisburg, TN 37091

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

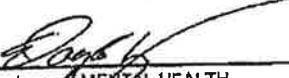
THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with hearing loss	vision Impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	N	N	N	3	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	N	N	N	13	Small Residential Board & Care
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008255
License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8255

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - 501 Park Ave S.

(Name of Facility or Service as Known to the Public)

501 Park Avenue South, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	Approved for persons with vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	Y	N	N	15	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	Y	N	N	16	Large Residential Board & Care
Mental Health Outpatient Facility	Y	N	N	n/a	Business

April 01, 2011

Date License Granted

March 31, 2012

Date License Expires

L000000008256

License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8256

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley

(Name of Facility or Service as Known to the Public)

717 Cumberland Drive, Clarksville, TN 37091

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with hearing loss	Approved for persons with vision Impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/e	Business
Alcohol & Drug Residential Detoxification Treatment	N	N	N	5	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	N	N	N	5	Small Residential Board & Care
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011

Date License Granted

March 31, 2012

Date License Expires

L000000008384

License Number

Commissioner of MENTAL HEALTH

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8384

State Strategic Plans

STATE OF TENNESSEE

Agency Strategic Plans

Executive Branch



Volume 1
Five-Year Strategic Plans

Phil Bredesen, Governor

September 2007

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STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE CAPITOL
NASHVILLE, TENNESSEE 37243-0285

DAVE GOETZ
COMMISSIONER

September 1, 2007

TO: The Honorable Phil Bredesen, Governor

Members of the 105th General Assembly

I am pleased to present to you the agency strategic plans for the Executive Branch agencies. The Administration continues to focus on effective and efficient delivery of services to the people of Tennessee, two goals of the Governmental Accountability Act of 2002.

The plans are agency plans, developed pursuant to the act.

In accordance with the Act, agencies are required to submit both a strategic plan and program performance measures. These are published in two separate volumes, which comprise the Agency Strategic Plans document. Volume 1 is Five-Year Strategic Plans, which addresses agency-wide information. Volume 2 is Program Performance Measures, which includes program-level information and performance standards and measures for each program at the budgetary unit level. These documents represent the commitment of the Administration to provide the General Assembly information which is useful in the budget process and agency oversight. The Administration views the planning process as interactive between the Administration and the General Assembly. We will continue to review the planning methods to ensure a productive process.

A total of 15 agencies will submit performance-based budget requests for 2008-2009 under the Governmental Accountability Act. Currently operating under performance-based budgets are nine agencies: Revenue, Environment and Conservation, Human Services, Safety, Finance and Administration, Economic and Community Development, Agriculture, Correction, and Transportation. In 2008-2009, six agencies are being added to the performance-based budget process: General Services, Education, Military, Commerce and Insurance, Financial Institutions; and Labor and Workforce Development.

The Administration believes that it is important for all agencies to participate in the strategic planning process; therefore, all Executive Branch agencies have submitted agency strategic plans, regardless of their performance-based budget status. The Tennessee Higher Education Commission and the Tennessee Student Assistance Corporation have submitted plans for their

own programs. It is the Administration's intent to fully incorporate all Executive Branch agencies under the performance-based budgeting requirements of the Governmental Accountability Act by fiscal year 2011-2012.

The Budget Staff and I look forward to working with the Governor, members of the General Assembly, the Governmental Accountability Commission, and the state agencies as we continue to evaluate and improve our implementation of the Governmental Accountability Act.

Sincerely,

M.D. Goetz, Jr.
Commissioner of Finance and Administration

State of Tennessee

Agency Strategic Plans Document

The Agency Strategic Plans document is presented in two volumes.

Volume 1 is Five-Year Strategic Plans. This includes an agency-wide plan, focused on the most important priorities of each agency head. Each plan includes a general description of the agency, a mission statement, major goals, strategies for achieving each goal, and performance measures, indicating a baseline for the previous year and progress toward achieving each goal over the next five-years. The plans also include the following additional agency-wide information: statutory and constitutional objectives; obstacles to meeting objectives and delivering services; means of overcoming obstacles; means of maximizing federal and other non-state sources of revenue; means of avoiding unnecessary costs and expenditures; and

future challenges and opportunities.

Volume 2 is Program Performance Measures. That volume includes further information on each of the several hundred programs of the Executive Branch agencies. For each program, defined as a budgetary unit identifiable in the budget document and the general appropriations act, the following program-specific information is provided: identification of mandated and optional services and the best means of providing them; program performance standards; program performance measures, indicating a baseline for the previous year and estimates for the current and next year; and means of addressing any change in services since the previous plan.

Volumes 1 and 2 together contain all the information required by the 2002 Governmental Accountability Act.

State of Tennessee

The Strategic Planning Process

In Tennessee State Government, agency strategic planning is a responsibility of program directors, agency planning and budget staffs, and agency heads throughout state government. Pursuant to law, the agency strategic plans within the Executive Branch are developed under guidelines issued by the Commissioner of Finance and Administration.

Preparation of the consolidated Agency Strategic Plans document for the Executive Branch is the responsibility of the Commissioner of Finance and Administration, who is the State Budget Director.

Within the Department of Finance and Administration, the Division of Budget is responsible for oversight of agency strategic plan development. Preparation, monitoring, and evaluation of strategic plans is a continual process throughout the year.

Function	Participants	Schedule
Preparation of Strategic Plans	Departments and Agencies Budget Division	April June
Executive Review	Budget Division	July August
Legislative Review	General Assembly	* September-May
Strategic Plan Implementation	Departments and Agencies	July-June
Performance Reporting	Departments and Agencies Commissioner of F&A Governmental Accountability Commission Finance Committees	Following Year January-May
Performance Review	Comptroller of the Treasury	Following Year July-June

**Note: The General Assembly has final approval of all strategic plans, performance measures, and standards through the general appropriations act.*

The preceding chart indicates the participants in the planning process and an approximate time schedule.

The strategic plans are agency plans, developed pursuant to law on a program-by-program basis. The law directs the Commissioner of Finance and Administration to consolidate the agency plans for transmittal jointly to the Governor and the General Assembly.

The Governmental Accountability Act of 2002 was enacted by Chapter 875 of the Public Acts of 2002 (codified at Tennessee Code Annotated, Title 9, Chapter 4, Part 56, and in some sections of budget law at Part 51). The Accountability Act requires the phase-in of strategic planning and performance-based budgeting. The law required that at least three agencies be included in performance-based budgeting in fiscal year 2004-2005. The Administration chose four agencies to start performance-based budgeting as of July 1, 2004. Those agencies are the departments of Revenue, Safety, Environment and Conservation; and Human Services. An additional five agencies submitted performance-based budgets for fiscal year 2005-2006. Those five agencies are the departments of Finance and Administration, Economic and Community Development, Agriculture, Correction, and Transportation. For fiscal year 2008-2009, six more are added to the list, making the total 15 agencies. The six agencies are General Services, Education, Military, Commerce and Insurance, Financial Institutions, and Labor and Workforce Development. All Executive Branch agencies of state government must be operating under the performance-based budget format by fiscal year 2011-2012.

The Administration has required all Executive Branch agencies to submit strategic plans, regardless of their performance-based budget status.

Contents of the Plans

The Governmental Accountability Act requires that agency strategic plans, accompanied by program performance

The Strategic Planning Process

standards and measures, contain at least the following information:

1. statutory and constitutional objectives of the entity;
2. identification of mandated and optional services and the means of providing them;
3. obstacles to meeting objectives and delivering services and means of overcoming obstacles;
4. means of maximizing federal and other non-state sources of revenue;
5. means of avoiding unnecessary costs and expenditures;
6. future challenges and opportunities.

Preparation of the Plans

In April, the staff of the Division of Budget issues guidelines to state agencies regarding the strategic planning process. These guidelines provide direction as to the content and format of strategic plans. The guidelines are based on the requirements of the Governmental Accountability Act.

The deadline for agency completion and transmission of the strategic plans to the Division of Budget is the first of July. During this preparation period, the staff of the Division of Budget meets as needed with agency planning and fiscal personnel to answer questions and provide assistance in developing their strategic plans.

Executive Review of the Plans

The Governmental Accountability Act directs the Commissioner of Finance and Administration to review, revise, and approve strategic plans and program performance standards and measures. (State agencies are directed by the law to include these revised performance standards and measures in the subsequent budget request.)

After the receipt of agency strategic plans, analysts with the Division of Budget begin the process of reviewing the plans, paying particular attention to proposed standards and measures. The Commissioner of Finance and Administration has the responsibility to evaluate the validity, reliability, and appropriateness of each

performance measure and standard and how the strategic plan and the performance measures are used in management decision-making and other agency processes.

Following review of the plans by the Division of Budget, recommendations are made to the Commissioner of Finance and Administration regarding content, as well as performance standards and measures. A consensus is sought with the agencies regarding performance standards and measures. After decisions have been finalized, the staff of the Division of Budget prepares the Agency Strategic Plans document for printing. The document must be submitted to the Governor and the General Assembly by September 1.

Legislative Review

The General Assembly has final approval of all strategic plans, performance measures, and standards through the general appropriations act.

In the spring of 2006, the Commissioner of Finance and Administration submitted a program performance report on the first four performance-based budget agencies to the Finance, Ways and Means committees of the Senate and House of Representatives. The Governmental Accountability Act requires that a compliance report must be submitted annually at a time that will allow the finance committees to consider the performance report while they are considering the general appropriations bill.

To further assist the General Assembly in review of agency performance, the 2002 public act created the Governmental Accountability Commission. It is comprised of officials who hold office by legislative appointment. They are the Comptroller of the Treasury, who serves as chairman; the Executive Director of the Fiscal Review Committee, vice chairman; and the Director of the Office of Legislative Budget Analysis, who serves as secretary of the commission.

Following the performance report by the Commissioner of Finance and Administration, the Governmental

The Strategic Planning Process

Accountability Commission is to review the commissioner's report and submit to the finance committees its written comments on the commissioner's report.

The Accountability Commission also may make recommendations to the finance committees on the performance of agencies; the reasonableness of performance standards and measures recommended in the budget document for the performance-based agencies; and on other strategic plan and program performance matters.

Strategic Plan Execution

When passage of the appropriations bill is complete and it is signed or enacted into law, the execution of agency strategic plans begins.

Annually, at the time the enacted budget (called the "work program" in budget law) is established, agencies may request adjustments to the performance measures and standards, based on changes in the program appropriations during the enactment of the general appropriations act. These adjustments require the approval of the Commissioner of Finance and Administration, who must maintain the official record of adjustments and must report adjustments to the chairmen of the Senate and House Finance, Ways and Means committees. The law provides that agencies themselves may not change the performance measures.

During the fiscal year, modifications to program performance standards and measures are allowed if an agency is required to modify its operations because of:

1. court action resulting in a restraining order, injunction, consent decree, or final judgement;
2. law or executive order;
3. additional federal or other funding.

All adjustments to performance standards and measures during the year also are subject to approval of the Commissioner of Finance and Administration, who must report the changes to the chairmen of the

House and Senate Finance, Ways and Means committees.

Comptroller's Performance Review

Aside from executive and legislative review of agency strategic plans and program performance, the 2002 public act, provides that each state agency engaged in performance-based budgeting is subject to performance review of its activities by the Comptroller of the Treasury. This provision grants discretion to the Comptroller to determine the matters to be reviewed, related to the manner in which the state agency is delivering services and achieving objectives. This performance review, according to the law, will at least include consideration of the efficient use of state and federal funds; additional non-state revenue or cost savings that could be achieved; and the extent to which strategic plan objectives are achieved.

Connection of Plans and the Budget

The Governmental Accountability Act of 2002 amended budget law to require that performance-based budgeting agencies include in budget requests the program performance standards and measures, as reviewed and revised by the Commissioner of Finance and Administration. These standards and measures are the ones included in this Agency Strategic Plans document for the nine performance-based agencies. After budget requests are submitted, the program performance measures, along with other strategic plan and budget request information, will assist staff of the Budget Division in analyzing agency budget requests.

Budget law, as amended by the 2002 Governmental Accountability Act, directs that certain other performance-based budget information be included in agency budget requests. This includes identification of program clients; the purpose of each program or client benefits; program costs and funding sources; fee collections and the adequacy of fees to support the program;

The Strategic Planning Process

assessment of whether each program is conducive to performance-based budgeting;

and assessment of the time needed to develop meaningful performance measures.

In reviewing budget requests and transmitting the budget document to the General Assembly, the Governor, with assistance of the Commissioner of Finance and Administration, may revise, add, or delete performance measures and standards as the Governor deems necessary. The General Assembly retains authority for final approval of performance standards and measures through the general appropriations act.

The amended budget law also requires that the budget document transmitted by the Governor to the General Assembly include a performance-based budget for each state

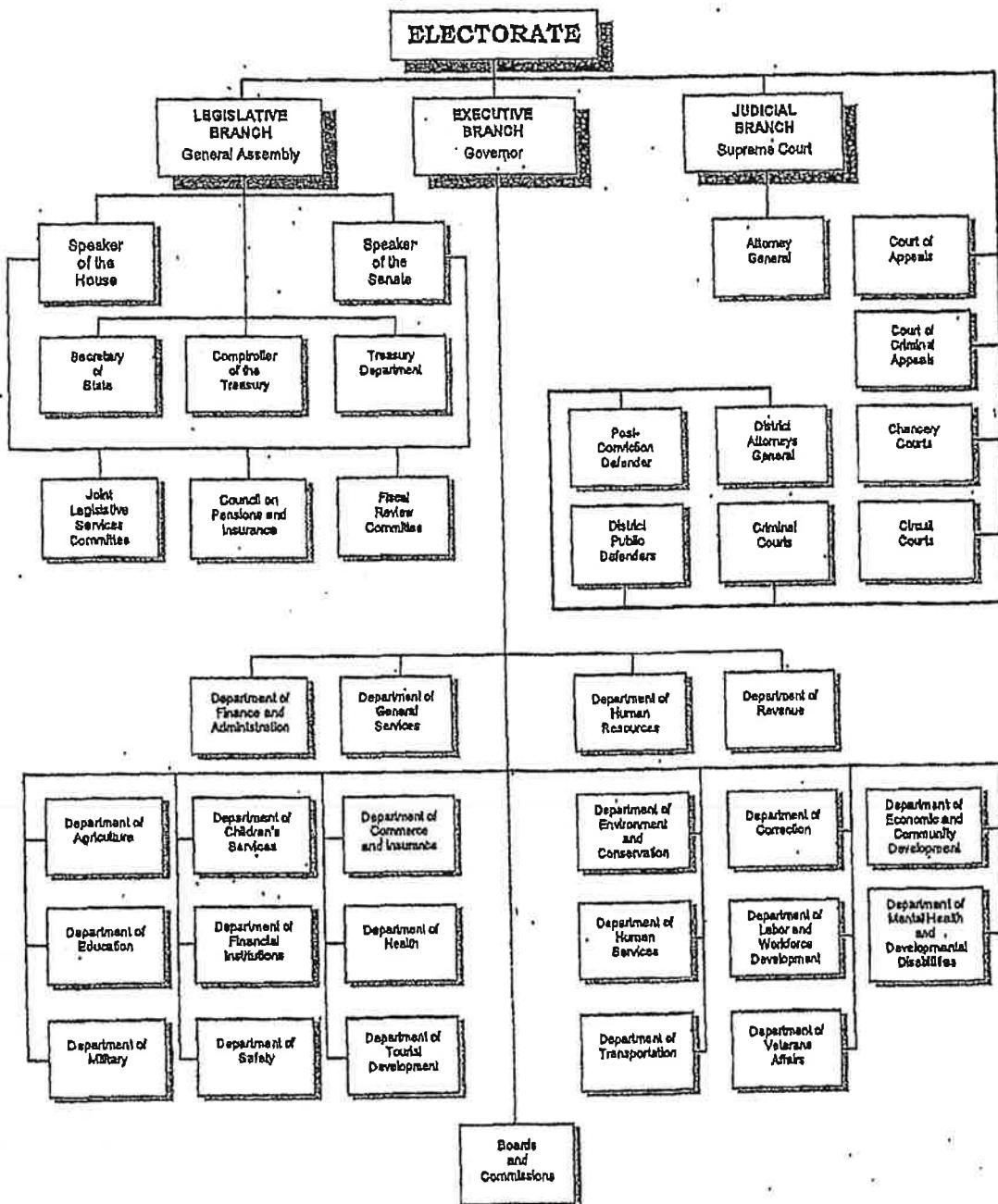
agency subject to performance-based budgeting. The performance-based budget must include program statements and performance measures.

The various reviews described above — executive, legislative, and performance audit — will utilize both the strategic plan and performance budget information to assess program performance.

Legislative intent to connect planning, budgeting, and accountability is evident in the 2002 Governmental Accountability Act. The General Assembly has stated in law that it intends to use this system in resource allocation decisions and program performance review.

TENNESSEE STATE GOVERNMENT ORGANIZATIONAL CHART

FISCAL YEAR 2007 - 2008



Department of Mental Health And Developmental Disabilities

In March 1953, the Department of Mental Health was created by enactment of the General Assembly to provide for the better treatment and welfare of persons with mental illness or mental retardation. In June 2000, the General Assembly re-created the agency, changed its name to the Department of Mental Health and Developmental Disabilities (MHDD), and passed a comprehensive revision of the mental health and developmental disability law, Title 33 of the Tennessee Code Annotated. The revised law expanded significantly the department's authority to coordinate, set standards, plan for, monitor, and promote the development and provision of services and supports to meet the needs of persons with mental illness, serious emotional disturbance, or developmental disabilities through the public and private sectors.

MHDD is the state's mental health and developmental disabilities authority and is responsible for system planning; setting policy and quality standards, licensing mental health services and facilities, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance or developmental disabilities. By agreement with the Bureau of TennCare, the department also oversees and monitors the programmatic components of the TennCare Partners Program. Monitoring responsibilities include assessment of the adequacy of the provider network and the quality of services provided. MHDD also licenses mental retardation services and facilities.

In February 2007, the Bureau of Alcohol and Drug Abuse Services was transferred to MHDD from the Department of Health by Executive Order 44. The bureau is responsible for planning, developing, administering, and evaluating a statewide system of services for persons at risk for substance abuse along with persons abusing substances. The integration of alcohol and drug abuse services within MHDD will streamline government and its resources and facilitate the opportunity to expand access to integrated treatment options. The bureau is now known as the Division of Alcohol and Drug Abuse Services.

Mission Statement

The mission of MHDD is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports based on the needs and choices of individuals and families served.

Goals

1. By FY 2012, MHDD will increase the public's knowledge and understanding of mental illness and substance abuse and its effective treatments by providing activities to 2,250 individuals to reduce stigma.
2. By FY 2012, MHDD will increase mental health and substance abuse service providers' understanding of the prevalence of and best practice treatments for co-occurring disorders by providing training on best practices to 25 mental health and substance abuse agencies.

3. By FY 2012, MHDD will enhance funding sources for a continuum of recovery and resilience services by a variety of methods, which includes maintaining a minimum of eleven active grant awards from non-state sources.
4. By FY 2012, MHDD will improve operations and increase the number of consistent practices used in the five Regional Mental Health Institutes (RMHIs) to 30.
5. By FY 2012, MHDD will provide 55 clinical rotations or internship experiences as a recruitment tool to promote public sector careers for mental health professionals.

Goal 1

By FY 2012, MHDD will increase the public's knowledge and understanding of mental illness and substance abuse and its effective treatments by providing activities to 2,250 individuals to reduce stigma.

Strategy for Achieving Goal 1

1. MHDD will conduct a statewide multi-media campaign to educate the public about mental illness and substance abuse and effective treatments that promote remission and recovery.

Performance Measure

1. Number of individuals who participate in an overcoming stigma activity.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
900	1,250	1,500	1,750	2,000	2,250

Goal 2

By FY 2012, MHDD will increase mental health and substance abuse service providers' understanding of the prevalence of and best practice treatments for co-occurring disorders by providing training on best practices to 25 mental health and substance abuse agencies.

Strategies for Achieving Goal 2

1. MHDD will train employees and service providers about co-occurring disorders and best practices for treatment.
2. MHDD will increase funding sources for a continuum of services for Tennesseans with co-occurring disorders.

Performance Measure

1. Number of community mental health and substance abuse agencies that have staff trained specifically on best practices to treat co-occurring disorders.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
6	12	15	18	22	25

Goal 3

By FY 2012, MHDD will enhance funding sources for a continuum of recovery and resilience services by a variety of methods, including maintaining a minimum of eleven active grant awards from non-state sources.

Strategies for Achieving Goal 3

1. MHDD will strive to enhance services in Tennessee with grant funding.

Performance Measure

1. Number of active grants from non-state sources.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
11	11	11	11	11	11

Goal 4

By FY 2012, MHDD will improve operations and increase the number of consistent practices used in the five Regional Mental Health Institutes (RMHIs) to 30.

Strategy for Achieving Goal 4

1. MHDD will standardize clinical practices through the use of consistent practices, including protocols, best practices, and/or evidence-based practices in the RMHIs.

Performance Measure

1. Number of consistent practices, including protocols, best practices, or evidence-based practices used in all five RMHIs.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
17	21	25	27	29	30

Goal 5

By FY 2012, MHDD will provide 55 clinical rotations or internship experiences as a recruitment tool to promote public sector careers for mental health professionals.

Strategy for Achieving Goal 5

1. MHDD will expand existing educational opportunities relative to careers in public mental health by providing clinical rotations or internship experiences in mental health professional fields.

Performance Measure

1. Number of individuals participating in a master's or doctoral level nursing, pharmacy, social work or psychology clinical rotation or internship through MHDD.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
40	43	46	49	52	55

Additional Agency Information

Statutory and Constitutional Objectives

TCA 4-3-1603 assigns MHDD the duty and power to provide the best possible care for people with mental illness, serious emotional disturbance, or developmental disability in the state by improving existing facilities and by the development of future facilities and programs.

TCA 33-1-201 gives the department responsibility for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or developmental disabilities.

TCA 33-1-201 and 33-2-101 require the department to plan and promote a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services and supports based on the needs and choices of service recipients and their families. Service recipients and service recipients' families must be included in planning, developing, and monitoring the service systems.

TCA 33-1-302 and 33-1-303 authorize the department to construct, maintain, and operate facilities and to have general responsibility for the proper and efficient operation of its facilities.

TCA 33-1-307 directs the department to establish a structured information system to gather all data necessary to carry out all of its duties related to planning, needs assessment, standard setting, evaluation, and development of services and supports for current and potential service recipients.

TCA 33-1-401 and 33-1-402 mandate a statewide planning and policy council to assist in planning a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services and supports and to advise the department on policy, budget requests, and developing and evaluating services and supports.

TCA 33-2-201 requires the department to prepare and maintain a three-year plan, updated annually, for mental health and developmental disabilities services based on the statewide planning and policy council's recommendations and the assessment of the public's need for mental health and developmental disability services and supports.

TCA 33-2-202 and 33-2-203 require the department to maintain two other tiers of planning and policy councils, state and regional, to provide citizen input into policy planning. TCA 33-2-202 directs the department to maintain a statewide network of mental health and developmental disabilities regional planning councils, as well as a statewide Mental Health Planning and Policy Council and a statewide Developmental Disabilities Planning and Policy Council, which report community service needs and the adequacy of local service system delivery to the MHDD and to the MHDD Planning and Policy Council.

TCA 33-2-301 and 33-2-302 mandate the department to set and regulate compliance with basic quality standards for services and supports to all persons in Tennessee served on the basis of mental illness, serious emotional disturbance, or developmental disability.

TCA 33-2-403 and 33-2-404 provide authority to license and adopt rules for licensure of services and facilities operated for provision of mental health, developmental disability, and personal support services.

TCA 33-2-403 - 407, TCA 33-2-412, 413, and 417 mandate that facilities comply with MHDD licensure rules, chapters 0940-5-1 through 39, including life safety.

TCA 33-2-501 directs the department to develop an array of transportation options for all regions of the state.

TCA 33-2-1101 requires the department to calculate the charges for services it provides. The methodology for determining these costs must be approved by the Comptroller of the Treasury and the Commissioner of Finance and Administration. TCA 33-2-1102 requires MHDD to establish rules to determine indigency and reimbursement.

TCA, Title 33, Chapter 6, Parts 2, 4, and 5, 33-7-301 and 33-7-303, and 37-1-128 require RMHIs to admit individuals who meet admission criteria or are court-ordered for admission for forensic or juvenile court evaluations; TCA 33-6-308 and 33-6-701 require the release of the individuals when they no longer meet the standards under which they were admitted; and TCA 33-3-101(c) requires the services to be in accordance with community standards to the extent that facilities, equipment, and personnel are available.

The 1975 U.S. Supreme Court decision in *O'Connor v. Donaldson* requires that when the liberty of a person with mental illness is restricted to a psychiatric hospital, the person must receive active treatment or be released.

TCA, Title 33, Chapter 6; Part 4, TCA 33-3-403, and 33-3-412 require the RMHIs to admit individuals who meet emergency involuntary criteria regardless of bed availability including emergency transfers from the Department of Correction (DOC) and the Department of Children's

Services (DCS) youth development centers; and TCA, Title 33, Chapter 6, Parts 2 and 5, TCA 33-3-401 and 402 admissions, which include non-emergency transfers from DOC and DCS youth development centers, are contingent on the availability of suitable accommodations. "Suitable accommodations" means having a specified percentage of operational beds vacant and therefore available for use.

TCA 33-6-103 and 33-8-103 require the department to maintain an array of services and supports for adults with mental illness and children with serious emotional disturbance who are priority populations.

TCA 40-33-2 and 55-10-4 established and funded the Alcohol and Drug Addiction Treatment Fund (ADAT). This fund was established to allow people who are declared indigent access to alcohol and drug services.

TCA 68-24-101 et seq. established the "Comprehensive Alcohol and Drug Treatment Act of 1973" and "Alcohol Abuse Prevention Act of 1990" stating the prevention of alcoholism and drug dependence should be accomplished in a number of ways, including public education concerning the causes, symptoms, and nature of alcoholism and drug dependence. In order to educate the public, the department is required to prepare and distribute suitable educational material to schools and interested members of the public, render assistance to suitable local agencies, and provide activities promoting public interest in and information about substance abuse and dependence.

Obstacles to Meeting Objectives and Delivering Services and Means of Overcoming Obstacles

Obstacle 1 - MHDD's ability to ensure availability of services and supports for uninsured and underinsured persons is limited due to lack of sufficient funding streams, leaving many persons in the state with limited access to timely, appropriate care in the most appropriate environment. Recent changes in TennCare eligibility, TennCare disenrollment, and actuarial changes for state only and judicial services and the immediate necessity to recapture/use state dollars previously transferred to TennCare for Medicaid match are among the challenges in adequately funding the state's public mental health and substance abuse system. Many of the access limitations in mental health and substance abuse services reflect provider decisions (due to lack of resources) to limit or cease providing mental health and substance abuse services, limited private insurance coverage for mental health and substance abuse services, and the historically disproportionately poor allocation of health care dollars to the prevalence of mental illness and substance abuse. In addition, mental health and substance abuse sub specialists are scarce, and reimbursable options for mental health and substance abuse are not fully aligned with treatments that have proven to be "best practices". A lack of insurance parity is highlighted in access to A&D services due to existing lifetime limitations placed on A&D benefits. Early intervention services are not at scale, especially for mental health issues. Many early intervention programs funded by the department are funded only in certain areas of the state and access is not available to all who could benefit.

In response to these realities, the department is exploring several viable options to meet the mental health and substance abuse needs of those individuals who have been impacted by funding shifts, especially in TennCare. These options include expanding eligibility for the Mental Health Safety Net package of mental health services, working with Finance and Administration to ensure that the Cover Tennessee products offer mental health and substance abuse benefits and that they

are utilized, and raising awareness in the business community of the importance of including mental health and substance abuse benefits in employee-based health insurance products.

Obstacle 2 - In March 2002, people with developmental disabilities other than mental retardation became eligible, subject to funding availability, for services and supports from MHDD. After years of waiting for a "home" agency, people with developmental disabilities continue to wait for the home agency to provide services to them. To date, only planning funds have been allocated with no appropriations to MHDD to provide services and support to persons with developmental disabilities.

This obstacle will remain until funds are appropriated to implement services for persons with developmental disabilities other than mental retardation. The department continues to seek additional funding opportunities through private or federally funded grants to expand the array of developmental disability services in Tennessee. Chapter 604, Public Acts, 2006, establishes a task force, led by the Division of Mental Retardation Services, to conduct a statewide assessment to study the needs of persons with a developmental disability other than mental retardation for whom comprehensive home and community based services do not exist and to develop a plan to provide cost effective home and community based services for such persons. MHDD is participating in this task force.

Obstacle 3 - TCA, Title 33 requires that the department license services as well as facilities. Many service providers do not provide services in a facility. This expanded authority has increased the number of licenses issued and thus the workload of the licensure section. Because the department's current licensure rules have in the past been focused on facilities, the licensure section has initiated an extensive revision of rules and procedures. In addition, the section has worked to improve communication with licensees. The department has recently hired an attorney to oversee this licensure responsibility.

Increased use of information technology in MHDD's administrative responsibilities assists in meeting additional requirements within current resources. The department is developing a licensure operations management system that allows MHDD to track and manage licensure functions more efficiently. Components of this system, such as computerized report completion and submission and incident tracking and follow up will reduce paperwork and improve staff efficiency.

Obstacle 4 - MHDD is challenged with building a data infrastructure to meet all federal and state mandates to gather data necessary to carry out duties related to planning, needs assessment, standard setting, evaluation, and development of services and supports for current and potential service recipients as well as completing an annual assessment of the public's need for mental health and developmental disability services and supports. Although MHDD has authority to request from other state and community agencies and the private sector, it lacks enforcement authority if requests for data/information are denied, unexplained, or unanswered. Also, there is nothing in state law requiring any county or local data about mental illness, serious emotional disturbance, or developmental disability to be reported to the department. The best and most accurate data come from those entities MHDD regulates or contracts with and can require to be reported. Thus, a significant portion of MHDD service system planning relies on extrapolating from national prevalence data and other policy and evidence-based research.

The department continues to develop a data infrastructure and collaborate with other state agencies, specifically the Department of Children's Services and the Department of Health, to

identify ways MHDD can use data collected by those agencies for mental health and developmental disability planning needs.

Obstacle 5 - The nationwide shortage of nurses, doctors and pharmacists, predicted to worsen in the next few years, presents tremendous challenges. Staffing, especially nurses and other qualified direct caregivers, is a major problem for the RMHIs. Without sufficient nursing staff, service recipient care is negatively impacted, and Joint Commission accreditation and Medicare certification are jeopardized which would result in a potential loss of revenue. The RMHIs also experience great difficulty in recruiting and retaining other clinical staff, particularly psychiatrists and pharmacists. Some state salaries, especially in health and mental health management and clinical classifications, are not competitive. Recruitment and retention of professionals as required in the state's complex mental health and developmental disability service system is increasingly more difficult, especially in some classes like nursing.

TCA 8-23-209, which was initiated by the Commissioner of MHDD, was the first step in addressing the nursing crisis in mental health by authorizing the flexibility to employ nurses to work a reduced schedule and accrue full benefits. In addition, voluntary overtime, mandatory overtime, and/or contract staff must be used when an RMHI cannot recruit and retain sufficient staff, which increases the per diem costs of care.

Obstacle 6 - Efficient operation of the RMHIs is affected by fluctuating demand for inpatient services. Service recipients are admitted based on statutory criteria, limiting the department's ability to balance treatment needs with space availability. Often, hospital admissions are directly related to a lack of intensive outpatient community mental health services and thus their discharges may be delayed if adequate aftercare housing, treatment, and support services are not readily available.

The department is working to decrease inpatient utilization by promoting the development of housing, crisis intervention services, and more readily available outpatient services for people with mental illness or serious emotional disturbance. The department is re-designing the crisis services model and is encouraging the mental health provider community to develop an improved community continuum in an effort to reduce over utilization of inpatient services at the RMHIs. The department continues to work with private providers to increase the availability of inpatient mental health services in non-state facilities.

Obstacle 7 - The age and design of the majority of the RMHIs make efficient operation extraordinarily difficult because of deteriorating physical plants and infrastructure and related high maintenance and staff requirements. The general maintenance costs have reached the level that replacement facilities are required for three of the RMHIs and extensive renovation at another.

Through a public and private collaboration, construction of a replacement facility for Memphis Mental Health Institute is underway and will be ready for occupancy in early fall of 2007. The department is in the final stages of pre-planning for a new Western Mental Health Institute and target date for completion of the facility is 2009. The department is also in the final stages of pre-planning for a new Lakeshore Mental Health Institute; however, since funds have not been appropriated for this project from the General Assembly, the project remains in the planning stage. Moccasin Bend Mental Health Institute is undergoing extensive renovations in which all patient care units will be located in the same building. This design will increase patient care services and staff efficiency. The date for completion of renovation is late 2007.

Means of Maximizing Federal and Other Non-State Sources of Revenue

The department has established an in-depth cost accounting system that tracks and distributes expenditures. This system ensures that all costs attributed to reimbursable activities are included in the amounts billed for services. Administrative Services' expenditures are included in the costs of all department services, which maximize the amount of federal and other non-state revenue the department receives.

Services to people with developmental disabilities can be provided via a 1915(c) waiver, which provides approximately \$2 in federal funds for each state dollar. This avenue maximizes the benefit of state funds to serve people with developmental disabilities, but it also creates an ongoing entitlement to services for eligible individuals. Expanding entitlement programs, especially in tight budget times, has not been seen as the best way forward.

MHDD maximizes available funds for services by applying for federal and private foundation grants. MHDD applies annually for the Community Mental Health Block Grant and uses the funds to provide services and fill gaps in the service system. Community Mental Health Services receives additional funding from other federal grants, including but not limited to: PATH Grant, Older Adult Treatment Services, Real Choice Systems Grant (Housing Within Reach), Methamphetamine Evidence-based Treatment and Healing Grant, Tennessee Lives Count, and Muletown Family Network's System of Care for Maury County.

The largest part of the RMHI funding comes from fees for in-patient mental health treatment. The department has a Revenue Advisory Committee (RAC) that oversees and advises on reimbursement activities to ensure that federal and other revenue is maximized. The RAC has focused on improving the accuracy of the RMHI billing processes to assure that all billable days are accounted for. The RAC has also worked on improving the success of the RMHIs in appealing denied claims.

Another means to maximize federal and other non-state sources of revenue is to maintain accreditation by the Joint and certification by the Centers for Medicare and Medicaid Services (CMS) for participation in the psychiatric Medicare program. Most payers for in-patient mental health services, whether private insurance, Medicare, or TennCare, require Joint Commission accreditation as a base qualification for reimbursement. All of the RMHIs are accredited and certified by CMS and have on-going efforts to maintain this status.

Means of Avoiding Unnecessary Costs and Expenditures

The Comptroller conducts a financial audit of MHDD every two years, and the department's audit section conducts continuous reviews (TCA 33-1-302(b) (1) and (2) and 4-3-304(7) and (9)). When problems with internal fiscal controls are found, the director of fiscal services establishes policy to address the issue, and audit follows up to ensure that the problem is corrected. In this way, unnecessary costs and expenditures are avoided, and the department ensures that all expenditures, payments, and contracts follow state and department policy. MHDD uses an invoice tracking system of all requested reimbursement for funded services to provide financial oversight. MHDD also monitors all contracts and grants as required by state policy. The department also has undergone periodic performance audits, with the last completed on June 15, 2006.

Title 33 revisions include additional authority for MHDD to avoid unnecessary costs by requiring the commissioner to initiate interagency agreements that enhance the efficiency and effectiveness of public fund expenditures, i.e., avoid duplication (TCA 33-1-308). The commissioner also is required to collaborate with all relevant state agencies to coordinate the administration of state programs and policies that directly affect service recipients with respect to treatment, habilitation, and education (TCA 33-1-304(2)). Pilot projects authorized by Title 33 are ways to experiment or improve service in unique ways (TCA 33-1-301(d)). Chapter 674, Public Acts, 2006, redefines indigent person allowing the MHDD to refine the collection and reimbursement process at the RMHIs thereby reducing unnecessary costs and expenditures (TCA 33-1-101(14) and Title 33, Chapter 2, Part 11). With the recent release of the Medicare Modernization Act and the Deficit Reduction Act (DRA), which provides alternatives for home and community based services, there are some potentially great leveraging opportunities for the populations that MHDD serves. The department will be pursuing a review of these opportunities over the next year as more information and guidance from the Centers for Medicare and Medicaid Services (DRA issuing agency) becomes available.

Since staffing costs are a major factor at each RMHI, personnel management is important in avoiding unnecessary costs. Efficient planning of schedules, combined with appropriate disciplinary action for time and attendance violations, maximize the utilization of available staff resources and minimize the need for overtime or use of more costly contract staff. The RMHIs have focused on flexibility of work schedules and making the work environment as appealing as possible to retain staff and reduce turnover.

The current national nursing shortage forces the RMHIs to use contract nurses. These nurses are used only when the RMHIs cannot be staffed with state employee nurses. MHDD has reduced the use of contract nurses in the last year and plans to continue reduction of contract services for cost savings and better service to our patients.

Future Challenges and Opportunities

The department is challenged to assure timely access to evidenced-based services and supports for the priority population as well as other persons with mental illness, serious emotional disturbance, or developmental disability in the current health care environment as funding sources wax and wane. Demand continues to exceed supply. MHDD must find means to increase the availability of effective community-based prevention, early intervention, treatment and rehabilitation services and reduce reliance on high-cost in-patient treatment settings to avoid potential lawsuits related to the U.S. Supreme Court decision in *L.C. & E.W. vs. Olmstead*. A related issue is the need for improved access to services tailored to high-risk and high-cost populations such as those with co-occurring disorders, children and youth, the elderly population, and those involved in the criminal or juvenile justice systems. The department has an opportunity to use a leverage model, such as the one used by the housing initiative, to meet these challenges.

In line with the Substance Abuse and Mental Health Service Administration's goals outlined in the President's New Freedom Commission Report, MHDD is working to transform the mental health and substance abuse system in Tennessee to promote resilience in children and youth and recovery for adults. MHDD has recently established a division to focus on implementing recovery services such as support, employment, transportation and housing for persons with mental illness and substance abuse.

The department is continuing to see an increased demand for services. In response to the growing immigrant population in Tennessee, the department is challenged with recruiting bilingual and multilingual providers and ensuring availability of culturally competent services to meet the mental health and developmental disability needs of this ever-growing population. Additionally, the MHDD system is challenged to provide Katrina evacuees that now live in Tennessee and National Guard troops returning from Iraq and Afghanistan access to appropriate mental health treatment. Recent research indicates a high incidence of post-traumatic stress disorder, suicide, and depression among these groups and the significant numbers could strain an already under-funded mental health system.

MHDD is mandated to develop an array of transportation options for persons with mental illness and developmental disabilities in all regions of the state. However, the department is challenged to provide this service with limited funding and has only been able to fulfill part of the mandate. The department continues to seek options to leverage funding to meet the transportation needs.

MHDD serves as the state's developmental disabilities authority and is responsible for promoting the development and provision of services and supports to persons with developmental disabilities, which includes persons diagnosed with mental retardation. Currently, persons diagnosed with mental retardation are receiving services from the Division of Mental Retardation Services (DMRS), which is in the Department of Finance and Administration. The Developmental Disabilities Planning and Policy Council, along with the MHDD Planning and Policy Council has recommended that responsibility for service provision for persons with developmental disabilities be located in one department rather than two. MHDD and DMRS are working with the Governor's Office toward addressing the Councils' recommendation.

MHDD is implementing the growing body of knowledge, which is research-based, on effective and efficient mental health service delivery options. Recent research has produced evidence-based best practices for the treatment of mental illness, which presents an opportunity for more effective treatment in the RMHIs and the community.

An integrated model of service delivery, which includes both physical and mental health components within a single contract (MCO), is currently being implemented by the Bureau of TennCare and MHDD in the Middle Tennessee region. This new model presents the department with opportunities to improve health and mental health for TennCare enrollees. MHDD will closely evaluate the effectiveness of the integrated contracting and delivery model to ensure positive outcomes on behavioral health measures. If proven effective, the Bureau of TennCare and MHDD may replicate the model statewide in the future. If effectiveness for the department's priority populations is compromised, MHDD will work to develop an alternative model.

In May 2006, the General Assembly passed Cover Tennessee, the Governor's plan to provide affordable and portable health insurance to uninsured Tennesseans. Department staff worked with the Department of Finance and Administration to ensure that all of the products, the Cover TN, Cover Rx, Cover Kids, and Access TN plans include mental health and substance abuse benefits. The department is working to ensure that persons with mental illness and substance abuse disorders are aware that this insurance coverage will provide one avenue to insurance coverage for need of mental health treatment.

DMHDD administers the Mental Health Safety Net Clinical Therapeutics and Recovery program to persons with serious and persistent mental illness (SPMI) that were disenrolled from TennCare beginning in June 2005. The program is provided through 19 community-based, non-profit

mental health agencies across the state and provides the core, vital services that people with SPMI need to continue leading functional, productive lives.

In 2006, the General Assembly passed Public Chapter 812, which called for DMHDD, in conjunction with community mental health providers, service recipients, family members, and other appropriate state and local agencies to study and recommend options for access to non-emergency behavioral health services for uninsured Tennesseans. The report recommended different options. This presents a great opportunity for DMHDD to partner with local community providers to provide access to mental health and substance abuse services.

Department of Health

Tennessee's Department of Health is responsible for the health and safety of all citizens and visitors to the state. As a public health agency, the department must monitor the health status of Tennesseans, diagnose and investigate health problems, and mobilize local communities to address health-related issues. The department develops policies and plans that support health goals, enforce laws and regulations that protect the health of all residents and visitors, links people to needed health care, and licenses and regulates health care practitioners and facilities.

Mission Statement

The mission of the Department of Health is to promote, protect, maintain, and restore the health of people living, working, or visiting the State of Tennessee by facilitating access to high quality preventive and primary care services. The department works in three major areas to provide service: delivery of personal and community health care and prevention services; quality control in the health care delivery system; and alcohol and drug abuse prevention and treatment.

Goals

1. By FY 2012, have a diversified public health workforce of qualified, competent, and stable employees who fulfill the mission of this department by leading by example, teamwork, and providing exemplary services to the citizens of the state.
2. By FY 2012, build statewide partnerships to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status. Assist partners and communities to organize and undertake actions to improve the health of the state's communities.
3. By FY 2012, raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well being, and to give newborn babies a better start in life. This initiative specifically targets cardiovascular disease, obesity, diabetes, infant mortality, prenatal care, and adolescent pregnancy, and the elimination of racial and ethnic health disparities in these areas.
4. By FY 2012, monitor the health status of Tennesseans and identify potential solutions and approaches to address any community problems affecting the health status of citizens. Develop critical capacity building around the conceptualizing, planning, and implementing of the state health plan.
5. By FY 2012, ensure that the critical and essential public and personal health services are delivered to the citizens and visitors of Tennessee ensuring the protection of all the population's health.

Goal 1

By FY 2012, have a diversified public health workforce of qualified, competent, and stable employees who fulfill the mission of this department by leading by example, teamwork, and providing exemplary services to the citizens of the state.

Strategies for Achieving Goal 1

1. Develop workforce development plans; based on an assessment that establishes benchmarks and actions needed to recruit, maintain, and sustain a diversified and competent workforce.
2. Provide resource development programs for current staff, as well as future public health employees (interns), that include training in leadership and management, cultural beliefs and practices influencing health, application of information technologies, and competencies in health occupations.
3. Review workforce assessment activities to determine if personal health care and public health workforces fill current and future demands for health services in the state.

Performance Measures

1. Percent of total health department employees who are racial minorities.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
17%	19%	21%	23%	24%	24%

2. Number of interns employed to train in public health.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
28	30	33	35	40	45

Goal 2

By FY 2012, build statewide partnerships to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status. Assist partners and communities to organize and undertake actions to improve the health of the state's communities.

Strategies for Achieving Goal 2

1. Engage communities and build public health support on a variety of health issues by identifying, convening, and communicating with organizations that contribute to or benefit from the delivery of essential public health services.
2. Organize partnerships for public health to foster the sharing of resources, responsibilities, collaborative decision-making, and accountability for delivering essential public health services at the state and local levels.
3. Review public health support building and partnership facilitation processes and institute improvements based on assessment findings in order to continually enhance partnerships and public health support relationships.
4. Partner with schools, faith based communities, work sites, personal care providers, and others to leverage broad based resources and to focus assets statewide that reinforce healthier lifestyles and better starts in life through health information, health education, and health promotion.

Performance Measure

1. Percent of counties that have organized partnerships for public health essential services at state and local levels.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
35%	45%	65%	85%	95%	100%

Goal 3

By FY 2012, raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well being, and to give newborn babies a better start in life. This initiative specifically targets cardiovascular disease, obesity, diabetes, infant mortality, prenatal care, and adolescent pregnancy, and the elimination of racial and ethnic health disparities in these areas.

Strategies for Achieving Goal 3

1. Synergize the current programs and maximize their potential by coordinating services in order to deliver holistic health care to our population.
2. Develop and analyze the necessary health data to specify the focus of activities as well as evaluate the progress of these activities designed to improve the healthy lifestyles and better life starts programs in Tennessee.
3. Empower the general population about their own individual health issues by designing and implementing health communications that provide screening and follow-up opportunities as well as provide a tool that an individual can use to monitor his progress to a healthier lifestyle.
4. Create and use health informational, educational, and promotional activities designed to reach targeted populations in order to eliminate health disparities.

Performance Measure

1. Percent of counties that have developed health education and promotion programs with partners for a healthier lifestyle and a better start in life.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
40%	50%	60%	85%	95%	100%

Goal 4

By FY 2012, monitor the health status of Tennesseans and identify potential solutions and approaches to address any community problems affecting the health status of citizens. Develop critical capacity building around the conceptualizing, planning, and implementing of the state health plan.

Strategies for Achieving Goal 4

1. Build department's capacity for technical assistance, evaluation, and investigation to support intradepartmental programs, partnership activities, and respond to community's health issues.
2. Support development of a comprehensive statewide health plan that addresses strategic and operational directions for preventive interventions for individuals and community populations. The plan should address system and infrastructure changes to improve capacity and preparedness for emergencies. Critical health and health care improvements will be guided by the state health profile.
3. Review activities to develop policies and plans that support individual and statewide health efforts on a periodic basis and use results from the reviews to improve the quality and outcome of the department's efforts.

Performance Measure

1. Percent of counties who have modified and implemented health improvements to improve the public health status in their counties.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
40%	50%	75%	80%	100%	100%

Goal 5

By FY 2012, ensure that the critical and essential public and personal health services are delivered to the citizens and visitors of Tennessee ensuring the protection of all the population's health.

Strategies for Achieving Goal 5

1. Review existing and proposed state laws and regulations to assure that these reflect current knowledge and best practices about public health and enforcement practices.
2. Administer public health enforcement activities within the department's jurisdiction in accordance with clear guidelines and statutory authority.
3. Work with the health care industry to assure access, utilization, and quality of health care for persons living in the state.
4. Improve access to health care for the underserved populations within the state.

Performance Measures

1. Percent of counties that adequately have developed a cohesive health system including public, private and voluntary organizations working together to ensure the services are provided to protect and improve the health of its citizens.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
50%	55%	70%	85%	95%	100%

Department of Health

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Additional Agency Information

Statutory and Constitutional Objectives

TCA 4-3-1802 states that the Department of Health shall be under the charge and general supervision of the Commissioner of Health. TCA 4-3-103 states that each department shall be vested respectively with such powers and duties as set by law and charged with the administration, execution, and performance of such laws as the General Assembly may enact.

TCA 68-1-104 requires the Commissioner of the Department of Health to have the general supervision of the interests of health and life of the citizens of this state. TCA 68-1-104(2) requires the commissioner to investigate the causes of disease, especially epidemics, which require laboratory confirmation.

TCA 68-11-201 et seq. charges the Department of Health to license and regulate health care facilities. The department has the authority to conduct reviews of all facilities licensed under this part in order to determine compliance with fire and life safety code regulations as promulgated by this program's Board for Licensing Health Care Facilities. Further, TCA 12-4-320 requires Health Licensure and Certification to administer the Residential Homes for the Aged program.

TCA 68-140-501 et seq. "Emergency Medical Services Act of 1983" and 68-14-201 et seq. is the statutory basis for the Emergency Medical Services division of the Department of Health.

TCA 63-1-101 et seq. gives the division of Health Related Boards, in the Department of Health, responsibility for licensing those persons engaged in the "practice of the healing arts" plus all administrative, fiscal, inspectional, and clerical functions associated with these boards.

Tennessee Vital Records Act of 1977, TCA 68-3-101 et seq. requires the Department of Health to collect, compile, and preserve all vital records for births, deaths, marriages, and divorces for the state. TCA 68-55-101 et seq. requires the Department of Health to maintain a registry of persons with traumatic brain injury. TCA 68-1-1001 et seq. requires the department to collect, compile, and maintain data concerning all diagnosed cancer cases throughout the state for dissemination to all appropriate members of the medical, scientific, and academic research communities for study and research. TCA 68-5-501 et seq. requires the department to develop and maintain a reporting system to collect data to facilitate the compilation of statistical information on causes, methods of treatment, and prevention of genetic disorders and birth defects.

TCA 62-38-201 et seq. requires the Department of Health to regulate, certify, and inspect tattoo parlors, tattoo artists, and body piercing establishments. TCA 68-8-1 establishes the Tennessee Anti-Rabies Law, authorizing the Department of Health to promulgate rules and regulations pertaining to the vaccination of dogs against rabies. TCA 68-14-301 et seq. establishes inspections, permits and licenses, and rules for hotels, food service establishments, public swimming pools, and bed and breakfast establishments. TCA 68-110-1 establishes the rules and regulations of organized camps.

TCA 68-5-401 requires the Department of Health to provide genetic screenings for all newborns, while TCA 68-34-104 requires each public health agency in the state to provide contraceptive procedures, supplies, and information. The U.S Department of Health and Human Service's maternal and child health national agenda, as outlined in Healthy People 2010, seeks to increase

Department of Health

the health and well-being of women, infants, children, and families by addressing the most significant issues and risk factors affecting maternal and child death rates. U.S. Title 427 -V-701 appropriates funds to address the following at the state level: (1) Assure that low-income mothers and children have access to quality maternal and child health services; (2) Reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children; (3) Increase the number of children (especially preschool children) appropriately immunized against disease; (4) Promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women and preventive and primary care services for low-income children; and (5) Provide and promote family-centered, community-based, coordinated care for children with special health care needs.

Obstacles to Meeting Objectives and Delivering Services and Means of Overcoming Obstacles

Obstacle 1 - Many Tennesseans are not knowledgeable about health promotion and disease prevention, and many lack appropriate motivation to change their behaviors. The effectiveness of the department's service delivery and the overall health of Tennesseans may be hampered, if the multiple determinants of health, i.e., socioeconomic, environmental, behavioral, and biological, are not all considered and addressed.

To overcome this obstacle, the department plans to develop health promotion and health education materials that motivate and empower Tennesseans to be well informed in order to make positive choices concerning their health and futures. Also, the department will design strategic partnerships among health care providers and local, state, and federal agencies, both public and private, and to share the objectives of integration of the system to maximize preventive efforts and to provide more holistic care. Public health employees and partners must create synergy in existing programs and structures as well as maximize collaborative efforts to begin delivering public health services in a new holistic approach.

Means of Maximizing Federal and Other Non-State Sources of Revenue

The department draws down all earned and available federal revenue as required by Finance and Administration's Policy 20, which governs cash management. Services that are either wholly or partially funded by federal dollars are tied to the appropriate federal grant in the State of Tennessee Accounting and Reporting System (STARS). As expenses are incurred, STARS produces a daily drawn-down report, which is used to electronically draw federal revenue directly from the federal government. Program staff continuously reviews the Catalog of Federal Domestic Assistance (CFDA), as well as the Federal Register for grants opportunities.

Means of Avoiding Unnecessary Costs and Expenditures

Training, controls, procedures, and management review of proposed expenditures and review of accounting reports are the means of avoiding unnecessary expenditures. Also, the department undergoes external and performance audits by the Comptroller's Office. The last financial and compliance audit conducted by the Comptroller's office was released in April 2007, for the fiscal year ending June 30, 2006. The last performance audit of the department was released in October

2003. In addition, the Department of Health performs periodic internal audits of expenditures and various accounting reports.

Future Challenges and Opportunities

The department faces the challenge of a growing Latino community throughout the state. The challenge is to overcome language and cultural differences that may become obstacles to serving this population. However, it is also an opportunity for the department to devise new and innovative ways to serve this segment of the population.

- VII Assurances – Non construction
- VIII Proof of Nonprofit status
- IX BVI Licensure and Accreditations
- X State Strategic Plan

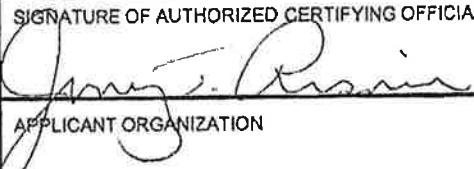
**ASSURANCE
of Compliance with SAMHSA Charitable Choice
Statutes and Regulations
SMA 170**

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Executive Director
APPLICANT ORGANIZATION	DATE SUBMITTED
Buffalo Valley Inc	6-15-11

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

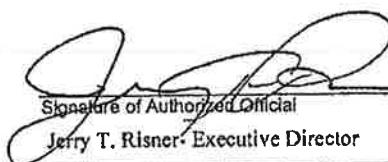
THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

6/14/11
Date



Signature of Authorized Official
Jerry T. Risner, Executive Director

Name and Title of Authorized Official (please print or type)

Buffalo Valley, Inc.

Name of Healthcare Facility Receiving/Requesting Funding

501 Park Ave. S. P.O. Box 879

Street Address

Hohenwald, TN 38462-0879

City, State, Zip Code

Internal Revenue Service

Date: October 16, 2000

Buffalo Valley, Inc.
PO Box 879
Hohenwald, TN 38462-0879

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Person to Contact:

Judy Simonson 31-04016

Customer Service Representative

Toll Free Telephone Number:

8:00 a.m. to 9:30 p.m. EST

877-829-5500

Fax Number:

513-263-3756

Federal Identification Number:

58-1374964

Dear Sir or Madam:

This letter is in response to your request for affirmation of your organization's exempt status.

Our records indicate that a determination letter issued in September 1979 granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in section 509(a)(1) and 170(b)(1)(A)(vi).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than \$25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of \$20 a day, up to a maximum of \$10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of \$100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, bequests, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Buffalo Valley, Inc.
58-1374964

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

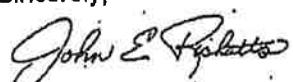
The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. You are also required to make available for public inspection a copy of your organization's exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of \$20 a day for each day you do not make these documents available for public inspection (up to a maximum of \$10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,



John E. Ricketts, Director, TE/GE
Customer Account Services



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

BUFFALO VALLEY, INC.
PO BOX 879
Hohenwald, TN 38462

February 17, 2011

Request Type: No Fee Certificate of Existence/Authorization
Request #: 0032194

Issuance Date: 02/17/2011
Copies Requested: 1

Document Receipt

Receipt #:

Filing Fee:

Regarding: BUFFALO VALLEY, INC.
Filing Type: Corporation Non-Profit - Domestic
Formation/Qualification Date: 08/09/1978
Status: Active
Duration Term: Perpetual

Control #: 55035
Date Formed: 08/09/1978
Formation Locale: Lewis County
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

BUFFALO VALLEY, INC.

- * is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;
- * has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;
- * has filed the most recent corporation annual report required with this office;
- * has appointed a registered agent and registered office in this State;
- * has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

A handwritten signature in black ink, appearing to read "Tre Hargett".
Tre Hargett
Secretary of State

Processed By: Nichole Hambrick

Buffalo Valley, Inc.
Hudspeth, TX

Healthcare Center



The Joint Commission

Accredited Organization - Accredited Organization

Healthcare Quality Accreditation Institute

February 1, 2009

David A. Edwards

Mark Glass

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH
AND DEVELOPMENTAL DISABILITIES



INITIAL LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES GRANTS THIS
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO ESTABLISH A NEW FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Nashville

(Name of Facility or Service as Known to the Public)

105 Oak Valley Drive, Nashville, TN 37207

(Street Address or Location, City or Town)

THE CONDITIONS OF THE ISSUANCE OF THIS INITIAL LICENSE ARE FOUND AT RULE 0940-5-2-.10(1) OF
THE RULES OF THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	Approved for persons with vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	Y	Y	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	Y	Y	Y	6	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	Y	Y	Y	6	Small Residential Board & Care
Mental Health Outpatient Facility	Y	Y	Y	n/a	Business

October 01, 2010

Date License Granted

September 30, 2011

Date License Expires

1000000007491

License Number

Virginia Carter Bass
Commissioner of Mental Health and Developmental Disabilities

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

7491

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Maple

(Name of Facility or Service as Known to the Public)

221 South Maple, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with hearing loss	Approved for persons with vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	Y	N	Y	3	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	Y	N	N	13	Small Residential Board & Care
Mental Health Outpatient Facility	Y	N	N	n/a	Business

Waiver(s): 0940-5-5-.06(e)(1)&(2)

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008251
License Number



Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

0251

86

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - 511 Park Ave S

(Name of Facility or Service as Known to the Public)

511 Park Avenue South, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Alcohol & Drug Residential Rehabilitation Treatment	N	N	N	6	Small Residential Board & Care
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011

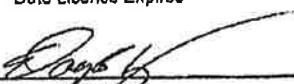
Date License Granted

March 31, 2012

Date License Expires

L000000008252

License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8252

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - East 4th

(Name of Facility or Service as Known to the Public)

100 East 4th Street, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011

Date License Granted

March 31, 2012

Date License Expires

L000000008253

License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8253

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Lewisburg

(Name of Facility or Service as Known to the Public)

218 Martin Street, Lewisburg, TN 37091

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with hearing loss	Approved for persons with vision impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008254
License Number

Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8254

89

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - Residential Rehab.

(Name of Facility or Service as Known to the Public)

554 2nd Avenue North #1, Lewisburg, TN 37091

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with			Occupancy Classification
		hearing loss	vision impairment	Capacity	
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	N	N	N	3	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	N	N	N	13	Small Residential Board & Care
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

1000000008255
License Number

Commissioner of MENTAL HEALTH

8255

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley - 501 Park Ave S.

(Name of Facility or Service as Known to the Public)

501 Park Avenue South, Hohenwald, TN 38462

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory Individuals	Approved for persons with hearing loss	vision Impairment	Capacity	Occupancy Classification
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	Y	N	N	15	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	Y	N	N	18	Large Residential Board & Care
Mental Health Outpatient Facility	Y	N	N	n/a	Business

April 01, 2011

Date License Granted

March 31, 2012

Date License Expires

L000000008256

License Number


Commissioner of MENTAL HEALTH

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

8256

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH



LICENSE

THE DEPARTMENT OF MENTAL HEALTH GRANTS THIS FULL
LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

BUFFALO VALLEY, INC.

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE
PROVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR PERSONAL SUPPORT,
OR ALCOHOL AND DRUG ABUSE SERVICES:

Buffalo Valley

(Name of Facility or Service as Known to the Public)

717 Cumberland Drive, Clarksville, TN 37091

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND
WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING
DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Distinct Category	Accessible to mobile, non- ambulatory individuals	Approved for persons with			Occupancy Classification
		hearing loss	vision impairment	Capacity	
Alcohol & Drug Non-Residential Rehabilitation Treatment	N	N	N	n/a	Business
Alcohol & Drug Residential Detoxification Treatment	N	N	N	5	Small Residential Board & Care
Alcohol & Drug Residential Rehabilitation Treatment	N	N	N	5	Small Residential Board & Care
Mental Health Outpatient Facility	N	N	N	n/a	Business

April 01, 2011
Date License Granted

March 31, 2012
Date License Expires

L000000008384
License Number

Commissioner of MENTAL HEALTH

8384

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

State Strategic Plans

STATE OF TENNESSEE

Agency Strategic Plans

Executive Branch



**Volume 1
Five-Year Strategic Plans**

Phil Bredesen, Governor

September 2007

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Agency Strategic Plans Executive Branch

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STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE CAPITOL
NASHVILLE, TENNESSEE 37243-0285

DAVE GOETZ
COMMISSIONER

September 1, 2007

TO: The Honorable Phil Bredesen, Governor
Members of the 105th General Assembly

I am pleased to present to you the agency strategic plans for the Executive Branch agencies. The Administration continues to focus on effective and efficient delivery of services to the people of Tennessee, two goals of the Governmental Accountability Act of 2002.

The plans are agency plans, developed pursuant to the act.

In accordance with the Act, agencies are required to submit both a strategic plan and program performance measures. These are published in two separate volumes, which comprise the Agency Strategic Plans document. Volume 1 is Five-Year Strategic Plans, which addresses agency-wide information. Volume 2 is Program Performance Measures, which includes program-level information and performance standards and measures for each program at the budgetary unit level. These documents represent the commitment of the Administration to provide the General Assembly information which is useful in the budget process and agency oversight. The Administration views the planning process as interactive between the Administration and the General Assembly. We will continue to review the planning methods to ensure a productive process.

A total of 15 agencies will submit performance-based budget requests for 2008-2009 under the Governmental Accountability Act. Currently operating under performance-based budgets are nine agencies: Revenue, Environment and Conservation, Human Services, Safety, Finance and Administration, Economic and Community Development, Agriculture, Correction, and Transportation. In 2008-2009, six agencies are being added to the performance-based budget process: General Services, Education, Military, Commerce and Insurance, Financial Institutions; and Labor and Workforce Development.

The Administration believes that it is important for all agencies to participate in the strategic planning process; therefore, all Executive Branch agencies have submitted agency strategic plans, regardless of their performance-based budget status. The Tennessee Higher Education Commission and the Tennessee Student Assistance Corporation have submitted plans for their

own programs. It is the Administration's intent to fully incorporate all Executive Branch agencies under the performance-based budgeting requirements of the Governmental Accountability Act by fiscal year 2011-2012.

The Budget Staff and I look forward to working with the Governor, members of the General Assembly, the Governmental Accountability Commission, and the state agencies as we continue to evaluate and improve our implementation of the Governmental Accountability Act.

Sincerely,

M.D. Goetz, Jr.
Commissioner of Finance and Administration

State of Tennessee

Agency Strategic Plans Document

The Agency Strategic Plans document is presented in two volumes.

Volume 1 is Five-Year Strategic Plans. This includes an agency-wide plan, focused on the most important priorities of each agency head. Each plan includes a general description of the agency, a mission statement, major goals, strategies for achieving each goal, and performance measures, indicating a baseline for the previous year and progress toward achieving each goal over the next five-years. The plans also include the following additional agency-wide information: statutory and constitutional objectives; obstacles to meeting objectives and delivering services; means of overcoming obstacles; means of maximizing federal and other non-state sources of revenue; means of avoiding unnecessary costs and expenditures; and

future challenges and opportunities.

Volume 2 is Program Performance Measures. That volume includes further information on each of the several hundred programs of the Executive Branch agencies. For each program, defined as a budgetary unit identifiable in the budget document and the general appropriations act, the following program-specific information is provided: identification of mandated and optional services and the best means of providing them; program performance standards; program performance measures, indicating a baseline for the previous year and estimates for the current and next year; and means of addressing any change in services since the previous plan.

Volumes 1 and 2 together contain all the information required by the 2002 Governmental Accountability Act.

State of Tennessee

The Strategic Planning Process

In Tennessee State Government, agency strategic planning is a responsibility of program directors, agency planning and budget staffs, and agency heads throughout state government. Pursuant to law, the agency strategic plans within the Executive Branch are developed under guidelines issued by the Commissioner of Finance and Administration.

Preparation of the consolidated Agency Strategic Plans document for the Executive Branch is the responsibility of the Commissioner of Finance and Administration, who is the State Budget Director.

Within the Department of Finance and Administration, the Division of Budget is responsible for oversight of agency strategic plan development. Preparation, monitoring, and evaluation of strategic plans is a continual process throughout the year.

The strategic plans are agency plans, developed pursuant to law on a program-by-program basis. The law directs the Commissioner of Finance and Administration to consolidate the agency plans for transmittal jointly to the Governor and the General Assembly.

The Governmental Accountability Act of 2002 was enacted by Chapter 875 of the Public Acts of 2002 (codified at Tennessee Code Annotated, Title 9, Chapter 4, Part 56, and in some sections of budget law at Part 51). The Accountability Act requires the phase-in of strategic planning and performance-based budgeting. The law required that at least three agencies be included in performance-based budgeting in fiscal year 2004-2005. The Administration chose four agencies to start performance-based budgeting as of July 1, 2004. Those agencies are the departments of Revenue, Safety, Environment and Conservation; and Human Services. An additional five agencies submitted performance-based budgets for fiscal year 2005-2006. Those five agencies are the departments of Finance and Administration, Economic and Community Development, Agriculture, Correction, and Transportation. For fiscal year 2008-2009, six more are added to the list, making the total 15 agencies. The six agencies are General Services, Education, Military, Commerce and Insurance, Financial Institutions, and Labor and Workforce Development. All Executive Branch agencies of state government must be operating under the performance-based budget format by fiscal year 2011-2012.

The Administration has required all Executive Branch agencies to submit strategic plans, regardless of their performance-based budget status.

Contents of the Plans

The Governmental Accountability Act requires that agency strategic plans, accompanied by program performance

Function	Participants	Schedule
Preparation of Strategic Plans	Departments and Agencies Budget Division	April June
Executive Review	Budget Division	July August
Legislative Review	General Assembly	* September-May
Strategic Plan Implementation	Departments and Agencies	July-June
Performance Reporting	Departments and Agencies Commissioner of P&A Governmental Accountability Commission Finance Committees	Following Year January-May
Performance Review	Comptroller of the Treasury	Following Year July-June

*Note: The General Assembly has final approval of all strategic plans, performance measures, and standards through the general appropriations act.

The preceding chart indicates the participants in the planning process and an approximate time schedule.

The Strategic Planning Process

standards and measures, contain at least the following information:

1. statutory and constitutional objectives of the entity;
2. identification of mandated and optional services and the means of providing them;
3. obstacles to meeting objectives and delivering services and means of overcoming obstacles;
4. means of maximizing federal and other non-state sources of revenue;
5. means of avoiding unnecessary costs and expenditures;
6. future challenges and opportunities.

Preparation of the Plans

In April, the staff of the Division of Budget issues guidelines to state agencies regarding the strategic planning process. These guidelines provide direction as to the content and format of strategic plans. The guidelines are based on the requirements of the Governmental Accountability Act.

The deadline for agency completion and transmission of the strategic plans to the Division of Budget is the first of July. During this preparation period, the staff of the Division of Budget meets as needed with agency planning and fiscal personnel to answer questions and provide assistance in developing their strategic plans.

Executive Review of the Plans

The Governmental Accountability Act directs the Commissioner of Finance and Administration to review, revise, and approve strategic plans and program performance standards and measures. (State agencies are directed by the law to include these revised performance standards and measures in the subsequent budget request.)

After the receipt of agency strategic plans, analysts with the Division of Budget begin the process of reviewing the plans, paying particular attention to proposed standards and measures. The Commissioner of Finance and Administration has the responsibility to evaluate the validity, reliability, and appropriateness of each

performance measure and standard and how the strategic plan and the performance measures are used in management decision-making and other agency processes.

Following review of the plans by the Division of Budget, recommendations are made to the Commissioner of Finance and Administration regarding content, as well as performance standards and measures. A consensus is sought with the agencies regarding performance standards and measures. After decisions have been finalized, the staff of the Division of Budget prepares the Agency Strategic Plans document for printing. The document must be submitted to the Governor and the General Assembly by September 1.

Legislative Review

The General Assembly has final approval of all strategic plans, performance measures, and standards through the general appropriations act.

In the spring of 2006, the Commissioner of Finance and Administration submitted a program performance report on the first four performance-based budget agencies to the Finance, Ways and Means committees of the Senate and House of Representatives. The Governmental Accountability Act requires that a compliance report must be submitted annually at a time that will allow the finance committees to consider the performance report while they are considering the general appropriations bill.

To further assist the General Assembly in review of agency performance, the 2002 public act created the Governmental Accountability Commission. It is comprised of officials who hold office by legislative appointment. They are the Comptroller of the Treasury, who serves as chairman; the Executive Director of the Fiscal Review Committee, vice chairman; and the Director of the Office of Legislative Budget Analysis, who serves as secretary of the commission.

Following the performance report by the Commissioner of Finance and Administration, the Governmental

The Strategic Planning Process

Accountability Commission is to review the commissioner's report and submit to the finance committees its written comments on the commissioner's report.

The Accountability Commission also may make recommendations to the finance committees on the performance of agencies; the reasonableness of performance standards and measures recommended in the budget document for the performance-based agencies; and on other strategic plan and program performance matters.

Strategic Plan Execution

When passage of the appropriations bill is complete and it is signed or enacted into law, the execution of agency strategic plans begins.

Annually, at the time the enacted budget (called the "work program" in budget law) is established, agencies may request adjustments to the performance measures and standards, based on changes in the program appropriations during the enactment of the general appropriations act. These adjustments require the approval of the Commissioner of Finance and Administration, who must maintain the official record of adjustments and must report adjustments to the chairmen of the Senate and House Finance, Ways and Means committees. The law provides that agencies themselves may not change the performance measures.

During the fiscal year, modifications to program performance standards and measures are allowed if an agency is required to modify its operations because of:

1. court action resulting in a restraining order, injunction, consent decree, or final judgement;
2. law or executive order;
3. additional federal or other funding.

All adjustments to performance standards and measures during the year also are subject to approval of the Commissioner of Finance and Administration, who must report the changes to the chairmen of the

House and Senate Finance, Ways and Means committees.

Comptroller's Performance Review

Aside from executive and legislative review of agency strategic plans and program performance, the 2002 public act provides that each state agency engaged in performance-based budgeting is subject to performance review of its activities by the Comptroller of the Treasury. This provision grants discretion to the Comptroller to determine the matters to be reviewed, related to the manner in which the state agency is delivering services and achieving objectives. This performance review, according to the law, will at least include consideration of the efficient use of state and federal funds; additional non-state revenue or cost savings that could be achieved; and the extent to which strategic plan objectives are achieved.

Connection of Plans and the Budget

The Governmental Accountability Act of 2002 amended budget law to require that performance-based budgeting agencies include in budget requests the program performance standards and measures, as reviewed and revised by the Commissioner of Finance and Administration. These standards and measures are the ones included in this Agency Strategic Plans document for the nine performance-based agencies. After budget requests are submitted, the program performance measures, along with other strategic plan and budget request information, will assist staff of the Budget Division in analyzing agency budget requests.

Budget law, as amended by the 2002 Governmental Accountability Act, directs that certain other performance-based budget information be included in agency budget requests. This includes identification of program clients; the purpose of each program or client benefits; program costs and funding sources; fee collections and the adequacy of fees to support the program;

The Strategic Planning Process

assessment of whether each program is conducive to performance-based budgeting;

and assessment of the time needed to develop meaningful performance measures.

In reviewing budget requests and transmitting the budget document to the General Assembly, the Governor, with assistance of the Commissioner of Finance and Administration, may revise, add, or delete performance measures and standards as the Governor deems necessary. The General Assembly retains authority for final approval of performance standards and measures through the general appropriations act.

The amended budget law also requires that the budget document transmitted by the Governor to the General Assembly include a performance-based budget for each state

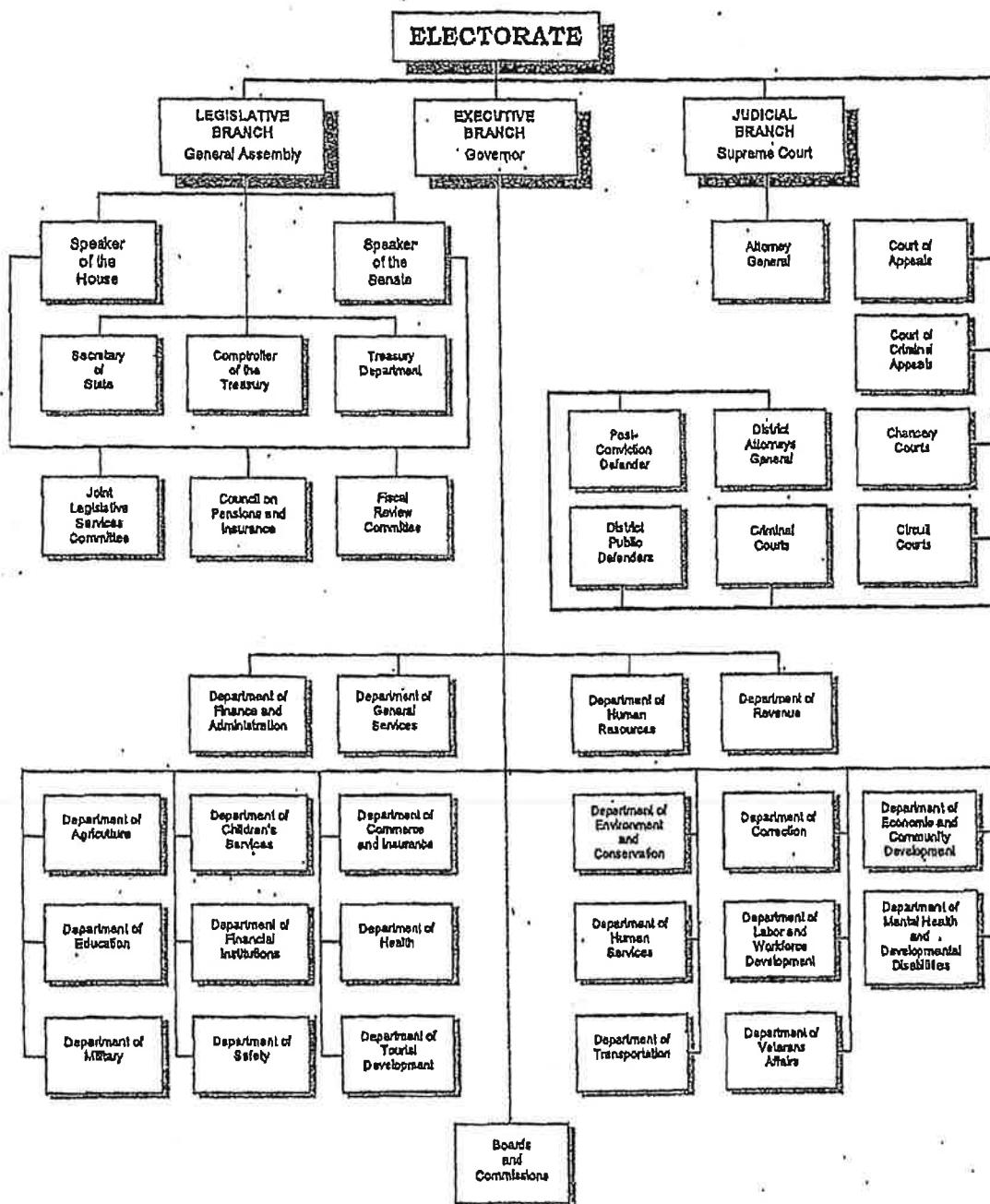
agency subject to performance-based budgeting. The performance-based budget must include program statements and performance measures.

The various reviews described above -- executive, legislative, and performance audit -- will utilize both the strategic plan and performance budget information to assess program performance.

Legislative intent to connect planning, budgeting, and accountability is evident in the 2002 Governmental Accountability Act. The General Assembly has stated in law that it intends to use this system in resource allocation decisions and program performance review.

TENNESSEE STATE GOVERNMENT ORGANIZATIONAL CHART

FISCAL YEAR 2007 - 2008



Department of Mental Health And Developmental Disabilities

In March 1953, the Department of Mental Health was created by enactment of the General Assembly to provide for the better treatment and welfare of persons with mental illness or mental retardation. In June 2000, the General Assembly re-created the agency, changed its name to the Department of Mental Health and Developmental Disabilities (MHDD), and passed a comprehensive revision of the mental health and developmental disability law, Title 33 of the Tennessee Code Annotated. The revised law expanded significantly the department's authority to coordinate, set standards, plan for, monitor, and promote the development and provision of services and supports to meet the needs of persons with mental illness, serious emotional disturbance, or developmental disabilities through the public and private sectors.

MHDD is the state's mental health and developmental disabilities authority and is responsible for system planning, setting policy and quality standards, licensing mental health services and facilities, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance or developmental disabilities. By agreement with the Bureau of TennCare, the department also oversees and monitors the programmatic components of the TennCare Partners Program. Monitoring responsibilities include assessment of the adequacy of the provider network and the quality of services provided. MHDD also licenses mental retardation services and facilities.

In February 2007, the Bureau of Alcohol and Drug Abuse Services was transferred to MHDD from the Department of Health by Executive Order 44. The bureau is responsible for planning, developing, administering, and evaluating a statewide system of services for persons at risk for substance abuse along with persons abusing substances. The integration of alcohol and drug abuse services within MHDD will streamline government and its resources and facilitate the opportunity to expand access to integrated treatment options. The bureau is now known as the Division of Alcohol and Drug Abuse Services.

Mission Statement

The mission of MHDD is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports based on the needs and choices of individuals and families served.

Goals

1. By FY 2012, MHDD will increase the public's knowledge and understanding of mental illness and substance abuse and its effective treatments by providing activities to 2,250 individuals to reduce stigma.
2. By FY 2012, MHDD will increase mental health and substance abuse service providers' understanding of the prevalence of and best practice treatments for co-occurring disorders by providing training on best practices to 25 mental health and substance abuse agencies.

3. By FY 2012, MHDD will enhance funding sources for a continuum of recovery and resilience services by a variety of methods, which includes maintaining a minimum of eleven active grant awards from non-state sources.
4. By FY 2012, MHDD will improve operations and increase the number of consistent practices used in the five Regional Mental Health Institutes (RMHIs) to 30.
5. By FY 2012, MHDD will provide 55 clinical rotations or internship experiences as a recruitment tool to promote public sector careers for mental health professionals.

Goal 1

By FY 2012, MHDD will increase the public's knowledge and understanding of mental illness and substance abuse and its effective treatments by providing activities to 2,250 individuals to reduce stigma.

Strategy for Achieving Goal 1

1. MHDD will conduct a statewide multi-media campaign to educate the public about mental illness and substance abuse and effective treatments that promote remission and recovery.

Performance Measure

1. Number of individuals who participate in an overcoming stigma activity.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
900	1,250	1,500	1,750	2,000	2,250

Goal 2

By FY 2012, MHDD will increase mental health and substance abuse service providers' understanding of the prevalence of and best practice treatments for co-occurring disorders by providing training on best practices to 25 mental health and substance abuse agencies.

Strategies for Achieving Goal 2

1. MHDD will train employees and service providers about co-occurring disorders and best practices for treatment.
2. MHDD will increase funding sources for a continuum of services for Tennesseans with co-occurring disorders.

Performance Measure

1. Number of community mental health and substance abuse agencies that have staff trained specifically on best practices to treat co-occurring disorders.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
6	12	15	18	22	25

Goal 3

By FY 2012, MHDD will enhance funding sources for a continuum of recovery and resilience services by a variety of methods, including maintaining a minimum of eleven active grant awards from non-state sources.

Strategies for Achieving Goal 3

1. MHDD will strive to enhance services in Tennessee with grant funding.

Performance Measure

1. Number of active grants from non-state sources.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
11	11	11	11	11	11

Goal 4

By FY 2012, MHDD will improve operations and increase the number of consistent practices used in the five Regional Mental Health Institutes (RMHIs) to 30.

Strategy for Achieving Goal 4

1. MHDD will standardize clinical practices through the use of consistent practices, including protocols, best practices, and/or evidence-based practices in the RMHIs.

Performance Measure

1. Number of consistent practices, including protocols, best practices, or evidence-based practices used in all five RMHIs.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
17	21	25	27	29	30

Goal 5

By FY 2012, MHDD will provide 55 clinical rotations or internship experiences as a recruitment tool to promote public sector careers for mental health professionals.

Strategy for Achieving Goal 5

1. MHDD will expand existing educational opportunities relative to careers in public mental health by providing clinical rotations or internship experiences in mental health professional fields.

Performance Measure

1. Number of individuals participating in a master's or doctoral level nursing, pharmacy, social work or psychology clinical rotation or internship through MHDD.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
40	43	46	49	52	55

Additional Agency Information

Statutory and Constitutional Objectives

TCA 4-3-1603 assigns MHDD the duty and power to provide the best possible care for people with mental illness, serious emotional disturbance, or developmental disability in the state by improving existing facilities and by the development of future facilities and programs.

TCA 33-1-201 gives the department responsibility for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or developmental disabilities.

TCA 33-1-201 and 33-2-101 require the department to plan and promote a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services and supports based on the needs and choices of service recipients and their families. Service recipients and service recipients' families must be included in planning, developing, and monitoring the service systems.

TCA 33-1-302 and 33-1-303 authorize the department to construct, maintain, and operate facilities and to have general responsibility for the proper and efficient operation of its facilities.

TCA 33-1-307 directs the department to establish a structured information system to gather all data necessary to carry out all of its duties related to planning, needs assessment, standard setting, evaluation, and development of services and supports for current and potential service recipients.

TCA 33-1-401 and 33-1-402 mandate a statewide planning and policy council to assist in planning a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services and supports and to advise the department on policy, budget requests, and developing and evaluating services and supports.

TCA 33-2-201 requires the department to prepare and maintain a three-year plan, updated annually, for mental health and developmental disabilities services based on the statewide planning and policy council's recommendations and the assessment of the public's need for mental health and developmental disability services and supports.

TCA 33-2-202 and 33-2-203 require the department to maintain two other tiers of planning and policy councils, state and regional, to provide citizen input into policy planning. TCA 33-2-202 directs the department to maintain a statewide network of mental health and developmental disabilities regional planning councils, as well as a statewide Mental Health Planning and Policy Council and a statewide Developmental Disabilities Planning and Policy Council, which report community service needs and the adequacy of local service system delivery to the MHDD and to the MHDD Planning and Policy Council.

TCA 33-2-301 and 33-2-302 mandate the department to set and regulate compliance with basic quality standards for services and supports to all persons in Tennessee served on the basis of mental illness, serious emotional disturbance, or developmental disability.

TCA 33-2-403 and 33-2-404 provide authority to license and adopt rules for licensure of services and facilities operated for provision of mental health, developmental disability, and personal support services.

TCA 33-2-403 - 407, TCA 33-2-412, 413, and 417 mandate that facilities comply with MHDD licensure rules, chapters 0940-5-1 through 39, including life safety.

TCA 33-2-501 directs the department to develop an array of transportation options for all regions of the state.

TCA 33-2-1101 requires the department to calculate the charges for services it provides. The methodology for determining these costs must be approved by the Comptroller of the Treasury and the Commissioner of Finance and Administration. TCA 33-2-1102 requires MHDD to establish rules to determine indigency and reimbursement.

TCA, Title 33, Chapter 6, Parts 2, 4, and 5, 33-7-301 and 33-7-303, and 37-1-128 require RMHIs to admit individuals who meet admission criteria or are court-ordered for admission for forensic or juvenile court evaluations; TCA 33-6-308 and 33-6-701 require the release of the individuals when they no longer meet the standards under which they were admitted; and TCA 33-3-101(c) requires the services to be in accordance with community standards to the extent that facilities, equipment, and personnel are available.

The 1975 U.S. Supreme Court decision in *O'Connor v. Donaldson* requires that when the liberty of a person with mental illness is restricted to a psychiatric hospital, the person must receive active treatment or be released.

TCA, Title 33, Chapter 6; Part 4, TCA 33-3-403, and 33-3-412 require the RMHIs to admit individuals who meet emergency involuntary criteria regardless of bed availability including emergency transfers from the Department of Correction (DOC) and the Department of Children's

Services (DCS) youth development centers; and TCA, Title 33, Chapter 6, Parts 2 and 5, TCA 33-3-401 and 402 admissions, which include non-emergency transfers from DOC and DCS youth development centers, are contingent on the availability of suitable accommodations. "Suitable accommodations" means having a specified percentage of operational beds vacant and therefore available for use.

TCA 33-6-103 and 33-8-103 require the department to maintain an array of services and supports for adults with mental illness and children with serious emotional disturbance who are priority populations.

TCA 40-33-2 and 55-10-4 established and funded the Alcohol and Drug Addiction Treatment Fund (ADAT). This fund was established to allow people who are declared indigent access to alcohol and drug services.

TCA 68-24-101 et seq. established the "Comprehensive Alcohol and Drug Treatment Act of 1973" and "Alcohol Abuse Prevention Act of 1990" stating the prevention of alcoholism and drug dependence should be accomplished in a number of ways, including public education concerning the causes, symptoms, and nature of alcoholism and drug dependence. In order to educate the public, the department is required to prepare and distribute suitable educational material to schools and interested members of the public, render assistance to suitable local agencies, and provide activities promoting public interest in and information about substance abuse and dependence.

Obstacles to Meeting Objectives and Delivering Services and Means of Overcoming Obstacles

Obstacle 1 - MHDD's ability to ensure availability of services and supports for uninsured and underinsured persons is limited due to lack of sufficient funding streams, leaving many persons in the state with limited access to timely, appropriate care in the most appropriate environment. Recent changes in TennCare eligibility, TennCare disenrollment, and actuarial changes for state only and judicial services and the immediate necessity to recapture/use state dollars previously transferred to TennCare for Medicaid match are among the challenges in adequately funding the state's public mental health and substance abuse system. Many of the access limitations in mental health and substance abuse services reflect provider decisions (due to lack of resources) to limit or cease providing mental health and substance abuse services, limited private insurance coverage for mental health and substance abuse services, and the historically disproportionately poor allocation of health care dollars to the prevalence of mental illness and substance abuse. In addition, mental health and substance abuse sub specialists are scarce, and reimbursable options for mental health and substance abuse are not fully aligned with treatments that have proven to be "best practices". A lack of insurance parity is highlighted in access to A&D services due to existing lifetime limitations placed on A&D benefits. Early intervention services are not at scale, especially for mental health issues. Many early intervention programs funded by the department are funded only in certain areas of the state and access is not available to all who could benefit.

In response to these realities, the department is exploring several viable options to meet the mental health and substance abuse needs of those individuals who have been impacted by funding shifts, especially in TennCare. These options include expanding eligibility for the Mental Health Safety Net package of mental health services, working with Finance and Administration to ensure that the Cover Tennessee products offer mental health and substance abuse benefits and that they

are utilized, and raising awareness in the business community of the importance of including mental health and substance abuse benefits in employee-based health insurance products.

Obstacle 2 - In March 2002, people with developmental disabilities other than mental retardation became eligible, subject to funding availability, for services and supports from MHDD. After years of waiting for a "home" agency, people with developmental disabilities continue to wait for the home agency to provide services to them. To date, only planning funds have been allocated with no appropriations to MHDD to provide services and support to persons with developmental disabilities.

This obstacle will remain until funds are appropriated to implement services for persons with developmental disabilities other than mental retardation. The department continues to seek additional funding opportunities through private or federally funded grants to expand the array of developmental disability services in Tennessee. Chapter 604, Public Acts, 2006, establishes a task force, led by the Division of Mental Retardation Services, to conduct a statewide assessment to study the needs of persons with a developmental disability other than mental retardation for whom comprehensive home and community based services do not exist and to develop a plan to provide cost effective home and community based services for such persons. MHDD is participating in this task force.

Obstacle 3 - TCA, Title 33 requires that the department license services as well as facilities. Many service providers do not provide services in a facility. This expanded authority has increased the number of licenses issued and thus the workload of the licensure section. Because the department's current licensure rules have in the past been focused on facilities, the licensure section has initiated an extensive revision of rules and procedures. In addition, the section has worked to improve communication with licensees. The department has recently hired an attorney to oversee this licensure responsibility.

Increased use of information technology in MHDD's administrative responsibilities assists in meeting additional requirements within current resources. The department is developing a licensure operations management system that allows MHDD to track and manage licensure functions more efficiently. Components of this system, such as computerized report completion and submission and incident tracking and follow up will reduce paperwork and improve staff efficiency.

Obstacle 4 - MHDD is challenged with building a data infrastructure to meet all federal and state mandates to gather data necessary to carry out duties related to planning, needs assessment, standard setting, evaluation, and development of services and supports for current and potential service recipients as well as completing an annual assessment of the public's need for mental health and developmental disability services and supports. Although MHDD has authority to request from other state and community agencies and the private sector, it lacks enforcement authority if requests for data/information are denied, unexplained, or unanswered. Also, there is nothing in state law requiring any county or local data about mental illness, serious emotional disturbance, or developmental disability to be reported to the department. The best and most accurate data come from those entities MHDD regulates or contracts with and can require to be reported. Thus, a significant portion of MHDD service system planning relies on extrapolating from national prevalence data and other policy and evidence-based research.

The department continues to develop a data infrastructure and collaborate with other state agencies, specifically the Department of Children's Services and the Department of Health, to

identify ways MHDD can use data collected by those agencies for mental health and developmental disability planning needs.

Obstacle 5 - The nationwide shortage of nurses, doctors and pharmacists, predicted to worsen in the next few years, presents tremendous challenges. Staffing, especially nurses and other qualified direct caregivers, is a major problem for the RMHIs. Without sufficient nursing staff, service recipient care is negatively impacted, and Joint Commission accreditation and Medicare certification are jeopardized which would result in a potential loss of revenue. The RMHIs also experience great difficulty in recruiting and retaining other clinical staff, particularly psychiatrists and pharmacists. Some state salaries, especially in health and mental health management and clinical classifications, are not competitive. Recruitment and retention of professionals as required in the state's complex mental health and developmental disability service system is increasingly more difficult, especially in some classes like nursing.

TCA 8-23-209, which was initiated by the Commissioner of MHDD, was the first step in addressing the nursing crisis in mental health by authorizing the flexibility to employ nurses to work a reduced schedule and accrue full benefits. In addition, voluntary overtime, mandatory overtime, and/or contract staff must be used when an RMHI cannot recruit and retain sufficient staff, which increases the per diem costs of care.

Obstacle 6 - Efficient operation of the RMHIs is affected by fluctuating demand for inpatient services. Service recipients are admitted based on statutory criteria, limiting the department's ability to balance treatment needs with space availability. Often, hospital admissions are directly related to a lack of intensive outpatient community mental health services and thus their discharges may be delayed if adequate aftercare housing, treatment, and support services are not readily available.

The department is working to decrease inpatient utilization by promoting the development of housing, crisis intervention services, and more readily available outpatient services for people with mental illness or serious emotional disturbance. The department is re-designing the crisis services model and is encouraging the mental health provider community to develop an improved community continuum in an effort to reduce over utilization of inpatient services at the RMHIs. The department continues to work with private providers to increase the availability of inpatient mental health services in non-state facilities.

Obstacle 7 - The age and design of the majority of the RMHIs make efficient operation extraordinarily difficult because of deteriorating physical plants and infrastructure and related high maintenance and staff requirements. The general maintenance costs have reached the level that replacement facilities are required for three of the RMHIs and extensive renovation at another.

Through a public and private collaboration, construction of a replacement facility for Memphis Mental Health Institute is underway and will be ready for occupancy in early fall of 2007. The department is in the final stages of pre-planning for a new Western Mental Health Institute and target date for completion of the facility is 2009. The department is also in the final stages of pre-planning for a new Lakeshore Mental Health Institute; however, since funds have not been appropriated for this project from the General Assembly, the project remains in the planning stage. Moccasin Bend Mental Health Institute is undergoing extensive renovations in which all patient care units will be located in the same building. This design will increase patient care services and staff efficiency. The date for completion of renovation is late 2007.

Means of Maximizing Federal and Other Non-State Sources of Revenue

The department has established an in-depth cost accounting system that tracks and distributes expenditures. This system ensures that all costs attributed to reimbursable activities are included in the amounts billed for services. Administrative Services' expenditures are included in the costs of all department services, which maximize the amount of federal and other non-state revenue the department receives.

Services to people with developmental disabilities can be provided via a 1915(c) waiver, which provides approximately \$2 in federal funds for each state dollar. This avenue maximizes the benefit of state funds to serve people with developmental disabilities, but it also creates an ongoing entitlement to services for eligible individuals. Expanding entitlement programs, especially in tight budget times, has not been seen as the best way forward.

MHDD maximizes available funds for services by applying for federal and private foundation grants. MHDD applies annually for the Community Mental Health Block Grant and uses the funds to provide services and fill gaps in the service system. Community Mental Health Services receives additional funding from other federal grants, including but not limited to: PATH Grant, Older Adult Treatment Services, Real Choice Systems Grant (Housing Within Reach), Methamphetamine Evidence-based Treatment and Healing Grant, Tennessee Lives Count, and Muletown Family Network System of Care for Maury County.

The largest part of the RMHI funding comes from fees for in-patient mental health treatment. The department has a Revenue Advisory Committee (RAC) that oversees and advises on reimbursement activities to ensure that federal and other revenue is maximized. The RAC has focused on improving the accuracy of the RMHI billing processes to assure that all billable days are accounted for. The RAC has also worked on improving the success of the RMHIs in appealing denied claims.

Another means to maximize federal and other non-state sources of revenue is to maintain accreditation by the Joint and certification by the Centers for Medicare and Medicaid Services (CMS) for participation in the psychiatric Medicare program. Most payers for in-patient mental health services, whether private insurance, Medicare, or TennCare, require Joint Commission accreditation as a base qualification for reimbursement. All of the RMHIs are accredited and certified by CMS and have on-going efforts to maintain this status.

Means of Avoiding Unnecessary Costs and Expenditures

The Comptroller conducts a financial audit of MHDD every two years, and the department's audit section conducts continuous reviews (TCA 33-1-302(b) (1) and (2) and 4-3-304(7) and (9)). When problems with internal fiscal controls are found, the director of fiscal services establishes policy to address the issue, and audit follows up to ensure that the problem is corrected. In this way, unnecessary costs and expenditures are avoided, and the department ensures that all expenditures, payments, and contracts follow state and department policy. MHDD uses an invoice tracking system of all requested reimbursement for funded services to provide financial oversight. MHDD also monitors all contracts and grants as required by state policy. The department also has undergone periodic performance audits, with the last completed on June 15, 2006.

Title 33 revisions include additional authority for MHDD to avoid unnecessary costs by requiring the commissioner to initiate interagency agreements that enhance the efficiency and effectiveness of public fund expenditures, i.e., avoid duplication (TCA 33-1-308). The commissioner also is required to collaborate with all relevant state agencies to coordinate the administration of state programs and policies that directly affect service recipients with respect to treatment, habilitation, and education (TCA 33-1-304(2)). Pilot projects authorized by Title 33 are ways to experiment or improve service in unique ways (TCA 33-1-301(d)). Chapter 674, Public Acts, 2006, redefines indigent person allowing the MHDD to refine the collection and reimbursement process at the RMHIs thereby reducing unnecessary costs and expenditures (TCA 33-1-101(14) and Title 33, Chapter 2, Part 11). With the recent release of the Medicare Modernization Act and the Deficit Reduction Act (DRA), which provides alternatives for home and community based services, there are some potentially great leveraging opportunities for the populations that MHDD serves. The department will be pursuing a review of these opportunities over the next year as more information and guidance from the Centers for Medicare and Medicaid Services (DRA issuing agency) becomes available.

Since staffing costs are a major factor at each RMHI, personnel management is important in avoiding unnecessary costs. Efficient planning of schedules, combined with appropriate disciplinary action for time and attendance violations, maximize the utilization of available staff resources and minimize the need for overtime or use of more costly contract staff. The RMHIs have focused on flexibility of work schedules and making the work environment as appealing as possible to retain staff and reduce turnover.

The current national nursing shortage forces the RMHIs to use contract nurses. These nurses are used only when the RMHIs cannot be staffed with state employee nurses. MHDD has reduced the use of contract nurses in the last year and plans to continue reduction of contract services for cost savings and better service to our patients.

Future Challenges and Opportunities

The department is challenged to assure timely access to evidenced-based services and supports for the priority population as well as other persons with mental illness, serious emotional disturbance, or developmental disability in the current health care environment as funding sources wax and wane. Demand continues to exceed supply. MHDD must find means to increase the availability of effective community-based prevention, early intervention, treatment and rehabilitation services and reduce reliance on high-cost in-patient treatment settings to avoid potential lawsuits related to the U.S. Supreme Court decision in *L.C. & E.W. vs. Olmstead*. A related issue is the need for improved access to services tailored to high-risk and high-cost populations such as those with co-occurring disorders, children and youth, the elderly population, and those involved in the criminal or juvenile justice systems. The department has an opportunity to use a leverage model, such as the one used by the housing initiative, to meet these challenges.

In line with the Substance Abuse and Mental Health Service Administration's goals outlined in the President's New Freedom Commission Report, MHDD is working to transform the mental health and substance abuse system in Tennessee to promote resilience in children and youth and recovery for adults. MHDD has recently established a division to focus on implementing recovery services such as support, employment, transportation and housing for persons with mental illness and substance abuse.

The department is continuing to see an increased demand for services. In response to the growing immigrant population in Tennessee, the department is challenged with recruiting bilingual and multilingual providers and ensuring availability of culturally competent services to meet the mental health and developmental disability needs of this ever-growing population. Additionally, the MHDD system is challenged to provide Katrina evacuees that now live in Tennessee and National Guard troops returning from Iraq and Afghanistan access to appropriate mental health treatment. Recent research indicates a high incidence of post-traumatic stress disorder, suicide, and depression among these groups and the significant numbers could strain an already under-funded mental health system.

MHDD is mandated to develop an array of transportation options for persons with mental illness and developmental disabilities in all regions of the state. However, the department is challenged to provide this service with limited funding and has only been able to fulfill part of the mandate. The department continues to seek options to leverage funding to meet the transportation needs.

MHDD serves as the state's developmental disabilities authority and is responsible for promoting the development and provision of services and supports to persons with developmental disabilities, which includes persons diagnosed with mental retardation. Currently, persons diagnosed with mental retardation are receiving services from the Division of Mental Retardation Services (DMRS), which is in the Department of Finance and Administration. The Developmental Disabilities Planning and Policy Council, along with the MHDD Planning and Policy Council has recommended that responsibility for service provision for persons with developmental disabilities be located in one department rather than two. MHDD and DMRS are working with the Governor's Office toward addressing the Councils' recommendation.

MHDD is implementing the growing body of knowledge, which is research-based, on effective and efficient mental health service delivery options. Recent research has produced evidence-based best practices for the treatment of mental illness, which presents an opportunity for more effective treatment in the RMHIs and the community.

An integrated model of service delivery, which includes both physical and mental health components within a single contract (MCO), is currently being implemented by the Bureau of TennCare and MHDD in the Middle Tennessee region. This new model presents the department with opportunities to improve health and mental health for TennCare enrollees. MHDD will closely evaluate the effectiveness of the integrated contracting and delivery model to ensure positive outcomes on behavioral health measures. If proven effective, the Bureau of TennCare and MHDD may replicate the model statewide in the future. If effectiveness for the department's priority populations is compromised, MHDD will work to develop an alternative model.

In May 2006, the General Assembly passed Cover Tennessee, the Governor's plan to provide affordable and portable health insurance to uninsured Tennesseans. Department staff worked with the Department of Finance and Administration to ensure that all of the products, the Cover TN, Cover Rx, Cover Kids, and Access TN plans include mental health and substance abuse benefits. The department is working to ensure that persons with mental illness and substance abuse disorders are aware that this insurance coverage will provide one avenue to insurance coverage for need of mental health treatment.

DMHDD administers the Mental Health Safety Net Clinical Therapeutics and Recovery program to persons with serious and persistent mental illness (SPMI) that were disenrolled from TennCare beginning in June 2005. The program is provided through 19 community-based, non-profit

mental health agencies across the state and provides the core, vital services that people with SPMI need to continue leading functional, productive lives.

In 2006, the General Assembly passed Public Chapter 812, which called for DMHDD, in conjunction with community mental health providers, service recipients, family members, and other appropriate state and local agencies to study and recommend options for access to non-emergency behavioral health services for uninsured Tennesseans. The report recommended different options. This presents a great opportunity for DMHDD to partner with local community providers to provide access to mental health and substance abuse services.

Department of Health

Tennessee's Department of Health is responsible for the health and safety of all citizens and visitors to the state. As a public health agency, the department must monitor the health status of Tennesseans, diagnose and investigate health problems, and mobilize local communities to address health-related issues. The department develops policies and plans that support health goals, enforce laws and regulations that protect the health of all residents and visitors, links people to needed health care, and licenses and regulates health care practitioners and facilities.

Mission Statement

The mission of the Department of Health is to promote, protect, maintain, and restore the health of people living, working, or visiting the State of Tennessee by facilitating access to high quality preventive and primary care services. The department works in three major areas to provide service: delivery of personal and community health care and prevention services; quality control in the health care delivery system; and alcohol and drug abuse prevention and treatment.

Goals

1. By FY 2012, have a diversified public health workforce of qualified, competent, and stable employees who fulfill the mission of this department by leading by example, teamwork, and providing exemplary services to the citizens of the state.
2. By FY 2012, build statewide partnerships to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status. Assist partners and communities to organize and undertake actions to improve the health of the state's communities.
3. By FY 2012, raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well being, and to give newborn babies a better start in life. This initiative specifically targets cardiovascular disease, obesity, diabetes, infant mortality, prenatal care, and adolescent pregnancy, and the elimination of racial and ethnic health disparities in these areas.
4. By FY 2012, monitor the health status of Tennesseans and identify potential solutions and approaches to address any community problems affecting the health status of citizens. Develop critical capacity building around the conceptualizing, planning, and implementing of the state health plan.
5. By FY 2012, ensure that the critical and essential public and personal health services are delivered to the citizens and visitors of Tennessee ensuring the protection of all the population's health.

Goal 1

By FY 2012, have a diversified public health workforce of qualified, competent, and stable employees who fulfill the mission of this department by leading by example, teamwork, and providing exemplary services to the citizens of the state.

Strategies for Achieving Goal 1

1. Develop workforce development plans; based on an assessment that establishes benchmarks and actions needed to recruit, maintain, and sustain a diversified and competent workforce.
2. Provide resource development programs for current staff, as well as future public health employees (interns), that include training in leadership and management, cultural beliefs and practices influencing health, application of information technologies, and competencies in health occupations.
3. Review workforce assessment activities to determine if personal health care and public health workforces fill current and future demands for health services in the state.

Performance Measures

1. Percent of total health department employees who are racial minorities.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
17%	19%	21%	23%	24%	24%

2. Number of interns employed to train in public health.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
28	30	33	35	40	45

Goal 2

By FY 2012, build statewide partnerships to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status. Assist partners and communities to organize and undertake actions to improve the health of the state's communities.

Strategies for Achieving Goal 2

1. Engage communities and build public health support on a variety of health issues by identifying, convening, and communicating with organizations that contribute to or benefit from the delivery of essential public health services.
2. Organize partnerships for public health to foster the sharing of resources, responsibilities, collaborative decision-making, and accountability for delivering essential public health services at the state and local levels.
3. Review public health support building and partnership facilitation processes and institute improvements based on assessment findings in order to continually enhance partnerships and public health support relationships.
4. Partner with schools, faith based communities, work sites, personal care providers, and others to leverage broad based resources and to focus assets statewide that reinforce healthier lifestyles and better starts in life through health information, health education, and health promotion.

Performance Measure

1. Percent of counties that have organized partnerships for public health essential services at state and local levels.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
35%	45%	65%	85%	95%	100%

Goal 3

By FY 2012, raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well being, and to give newborn babies a better start in life. This initiative specifically targets cardiovascular disease, obesity, diabetes, infant mortality, prenatal care, and adolescent pregnancy, and the elimination of racial and ethnic health disparities in these areas.

Strategies for Achieving Goal 3

1. Synergize the current programs and maximize their potential by coordinating services in order to deliver holistic health care to our population.
2. Develop and analyze the necessary health data to specify the focus of activities as well as evaluate the progress of these activities designed to improve the healthy lifestyles and better life starts programs in Tennessee.
3. Empower the general population about their own individual health issues by designing and implementing health communications that provide screening and follow-up opportunities as well as provide a tool that an individual can use to monitor his progress to a healthier lifestyle.
4. Create and use health informational, educational, and promotional activities designed to reach targeted populations in order to eliminate health disparities.

Performance Measure

1. Percent of counties that have developed health education and promotion programs with partners for a healthier lifestyle and a better start in life.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
40%	50%	60%	85%	95%	100%

Goal 4

By FY 2012, monitor the health status of Tennesseans and identify potential solutions and approaches to address any community problems affecting the health status of citizens. Develop critical capacity building around the conceptualizing, planning, and implementing of the state health plan.

Strategies for Achieving Goal 4

1. Build department's capacity for technical assistance, evaluation, and investigation to support intradepartmental programs, partnership activities, and respond to community's health issues.
2. Support development of a comprehensive statewide health plan that addresses strategic and operational directions for preventive interventions for individuals and community populations. The plan should address system and infrastructure changes to improve capacity and preparedness for emergencies. Critical health and health care improvements will be guided by the state health profile.
3. Review activities to develop policies and plans that support individual and statewide health efforts on a periodic basis and use results from the reviews to improve the quality and outcome of the department's efforts.

Performance Measure

1. Percent of counties who have modified and implemented health improvements to improve the public health status in their counties.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
40%	50%	75%	80%	100%	100%

Goal 5

By FY 2012, ensure that the critical and essential public and personal health services are delivered to the citizens and visitors of Tennessee ensuring the protection of all the population's health.

Strategies for Achieving Goal 5

1. Review existing and proposed state laws and regulations to assure that these reflect current knowledge and best practices about public health and enforcement practices.
2. Administer public health enforcement activities within the department's jurisdiction in accordance with clear guidelines and statutory authority.
3. Work with the health care industry to assure access, utilization, and quality of health care for persons living in the state.
4. Improve access to health care for the underserved populations within the state.

Performance Measures

1. Percent of counties that adequately have developed a cohesive health system including public, private and voluntary organizations working together to ensure the services are provided to protect and improve the health of its citizens.

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
50%	55%	70%	85%	95%	100%

Additional Agency Information

Statutory and Constitutional Objectives

TCA 4-3-1802 states that the Department of Health shall be under the charge and general supervision of the Commissioner of Health. TCA 4-3-103 states that each department shall be vested respectively with such powers and duties as set by law and charged with the administration, execution, and performance of such laws as the General Assembly may enact.

TCA 68-1-104 requires the Commissioner of the Department of Health to have the general supervision of the interests of health and life of the citizens of this state. TCA 68-1-104(2) requires the commissioner to investigate the causes of disease, especially epidemics, which require laboratory confirmation.

TCA 68-11-201 et seq. charges the Department of Health to license and regulate health care facilities. The department has the authority to conduct reviews of all facilities licensed under this part in order to determine compliance with fire and life safety code regulations as promulgated by this program's Board for Licensing Health Care Facilities. Further, TCA 12-4-320 requires Health Licensure and Certification to administer the Residential Homes for the Aged program.

TCA 68-140-501 et seq. "Emergency Medical Services Act of 1983" and 68-14-201 et seq. is the statutory basis for the Emergency Medical Services division of the Department of Health.

TCA 63-1-101 et seq. gives the division of Health Related Boards, in the Department of Health, responsibility for licensing those persons engaged in the "practice of the healing arts" plus all administrative, fiscal, inspectional, and clerical functions associated with these boards.

Tennessee Vital Records Act of 1977, TCA 68-3-101 et seq. requires the Department of Health to collect, compile, and preserve all vital records for births, deaths, marriages, and divorces for the state. TCA 68-55-101 et seq. requires the Department of Health to maintain a registry of persons with traumatic brain injury. TCA 68-1-1001 et seq. requires the department to collect, compile, and maintain data concerning all diagnosed cancer cases throughout the state for dissemination to all appropriate members of the medical, scientific, and academic research communities for study and research. TCA 68-5-501 et seq. requires the department to develop and maintain a reporting system to collect data to facilitate the compilation of statistical information on causes, methods of treatment, and prevention of genetic disorders and birth defects.

TCA 62-38-201 et seq. requires the Department of Health to regulate, certify, and inspect tattoo parlors, tattoo artists, and body piercing establishments. TCA 68-8-1 establishes the Tennessee Anti-Rabies Law, authorizing the Department of Health to promulgate rules and regulations pertaining to the vaccination of dogs against rabies. TCA 68-14-301 et seq. establishes inspections, permits and licenses, and rules for hotels, food service establishments, public swimming pools, and bed and breakfast establishments. TCA 68-110-1 establishes the rules and regulations of organized camps.

TCA 68-5-401 requires the Department of Health to provide genetic screenings for all newborns, while TCA 68-34-104 requires each public health agency in the state to provide contraceptive procedures, supplies, and information. The U.S Department of Health and Human Service's maternal and child health national agenda, as outlined in Healthy People 2010, seeks to increase

Department of Health

the health and well-being of women, infants, children, and families by addressing the most significant issues and risk factors affecting maternal and child death rates. U.S. Title 427 -V-701 appropriates funds to address the following at the state level: (1) Assure that low-income mothers and children have access to quality maternal and child health services; (2) Reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children; (3) Increase the number of children (especially preschool children) appropriately immunized against disease; (4) Promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women and preventive and primary care services for low-income children; and (5) Provide and promote family-centered, community-based, coordinated care for children with special health care needs.

Obstacles to Meeting Objectives and Delivering Services and Means of Overcoming Obstacles

Obstacle 1 - Many Tennesseans are not knowledgeable about health promotion and disease prevention, and many lack appropriate motivation to change their behaviors. The effectiveness of the department's service delivery and the overall health of Tennesseans may be hampered, if the multiple determinants of health, i.e., socioeconomic, environmental, behavioral, and biological, are not all considered and addressed.

To overcome this obstacle, the department plans to develop health promotion and health education materials that motivate and empower Tennesseans to be well informed in order to make positive choices concerning their health and futures. Also, the department will design strategic partnerships among health care providers and local, state, and federal agencies, both public and private, and to share the objectives of integration of the system to maximize preventive efforts and to provide more holistic care. Public health employees and partners must create synergy in existing programs and structures as well as maximize collaborative efforts to begin delivering public health services in a new holistic approach.

Means of Maximizing Federal and Other Non-State Sources of Revenue

The department draws down all earned and available federal revenue as required by Finance and Administration's Policy 20, which governs cash management. Services that are either wholly or partially funded by federal dollars are tied to the appropriate federal grant in the State of Tennessee Accounting and Reporting System (STARS). As expenses are incurred, STARS produces a daily drawn-down report, which is used to electronically draw federal revenue directly from the federal government. Program staff continuously reviews the Catalog of Federal Domestic Assistance (CFDA), as well as the Federal Register for grants opportunities.

Means of Avoiding Unnecessary Costs and Expenditures

Training, controls, procedures, and management review of proposed expenditures and review of accounting reports are the means of avoiding unnecessary expenditures. Also, the department undergoes external and performance audits by the Comptroller's Office. The last financial and compliance audit conducted by the Comptroller's office was released in April 2007, for the fiscal year ending June 30, 2006. The last performance audit of the department was released in October

2003. In addition, the Department of Health performs periodic internal audits of expenditures and various accounting reports.

Future Challenges and Opportunities

The department faces the challenge of a growing Latino community throughout the state. The challenge is to overcome language and cultural differences that may become obstacles to serving this population. However, it is also an opportunity for the department to devise new and innovative ways to serve this segment of the population.

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:	2. * Status of Federal Action:	3. * Report Type:		
<input type="checkbox"/> a. contract <input checked="" type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change		
4. Name and Address of Reporting Entity:				
<input checked="" type="checkbox"/> Prime <input type="checkbox"/> SubAwardee				
* Name	Buffalo Valley, Inc			
* Street 1	501 Park Ave. S.	Street 2		
* City	Hohenwald	State TN, Tennessee Zip 38462		
Congressional District, if known: 4				
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:				
\$ 280,000.00				
10. a. Name and Address of Lobbying Registrant:				
Prefix	None	* 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	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:	Barbara Smith			
* Name:	Prefix	* First Name	Middle Name	
	Jerry	T.		
* Last Name	Risner			
Title:	Executive Director		Telephone No.:	931-796-4256
Date:	06/15/2011			

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: Buffalo Valley, Inc.

DUNS Number: 8307462360000

* Street1: 501 Park Ave. S.

Street2:

* City: Hohenwald

County: Lewis

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 38462-0879

* Project/ Performance Site Congressional District: TN - 000

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)

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