

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	<input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	<input type="text"/>
* 3. Date Received:		4. Applicant Identifier:
06/13/2011		<input type="text"/>
5a. Federal Entity Identifier:		5b. Federal Award Identifier:
<input type="text"/>		<input type="text"/>
State Use Only:		
6. Date Received by State:		7. State Application Identifier:
8. APPLICANT INFORMATION:		
* a. Legal Name: Promesa Behavioral Health, Inc.		
* b. Employer/Taxpayer Identification Number (EIN/TIN): 77.0174896		* c. Organizational DUNS: 9615707640000
d. Address:		
* Street1:	7475 N. Palm Avenue	
Street2:	Ste 107	
* City:	Fresno	
County/Parish:	Fresno	
* State:	CA: California	
Province:		
* Country:	USA: UNITED STATES	
* Zip / Postal Code:	93711-5763	
e. Organizational Unit:		
Department Name: Tele-Care	Division Name: TOADS	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: Dr.	* First Name: Carol	
Middle Name: L		
* Last Name: Scroggins		
Suffix: Ph.D		
Title: Grantswriter		
Organizational Affiliation:		
<input type="text"/>		
* Telephone Number: 559.312.7118	Fax Number: 559.439.5411	
* Email: cscroggins@promesabehavioral.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.):

Congressional Districts affected by.pdf

Add Attachment

Delete Attachment

View Attachment

* 15. Descriptive Title of Applicant's Project:

TOADS: Telecare Outpatient Alcohol and Drug Services

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

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="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="42,000.00"/>
* g. TOTAL	<input type="text" value="322,000.00"/>

* 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:

BUDGET INFORMATION - Non-Construction Programs

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

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. TOADS: Telecare Outpatient Alcohol and Drug Services	93.243	\$ 280,000.00	\$	\$	\$	\$ 280,000.00
2.						
3.						
4.						
5. Totals		\$ 280,000.00	\$	\$	\$	\$ 280,000.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	(1)	(2)	GRANT PROGRAM, FUNCTION OR ACTIVITY		Total (5)
			(3)	(4)	
TOANS: Telecare Outpatient Alcohol and Drug Services					\$ 73,940.00
a. Personnel	\$ 73,940.00	\$	\$		\$ 73,940.00
b. Fringe Benefits	19,862.00				19,862.00
c. Travel	3,730.00				3,730.00
d. Equipment	18,000.00				18,000.00
e. Supplies	2,833.00				2,833.00
f. Contractual	64,000.00				64,000.00
g. Construction					
h. Other	97,635.00				97,635.00
i. Total Direct Charges (sum of 6a-6h)	280,000.00				\$ 280,000.00
j. Indirect Charges					\$
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. TI-11-002	\$ 42,000.00	\$	\$	\$ 42,000.00	
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)	\$ 42,000.00	\$	\$	\$ 42,000.00	
SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 280,000.00	\$ 60,000.00	\$ 80,000.00	\$ 60,000.00	\$ 80,000.00
14. Non-Federal					
15. TOTAL (sum of lines 13 and 14)	\$ 280,000.00	\$ 60,000.00	\$ 80,000.00	\$ 60,000.00	\$ 80,000.00
SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT					
(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)				
	(b) First	(c) Second	(d) Third	(e) Fourth	
16. TI-11-002	\$ 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:	840,000				
22. Indirect Charges:					
23. Remarks:	telecare substance abuse treatment for unmet/unserve populations				

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TELECARE OUTPATIENT ALCOHOL AND DRUG SERVICES**PROMESA BEHAVIORAL HEALTH, INC.**

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

No. TI-11-002 (CFDA No.: 93.243

ABSTRACT

TOADS (Telecare Outpatient Alcohol and Drug Services) is located in the office of the telecare program Prescription Drug Recovery in Hanford, California which also houses the telecare addiction counseling staff and the network hub for all of the IT services for telecare programs. The local network encompasses a geographical area of Madera County to the north to Tulare County to the south, with the centralized data center supporting network connections to the project sites. Although this reflects the geographic extent of the *local* network, the catchment area for program is the entire State of California, as Promesa Behavioral Health receives client referrals from 14 counties. Additional equipment will be installed at the Fresno Promesa Data Center where all video and data circuits will terminate, and from where the network will be maintained. The network hub will include ISDN lines and secure high speed Internet connections so that Telepsychiatry services can be set up with off-net, non-direct connected locations. Chief of Medical Service, H.A. Cruz, M.D. will be supervising the telecare treatment services.

The communities which could be served by the TOADS are throughout California, with client referrals coming from many other counties, although the physical connections for this grant submission include four counties Fresno, Kings, Madera and Tulare. These sites service nearly 500 clients a year.

TOADS aims to provide voluntary patient evaluation, assessment, intake and telecare treatment to individuals who are experiencing acute psychiatric distress related to substance abuse. Promesa has been providing telecare based treatment services since 2009, when we established Tele-Care to provide telepsychiatry to clients who were outside our headquarters service area in Fresno, California. The intent of telecare was to eliminate the possibility of boundary concerns for an already sensitive population. Promesa has established bilingual/bicultural expertise in providing services to children and adolescents, transitional aged youth, LGBTQ, sex offenders, and the full spectrum of mental illness, including co-occurring disorders and substance abuse. The Tele-Care program services areas without direct mental health services, such as rural communities as well as those regions of the Central Valley from which travel represents a significant commitment in time. This project is about providing innovative and secure videoconferencing technology that creates an interaction between families, clients, various judicial systems and the treatment facility to enhance treatment and reduced costs for all involved parties.

TELECARE OUTPATIENT ALCOHOL AND DRUG SERVICES
PROMESA BEHAVIORAL HEALTH, INC.

Grants to Expand Care Coordination through the Use of Health Information Technology in
Targeted Areas of Need
No. TI-11-002 (CFDA) No.: 93.243

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Department of Health and Human Services**Substance Abuse and Mental Health Services Administration****TI-11-002: Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need****Telecare Outpatient Alcohol and Drug Services (TOADS)**

Promesa Behavioral Health, Inc.

Program Narrative:**Section A: Statement of Need**

Although the Central Valley HIDTA region consists of 10 counties: Fresno, Kern, Kings, Madera, Merced, Sacramento, San Joaquin, Shasta, Stanislaus, and Tulare, Promesa Behavioral Health is submitting the **Telecare Outpatient Alcohol and Drug Services (TOADS)** application specifically to serve four – Kings, Fresno, Madera and Tulare. The region as a geographic area of California encompasses nearly 32,000 square miles in central California, with a population of approximately 5 million. The population of the four county area we are identifying for service 1,642,331 is: with Fresno County being the largest in terms of square miles. The key metropolitan hubs are Fresno, Hanford and Visalia as well as expansive, sparsely populated rural areas.

Quick Facts of the Selected Four Counties:

Fresno is 49.3% Latino, 34.6% White, 5.8% black and 9% Asian, 22.1% with a total population of 915,267

Kings is 49.9% Latino, 36.9% white, 8.1% black and 3.4% Asian, 17.9% below poverty with a total population of 148,764

Madera is 51.7% Latino, 39.4% white, 4.6% black and 2.1% Asian, 18.2% below poverty with a total population of 148,632

Tulare is 58.3% Latino, 35% white, 2.1% black and 3.6% Asian, 21.5% below poverty, with a total population of 429,668

The overall region is dominated by agribusiness, which produces some of the highest yields in the country for grains, fruits and vegetables. This large industry relies heavily upon seasonal and temporary workers, who constitute a socioeconomic underclass that is often invisible to the greater community, with an exception being criminal behavior. This is not to imply, however, that all drug-related crime is committed by ag workers, however, poverty and drug related offenses (especially at the lower levels) seem to be a matched pair. There are strong correlations connecting such crime and class.

In reviewing the National Survey on Drug Use and Health interview data certain characteristics seemed to pop out as significant – of which income was one crucial factor. Sociodemographic differences among racial/ethnic subgroups explain, at least in part, the subgroups' different prevalence of substance use, alcohol dependence, and need for illicit drug abuse treatment. For

example, relative to the total U.S. population, individuals in households with low family income have a high prevalence of use of any illicit drug, and the percentage of population with low family income – income seems to be the more determinant factor than ethnicity. However, within the Central Valley, there is a high percentage of low income Latinos, as well as Southeast Asians (many of whom were re-located to the Valley as Hmong, Lao and Cambodian refugees). Thus, family income differences *partially* account for the relatively high prevalence of illicit drug use among Latinos, and non-Hispanic blacks. Yet none of the sociodemographic variables that are introduced in our analyses, including region, population density, language of interview, family income, health insurance coverage, receipt of welfare, educational attainment, school dropout status, marital status, employment status, and number of children, fully accounts for racial/ethnic differences in substance use.

We also show that, regardless of racial/ethnic subgroup, relatively high prevalence of illicit drug use are found among individuals who reside in the West; reside in metropolitan areas with populations greater than 1 million; would use English rather than Spanish in the NHSDA interview; lack health insurance coverage; are unemployed; have 9 to 11 years of schooling; or have never been married. Moreover, regardless of racial/ethnic subgroup, adolescents who dropped out of school or who reside in households with fewer than two biological parents have relatively high prevalence of past-year use of cigarettes, alcohol, and illicit drugs.

One factor that accounts for the high incidence of drug use – whether treated or not – is this region is designated as a High Intensity Drug Trafficking Area (HIDTA) by the National Drug Intelligence Center (2010) and is vulnerable to drug trafficking from the Southwest Border because of its proximity to that region. The Valley's highway infrastructure (Interstate 5 and Highway 99 are major interstate traffic corridors) which insures quick and direct access to drug sources located in Mexico and Canada enable drug traffickers to transport significant quantities of ice methamphetamine, cocaine, marijuana, heroin, and MDMA into and through the HIDTA region for local consumption and to drug markets throughout the country.

Where there is frequent transportation of illicit substances, there is usually a parallel addiction problem. In looking at data concerning treatment, public treatment admissions for heroin abuse totaled 5,296 in 2009, ranking the drug behind only methamphetamine (11,339) and marijuana (7,047). Mexican black tar heroin is the most available type of heroin in the area. It is abused most often in metropolitan areas of the region, primarily in Fresno and Sacramento. Much of the MDMA available in the region is manufactured in Canada and transported into the area for abuse or further transport to southern California. GHB (gamma-hydroxybutyrate), ketamine, LSD (lysergic acid diethylamide), PCP (phencyclidine), psilocybin, and Rohypnol (flunitrazepam) are also distributed and abused to varying degrees throughout the region. Public treatment admissions in the HIDTA region remain high despite preliminary 2009 data showing decreases, the exception being the "other drug" category. According to the California Department of Alcohol and Drug Programs, methamphetamine was identified more often than any other drug as the primary substance of abuse from 2004 through 2009.

In 2009, approximately 40 percent of individuals admitted to public treatment centers in the HIDTA region were admitted for methamphetamine abuse. Treatment admissions for marijuana abuse are also high but are not considered to be as significant as those for methamphetamine

abuse, the effects of which are much more difficult to treat. Cocaine is also abused throughout the Central Valley, but to a lesser extent. Treatment center admissions for other drugs have steadily increased, nearly doubling from 2004 to 2009, while other admissions for major drug categories fluctuated during the same time frame. Oxycodones are among the most commonly abused CPDs in the region; however, heroin abuse may increase as some oxycodone abusers find it easier to obtain heroin, according to treatment professionals in the area. Hydrocodones, benzodiazepines, and carisoprodol are also commonly abused in the region.

In recent studies Kings and Fresno Counties have been demonstrated to have a growing prescription opioid abuse problem. Based on the statistics from SAMHSA, both counties fall in Region 8 (Fresno, Kings, Madera, Mariposa, Tulare) out of the 15 designated in the state of California. Region 8 is number two and second highest out of 7 levels in the percentage rate that is not receiving treatment. It is estimated that only 35% of men and 30% of women who perceive a need for treatment actually receive it in the Region.

Region 8 is also the third highest in the growing prescription opioid abuse category in the state behind Region 2¹ and Region 1² respectively. What is readily apparent is that there is a tremendous lack of treatment and it is becoming more and more apparent.

Within the contextual framework of the national theater of prescription opioid abuse, the 2006 National Survey on Drug Use and Health (NSDUH), sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides data that illustrates the increase in prescription opioid abuse in the last decade:

- Between 1999 and 2006, the number of persons aged 12 and older illicitly using prescription pain relievers in the month prior to being surveyed increased from 2.6 million in 1999 to 5.2 million in 2006;
- In 2006, 5.2 million surveyed persons had used prescription pain relievers illicitly in the past month, compared with 0.3 million people who had used heroin;
- In 2006, 2.2 million persons aged 12 or older used prescription pain relievers illicitly for the first time. This is more than any other illicit drug, surpassing marijuana (2.1 million new users), and dwarfing heroin (91,000 new users). While past year initiates for prescription pain relievers have increased 63% from 1997-2006, past year initiates for heroin have decreased by 20% during that same period;
- Prescription opioids have been suggested to be an important gateway drug, and the fact that they are prescribed by doctors lulls users into believing they are safe;
- The great majority of illicitly used prescription opioids are obtained from a physician, or from internet ordering from unregulated sources, not from drug dealers

Noticeably this is not a situation that will be eradicated anytime soon or in our generation for that matter. The necessity for specialty treatment is very evident and in demand.

¹ El Dorado, Napa, Nevada, Placer, Sacramento, Sierra, Solano, Sonoma, Sutter, Yolo, Yuba

² Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity)

At this time, the location of greatest need and without any services available in our region is in Kings County, California commonly referred to as the Hanford–Corcoran Metropolitan Statistical Area (HCMSA). It consists of one county – Kings – in California's Central San Joaquin Valley. As of the 2000 census, the HCMSA had a population of 129,461 (although a July 1, 2009 estimate placed the population at 159,518) What can be gleaned from this is the lack of prescription opioid addiction treatment facilities available to the Hanford–Corcoran MSA, including nearby cities such as Lemoore, Armona, and Stratford. Also, neighboring municipalities in Tulare County such as Visalia and Tulare, reflect the same level of being unserved and/or underserved. As a result of the lack of services, some consumers are traveling out of town 40+ miles seeking opioid addiction treatment. Furthermore, although these clients do travel, there are a limited number of physicians in the Central Valley who are certified to provide Suboxone treatment services. The net result is that consumers are forced to do without services due to lack of accessibility, lack of specialty providers, and lack of supportive infrastructure.

Kings County is home of the Navy's largest Master Jet Air Station. Naval Air Station (NAS) Lemoore was selected as the West Coast site for the Navy's newest strike-fighter aircraft, the F/A-18E/F Super Hornet. This decision has brought approximately 92 additional aircraft, 1,850 additional active duty personnel and 3,000 family members to NAS Lemoore. Several associated facility additions or improvements have further increased the local population. A report in USA Today states that military doctors wrote almost 3.8 million prescriptions for narcotic painkillers for service members in 2009—more than four times the 866,773 prescriptions written in 2001. Reports published from the Pentagon recently describe how prescription drug addiction has reached deep into all the armed forces, affecting thousands of personnel. This sets the stage for the Promesa national project campaign for potential treatment of consumers from the ranks of the enlisted, dependent, or even discharged personnel. The nearest Veteran's Administration Suboxone Program is in Fresno, about an hour travel time from the Naval Air Station. Moreover, the Military Health System, in its 2010 and 2011 conferences, focused attention upon electronic health records and health information technologies services.

In Fresno, CA there are only two Suboxone treatment facilities with a limited amount of certified doctors authorized to prescribe and monitor Suboxone. This creates a large population underserved for opioid addiction in Fresno. There are cases where there is no essential mental health service component combined with the opioid treatment. Inherently, this moves the consumer's recovery condition to a state of being clean but, without the tools on how to continue that recovery beyond pharmaceutical treatment. The consequence is that these clients often, unfortunately, relapse.

The situation of limited treatment options and unmet need is similar in Fresno, Tulare and Madera Counties as well. Even though there are a number of facilities providing services, access is limited due to transportation, language or fiscal barriers.

For example, within Tulare County the focus of drug and alcohol rehab treatment providers are 22 substance abuse treatment facilities, 3 detoxification facilities, 2 methadone maintenance and detox facilities, 2 methadone detoxification facilities, 4 halfway house facilities, 1 authorized to prescribe buprenorphine to support treatment, 18 outpatient facilities, 0 partial hospitalization treatment facilities, 4 residential short-term rehab facilities, 4 residential long-term rehab

facilities, 0 hospital inpatient facilities. Within the County, there are specialized Drug Rehab and Alcohol Treatment Programs which include 5 facilities that provide rehab services for adolescents, 8 facilities that provide rehab services for dual-diagnosis disorders, 0 facilities that provide rehab services for persons with HIV/AIDS, 0 facilities that provide rehab services for gays and lesbians, 0 facilities that provide rehab services for seniors and older adults, 4 facilities that provide rehab services for pregnant or postpartum women, 5 facilities that provide rehab services for women, 0 facilities that provide rehab services for residential beds for clients' children, 4 facilities that provide rehab services for men, 2 facilities that provide rehab services for DUI offenders, 6 facilities that provide rehab services for criminal justice clients.

Often those without the means to pay for treatment are those who do not receive services. In Tulare County, there are several types of payment accepted in Tulare County for drug and alcohol rehab services which include 17 rehab programs that accept self-payment, 6 that accept some type of public insurance (MediCal, Medicare or state financial aid), 3 rehab programs that accept military insurance, 6 rehab programs that accept private health insurance, 2 rehab programs that accept access to Recovery voucher, 4 rehab programs that accept payment on a sliding fee scale, 3 rehab programs that accept some form of payment assistance.

Within the SAMSHA directory of drug and alcohol treatment rehab services, Madera County has the following breakdown of services: 4 substance abuse treatment programs, 0 detoxification treatment programs, 0 methadone maintenance and detox treatment programs, 0 methadone detoxification treatment programs, 0 halfway house treatment programs, 0 authorized to provide buprenorphine as a treatment option, 4 outpatient treatment programs, 0 partial hospitalization treatment programs, 0 residential short-term rehab treatment programs, 0 residential long-term rehab treatment programs, 0 hospital inpatient treatment programs. Within the County, there are specialized Drug Rehab and Alcohol Treatment Programs which include 2 drug and alcohol treatment for adolescents, 2 drug and alcohol treatment for dual-diagnosis disorders, 1 drug and alcohol treatment for persons with HIV/AIDS, 0 drug and alcohol treatment for gays and lesbians, 0 drug and alcohol treatment for seniors and older adults, 0 drug and alcohol treatment for pregnant or postpartum women, 3 drug and alcohol treatment for women, 0 drug and alcohol treatment for residential beds for clients' children, 1 drug and alcohol treatment for men, 0 drug and alcohol treatment for DUI offenders, 2 drug and alcohol treatment for criminal justice clients.

There are several types of payment accepted in Madera County for drug and alcohol rehab services which include 4 rehab services that accept self-payment, 3 that accept public insurance, like MediCal, however, none accept Medicare as a method of payment), 0 rehab services that accept military insurance, 1 rehab services that accept private health insurance, 0 rehab services that accept access to Recovery voucher, 3 rehab services that accept payment on a sliding fee scale, 3 rehab services that accept some form of payment assistance.

In reviewing the services in Fresno County, the SAMSHA directory of substance abuse treatment rehab programs, notes that there are 42 substance abuse treatment services, 11 detoxification services, 7 methadone maintenance and detox services, 6 methadone

detoxification services, 3 halfway house services, 4 authorized to provide buprenorphine in treatment services, 38 outpatient services, 2 partial hospitalization treatment services, 8 residential short-term rehab services, 7 residential long-term rehab services, 1 hospital inpatient services. Regarding specialized drug rehab and alcohol treatment programs in Fresno County there are a number of such services that include 12 drug and alcohol services for adolescents, 12 drug and alcohol services for dual-diagnosis disorders, 4 drug and alcohol services for persons with HIV/AIDS, 3 drug and alcohol services for gays and lesbians, 2 drug and alcohol services for seniors and older adults, 15 drug and alcohol services for pregnant or postpartum women, 11 drug and alcohol services for women, 2 drug and alcohol services for residential beds for clients' children, 7 drug and alcohol services for men, 3 drug and alcohol services for DUI offenders, 15 drug and alcohol services for criminal justice clients. These programs' payment and financial assistance options include several types of payment. Among these, are drug and alcohol facilities that accept self-payment, 20 drug and alcohol facilities that accept Medicaid, 14 drug and alcohol facilities that accept state financial aid, 12 drug and alcohol facilities that accept Medicare, 4 drug and alcohol facilities that accept military insurance, 15 drug and alcohol facilities that accept private health insurance, 2 drug and alcohol facilities that accept access to Recovery voucher, 19 drug and alcohol facilities that accept payment on a sliding fee scale, 17 drug and alcohol facilities that accept some form of payment assistance.

Despite the appearance of available services in the 4 counties, another revealing statistic is that approximately 30% of females compared to 35% of males who needed drug treatment received it in the last year, which left a treatment gap of unmet need of 70% and 65%, respectively.

We know that many more men than women will succumb to the effects of drugs and alcohol. We also know that the ramifications for drug and alcohol abuse in men tend to be more serious; meaning that their abuse leads to long-term financial, physical, mental and social problems. Many men will shorten their life spans by as much as 25% due to the long-term effects of drugs and alcohol.

Telecare services contribute to economic savings

A most obvious community and client benefit from telecare services is that it will address is the cost of travel which impacts all participants, health care providers, patients, families, indeed, all systems involved. Other outcomes have been demonstrated, such as decreased criminal activity, decreased rates of incarceration and improved family functioning. In addition, evidence is emerging of considerable benefits regarding cost savings associated with CBT.

Finally, these cost savings are especially noteworthy when the superior clinical outcomes and reductions in criminal activity demonstrated by CBT based telecare are considered. The cost of a telecare based course of treatment is about \$1,400, compared to \$7,415-\$10,000 for outpatient treatment, depending upon the setting and duration. Attending to cost savings is an essential detail, as substance abuse disorders often evolve into a chronic disease that affects about 9.5% of the general adult population and of these, only about 10% are treated, and 40% are denied treatment because of financial barriers (Chalk, 2011). Yet, research shows that integrated care

through early intervention and economical screening has reduced substance abuse and saved health care dollars – public health insurance savings are increased, inpatient and emergency department costs decline and total lifetime treatment costs also decline.

One final benefit of this project is related to improved security and HIPAA compliance. Currently communication between patients, mental health specialists, court systems and families is via phone, fax, and e-mail or postal notification. The equipment chosen for this project provides encryption and is HIPAA compliant. Moreover, our online protocols ensure patient privacy. We undertake every precaution to ensure that client records and communications are protected. For example, when communicating on line with a client, the contact identifiers are patient numbers, never names. The only place a client's name is ever recorded is during the assessment and intake process during the initial registration. All client communication thereafter is done via a numerical identifier.

Section B: Proposed Evidence-Based Service/Practice

TOADS (Telecare Outpatient Alcohol and Drug Services) aims to provide voluntary patient evaluation, assessment, intake and telecare treatment to individuals who are experiencing acute psychiatric distress related to substance abuse. Promesa has been providing telecare based treatment services since 2009, when we established Tele-Care to provide telepsychiatry to clients who were outside our headquarters service area in Fresno, California. The intent of telecare was to eliminate the possibility of boundary concerns for an already sensitive population. Promesa has established bilingual/bicultural expertise in providing services to children and adolescents, transitional aged youth, LGBTQ, sex offenders, and the full spectrum of mental illness, including co-occurring disorders and substance abuse. The Tele-Care program services both juveniles and adults in areas without direct mental health services, such as rural communities as well as those regions of the Central Valley from which travel represents a significant commitment in time. Many communities in the Sierra Nevada Mountains are quite treacherous to drive in inclement weather, therefore making regularly scheduled in-person counseling session unfeasible for autumn and winter months.

The Central Valley region is characterized geographically with several distinct terrains – alluvial plains, upon which the vast majority of agricultural is based, to foothills to alpine mountains. Fresno, Madera and Tulare counties each contain these varying topographies (Kings tends to be almost exclusively alluvial). Scattered throughout these vast territories are small towns and unincorporated areas – in Fresno County there are 139 unincorporated communities, 13 small towns and 2 large cities; in Kings County there are 35 unincorporated communities and 4 small and mid-sized cities; in Madera County there are 60 unincorporated communities and 2 small cities; in Tulare County there are 171 unincorporated communities and 8 cities (small and medium sized). The common factor uniting all of these unincorporated areas is the fact that few services are located there. In many places, the governing body is the local Water Board or Irrigation District. Communities might have a grocery, a pharmacy, a church, a service station and recreational facility, but generally no doctor, dentist or hospital. A few might also have services provided by a nonprofit organization. However, for those seeking assistance with substance abuse, addiction or other mental health concerns, the only places to receive those services are the main urban hubs or County seats (Fresno, Madera, Hanford, Tulare).

Following upon the success of Tele-Care, in 2010, we expanded these services to include PDR (Prescription Drug Recovery) in Kings County, which has the least number of providers (detailed above). To date, telecare services have been largely self-pay. Clients are all provided intake, assessment and a technology overview when enrolled as a telecare patient. This ensures clients will know how to use the videoconferencing and coding to access their counselor. This initial assessment takes between 3-4 hours. And, for those who are being prescribed Suboxone, a stabilization observation period of up to 3 hours is also included, so that the prescribing psychiatrist can be assured that the patient is receiving the correct milligrams of the medication. Patients are scheduled for an initial six months of online counseling sessions, with monthly in-office visits with the psychiatrist for medication checkups and monitoring.

Our goal is for patients with prescription drug addiction to be completely off the Suboxone and the problematic prescription drugs by the end of the six months. The protocol for Suboxone treatment is a two stage process – stabilization (the amelioration of signs and symptoms of withdrawal) followed by a tapering of the medication to zero. The stabilization dose varies from person to person. Some patients are stabilized with as little as 8 mg and others require the maximum dose of 32 mg. Patients can be detoxified (tapered) once stabilized via a “moderate-period” reduction rate of 2 mg every two to three days. Therefore a patient stabilized on 32 mg may need two to three weeks to successfully taper to zero. Some patients may need to taper more slowly via the “long-period” reduction which could occur over many weeks and months. Patient selection for “moderate versus long” withdrawal detoxification is crucial. Some patients may require a slower detoxification occurring over a number of weeks and other patients may require maintenance therapy with buprenorphine. For those patients who cannot be stabilized or withdrawn from buprenorphine on an outpatient basis, these cases are referred for inpatient residential treatment. In all cases, all patients must be engaged in rehabilitative counseling for support and to move into the later stages of addiction treatment and sustained recovery.

If a patient relapses or becomes noncompliant with the telecare treatment plan the “take home” or prescription privilege becomes modified as necessary so that our staff might better engage the patient in treatment, including but not limited to, intensification and more frequent telecare sessions or placement in group counseling services and reassessment for appropriate level of care.

For substance abuse patients receiving telecare counseling without Suboxone (whose substance abuse issues are alcohol, methamphetamine, heroin, cocaine or other substance), their assessment is done using the Addiction Severity Index (ASI). This assessment instrument is an industry standard to enable addiction counselors to determine the lifestyle factors that have contributed to their substance abuse problems. The ASI was designed to be administered in a wide variety of settings, and has shown reliability in cross-cultural groups as well. The ASI provides counseling staff with a profile of the patient. This profile aids in the development of a treatment plan. For the purposes of telecare-based treatment, the ASI scores enable the counselor to determine if a patient would respond to a digital method of counseling. It is encouraging that a recent study examined this very question. McKay, et. al, 2005, in a study of alcohol and cocaine dependency found that telephone based continuing care seemed to be an effective ‘step down’ treatment for most patients who completed an initial stabilization period, compared with those who were in intensive face to face interventions. This and other research gives us encouragement that, for

those clients who are unable to engage in face to face counseling sessions that telecare would be a viable and reliable form of alternative treatment for them.

The goal of TOADS is to support people in stabilizing their symptoms so that they may recover at home and in their communities. TOADS aims to serve those who live in isolated rural communities, without easy access to services in the main urban hubs of Fresno, Hanford, Madera, or Visalia. Embedded in this goal is the intention to serve those who have no access to community based services, either because they are not available or because they lack the means to pay for treatment.

Services will be delivered by a multidisciplinary, culturally-competent staff and will include a broad array of medical, mental health and recovery-centered supports based on the cognitive behavioral model of treatment applied to telecare services:

- Risk-focused assessments, covering mental health and substance abuse
- Psychiatric assessment, recovery plan through telecare treatment
- Medication administration and management, when deemed necessary, is under supervision for a board certified psychiatrist (this is done through office visits)
- Family and support system engagement via telecare
- Web based peer support and community group meetings

And individualized treatment plans, which also focus on the process of awakening hope and enlivening the recovery journey which will be covered in the initial intake and assessment are delivered through the telecare network . The goal of this program is to provide a recovery-oriented, trauma-informed learning environment that promotes independence, self-responsibility and self-determination through participating in a telecare program.

Based in Hanford, California, TOADS (delivered within Promesa Behavioral Health's PDR program (Prescription Drug Recovery), the program specializes in providing services and supports for individuals with addiction issues. TOADS provides a full spectrum of telecare services for substance abuse issues, including outpatient and community-based care, case management, and administrative services.

By providing online real-time, interactive audio and video-based alcohol and drug abuse treatment, TOADS brings electronic, web based, mobile treatment to its clients. TOADS is designed to be ideal for anyone who is looking for an alternative to traditional treatment programs, who is unable to access traditional treatment programs or who wants to strengthen recovery after completing a traditional treatment program. TOADS uses a proven treatment approach that is based on cognitive behavioral therapy, supported by strong connections to other successful treatment strategies, such as the 12-Step philosophy, online sessions present information on relapse prevention, medical aspects of addiction, anger management and other topics. In this dynamic, interactive setting, those assigned to group sessions will talk to each other under the guidance of an experienced addiction counselor.

The evidenced based treatment modality utilized by Promesa in addiction treatment is Cognitive-Behavioral Therapy (CBT), which is an empirically supported treatment that focuses on patterns

of thinking that are maladaptive and the beliefs that underlie such thinking. For example, a person who is depressed may have the belief, "I'm worthless," and a person with a phobia may have the belief, "I am in danger." While the person in distress likely holds such beliefs with great conviction, with a therapist's help, the individual is encouraged to view such beliefs as hypotheses rather than facts and to test out such beliefs by running experiments. Telecare aids in changing these thought patterns by giving patients more frequent access to a counselor (than the typical once a week or once a month appointment). Continuous contact through texting and voice messaging enables the client to perhaps more quickly establish new behavioral patterns.

As Obregon details in her 2011 article, r u ok? there are active investigations into the promising applicability of mobile technology, such as wireless communication devices, for use in therapeutic treatments for a wide variety of ailments. One technique in mobile therapy is to use text message correspondence between patients and therapists as a mean to maintain advances made in face to face therapy sessions, as well as to sustain those post-treatment. As with any treatment plan, the goals of mobile therapy are to keep patients actively engaged with their treatment, alleviate their symptoms, and to increase the effectiveness of traditional face-to-face therapy (Boschen & Casey, 2008). More specifically, mobile therapy is currently being applied to Cognitive Behavioral Therapy (CBT) (Boschen & Casey, 2008), a treatment method that focuses on changing thoughts concerning a specific event or object to alter the (previous) behavioral response (Corey, 2009) and to create new behavioral patterns.

While researchers agree that CBT is an effective treatment for a range of disorders (Butler, Champman, Forman, & Beck, 2006; Westbrook & Kirk, 2005), they also identify quite a few areas for improvement. These include difficulties with adherence to self-monitoring methods such as using a journal to record feelings toward treatment and issues with homework assignment completion, both of which are common techniques used in CBT (Boschen & Casey, 2008). In many treatment settings for substance abuse disorders CBT is often the selected strategy, leaving patients vulnerable to the limitations associated with the use of CBT. It is these same issues that TOADS aims to rectify with our use of mobile therapy. Stated simply, the addition of mobile therapy to CBT could produce more effective results for patients by encouraging greater involvement in the therapeutic process through the use of practical and engaging mediums.

Furthermore, many patients experience difficulties in applying strategies learned in the clinical setting in the real world, which can increase frustration with treatment and lead to relapse. The research we reviewed expressed the belief that, in combination with CBT, mobile therapy *will* address these issues, thereby increasing the effectiveness of therapeutic treatments for many patients (Boschen & Casey, 2008). The advantages of texting, for example, is that it fulfills the journaling portion of therapy, because it is based upon an enjoyable activity – texting – that patients already engage in (it's not an additional assignment, for example) and the generated texts constitute a record of feelings, ideas, thoughts, impulses and the like, which are valuable in CBT and in aiding the patient to examine their progress through recovery.

Thus far, technological devices, such as mobile phones and computers, have been successfully implemented throughout medical settings, as evident from cancer research (Forbat, Maguire, McCann, Illingworth, & Kearney, 2009) and studies of diabetes (Bellazzi et al., 2004), laying the groundwork for its potential in the field of mental health. More specifically, research has shown

promising evidence that mobile therapy is effective because it provides patients with immediate feedback and better self-monitoring outside the clinical setting (Boschen & Casey, 2008).

This is important for those receiving CBT because of the promise it demonstrates for improving the quality of treatment in the 'real' world. Also, the brief exchanges provide addiction counselors with accurate and regularly updated data to inform treatment plans. With the great proliferation of wireless usage within modern society, many researchers suggest that the accessibility and prevalence of mobile phone use will increase patient engagement and help with maintenance of treatment over time.

As an added benefit, mobile therapy has the potential to greatly decrease the cost of traditional face-to-face therapy while still maintaining effectiveness (Crow, Mitchell, Crosby, Swanson, Wonderlich, & Lancaster, 2009). The combination of low cost, ease of use, and accessibility in a society that values the use of instant communication could make mobile-based therapy plausible for a wide range of disorders as well as a broad range of patients. Telecare has proved an effective tool in reaching patients of all age groups – even seniors who respond well to technological additions to treatment and access to their doctors (Barlow, et. al., 2009; McKay, et.al, 2005).

In our review of CBT and its application in telecare, we found that the benefits of mobile therapy lie in its ability to help patients receive more individual attention from therapists (Shapiro et al., 2010) and addiction counselors. Because, as a means not only of communication but also of getting, exchanging information, being entertained irrespective of social class or literacy level, cell phone usage is a ubiquitous presence in life -- these benefits combine effortlessly considering society's increasing tendency to communicate via text messaging as opposed to voice conversations (Parr, 2010). The combination of instant communication, availability, and user friendliness indicate that mobile-based interventions could be the future of psychotherapy, k? (Obregon, 2011).

The addiction counselors at Promesa have observed client responses similar to those discussed in research with cognitive-behavioral therapies (CBTs). CBT is among the most frequently evaluated approaches used to treat substance use disorders, has been shown to be effective in several clinical trials of cocaine-dependent individuals and other types of substance users, especially those 18-30 who have more affinity for electronic communication and are comfortable with instant messaging, texting, e-mailing, tweeting, Facebook® and other forms of electronic connecting. Our clients respond well to telecare based CBT, we believe, because:

- It is based on social learning and behavioral theories of drug abuse
- The basic approach is "recognize, avoid, and cope" these learning strategies are
- easily communicated via telecommunications
- Treatment is organized around a functional analysis of substance use; i.e.,
- understanding substance use with respect to its antecedents and consequences,
- insights are amenable to text messaging, for example.
- Skills training -- that is easily reinforced through web-enabled mobile phones -- is
- focused on strategies for coping with craving, fostering motivation to change,
- managing thoughts about drugs, developing problem solving skills, planning for and

- managing high-risk situations, identifying apparently irrelevant decisions, and
- cultivating drug refusal skills.
- Underlying principles of CBT are that:
 - (a) basic skills should be mastered before more complex ones are given,
 - (b) material presented by the addiction counselor is matched to patient needs,
 - (c) repetition fosters the development of skills which are easy to deliver by web based methods,
 - (d) since practice is needed for mastery of skills, patients get more reinforcement from addiction counselors,
 - (e) the patient is an active participant in treatment, and
 - (f) skills taught are generalizable to a variety of problem areas.

Anestis (2009) notes that there is nothing inherent in CBT that would make it be inappropriate for use with diverse clients. In line with that observation, Promesa's substance abuse counselors have successfully utilized CBT with many of our Latino, Asian and African American clients. In fact, Hays (1995) notes specific ways in which CBT may be particularly useful for multicultural clients:

- *CBT emphasizes the uniqueness of the individual*: At its core, CBT argues that the treatment should be adapted to meet the needs of the individual.
- *CBT focuses on client empowerment*: The inherent belief that clients are in control and, therefore, capable of bringing about change themselves helps create a collaborative relationship which appreciates individual and cultural differences.
- *CBT focuses on conscious processes and specific behaviors (instead of unconscious processes and abstract ideas)*: Hays notes that this may be especially important when therapy is conducted in a client's second (or third, etc.) language or with an interpreter. Research indicates that fluency in a 2nd language is negatively affected by emotional distress. A therapy that emphasizes theoretical and abstract ideas may result in a greater potential for misunderstanding between the therapist and a distressed client.
- *CBT integrates assessment throughout the course of therapy*: This cognitive-behavioral assessment maps progress from the client's perspective. In fact, assessment measures could easily be added to the battery that address concepts important to the client (e.g., the family's views of the client's progress). Additionally, this emphasis on continuing assessment demonstrates therapist commitment and respect for the client's opinion, which is important for all clients, but perhaps more so for the client and therapist whose backgrounds differ.

Promesa's counseling staff is aware that there are some limitations to utilizing CBT with multicultural clients. In following the observations of Hays who notes, for example , that CBT possesses some constraints that must be considered with diverse clients. CBT does value characteristics such as assertiveness, personal independence, verbal ability, and change, concepts that are prioritized in the United States, but not in many other cultures. CBT certainly has the potential to assist clients with other values, yet counselors must work hard to battle their own subtle biases that support these concepts.

Additionally, CBT generally de-emphasizes the importance of the client's history (i.e., it is very present-focused). Counselors, when working with multi-ethnic clients, must be cognizant of the fact that (for many Latino and Asian clients, in particular) disregard of differences in a client's upbringing and experiences in the world is often seen as disrespectful and discounting and, for many (especially refugees) that the past is relevant to the problems at hand (e.g., these developmental concepts should, thus, be incorporated into the cognitive schema). Finally, CBT emphasizes rational thinking and the scientific method, styles of thinking that are decidedly Euro-American and masculine. Certainly, these styles of thinking and interaction could be modified to fit the client's perspective.

Hays (1995) recommends several examples from the literature of adapting CBT to specific aspects of culture. These adaptations do not change the basic work and techniques of CBT, instead they incorporate and appreciate diverse beliefs into the standard CBT protocol. The principles and practice of CBT appear to be compatible with the expectations favored by Chinese people, specifically, and in other Asian populations more generally, as it promotes self-help and is psycho-educational; teaching new coping skills to manage emotional problems. The CBT framework also takes into account the client's problems in relation to cultural factors such as the impact of immigration, somatic complaints, interpersonal relationships, and other areas of importance (Williams, Foo, et al., 2006).

Section C: Proposed Implementation Approach

TOADS is located in the office of the telecare program PDR in Hanford, California which also houses the telecare addiction counseling staff and the network hub for all of the IT services for telecare programs. The local network encompasses a geographical area of Madera County to the north to Tulare County to the south, with the centralized data center supporting network connections to the project sites. Although this reflects the geographic extent of the *local* network, the catchment area for program is the entire State of California, as Promesa Behavioral Health receives client referrals from San Diego, San Bernardino, Alameda, Contra Costa, San Francisco, Los Angeles, and other counties. Additional equipment will be installed at the Fresno Promesa Data Center where all video and data circuits will terminate, and where the network will be maintained. The network hub will include ISDN lines and secure high speed Internet connections so that Telepsychiatry services can be set up with off-net, non-direct connected locations. Chief of Medical Service, H.A. Cruz, M.D. will have access to a customized unit, for use in supervising the services provided at the Hanford and Fresno sites.

The communities which could be served by the TOADS are throughout California, with client referrals coming from San Diego, San Bernardino, Alameda, Contra Costa, San Francisco, Los Angeles, and many other counties, although the physical connections for this grant submission include four counties Fresno, Kings, Madera and Tulare. These sites service nearly 500 clients a year.

Crucial to this grant is linkage to probation offices, municipal and superior courts, and mental health service providers located in the county of origin of the minor so that interdigitated services that include the family can occur. This will minimize travel, travel time, and accessibility barriers such as geography, language, and cultural competency. It will allow for a

seamless integration between services provided by multiple local agencies to a higher level of care such as group placement, and transition back to the county of origin.

According to February 2004 government report on *Innovation, Demand and Investment in Telehealth*, "Other studies suggest that mental health and related counseling is, in some cases, more effective when televideo-conferenced, allowing the patient the security of privacy and the flexibility of connecting with a counselor on his or her schedule. The flexibility afforded by telehealth technology also offers the provider and patients more options than a face-to-face encounter."

The National Health Survey offers estimations that approximately 10% of the general population of any county area suffers from chronic and persistent mental illness related to substance abuse. However, they are the very ones who need family support more than ever but are receiving a specialized treatment that takes away the family when sent for institutional care; however, with Telecare service, patients are more likely to recover in a 'natural' and familiar setting of their home and community.

This project is about providing innovative and secure videoconferencing technology that creates an interaction between families, clients, various judicial systems and the treatment facility to enhance treatment and reduced costs for all involved parties.

- **Describe your experience using health information technology for treating substance using populations. Describe your successes, challenges and outcomes.**

For the past three years, Telehealth video service has been crucial in keeping the delivery of the continuity of care to consumers of our prescription drug recovery clientele. One of the biggest barriers to overcome was getting services to the consumers that lived in far distal locations. The Central Valley region of California is characterized by a few large urban hubs, which serve a large number of small rural towns or isolated unincorporated communities. For example, in Fresno County, the metropolis of Fresno/Clovis contains over half of the County's population (Fresno Council of Governments, 2011) with 14 small towns and 139 unincorporated areas. The majority of treatment services are in Fresno proper (and as the state budget crisis deepens, the County has been closing its rural service centers to save costs). Thus, for those who need services, it requires frequent trips to 'the city.' Some clients have trips of over an hour (one way). While Madera and Kings counties are smaller in area, the urban/rural pattern while Tulare County reflects a similar pattern of 3 large cities (Visalia, Tulare and Porterville), with a scattering of rural towns (8) and (171) unincorporated areas. Travel distances are a significant challenge not only to clients needing services but to providers as well, who may elect to send counselors to meet clients (however, there is a time and mileage cost incurred and lots of 'down time' for counselors as they travel).

One of the consistent challenges faced by clients and provider agencies is the issue of reliable access to transportation and who live in disenfranchised, unserved/underserved locations, making the needed or specialty impossible to obtain. Among the specialty care needed (and often an unmet need) are mental health and substance abuse services. To meet this need and to more effectively serve clients, Promesa opened satellite clinics with Telehealth access

strategically located within a close proximity of surrounding unserved rural communities, consumers were not only more willing and but also more apt to obtain services. Presently, Promesa is serving clients who have prescription drug dependency, however, the number of individuals with substance abuse issues needing services is greater than this *one* problem.

With the Telehealth services, the doctors and addiction counselors may be located anywhere yet be able to continue treating the consumers via high definition, secure, encrypted Telehealth video services. The movement towards EHR (electronic health records) has created ease for doctors to have access to the patients' information in extreme cases (a doctor off site could conceivably be in a car, accessing EPHI electronic patient health information via Smartphone -- or any wireless device with video technology). So, where the consumers once had to possibly drive 75 to 200 miles (one way) for such specialty care, they could now receive valuable services and treatment with in their own nearby community, with a professional using modern technology to support their recovery. This not only represents a cost savings to the client but also to the doctor/counselor/service provider.

- **Describe your organization's current capacity in HIT. Is your existing EHR system interoperable with general medical/primary care systems. Explain how your current HIT infrastructure enhances or limits the quality of care your organization provides. Explain how it enhances or limits your efficiency as an organization.**

Promesa's technology and data infrastructure is currently in position to adapt to the expansion of both the network traffic technology (video, messaging and connectivity to distal locations) and growing data warehousing needs. To build for expansion was one of the important factors during its initial development. With this in mind, the HIT consulting firm insured that there was added room from server growth for application evolution and additional storage area network space was thereby incorporated. The current EHR system, Anasazi, is a certified ONC-ATCB EHR application that is interoperable with general medical and primary care systems. The existing design and scalability of the data networking infrastructure augments the dynamic landscape of quality of care. Its configuration adapts to the newer ways that doctors and clinicians access EPHI/ EHR securely, making their assessments and access to patients' information nearly instantaneous. The quality of care our telecare staff provides, then, is inherently beneficial on all levels due to this adaptability and readiness. Furthermore, intrinsically, the technology position benefits the entire organization to move with the times of change regarding how electronic information is handled, maintained and delivered. This insures that agency which is consuming such needed and vital services can protect and maintain current patient loads, yet grow simultaneously as the demand for telecare counseling services also grows.

Provide a detailed description of how the expansion and/or enhancement of electronic tools will be used to reach the specified population(s) of focus.

As a continued and innovative approach to reach communities that are unserved and disenfranchised, the focus will be bringing the care even closer through the means of internet

technologies, newer Smartphone technology and remote secure technology services via cellular services. The approach is twofold; clinical and consumer:

- Smartphone technology that can text, video or have internet access to needed support resources for consumers, especially those who cannot get to a secure web-based terminal (such as a laptop, with a webcam, set up in a health care clinic, pharmacy or private office in a central community setting). For clients who have Smartphones (and agree to use this emerging technology as their communication device for treatment) will be provided confidentiality training during their assessment, intake and treatment planning appointment (which will be done in person). Clients will be provided with an access code to ensure their privacy during treatment sessions, texting correspondence and other communications.
 - Doctors and addiction counselors on-the-go with newer video Smartphone and cellular laptop technology that can securely access EHR of consumers receiving in-the-moment information or scheduled consultation/ treatment;
 - Internet services for consumers to access needed resources and other ancillary treatment collateral i.e. steps for self-help or substance abuse information and knowledge databases through on line access;
 - Existing EHR platform built to scale for expanding electronic record keeping;
 - Security around the EHR to continue matching and exceeding HIPAA regulations;
 - Emergency tracking services. Electronic devices (like Smartphones and laptops (laptops enable video or IM'g (instant messaging)) with GPS built in to enable 911 responses to track emergency event locations (for example, a psychiatric crisis, evidence of immediate violence, an expressed threat of homicide or suicide or possible overdosing).
 - Additionally, we seek to expand Telecare services to un-served and/or under-served populations in the Central Valley, as we are anticipating the impact of the Affordable Care Act (ACA) (which is expected to be completely 'rolled out' by 2015). We expect that – by demonstrating the cost effectiveness of Telecare for substance abuse treatment that would be the primary model of care for this condition. Moreover, many private insurance companies either do not reimburse for mental health services, or mental health is the least supported of health services. If there isn't a subsidy or assistance plan, then those who need addiction recovery services often go without treatment. Under the ACA, this limitation as an insured benefit should be lifted.
 - For example, the Suboxone supported recovery services we currently offer are strictly a fee for service program, as this treatment is not covered by insurance, or is only covered under (under-reimbursed) mental health provisions. Patients have discovered that if this medication isn't a covered benefit, they can buy it through the internet from countries which neither require a prescription nor

regulate its sale. The jeopardy in that, of course, is the danger associated with any self-medication – patients may never reach the stabilization that will bring about recovery, as the dosage requirements are highly individualized and require an experienced doctor's supervision.

- Currently our other mental health/substance abuse services are billed either to MediCal, Medicare or other public/private insurance. Or, for those without insurance and who do not qualify for a public program, we have a fee for service policy, where all patients make sliding scale payments for treatment, as it is received.
- With Telecare, this cost of treatment represents a vast savings over residential and/or traditional office-based outpatient care. Moreover, with telecare not only is money saved over time, but also time invested in recovery.
- **Demonstrate that any EHR software you propose to use meets the requirements of the Office of the National Coordinator for Health Information Technology- Authorized Testing and Certification Bodies (ONC-ATCBs).**

Anasazi Software has become a certified application for meaningful use by the ONC-ATCB's testing authorizer, Drummond Group. Thus, Anasazi is a certified application as an Electronic Health Record ONC-ATCB program. The EHR application within this program will meet the growth demand for EHR. The doctor's homepage will meet the expansion of services and physicians will be able to utilize the e-Prescribe function, to ensure that medications are quickly and easily filled, yet keep client confidentiality in check, reduce paper work, instantly update client treatment plans. These electronic functions have the added bonus to reduce spending and 'hard' copy paperwork. The clinician's homepage effectively manages the assigned case loads, allows staff to communicate in a HIPAA-secure environment, perform instant chart audits, noting outstanding tasks at a glance and enables supervisors to monitor staff productivity.

An added benefit of the Anasazi is its revenue management features, which deliver comprehensive bill trace, service test recalculation, robust reporting, and -- where applicable -- the 837P & 837I claim submission, 835 electronic remittance advice as well as an automated billing modality and service code assignment, superior billing suspense mechanism and the customized billing algorithm.

The assessment and treatment plan system can do full automation of the clinical processes, thereby reducing clinician time and effort on paperwork, which increases productivity, brings in more billable-hours revenue and enhances quality of care. Management reporting will track revenue, unduplicated client assignments, third-party billing, caseload performance, accounts receivable, review notifications, and payments/collections performance.

The inclusive fully integrated scheduling system has the flexibility to define schedules for clients, clinicians, treatment or interview rooms, equipment and transportation. Allows for multiple schedules at a single time, and view a schedule over one day, two days, a week or a month. The daily scheduling reports for each clinician detail productivity and no-show rates.

When scheduling appointments, a search for available clinicians who have the required licensing and credentials to warrant billing under a particular client's benefit plan is also a feature and available. This flexibility of the Anasazi components meets the needs of both the agency staff and the clients, whereby electronic notifications are sent to clients and alerts to counselors. Productivity goes up, because travel time is decreased (for the counselor). Patient no-shows also decrease, as the travel time for clients is eliminated or greatly reduced.

Promesa has ensured that all of the application equipment and data warehousing/storage is located in a HIPAA compliant environment. This equipment facility is complete with all environmental controls; cooling, with an FM-200 dry fire retardant system and 24/7 diesel generator system to ensure data is always accessible even in extended power outages (which sometimes happen in California during peak usage periods – typically summer – when local power companies implement a rolling blackout pattern to reduce loads on their system). Only a few key personnel are authorized to access the equipment and the data storage facility. In order to do so, HID badge-electronic access to servers and data warehousing network in the telecom collocation is required. Only personnel with security authorization and cleared background checks are issued such access. Presently, only Dr. Cruz, Chief of Medical Services, Cindy Gonzales, the program manager, and John Kasdorf, the consulting HIT technician have authorized access. All equipment is locked and secured within its locked caged location area, meeting and exceeding both HIPAA and NSA standards for security.

- **Explain how you will address the following factors influencing the expansion and/or enhancement of HIT (including but not limited to EHR and telemedicine systems and tools):**

Our EPHI/EHR will continue to grow, as it is fast becoming the local and regional industry standard. Because our intent was to grow, with leadership in telecare, our Board and staff recognized that we needed to ensure that the initial design of the infrastructure that houses that repository of health information was flexible and met all the regulations regarding telehealth services. This flexibility is critical to cost effectively adapt to the expansion and growth of that specific system. As more and more individuals seek the comfort and ease of obtaining mental (and other) health services through telecare, that will influences the growth in EHR. Our telehealth technology consulting firm has configured the infrastructure to start out with 15% storage and server power with projected 60% full load at end of the three year span for this project, which gives 25% for unforeseen or unpredictable storage and server needs. The agency is assured that this should be more than appropriate for the 3 years of operations and beyond that time frame into a self sustaining future for TOADS.

Telehealth video and messaging systems will be leveraged more and more against emerging companies that offer HIPAA compliant video switching infrastructure leasing and messaging systems to medical and other healthcare organizations. This competition and ever-improving technology and software will move needed core native network upgrades and appliance costs from a depreciated asset and expense to operational costs and begin to move the expansion equipment into a services based configuration. It is anticipated that improvements in technology

and software will accelerate over the three years of the project, and new items would be added towards the very late middle and end of the 3 year project.

By leveraging the core infrastructure to a more security driven, data warehousing environment and commissioning additional HIPAA compliant, video switching and messaging system providers (such as Glowpoint, Verizon), ongoing maintenance costs and replacement costs will decrease over the life of the project. This will inherently be reflected in lower staffing needs, lessen the need for new equipment and move revenue streams into the business side of telecare operations. Sustainability will also inherently benefit from this configuration as the business adapts to the growing influences of growth and change, as the community responds favorably to the convenience and cost-savings of telecare, and as the mental health substance abuse treatment providers realize the benefits of serving clients through technology-based services.

- **Organizational factors (i.e. redesign of workflows, capabilities of your practice, day-to-day operations of your practice).**

Since Promesa is a current telecare provider, we are ready to implement the project upon award. We have established workflow patterns in place for telecare staff, who schedule clients upon referral, guide them through the intake, assessment and orientation to telecare, schedule the teleconferences between client and counselor, routinely send out appointment reminders to clients, answer questions promptly and serve as ambassadors of the program to clinicians, practitioners and others in the health care field. Our two existing telecare staff, under the supervision of a Chief of Medical Services, would be able to absorb another 60+ clients. At that caseload threshold, Promesa would hire another addiction counselor to provide direct services to an additional 30, and so on. Our Chief of Medical Services can oversee 20 or more counselors, each with caseloads of about 30 clients. In our substance abuse treatment program, there are 5 addiction counselors who are providing telecare support to their clients, along with a staff of 10 who provide traditional in-person counseling.

Since we serve clients from 14 Counties throughout California, our staff is adept at collecting and analyzing a multitude of data. Each contracting agency, while requiring essentially the same information about client progress, have different formats for their reports and data presentation. Consequently, our staff is very sensitive to maintaining appropriate documentation on our clients.

- **Provider training and competence factors (i.e., disparity in IT dexterity among clinicians and staff)**

Promesa's staff (in every division: Foster Family Agency, Group Homes, Independent Living Skills and other Juvenile Services, Community Outreach and Telecare) attend training in a wide variety of topics on a regular basis. Training ranges from broad overviews to very detailed and technical areas. Therefore, scheduling training to cover what might be regarded as 'Gap technology training' would be a routine activity for staff. In the first month after award, we will hold trainings for 4 small groups, independently, over a course of 1 to 2 days, 6 hours each day in order to allow staff time to absorb the technological information. While all of our staff are computer literate (each staff has to collect data on each client in their caseload, and generate

reports to every county that has placed a client with us, as well as reports for each contract or funder), consequently, each staff member is quite adroit at data collection and data analysis. Each staff is also well versed in the requirements of electronic patient privacy and client confidentiality. Of course, the IT dexterity of staff ranges from novice to adept.

IT dexterity training for staff would include media (such as video, texting, HIPAA compliance) and technologies (Smartphones, laptops, video infrastructures). In the initial stages of expanding telecare to a wider client pool, the video support will be thoroughly tested prior to ensure that both the staff and clients can handle the increase in ‘traffic.’ This testing will include mock sessions for doctors to get acclimated to the different ways of accessing distal sites and/or consumer’s Telehealth services delivered over Smartphone video, cellular laptop HD (high definition) or the ‘standard’ video teleconferencing to receive telehealth services.

For staff assigned to clinical and billing functions, an EHR overview and service code entry training will be conducted. Again, this training is best conducted in small groups over a course of 1 to 2 days, 6 hours each day. The requirements in the beginning of services utilizing technology tools will be constant and permanent throughout the program’s lifecycle.

- **Relationship factors between provider and persons in treatment (i.e., immediate vs. long term impact on care, the ability of persons in treatment to use electronic tools)**

During the intake, assessment and orientation process, clients are given a thorough review of the telecare process and how to access their counselor or personal health information using technology. If the client is going to an assigned ‘station’ for telecare access (such as a health center), they are provided training on the equipment and systems access for that portal. If they are using their own iPhone or Smartphone, then they are provided orientation on how to access their counselor using their assigned communication codes. If they are using either their own laptop computer (with Skype or webcam technology) or one of the agency’s laptop stations, the training is on those technologies. In other words, whatever technology the client will be using in their telecare treatment, is what their training is geared toward. Thus, the client leaves the orientation with an awareness that they have access to IT support from technology support team. Our IT consultant is well versed in adapting and making immediate, cost effective modifications to both technology and applications, in order to make sure the continuity of care is as uninterrupted as possible and adaptations are transparent to the client.

Ongoing technical support will be one on one support for clients and counseling by the technology support team. This support entails connectivity maintenance, EHR updates and maintenance, device updates and maintenance and service testing i.e. video, IM’s and internet service.

Over the course of the project, refresher training for all technologies will be periodically executed and offered biennially for staff. This will maintain staff’s knowledge base, keep them up to date with changes and additions, and better assist them when dealing with client questions, before calling in the technical support team. An exception is if new technologies emerge that stream-line the delivery of care. In this case, the IT consultant will schedule an additional 1 to 2

day training with 4 hours allotted for time. Training will be leveraged from prior training thus enabling faster absorption of new knowledge for existing staff and clients.

- **Technical factors requiring additional staff or consultants (i.e., support maintenance, operation of the system)**

Growth factors will have a large part that governs the need for additional staff. Those growth support factors will come in the form of technology support services as the consumer base grows. As the technology changes and needed updates come alongside the consumer growth, there will be support staff added. While addressing the needs and inherent expenses, being fiscally responsible with the adaptation of additional staff will be first priority. Cross training within the technology support team will be first followed. When certain support team members champion in position, they will be first pick to train incoming new support team members. This will keep revenue for needed support services down while simultaneously moving operational revenue to the business' sustainability and operational needs. The result of this manner of management of operations keeps fiscal expenditures on consumer's services and other supplementary needs.

- **Financial factors (i.e., coverage of ongoing hardware upgrades and maintenance, software maintenance, IT staff and consultants, and refresher training costs that occur beyond the 3-year award period)**

With portability of equipment, comes the likelihood of accidental damages, which necessitates warranties and replacements. This likelihood is even more dramatic when equipment is placed in off-site locations (health clinics, pharmacies and libraries), where usage is less likely to be attentively monitored.

In nonprofits who are dealing with healthcare services, there is also expenditures for security, expansion of data storage due to EPHI/EHR growth and warranties that surround those needs. The key to managing EPHI costs, especially with an eye towards keeping these down in the long term, infrastructure maintenance and great planning are critical. The design of the EPHI expansion will be done such, a manner that positions the need for new appliances and data gear to be done so without an entire overhaul midway through the project. Larger chassis' for data servers and storage would be utilized without fully populating all bays. Positioning the infrastructure to meet the current needs while having room to grow will fiscally better serve the project in the long run.

The technology team that Promesa has in place has managed to set up EHR systems in several counties throughout the State. For example, this team has just designed Anasazi Software to enable their staff to convert Colusa County to the new Anasazi system from an inadequate older system, thus doubling their capacity to track billing and revenue.

The project technology lead (John Kasdorf) possesses experience of over 15 years in the Health Information Technology (HIT) professional services, including designing and establishing telecare technologies. This encompasses extensive video and cellular technology experience with

corresponding providers that deal with convergence services nationally and worldwide. This will benefit the project to move more expeditiously through the technology barriers and retain prudent technology design and expansion implementations. In addition, the project technology lead possesses an operational and environmental understanding of the business inter-workings of AOD and behavioral health services. This creates a solid and comprehensive establishment of mindfulness concerning the impact of such technological implementations and adhering to the necessities of patient privacy and confidentiality.

- **Show that the necessary groundwork (e.g., planning, development of memoranda of agreement, identification of potential facilities) has been completed or is near completion so that the project can be implemented and service delivery can begin as soon as possible and by the 4th month of the project at the latest.**

Promesa is already set up to implement service delivery upon award, as we have the facilities in place, with existing telecare equipment, secured facilities, compliant encryption services and patient privacy protocols already developed. We have on board a supervising Chief of Medical Services, Dr. Herbert Cruz, who has provided telepsychiatry services for over ten years. John Kasdorf, who serves as a consultant to the project from Telecare Technologies, Inc., has installed telehealth systems as well as trained doctors and staff throughout California regarding the use of high definition video conferencing equipment and telecare services. Moreover, he is well versed in several key telehealth software systems and can advise on those that would be of most benefit to us – in this case, the Anasazi.

In terms of installing additional equipment, in remote areas of the Sierra Nevada where broadband is not yet available, we plan to use Smartphones or similar devices, which do work from satellite feeds.

- **Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.**

One potential barrier that we have identified is securing collocation agreements with other providers in remote communities, such as Ahwahnee (a small mountain hamlet located near the Yosemite National Forest) or Squaw Valley. One key factor in setting up remote locations (apart from whether or not there is broadband or satellite available), is the need to ensure session privacy for clients. It's not just the distance that is daunting, to both clients and staff, but also the availability of secure spaces. We are negotiating with the California Association of Pharmacists to work with their members to place videoconferencing equipment in locations that are accessible to clients. For those pharmacies which currently offer vaccinations and wellness checks (which have to be done from a private, secure space) are, thus, already seeking additional services to provide to the customers, a telecare link would be an additional benefit. Other collocation resources we have examined are public libraries. The local network of libraries has branches located in many remote unincorporated communities (Piedra, a very small hamlet, for example or Auberry, in the Sierra foothills). Libraries could check out the equipment for on-site use to clients, who go to a secure or private space within the library to hold their telecare session.

- . Another barrier we have identified is community awareness of telecare as a viable option for treatment. Presently, telecare is not widely known in the San Joaquin Valley – not widely known by clinicians nor by clients. Our strategy to overcome this is to broaden our community outreach about telecare. We are seeking publicity on local media (both English and Spanish language media), local newspapers and public media (Valley PBS and KVPR) to schedule presentations about telecare. Additionally, our staff, especially the Chief of Medical Services will make presentations to the Medical Societies of each of our target counties, as well as to conferences and conventions throughout the State.
 - **Describe your plan to continue the project after the funding period ends. Also describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.**

Our plan to continue the project after the funding period ends has a two-pronged approach. One is a fee for service option. Presently, our telecare services are all private pay, with clients supporting the entire cost of treatment out of pocket. Our plan for clients who have less financial resources is to offer a sliding scale, yet nonetheless charge a fee for services offered. The current telecare clients pay \$1,400 for a six-month course of treatment (that's \$800 for the initial intake, assessment, orientation and medication stabilization observation) and \$200 per month for telecare counseling sessions and phase-out medication monitoring).

An additional strategy is third-party billing. In our Substance Abuse Treatment program, we currently bill MediCal and other insurance entities for reimbursement for treatment for clients enrolled in these programs. We are anticipating that with the full rollout of the Affordable Care Act (by 2015), that mental health/substance abuse treatment will be more fully covered under the provisions of the Act. Consequently, we are expecting more revenue from this resource.

Section D: Staff and Organizational Experience

Promesa has hired a diversity of highly qualified mental health and substance abuse professional staff. These professionals have all either earned Bachelor's or Master's degrees in mental health, marriage and family therapy, or substance abuse services. Staff are bilingual (Hmong/English, Spanish/English, Chinese/English as well as access to translation services from a network of local mutual assistance associations (Cambodian, Vietnamese, Oaxaqueño, Russian among others) and bicultural (from the communities/ethnicities represented by the client population – rural, or poor urban neighborhoods, immigrants, refugees and so on). In our current, more traditional outpatient substance abuse treatment programs, we have 8 full time bilingual/bicultural counselors (all at the Master's level), who provide intervention, prevention and treatment services to both juveniles and adults. The client mix is reflective of the ethnic makeup of the San Joaquin Valley : 60% of our clients are Hispanic, in rural communities the Hispanic percentage is higher; in urban settings, we do see a higher percentage of African Americans than the 8% of their local population numbers – about 19% of our clientele; about 15% of our caseload is white, and the remaining 6% are Asian and Native American. Presently, five of our staff are including telecare as part of their treatment protocols for clients and the remaining three have plans to train in telecare. Although we have both men and women in our client pool, we serve slightly more men than women.

Promesa Behavioral Health considers “cultural competence” to be the overarching principle in providing substance abuse treatment services and treatment. Our staff is bilingual and bicultural, but most importantly, have years of experience working with the diversity of multicultural populations found in the Central Valley. Many of our staff are bilingual/bicultural Spanish/English and were raised in Latino immigrant families and possess an insider’s understanding of Latino culture; similarly, our Asian staff are either of refugee background (Southeast Asia) or are of Chinese immigrant families. Because of their education and professional development, they also are adept at understanding other cultural backgrounds as well.

Overall Staff Requirement: *No counseling staff employed by the agency shall have a history or evidence of alcohol or other drug misuse for a minimum of two (2) years prior to date of hire or volunteer participation for the position of counselor. If the counselor indicates he/she is recovering, he/she shall have a minimum of two (2) years of continuous sobriety. Program Directors/Clinical Directors/Senior Counselors shall have a minimum of four (4) years of continuous sobriety, if recovering.*

Roles and Responsibilities

Role	Responsibility	Name	Estimated Time
Technology Project Director	<ul style="list-style-type: none"> • Network design. • Infrastructure needs. • Manage the technology activities. • Maintain the project plan. • Submit bi-weekly progress reports to Medical and Project Director. • Ensure the quality of deliverables. • Support in facilitating the submission of deliverables. • Participate in reviewing project activities, deliverables, reports and other documents as may be required. • Implementation of all hardware (wide area network and teleconference equipment.) • Train participants. • Participate in team meetings. • Provide materials. • Working with the vendor to troubleshoot any technical issues. • The setup of the training environment (network, video, installation) • Support network operations. • Coordinate access for training environment at respective site. • Support in coordinating site assessment times. • Be familiar with and assist with implementation of HIPAA compliance>Title 42 standards; 	John Kasdorf (resume attached)	5% - consulting

Role	Responsibility	Name	Estimated Time
	<ul style="list-style-type: none"> • Provide a clinical link between support services, clinical services, and technology support staff; • Be familiar with and assist with adherence to existing guidelines and laws governing the interface between technology systems and clinical services; and • Assist with converting to an e-Prescribing system as mandated by Federal Law • Support testing the teleconferencing equipment. • Signing off on functional requirements. • Participation in team meetings. 		
Chief Medical Director	<ul style="list-style-type: none"> • Participation in team meetings. • Signing off on the functional requirements. • Overall decision maker on all functional and fiscal requirements. • Clinical oversight and planning of care provided to clients. • Development of integrated community-based plan for the outreach and engagement of consumers. • Clinical interface with existing clinical services at identified primary and ancillary telecare sites. • Data acquisition and reporting to demonstrate key clinical deliverables. • Direct client care • Treatment planning with the treatment/therapy provider 	Herbert A. Cruz, M.D. <i>(vitae attached)</i>	50% - consulting
Program Director/Substance Abuse Counselor:	<ul style="list-style-type: none"> • Responsibility is to the Chief of Medical Services; • This is the primary administrative position at the program level; • Administratively responsible for the program as delegated by the Chief of Medical Services. Carries out assignments related to program planning, implementation and evaluation; and • The scope of responsibility includes day-to-day administrative operations, budget preparation and monitoring, fiscal and program statistical data systems, developing and ensuring compliance of contracts and agreements, licensure and insurance policies, developing and maintaining a viable public relations 	Cindy Gonzales <i>(resume attached)</i>	50%

Role	Responsibility	Name	Estimated Time
	<p>program including a close working relationship with relevant county boards and staff, and supervision of personnel functions, clinical records, and maintenance of physical facilities and equipment.</p>		
	<ul style="list-style-type: none"> • Provides leadership and coordination of activities and develops and manages program activities of the service area consistent with the program needs of the people served; • Responsible for the appropriate allocation of program resources; • Provides direct services as required; • Recruitment, hiring, and training of new employees should program need arise for additional staff; • Knowledge of a major spreadsheet program and an understanding of accounting practices; • With a high level of independence, performs difficult and specialized administrative or clinical records supervisory duties requiring care, quality control, accuracy in detail, demonstrated organizational and leadership skills and initiative; • Responsibility for the position may be general administrative or clinical records supervision; This position supervises staff and coordinates function of area assigned; • Responsible with clinical records. Shall have a working knowledge of medical/psychiatric terminology, principles and practices, and diagnoses coding procedures; • Provide administrative support to Chief of Medical Services; • Maintains administrative files and contract files; • Performs administrative functions; such as scheduling and coordinating meetings as directed; • Performs typing functions proficiently; 		
Substance Abuse Counselor:	<ul style="list-style-type: none"> • Under general supervision of Program Director, assists in the service delivery program to clients; • Proven proficiency in the service delivery program through experience and 	TBD <i>(job description included)</i>	100%

Role	Responsibility	Name	Estimated Time
	<p>knowledge of therapeutic clinical treatment. Demonstrate initiative and leadership in developing and maintaining the service delivery program under his/her responsibilities;</p> <ul style="list-style-type: none"> • Responsible with clinical records. Shall have a working knowledge of medical/psychiatric terminology, principles and practices, and diagnoses coding procedures; • With a high level of independence, performs difficult and specialized administrative or clinical records supervisory duties requiring care, quality control, accuracy in detail, demonstrated organizational and leadership skills and initiative • May supervise other staff; and • Functions independently at a high level of responsibility in areas such as emergency services and/or functions, consultation, education, and information. 		

Section E: Performance Assessment and Data

Outcome #1: To enroll, serve and ensure telecare substance abuse treatment completion of a broad spectrum of racial/ethnic/language clients in four Central Valley Counties.

Outcome #2: To increase access and utilization of telecare as a specialty mental health substance abuse recovery service for patients in each of the identified counties.

Outcome #3: To provide increased client and/or authorized family contact for existing patients via videoconferencing technologies through TOADS resources and existing networks throughout the identified counties, indeed, California.

Outcome #4: To increase capacity and capability to link the TOADS to other networks in the region and to have the capacity to offer services and connectivity to additional patients and sites.

Promesa -- as a matter of course and as a requirement of every County and funder who supports our work – routinely collects data on each client referred to our agency. This data is not only used to prepare reports to each entity, but it also enables us to periodically review our performance, assess our projects and use the information to improve the management of our grant projects.

Such periodic assessment enable us to determine if we are meeting the goals we set forth in each award, but also to determine if the outcomes were what we intended to achieve. Assessment also allows us to not only report on the progress of the project and the clients we serve, but also what barriers or obstacles we encountered, and what strategies we employed to overcome these barriers in our performance assessment reports.

At a minimum, our performance assessment include the required performance measures identified by SAMHSA. We also outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
 - Our key outcome goals are for patients to enter recovery quickly and to sustain it even after they complete their course of telecare based treatment.
- What program/contextual factors were associated with outcomes?
 - We are confident that our clients will be more responsive to telecare based treatment, as barriers such as geography, distance and language will be reduced or eliminated.
- What individual factors were associated with outcomes, including race/ethnicity?
 - Cognitive Behavioral Therapy has a proven track record with most of the ethnic groups we serve. We are confident that our multiethnic clients will respond well to both the CBT approach and telecare, maintaining the clean and sober goals they set out to achieve and to sustain them over time.
- How durable were the effects?
 - We expect that the recovery effects experienced by our telecare clients will be sustained over time. Our confidence is based not only on our own experience with telecare based treatment, but research results which supports this optimism.

Promesa's staff collect data on clients using a multitude of demographic points, as well as client specific information (for example, client's personal recovery goals and their progress toward achieving these goals). Electronic communication with clients will be retained in the client's patient record (EHR) to aid in this personal tracking of client progress. As well as personal progress, specific demographic points will be collected (such as racial/ethnic group/primary language, etc. to allow us to monitor our progress in ensuring that disparities in services are minimized. Presently, our client service patterns are reflective of local population demographics (for example, the largest ethnic group in our service are Latino, the largest segment of clients we serve is Latino, followed by African American, Asian and Native American). Our staff also reflect this demographic pattern as well.

Process Questions included in our performance assessment::

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What led to the changes in the original plan?
- What effect did the changes have on the planned intervention and performance assessment?

- Which program staff provided services (specifically, modality, type, intensity, duration), to whom (individual characteristics of clients), in what context (telecare system, rural/urban community), and at what cost (facilities, personnel, dollars)?
- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
- How many individuals were reached through the program?

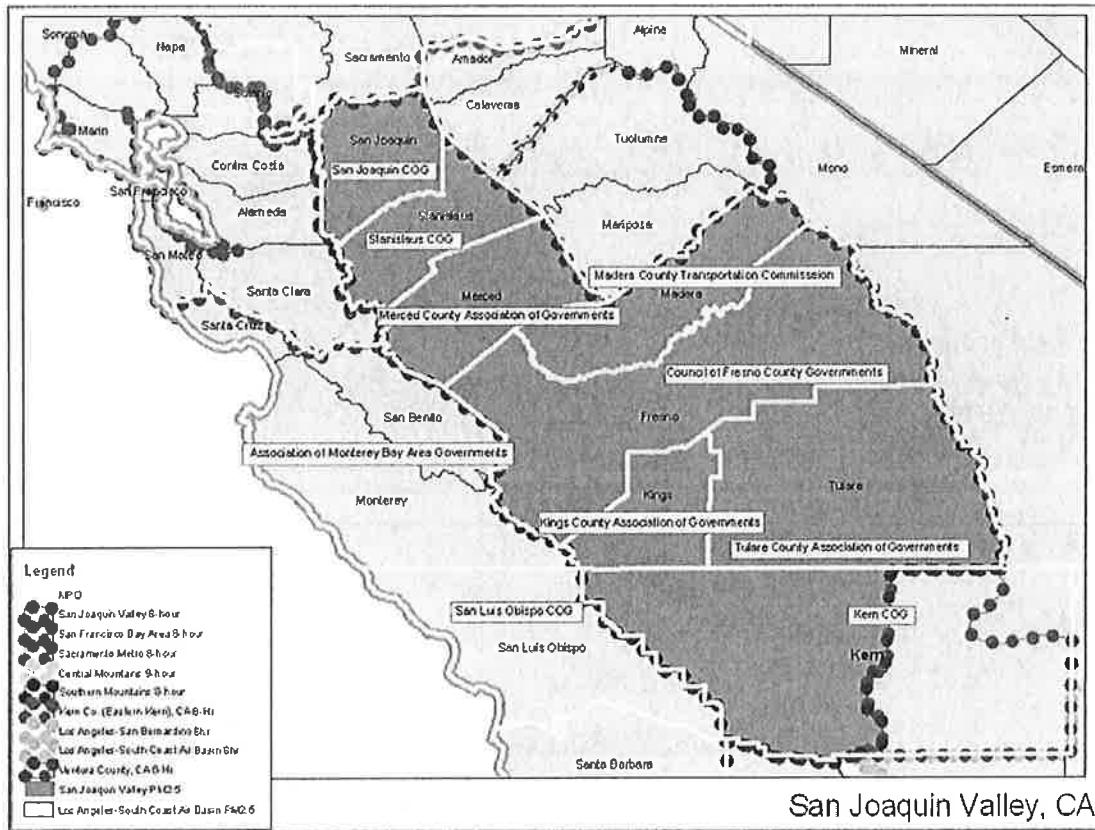
Building on Success. TOADS is based upon a successful model of delivery designed by Kings View TeleBehavioral Health which has demonstrated a successful implementation of telepsychiatry with its satellite or collocation sites throughout a defined service area. Telecare is effective due to its ability to offset the cost of service delivery and reduces the cost of access to rural sites. Because there are many isolated rural communities that are not served adequately by substance abuse providers, as a result of telecommunications equipment improvements over the past few years, especially Smartphone technology, enables telecare to be delivered more personally, right in the person's own hand, so to speak. By utilizing Smartphone's, it is possible for patients to have immediate access to an addiction counselor or other services, without having to wait to access other equipment. With Smartphone's, patients receive prompt, inexpensive and ongoing treatment, with cost-effective TOADS assures that each patient, regardless of location, can be served with telepsychiatry.

Geographic Location of TOADS Project

Headquarters: Fresno County

Telecare Project Main Office: Kings County

Secondary Locations: Madera and Tulare Counties:



Prepared by FJWA - HEPN-40

April 2005

Job Descriptions:**Position Title: Program Director**

Position Mission: Responsible for developing and managing the program.

Duties and Responsibilities:

1. Represent Promesa in the community by attending professional meetings with other community based organizations.
2. Work collaboratively with community agencies i.e. CPS, Mental Health, Probation, Parole, Juvenile Justice System, schools, etc.
3. Support staff by training, motivating, facilitating groups and creating a positive work environment that reflects the Promesa mission statement, with attention to Tele-Care.
4. Organize and coordinate work schedules, review and define human resources.
5. Direct supervision of over all staff.
6. Maintain program certification standards
7. Directly responsible for budget and program expenditures.
8. Maintain and review quality of professional standards of program curriculum and quality of services delivered to program consumers.
9. Actively pursuing Grants and the development of alternative funding.
10. Interviewing, hiring, reviewing employee development and termination

Education and Experience Qualifications:

1. Bachelors degree required, Masters' degree preferred;
2. Administrative experience and capabilities including budgeting; responsibilities and personal management;
3. Demonstrated knowledge of applicable state and federal regulations;
4. Two (2) years of experience supervising personnel;
5. One (1) year of experience managing program budget including preparing or directing the preparation of budgets and cost reports;
6. Certification in alcohol and drug counseling;

Position Title: Substance Abuse Counselor-direct services

Position Mission: Responsible for direct services in the program.

Duties and Responsibilities:

1. Represent Promesa in the community in a professional manner.
2. Work collaboratively with community agencies i.e. CPS, Mental Health, Probation, Parole, Juvenile Justice System, schools, etc.
3. Attend program sponsored training, demonstrate a positive attitude towards program consumers, incorporate motivational techniques in practice, and be creative and positive in the work environment.
4. Maintain consistent work schedule, maintain regular work attendance, demonstrates professional coordination skills with case loads.
5. Under the direct supervision of the Clinical Director.
6. Maintain program certification standards, model professional standards.
7. Facilitate groups and education classes in a professional, ethical manner
8. Maintain high quality standards of program curriculum and quality of services.
9. Knowledge of recovery principles and possess professional communication skills both verbally and in writing
10. Maintain files to include: documentation of progress, intake and assessment, treatment planning, discharge summaries
11. Initiate drug testing on an as needed basis
12. Complete weekly one to one visits with each client

Education and Experience Qualifications:

1. Associate of Science or Arts degree required (in human services, alcoholism counseling or psychology, Bachelors degree preferred;)
2. Must type at least 30 wpm, be computer literate
3. Demonstrated knowledge of clinical assessments;
4. A minimum of one (1) year of experience working in the addiction field. One year of experience means 1776 total hours of full or part-time, compensated or uncompensated, work experience;
5. Must provide written evidence of their qualifications;
6. Certification in alcohol and drug counseling or in the process of earning a certification from a state recognized certifying body;

Evidence Based Practices

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**D. Equipment: Telecare
Federal Request**

Item(s)	Rate	Cost
Laptop computers w/wireless remote	\$700/ea x 5	\$3,500
High Definition Cameras	10 x \$500/ea	3,000
Smartphones	30 x \$50	\$1,500
Software licenses	10 x \$1,000/ea	\$10,000
telecare equipment & Server	\$315,000	0
		\$18,000

Laptop computers with wireless remote capabilities will need to be installed at 5 host sites which do not have existing equipment to be dedicated to telecare project

10 high definition cameras for use in remote host sites (5 for active use and 5 for as backup replacements) for use in video teleconferencing between clients and addiction counseling staff

Smartphones, we anticipate that about 30 clients will not be in possession of internet enabled video capable wireless telephonic devices, nor have easy access to a telecare host site. For those clients, the project will provide a smartphone type communication device to enable these clients to participate in telecare treatment.

Software licenses to Anasazi , with staff training, to add capability to server to handle additional traffic to

The bridging equipment and server is already in place and several high definition cameras are already

CURRICULUM VITAE

NAME

Date and Place of Birth: Herbert A. Cruz, M.D.
09/15/56; City of New York
Current Title and Department: Psychiatrist
Address: 575 E. Locust Ave., Ste. 311, Fresno, CA 93720
Business Phone: (559) 696-7242

EDUCATION

07/86 – 06/89	U.C.S.F. -- Fresno Medical Education Program 2615 E. Clinton Ave. Fresno, CA 93726	General Psychiatry
05/85 – 05/86	St. Joseph Hospital 305 Kinsington Flint, MI 48503	Family Practice
09/81 – 06/85	Michigan State University College of Human Medicine East Lansing, MI 48825	M.D.
09/74 – 06/80	University of San Francisco 2130 Fulton Street San Francisco, CA 94902	B.S.-Biology

LICENSES, CERTIFICATIONS

California License: G057966; 07/28/96.

Board Certified: American Board of Psychiatry and Neurology 01/97 – 01/07; Recertified until 01/17
ABPN – Addiction Psychiatry; 04/97 – 04/07

09/06 – 06/97	Nevada State Board of Medical Examiners, License #7971
12/91 – Present	State of Washington, License #MD000292252 (unpaid since 1997)
06/86 – Present	State of California Medical Board, License #G057966
05/85 – 05/86	State of Michigan, Limited Educational License #005791 (inactive)
05/86 – Present	Drug Enforcement Administration Numbers in Good Standing

ACADEMIC APPOINTMENTS

01/00 – Present Assistant Clinical Professor, University of California, San Francisco

EMPLOYMENT

Current

06/09 - Present	WestCare 4944 E. Clinton Way Fresno, CA 93776 (559)251-4800	Chief of Medical Services Providing psychiatric and general medical direction to the corporation including substance abuse, general medical, and psychiatric domains. Provide supervision to Nurse Practitioners and Physician Assistants providing full-service medical and psychiatric care. Supervisor: Maurice Lee.
1996 - Present	Self Employed Consultant to various Group Homes for the treatment and management of chemically dependent, probation supervised, mentally ill, and/or sex offense perpetrating minors. Providing Suboxone detoxification and maintenance for Promesa, Inc. Letters upon request.	Consultant
05/02 – Present	Kings View Corporation, Telepsychiatry Program 575 E. Locust Ave., Ste. 311 Madera, CA 93720 (559) 256-0100 Provide direct service, program development, and supervision to telepsychiatry Service to Kings, Mariposa, Trinity, and Tulare Counties, and Far Northern Regional Center. Utilize both direct service and consultation model. Supervisor: Leon Hoover, CEO.	Head of Service
05/07 – 3/11	Fresno County Behavioral Health Selma Regional Center 3800 S. McCall Avenue Fresno, CA 93662 (559)453-6599 Providing direct services to adult consumers in a full-service County-contracted clinic. Area of focus is monolingual-Spanish and bilingual Latino clientele. Also work with the MHSA programs and supervise third year residents-in-training from U.C.S.F.-Fresno. Supervisor: Robert Ensom, M.D.	Contract Provider

Past

08/01 – 05/07	County of Tulare Health and Human Services Agency 5957 South Mooney Blvd. Visalia, CA 93277 (559) 737-4660, ext. 2578 Provide supervision to a staff of ten or more psychiatrists working in a full-service community mental health system of care in an integrated clinic setting consisting of five satellite clinics and three forensic sites. Supervisor: Cheryl Duerksen, Ph.D.	Mental Health Medical Director
08/02 – 07/03	Madera Counseling Center PO Box 1288 Madera, CA 93639 (559) 673-3508 Full range of community mental health services, including crisis, medication clinic, and ongoing therapy for a 15,000-visit-per-year CMH center. Supervisor: Orlando Collado, M.D.	Staff Psychiatrist
11/97-11/30	Fresno County Mental Health 4411 East Kings Canyon Fresno, CA 93702 (559) 453-4260 Provide medical and psychiatric leadership and consultation to the CMRT program, focusing on crisis intervention and dual diagnosis treatment. Supervisor: Frank Torrez, L.C.S.W. and Lawrence Levy, M.D.	Staff Psychiatrist
11/92 - 11/01	Kings View Residential Treatment Center 42675 Road 44 Reedley, CA 93654 (559) 638-2880 Medical management of 100-bed residential treatment center providing services to children and adolescent. CEO: Gerald Neufeld.	Medical Director
03/97 - 10/97	Valley Behavioral Health Network 7171 N. Cedar Fresno, CA 93710 (559) 638-2505 Provide full-time FTE of general and adolescent psychiatric services for a limited-partnership of Kings View, Cedar Vista, and Fresno Community Hospital. Board of Managers: Michael Waters, CEO.	Staff Psychiatrist
04/92 - 08/93	Cedar Vista Hospital, Front End Systems 7171 N. Cedar Fresno, CA 93711 (800) 338-8222 Provide medical clearance and crisis team back-up. Also, physician consultant for Utilization Review. Administrator, Lynn Horton.	Medical Director
11/91 - 08/93	Mental Health Services for Kings County 1393 Bailey Drive Hanford, CA 93230 (559) 582-4481 Full range of community mental health services, including crisis, medication clinic, and ongoing therapy for a 19,000-visit-per-year CMH center. Executive Director: Brenda Johnson-Hill.	Medical Director

03/90 - 01/91	Mental Health Services for Kings County 1393 Bailey Drive Hanford, CA 93230 (559) 582-4481 Full range of community mental health services, including crisis, medication clinic, and ongoing therapy. Executive Director: Brenda Johnson-Hill.	Director of Psychiatric Outreach Services
09/96 - 02/97	Atascadero State Hospital 10333 El Camino Real Atascadero, CA 93422 (805) 468-2005 Full-time staff psychiatrist for mentally ill inmates, particularly sexually violent predators. Acting Medical Director: David G. Saunders, M.D.	Staff Psychiatrist
08/94 - 08/96	Our Lady of Lourdes, Chemical Dependency Unit 520 N. Fourth Street Pasco, CA 99301 (509) 546-2378 One-third FTE providing full detoxification, inpatient, partial hospitalization, and relapse prevention programs in a general hospital setting with 22-bed capacity. Program Director: Colleen Dionne, CDC III.	Medical Director
04/95 - 08/96	Community Counseling Services of Adams County 165 N. First, Ste. 120 Othello, WA 99344 Full range of community mental health services, including crisis, medication clinic, and ongoing therapy for a rural community of approximately 143,000. Administrator: Kate Brueske.	Staff Psychiatrist
08/93 - 08/96	Nueva Esperanza Counseling Center 720 W. Court, #8 Pasco, WA 93301 (509) 545-6506 Full range of community mental health services, including crisis, medication clinic, and ongoing therapy for an 8,000-visit-per-year CMHC, most patients of whom are monolingual Hispanic. Executive Director: Guillermo Castaneda, M.A.	Medical Director
07/90 - 05/93	Performed as contractor of Sergio Ilic, M.D., Inc. (559) 265-5862 Workers' Compensation Cases. Reviewed and provided testimony for both plaintiffs and defendants.	Qualified Medical Examiner
07/90 - 08/93	County of Kings, California. 1393 Bailey Drive Hanford, CA 93230 (559) 582-4481 Performed evaluations as appointed to determine competency, sanity, and narcotic addiction. Letters from judges available.	Court-appointed Psychiatrist

12/90 - 12/91	Bridge Medical Group Performed geriatric consultations in accordance with O.B.R.A. and HCFA regulations.	Psychiatrist
07/90 - 12/91	Counties of Tulare, Fresno, and Madera. Perform evaluations as appointed to determine competency, sanity, and narcotic addiction.	Court-appointed Psychiatrist
08/90 - 01/92	California Comprehensive Alzheimer's Disease Center 1343 N. Wishon Ave. Fresno, CA 93728 (559) 233-3363. Performed psychiatric evaluations on individuals suspected of having Alzheimer's disease and made multi-disciplinary recommendations for care. Medical Director: David I. Margolin, M.D., Ph.D.	Chief Geropsychiatrist
09/89 - 07/91	County of Fresno. 4411 East Kings Canyon Fresno, CA 93702 (559) 453-4260	Medication Monitoring Physician
	Review 10 percent of all system-wide charts for completion and compliance with community standards and guidelines. Director: Donna Wigand, L.C.S.W.	
07/89 - 02/90	Valley Medical Center 445 S. Cedar Fresno, CA 93702 (559) 453-5124 Director community liaison, resident instructor and supervisor for a 2,600-visit-per-year psychiatric emergency room, which services Fresno County. Medical Director: Scott Ahles, M.D.	Director, Emergency Psychiatry Services
02/88 - 06/89	Tower Psychosocial Medical Clinic 1505 N. Wishon Ave. Fresno, CA 93704 (559) 268-8300 Outpatient psychiatric services with ongoing psychotherapy and psychopharmacology, primarily with monolingual Hispanic patients. Medical Director: Francisco Montalvo, M.D.	Psychiatrist
08/87 - 06/89	Every Day Health Care, Fresno, CA. Full service urgent care facility.	Physician
10/86 - 09/90	Family Walk-In Centers, Fresno, CA. Full service urgent care facility.	Physician

HONORS and AWARDS

06/87 – 07/89	Chief Resident, UCSF/Fresno Psychiatric Residency
1988	Awarded Rappaport Fellowship from the American Academy of Psychiatry and the Law
1988	Awarded Central California Psychiatric Society Outstanding Resident Award
1989	Outstanding Neurology Resident Certificate of Achievement
1989	Morton P. Weinstein Memorial Award for Outstanding Senior Resident

PROFESSIONAL ACTIVITIES

Membership in Professional Organizations

1993 to 1996	Benton-Franklin Medical Society
1992 to Present	California Medical Association
1988 to Present	Central California Psychiatric Association
	Fresno-Madera Medical Society
1985 to Present	American Medical Association
	(1988 Region V Councillor of the Medical House Officer Section)

RESEARCH SUPPORT

1999 Research Grant SB-29060/651, "Posttraumatic Stress Disorder." Total funds: \$16,880.
 Principal investigator: H. A. Cruz, M.D.

PUBLICATIONS

Presentation - Keynote Speaker on "*Ethnopsychopharmacology*" and "*Culturally Relevant Family Assessments*", Nuestra Cultura en La Comunidad: Hispanic Child Welfare Issues Conference sponsored by Region 2 of the Children's Administration, Service Alternatives for the State of Washington, June 19, 2002

Presentation - "*Switching Strategies for Atypical Antipsychotics*", Georgetown University Psychiatric Residents Grand Rounds on August 15, 2002

Presentation - "*Ethnopsychopharmacology*," Massachusetts General Hospital, Department of Psychiatry, Ground Rounds on March 22, 2001.

Publication - Leigh H, Cruz HA, Mallios R. Telepsychiatry appointments in a continuing care setting: kept, cancelled and no-shows. *Journal of Telemedicine and Telecare* 2009; 15:286-9

Publication - "*Detecting Early Signs of Depression in Adolescents*," California Speech-Language-Hearing Association Magazine, Vol., 20, No. 2, September 2002.

Publication – “*Street Gangs in the Tri-Cities*,” H.A. Cruz, M.D., and Mel J. Borbolla (pamphlet available for review).

Publication – “*A Truth Is Often Not A Truth When It Crosses Cultural Boundaries ...*,” The Journal of The California Alliance for the Mentally Ill, Vol., 10, No. 1, March 1999.

Poster Session – “*Effectiveness of Quetiapine in Patients with Dual Diagnosis*,” The American Psychiatric Association, IPS meeting in Orlando, Florida, October 12, 2001, and the National Organization of Correctional Psychiatrists in Albuquerque, New Mexico, November 3, 2001.

Publication pending – “*Sleep Disturbances in Medication-Free Psychiatric Inpatients: A Comparison of Depression and Schizophrenia*,” CruzHA, YoungclarkeDM, WilkinsE, DruckerAJ, BodarenkoSR, PickJ, and AdamsR. Submitted to the American Journal of Clinical Psychopharmacology.

Resume/Program Director

Ricardo Vásquez
1623 N. Encina Street
Visalia, CA.93291
559-732-2559 Home
559-730-1634
rvasquez@genesiskids.org

PROFILE

Background in heading a behavioral health agency providing substance abuse services to at-risk and hard-to-reach populations, community counseling services, anger management and violence prevention services, mental health counseling, transitional housing, and family services. Initiated and developed program that would work with families and heads of families to reduce gang-involvement, substance abuse and family violence. Skilled in supervision of para-professional and professional staff, expansion of programs, program development, timely funding and fiscal reports and extensive knowledge and expertise in the field of substance abuse and family treatment.

WORK HISTORY

Feb 2008 – currently **Director Substance Abuse Services**
Promesa Behavioral Health, Inc.
7475 N. Palm Ave
Fresno, CA.

Supervision of Outpatient Program
Coordination of Dual-Diagnosis services
Program Development

Nov 2000 – Oct. 2007 **Executive Director**
Primer Paso Institute, Inc.
310 N. Church St
Visalia, CA.

- Preparation and negotiation of county contracts
- Program Development

- Expanded programs
- Increased operating budget

Jan 1989 - Sep 1992 **Program Counselor**
Samaritan Village
Jamaica, NY

- Established outpatient component
- Worked with re-entry clients
- Familiarity with multiple treatment approaches

May 1983 - Nov 1988 **Resident Counselor**
Riverside House Inc.
Port Jervis, NY

- Supervisor of residential clients
- Maintained facility infrastructure
- Responsible for kitchen personnel and food budget

May 1976 - Dec 1979 **Counselor**
Watsonville Drug Abuse Council, Inc.
Watsonville, CA.

- Day Treatment of residential clients
- Incorporated children into treatment
- Acquired funds from United Way to create child-care program

EDUCATION

Jan 2006 – Present **California State University Fresno**
(Expected Comp. 2009)**Fresno, CA.**

MSW program

Sep 1999 - May 2003 **California State University Fresno**
Fresno, CA

GPA: 3.2
B.A. Philosophy-Religious Studies

Jan 1995 - May 1999 **College Of the Redwoods**
Eureka CA.

GPA: 3.4
Associate Degree Biology

Mar 1969 - Jul 1973 **University Of California**
Berkeley, CA

GPA: 3.0
B.A. Comparative Literature

SKILLS

- Speak fluent Spanish
- Strong negotiation and interpersonal skills
- certified substance abuse clinician
- Good writing skills
- Have both macro and micro managerial skills

JOHN KASDORF

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jkasdorf@telecaretechnologies.com

Objective:

As a dedicated, skilled professional in the field of technology I'm seeking an opportunity that will allow me to use my commerce building skills while providing resolution to technological challenges and produce new revenue streams that will have a lasting, positive social and economical impact.

Qualifications:

- Engineered and put into operation a California healthcare facility's technology infrastructure with 30+ plus locations; new core switching infrastructure, Telemedicine and Telepsychiatry video infrastructure and healthcare application services hardware infrastructure;
- Successfully organized, co-wrote and was awarded near one million dollars that funded a new Telepsychiatry/ Telemedicine, high definition technology infrastructure that can extent to national and international regions to deliver psychiatric and medical services;
- Negotiate and finalize contracts for data and video transport circuits, standardized core network with optical, Ethernet and multiservice carrier equipment for secure on and off-net , video conferencing, and electronic patient health information data delivery services;
- Designed and implemented a HIPAA compliant data center's environmental controls and network cabling, power, HID badge and Essex alarm security access with thermo and sound security system and FM200 fire retardant dry system;
- Designed, put into practice and direct the technology for Telepsychiatry and Telemedicine network that now serves rural areas throughout the state of California utilizing board certified medical doctors and psychiatric services;
- Awarded the new Central California telehealthcare network, supporting Radiology, Pain Management, Dermatology, Oncology and Mental Health services and lead technology consultant and designer for California e-health initiative project;
- Successfully achieved close to a million dollars in federal and state subsidies that pay recurring monthly costs of long haul circuits for healthcare video and data delivery; and
- Founded a telehealthcare technology company that specializes in high definition Telepsychiatry and Telemedicine video technology services and infrastructures that incorporate hand off/ lead in services such as medical professional services and medical consultation.

Work Experience:

Telecare Technologies, LLC

Founder, Telehealth Technology Architect, Dec 2007 to Present

- Co-develop new business plans in concert with medical directors and head of services for future Telehealth business ventures;
- Design and implement secure medical grade, high definition video network infrastructures that span metro, national and international locations;
- Design and implement secure switching network infrastructures that span metro, national and international locations;
- Technology developer and implementer for mobile healthcare trucks that service extreme rural locations that utilize telehealth technologies;
- Direct and manage the relationship with external development companies;
- Recruit, build and train IT team to self-sufficiency and increased knowledge base through on site experience and study materials;
- Direct, manage, plan and roll out of new implementations, policies and procedures; and
- Entrepreneurial and visionary ideas for new arms of business that heavily utilize telecare/telehealth technologies.

Kings View Corporation, Fresno, CA

Chief of Network Security, Director of Information Technology, March 2001 to Present

- Direct the management of the network operations center's day to day procedures;
- Oversee and direct the technology and network of 30+ healthcare facilities throughout California and contracts that incorporates Telepsychiatry technology services to hospitals and prison systems;
- Technology developer and implementer for mobile healthcare trucks that service extreme rural locations that utilize telecare technologies;
- Strategic technology research and design for telemedicine and Telepsychiatry;
- Technical development and execution of the Telepsychiatry and telemedicine technology services;
- Recruit, build and train IT team to self-sufficiency and increased knowledge base through on site experience and study materials;

- Internal development and design of healthcare application service provider (ASP) hardware foundation that is responsible for over twenty plus million dollars in Medi-Cal billing annually;
- Direct and manage the relationship with external development companies;
- Design, implement and manage all email, security, VoIP, video, data warehousing, thin client, application and switching infrastructures;
- Direct, manage, plan and roll out of new implementations, policies and procedures, corporate-wide, involving technology; and
- Entrepreneurial and visionary ideas for new arms of business that heavily utilize telecare technologies.

Nortel Networks, Worldwide

Senior Specialist, Systems Engineer; July 2000 to April 2001

- Lead for Cornerstone Cable Media Termination System - CMTS (High-Speed Video, Data and Voice Services) for the Western Region United States for large cable companies, Comcast, AT&T;
- Secondary lead for Succession (Next-Generation Packet Networks) for the Western Region United States; and
- Co-developed Carrier Passport (ATM, Frame Relay Multi-Service Switch) training courses for incoming field engineers.

Mind Information Systems (MIS), Visalia, CA

Senior Network Systems Engineer; June 1999 to June 2000

- Network infrastructure planning for large clients over 10000+ users;
- Infrastructure wire design and management;
- Designed and installed large wireless data networks spanning metro and statewide networks;
- Designed high speed access networks for leading regional ISP; and
- Implemented and trained on DWDM, SONet, future MPLS, Frame Relay, Point-to-Point circuits and xDSL core network systems.



Federal Emergency Management Agency (FEMA)

Network Ops Division, Washington D.C.; Pacific Region IX Headquarters, San Francisco, CA

DAE Agent; Network Specialist II, Hardware Specialist II, Software Specialist II: April 98 to June 99 (Inactive)

- Network administration support for western United States;
- Emergency disaster site network build and turn up;
- Disaster site local hand off training of technology triage network for emergency funding support;
- Lead support engineer; and
- Top Level Security Access Support Team; federal funding access.

GE Capital Information Technology Solutions (GECITS), Tulare, CA, Gaithersburg, MD

Global Systems Integration Engineer; July 1997 to May 1999

- Team lead for large customers that required national and global integration; Baan Software Corporation, Wells Fargo Bank, California State Lottery, Drake Engineering (Germany), GE Capital (Ireland), National Healthcare Organization, Cisco Networks;
- Performed quality control functions over projects before releasing to large clients;
- Systems administration of both network and phone systems; and
- Consulted on a multi-layer network project for National Health Care and Retirement Corporation.

E d u c a t i o n:

AIU University, Chicago, IL

- Master's of Information Technology Program, (Enrolling)

Heald College at Fresno, CA

- Awarded the Distinguished Graduate Award 2003
- A.A.S. in Electronics & Computer Technology, Fall 1996
- A.A.S. in Networking Technology, Summer of 1999

College of the Sequoias at Visalia, CA

- A.S. in Industrial Technology and Architecture, Summer 1992

Certifications & Special Training:

Nortel Networks Curriculum:

Certified Account Specialist NNCAS
Certified Support Specialist NNCSS

Other Certifications Held:

A+ Certification
Microsoft Certified Systems Engineer
Microsoft Certified Professional

Nortel Networks - Experience:

Passport (Multiservice Aggregation Switch)
Multi-service edge and core switching
Multi-service edge and core switching for ATM, Frame Relay, IP Video and Voice

Carrier IP

ATM, Frame Relay IP Customer to Carrier Virtual Routing

Large Cellular and ISP

Firewall, NAT, Subscriber Management and Services, (Universal Aggregation of DSL, Wireless, Cable, Internet Protocol)

Cindy M. Gonzales
544 N. Beatrice Dr.
Tulare, CA 93274
cindymgonzales@comcast.net
559.972-0464

OBJECTIVE:

To create, administer, and expand Suboxone/Telehealth services in the Central Valley while concurrently building a sustainable, profitable, and operational clinical model for future clinics nationwide.

QUALIFICATIONS:

- Assist Head of Medical Services and Executive Director in start-up and operation of Suboxone program;
- Work closely with Suboxone manufacturer Clinical Liaison in implementing program protocol;
- Obtain Drug Enforcement Administration (DEA) certification for current physician to prescribe/dispense Suboxone;
- Lead in reviews/audits by State of California Alcohol and Drug Program Division, Drug Enforcement Administration (DEA), Commission on Accreditation and Rehabilitation Facilities (CARF), and County of Tulare Health and Human Services Agency Alcohol and Drug Division

WORK EXPERIENCE:

Kings View Corporation – Kings View Substance Abuse Program – Tulare County – Tulare, CA

Methadone and Suboxone Treatment Facility

Clinic Operations Manager – 1990 to Present

Duties and Responsibilities:

Administrator:

- Work closely with, and assist the Head of Medical Services and Executive Director;
- Administratively responsible for the program as delegated by the Head of Medical Services and Executive Director.
- Carry out assignments related to program planning, implementation, and evaluation; and
- Responsible for day-to-day administrative operations, budget preparation and monitoring, fiscal and program statistical data systems, developing and ensuring compliance of contracts and agreements, licensure and insurance policies, developing and maintaining a viable public relations program including a close working relationship with relevant county boards and staff, and supervision of personnel functions, clinical records, and maintenance of physical facilities and equipment.

Operations Manager:

- Responsible for the management and supervision of two or more kinds of program service in one service area;
- Provide leadership and coordination of activities and develops and manages program activities of the service area consistent with the program needs of the people served;
- Responsible for the appropriate allocation of program resources;
- Provide direct services as required;
- Recruitment, hiring, and training of new employees should program need arise for additional staff;
- Knowledge of a major spreadsheet program and an understanding of accounting practices;
- With a high level of independence, performs difficult and specialized administrative or clinical records supervisory duties requiring care, quality control, accuracy in detail, demonstrated organizational and leadership skills and initiative;

- Responsibility of the position may be general administrative or clinical records supervision; supervises staff and coordinate functions of area assigned;
- Responsible for clinical records. Execute working knowledge of medical/psychiatric terminology, principles and practices, and diagnoses coding procedures;
- Provide administrative support to Head of Medical Services;
- Maintain administrative files and contract files;
- Perform administrative functions; such as scheduling and coordinating meetings as directed;

Program Technician:

- Under general supervision, assist in the service delivery program to clients;
- Provide proficiency in the service delivery program through experience and knowledge of therapeutic clinical treatment. Demonstrate initiative and leadership in developing and maintaining the service delivery program under his/her responsibilities;
- Supervise other staff; and
- Function independently at a high level of responsibility in areas such as emergency services and/or functions, consultation, education, and information.

Clinical technology oversight support and professional services support

- Assist with implementation of HIPAA compliance>Title 42 standards;
- Provide a clinical link between support services, clinical services, and technology support staff;
- Assist with adherence to existing guidelines and laws governing the interface between technology systems and clinical services; and
- Assist with converting to an e-Prescribing system as mandated by Federal Law

EDUCATION:

Corcoran High School – Corcoran, CA – 1973 to 1976 - Graduated

General Studies

College of the Sequoias – Visalia, CA – 1976 to 1977

Liberal Arts

College of the Sequoias – Visalia, CA – 2005 to 2008

Criminal Justice

TRAINING:

Workshops and trainings over a period of 20 years in topics such as, but not limited to:

- Round Table Discussion re: Suboxone presented by Suboxone treatment advocate;
- Training program for best practices in Suboxone-Here To Help Program;
- Suboxone Guidelines for Maintaining Compliance with Recordkeeping;
- Methadone Treatment Procedures;
- Urinalysis Procedures;
- Assessments and Treatment Plans;
- CARF Training;
- Corporate Compliance;
- Code of Conduct;
- HIPAA and Confidentiality;
- Methadone Induction;
- Emergency Medical Procedures;
- Achieving Adequate Methadone Dosing in the Treatment of Opioid Addiction;
- Methadone Dosing Safely;
- Outcomes in Alcohol and Drug Treatment;
- Ethics and Stress Management



Department of Behavioral Health
Donna Taylor, RN, Mental Health Director

Providing Quality Mental Health and Substance Abuse Services for the People of Fresno County

May 31, 2011

To Whom It May Concern:

This letter is to convey our strong support of Promesa Behavioral Health in their application for **Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted areas of Need** to expand services to traditionally underserved populations because of lack of access, transportation issues and financial constraints for providers to have a presence in the remote areas of rural Fresno County.

The **Project** will benefit from the highly structured, seamless care that Promesa incorporates into all of its programs. Clients will receive these services in a familiar linguistic and cultural milieu, incorporating naturally occurring social support systems, such as the family, indigenous healers, elders, or other community members who are respected and trusted. Promesa's experience and position in the community affords consumers the needed connections to a vast array of resources to augment the strengths they already possess as a first step to recovery and arresting of the illness of substance use disorders. Moreover, with their multilingual (Spanish, English, Hmong, etc.) professional staff and highly qualified evaluation team, program fidelity is insured.

Promesa Behavioral Health is best-equipped to provide these services given its long-standing commitment in providing services to rural and isolated populations.

Sincerely,

Dennis P. Koch, MPA
Deputy Alcohol and Drug Program Administrator

515 S. Cedar Ave. / Fresno, California 93702

(559) 600-6053 ♦ FAX (559) 600-6089

Equal Employment Opportunity ♦ Affirmative Action ♦ Disabled Employer
www.co.fresno.ca.us ♦ www.fresno.networkofcare.org



Youth Centers of America Parlier Youth Center

580 Tulare Street * Parlier * CA * 93648 * 559-646-3837 * Fax: 559-646-9627

June 3, 2011

This letter is to convey our strong support of Promesa Behavioral Health in their application for **Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted areas of Need** to expand services to traditionally underserved populations because of lack of access, transportation issues and financial constraints for providers to have a presence in the remote areas of rural Fresno County.

The strength and versatility of Promesa Behavioral Health is clearly evidenced in their proposal. The Project will benefit from the highly structured, seamless care that Promesa incorporates into all of its programs. Clients will receive these services in a familiar linguistic and cultural milieu, incorporating naturally occurring social support systems, such as the family, indigenous healers, elders, or other community members who are respected and trusted. Promesa's experience and position in the community affords consumers the needed connections to a vast array of resources to augment the strengths they already possess as a first step to recovery and arresting of the illness of substance use disorders. Moreover, with their multilingual (Spanish, English, Hmong, etc.) professional staff and highly qualified evaluation team, program fidelity is insured.

Promesa Behavioral Health is the best-equipped agency to provide these services given its long-standing commitment in providing services to rural and isolated populations. We are fully committed to supporting Promesa in their endeavor to apply for this project.

Sincerely,



Israel Lara Jr.

Board President of the Youth Centers of America



Youth Centers of America Parlier Youth Center

580 Tulare Street * Parlier * CA * 93648 * 559-646-3837 * Fax: 559-646-9627

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Sincerely,

Israel Lara Jr.

Board President of the Youth Centers of America

Mendota Unified School District

115 McCabe Avenue • Mendota, Ca 93640 • (559) 655-4942 • (559) 655-4944

Rosemary A. Ramirez • Raul S. Varela • Lupe Flores • Diana Toscano
Araceli Perez • Isobel Maldonado • Sergio Valdez

Gilbert Rossette, Superintendent



January 31, 2011

California Department of Alcohol and Drug Programs
Licensing and Certification Division
1700 N. K Street
Sacramento, California

In my capacity as Superintendent of Mendota Unified School District I attest to the school meeting all safety and fire regulations.

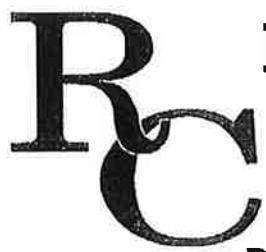
Additionally I have authorized for the provision of substance abuse services at the school by Promesa Behavioral Health.

Sincerely,

A handwritten signature in black ink that reads "Gilbert B. Rossette".

Gilbert B. Rossette
District Superintendent
Mendota Unified School District

"Building Scholars, Leaders and Champions"



Raisin City School

6425 W. Bowles/P.O. Box 69

Raisin City, CA 93652

Phone: 559-233-0128 FAX: 559-486-0891



BOARD of TRUSTEES

Nancy Schwabenland
Kathy Martin
Vangie Urias
Lorena Alvarado
Rafael Morfin

ADMINISTRATION

Juan R. Sandoval
Superintendent

January 27, 2011

California Department of Alcohol and Drug Programs

Licensing and Certification Division

1700 N. K Street

Sacramento, California

In my capacity as Superintendent of Raisin City School I attest to the school meeting all safety and fire regulations.

Additionally I have authorized for the provision of substance abuse services at the school by Promesa Behavioral Health.

Sincerely,

Juan R. Sandoval

Superintendent

Raisin City School



Department of the Treasury
Internal Revenue Service
P.O. Box 2508, Room 4010
Cincinnati OH 45201

In reply refer to: 4077550286
Oct. 02, 2009 LTR 4168C 0
77-0174896 000000 00
00028101
BODC: TE

PROMESA BEHAVIORAL HEALTH
7475 N PALM AVE STE 107
FRESNO CA 93711-5763



21745

Employer Identification Number: 77-0174896
Person to Contact: Vaida Singleton
Toll Free Telephone Number: 1-877-829-5500

Dear Taxpayer:

This is in response to your request of Sep. 16, 2009, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in March 1988, that recognized you as exempt from Federal income tax, and discloses that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section(s) 509(a)(1) and 170(b)(1)(A)(vi).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your 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.

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

Sincerely yours,

Cindy Westcott
Manager, EO Determinations

A 0694299

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

JUL 28 2009

CERTIFICATE OF AMENDMENT
OF
ARTICLES OF INCORPORATION
OF
GENESIS FAMILY CENTER
A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION

The undersigned certify that:

1. They are the President and Secretary, respectively, of GENESIS FAMILY CENTER, a California nonprofit public benefit corporation.
2. Article I of the Articles of Incorporation is hereby amended to read as follows:

"I

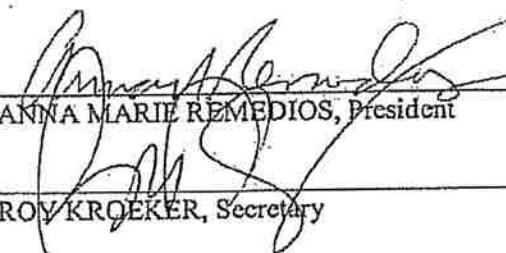
The name of the corporation is PROMESA BEHAVIORAL HEALTH."

3. The foregoing amendment of Articles of Incorporation has been duly approved by the Board of Directors.

4. The corporation has no members.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

Dated: July 24, 2009.


ANNA MARIE REMEDIOS, President

ROY KROEKER, Secretary



A 0694299



JM

State of California
Secretary of State

I, DEBRA BOWEN, Secretary of State of the State of California, hereby certify:

That the attached transcript of 1 page(s) has been compared with the record on file in this office, of which it purports to be a copy, and that it is full, true and correct.



IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of

JUL 31 2009

DEBRA BOWEN
Secretary of State

INSTRUCTIONS

1. Leave No Blanks - Where appropriate code items:
X = question not answered
N = question not applicable
Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments

ADDICTION SEVERITY INDEX**SEVERITY RATINGS**

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. Note: These severity ratings are optional.

Fifth Edition/1998 Version**SUMMARY OF
PATIENTS RATING SCALE**

- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

G1. I.D. NUMBER

--	--	--

G2. LAST 4 DIGITS OF SSN

--	--	--

G3. PROGRAM NUMBER

--	--	--

**G4. DATE OF
ADMISSION**

--	--	--	--	--

**G5. DATE OF
INTERVIEW**

--	--	--	--	--

G6. TIME BEGUN

		:		
--	--	---	--	--

G7. TIME ENDED

		:		
--	--	---	--	--

G8. CLASS:

- 1 - Intake
- 2 - Follow-up

--

G9. CONTACT CODE:

- 1 - In Person
- 2 - Phone

--

G10. GENDER:

- 1 - Male
- 2 - Female

--

**G11. INTERVIEWER
CODE NUMBER**

--	--

G12. SPECIAL:

- 1 - Patient terminated
- 2 - Patient refused
- 3 - Patient unable to respond

--

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

G13. GEOGRAPHIC CODE

--	--

G14. How long have you
lived at this address? _____
YRS. MOS.G15 Is this residence owned by you
or your family?

0 - No 1 - Yes

G16. DATE OF
BIRTH _____G17. RACE

- 1 - White (Not of Hispanic Origin)
- 2 - Black (Not of Hispanic Origin)
- 3 - American Indian
- 4 - Alaskan Native
- 5 - Asian or Pacific Islander
- 6 - Hispanic - Mexican
- 7 - Hispanic - Puerto Rican
- 8 - Hispanic - Cuban
- 9 - Other Hispanic

G18. RELIGIOUS PREFERENCE

- 1 - Protestant 4 - Islamic
- 2 - Catholic 5 - Other
- 3 - Jewish 6 - None

G19 Have you been in a controlled
environment in the past 30 days?

- 1 - No
- 2 - Jail
- 3 - Alcohol or Drug Treatment
- 4 - Medical Treatment
- 5 - Psychiatric Treatment
- 6 - Other _____

G20 How many days? _____**ADDITIONAL TEST RESULTS**G21. Shipley C.Q. _____G22. Shipley I.Q. _____G23. Beck Total Score _____G24. SCL-90 Total _____G25. MAST _____G26. _____ _____G27. _____ _____G28. _____ _____**SEVERITY PROFILE**

9									
8									
7									
6									
5									
4									
3									
2									
1									
0									
PROBLEMS	MEDICAL	EMPSUP	ALCOHOL	DRUG	LEGAL	PAMSOC	PSYCH		

MEDICAL STATUS

* M1. How many times in your life have you been hospitalized for medical problems? (Include o.d.'s, d.t.'s, exclude detox.)	<input type="text"/> <input type="text"/>	M5. Do you receive a pension for a physical disability? (Exclude psychiatric disability.)	<input type="checkbox"/>	M8. How important to you now is treatment for these medical problems?	<input type="checkbox"/>
		0 - No 1 - Yes _____	Specify		
M2. How long ago was your last hospitalization for a physical problem	<input type="text"/> YRS. <input type="text"/> MOS.	M6. How many days have you experienced medical problems in the past 30?	<input type="text"/> <input type="text"/>	INTERVIEWER SEVERITY RATING	
M3. Do you have any chronic medical problems which continue to interfere with your life?	<input type="checkbox"/>	FOR QUESTIONS M7 & M8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE		M9. How would you rate the patient's need for medical treatment?	<input type="checkbox"/>
0 - No 1 - Yes _____	Specify	M7. How troubled or bothered have you been by these medical problems in the past 30 days?	<input type="checkbox"/>	CONFIDENCE RATINGS	
M4. Are you taking any prescribed medication on a regular basis for a physical problem?	<input type="checkbox"/>	Comments	<input type="checkbox"/>	Is the above information significantly distorted by:	
0 - No 1 - Yes				M10. Patient's misrepresentation? 0 - No 1 - Yes	<input type="checkbox"/>
				M11. Patient's inability to understand? 0 - No 1 - Yes	<input type="checkbox"/>

EMPLOYMENT/SUPPORT STATUS

* E1. Education completed (GED = 12 years)	<input type="text"/> YRS. <input type="text"/> MOS.	E10. Usual employment pattern, past 3 years. 1 - full time (40 hrs/wk) 2 - part time (reg. hrs) 3 - part time (irreg., daywork) 4 - student 5 - service 6 - retired/disability 7 - unemployed 8 - in controlled environment	<input type="checkbox"/>	E18. How many people depend on you for the majority of their food, shelter, etc.?	<input type="checkbox"/>
* E2. Training or technical education completed	<input type="text"/> MOS.			E19. How many days have you experienced employment problems in the past 30?	<input type="text"/> <input type="text"/>
E3. Do you have a profession, trade or skill? 0 - No 1 - Yes _____	Specify	E11. How many days were you paid for working in the past 30? (include "under the table" work.)	<input type="text"/> <input type="text"/>	FOR QUESTIONS E20 & E21 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE	
E4. Do you have a valid driver's license? 0 - No 1 - Yes	<input type="checkbox"/>	How much money did you receive from the following sources in the past 30 days?		E20. How troubled or bothered have you been by these employment problems in the past 30 days?	<input type="checkbox"/>
E5. Do you have an automobile available for use? (Answer No if no valid driver's license.) 0 - No 1 - Yes	<input type="checkbox"/>	E12. Employment (net income)	<input type="text"/> <input type="text"/> <input type="text"/>	E21. How important to you now is counseling for these employment problems?	<input type="checkbox"/>
E6. How long was your longest full-time job?	<input type="text"/> YRS. <input type="text"/> MOS.	E13. Unemployment compensation	<input type="text"/> <input type="text"/> <input type="text"/>	INTERVIEWER SEVERITY RATING	
* E7. Usual (or last) occupation. (Specify in detail)	<input type="checkbox"/>	E14. DPA	<input type="text"/> <input type="text"/> <input type="text"/>	E22. How would you rate the patient's need for employment counseling?	<input type="checkbox"/>
E8. Does someone contribute to your support in any way? 0 - No 1 - Yes	<input type="checkbox"/>	E15. Pension, benefits or social security	<input type="text"/> <input type="text"/> <input type="text"/>	CONFIDENCE RATINGS	
E9. (ONLY IF ITEM E8 IS YES) Does this constitute the majority of your support? 0 - No 1 - Yes	<input type="checkbox"/>	E16. Mate, family or friends (Money for personal expenses). E17. Illegal	<input type="text"/> <input type="text"/> <input type="text"/>	Is the above information significantly distorted by:	
		Comments		E23. Patient's misrepresentation? 0 - No 1 - Yes	<input type="checkbox"/>
				E24. Patient's inability to understand? 0 - No 1 - Yes	<input type="checkbox"/>

--	--	--

PAST 30 LIFETIME USE
Days Yrs. Rt of
adm.

D1	Alcohol - Any use at all	<input type="text"/>	<input type="text"/>	<input type="text"/>
D2	Alcohol - To Intoxication	<input type="text"/>	<input type="text"/>	<input type="text"/>
D3	Heroin	<input type="text"/>	<input type="text"/>	<input type="text"/>
D4	Methadone	<input type="text"/>	<input type="text"/>	<input type="text"/>
D5	Other opiates/ analgesics	<input type="text"/>	<input type="text"/>	<input type="text"/>
D6	Barbiturates	<input type="text"/>	<input type="text"/>	<input type="text"/>
D7	Other sed/ hyp/tranq.	<input type="text"/>	<input type="text"/>	<input type="text"/>
D8	Cocaine	<input type="text"/>	<input type="text"/>	<input type="text"/>
D9	Amphetamines	<input type="text"/>	<input type="text"/>	<input type="text"/>
D10	Cannabis	<input type="text"/>	<input type="text"/>	<input type="text"/>
D11	Hallucinogens	<input type="text"/>	<input type="text"/>	<input type="text"/>
D12	Inhalants	<input type="text"/>	<input type="text"/>	<input type="text"/>

D13 More than one substance per day (Incl. alcohol).

Note: See manual for representative examples for each drug class

* Route of Administration: 1 = Oral, 2 = Nasal
3 = Smoking, 4 = Non IV inj., 5 = IV inj.

DRUG/ALCOHOL USE

D14 Which substance is the major problem? Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient.

D15. How long was your last period of voluntary abstinence from this major substance? (00 - never abstinent)
MOS.

D16. How many months ago did this abstinence end? (00 - still abstinent)

How many times have you:

- * D17 Had alcohol d.t.'s
- * D18 Overdosed on drugs

How many times in your life have you been treated for:

- * D19 Alcohol Abuse:
- * D20 Drug Abuse:

How many of these were detox only?

- * D21 Alcohol
- * D22 Drug

How much would you say you spent during the past 30 days on:

- D23 Alcohol
- D24 Drugs

Comments

D25 How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (Include NA, AA).

How many days in the past 30 have you experienced:

- D26 Alcohol Problems
- D27 Drug Problems

FOR QUESTIONS D28-D31 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

- D28 Alcohol Problems
- D29 Drug Problems

How important to you now is treatment for these:

- D30 Alcohol Problems
- D31 Drug Problems

INTERVIEWER SEVERITY RATING

How would you rate the patient's need for treatment for:

- D32 Alcohol Abuse
- D33 Drug Abuse

CONFIDENCE RATINGS

Is the above information significantly distorted by:

- D34 Patient's misrepresentation?
0 - No 1 - Yes
- D35 Patient's inability to understand?
0 - No 1 - Yes

--	--	--

L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.)

0 - No 1 - Yes

L2. Are you on probation or parole?

0 - No 1 - Yes

How many times in your life have you been arrested and charged with the following:

* L3 - shoplifting/vandalism

* L4 - parole/probation violations

* L5 - drug charges

* L6 - forgery

* L7 - weapons offense

* L8 - burglary, larceny, B & E

* L9 - robbery

* L10 - assault

* L11 - arson

* L12 - rape

* L13 - homicide, manslaughter

* L14 - prostitution

* L15 - contempt of court

* L16 - other

LEGAL STATUS

* L17 How many of these charges resulted in convictions?

--	--

How many times in your life have you been charged with the following:

* L18 Disorderly conduct, vagrancy, public intoxication

--	--

* L19 Driving while intoxicated

--	--

* L20 Major driving violations (reckless driving, speeding, no license, etc.)

--	--

* L21 How many months were you incarcerated in your life?

--	--

 MOS.

L22. How long was your last incarceration?

--	--

 MOS.

L23. What was it for?
*(Use code 3-16, 18-20.
If multiple charges, code most severe)*

--	--

L24. Are you presently awaiting charges, trial or sentence?

--

0 - No 1 - Yes

L25. What for? *(If multiple charges,
use most severe)*

--	--

L26. How many days in the past 30 were you detained or incarcerated?

--	--

L27 How many days in the past 30 have you engaged in illegal activities for profit?

--	--

FOR QUESTIONS L28 & L29 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

L28 How serious do you feel your present legal problems are?
(Exclude civil problems)

--

L29 How important to you now is counseling or referral for these legal problems?

--

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient's need for legal services or counseling?

--

CONFIDENCE RATINGS

Is the above information significantly distorted by:

L31 Patient's misrepresentation?
0 - No 1 - Yes

--

L32 Patient's inability to understand?
0 - No 1 - Yes

--

Comments

--	--	--

F1 Marital Status

- 1 - Married 4 - Separated
 2 - Remarried 5 - Divorced
 3 - Widowed 6 - Never Married

F2 How long have you been in this marital status?
(If never married, since age 18).

	YRS.		MOS.
--	------	--	------

F3 Are you satisfied with this situation?

- 0 - No
 1 - Indifferent
 2 - Yes

* F4 Usual living arrangements (past 3 yr.)

- 1 - With sexual partner and children
 2 - With sexual partner alone
 3 - With children alone
 4 - With parents
 5 - With family
 6 - With friends
 7 - Alone
 8 - Controlled environment
 9 - No stable arrangements

F5. How long have you lived in these arrangements.
(If with parents or family, since age 18).

	YRS.		MOS.
--	------	--	------

F6. Are you satisfied with these living arrangements?

- 0 - No
 1 - Indifferent
 2 - Yes

Do you live with anyone who:
 0 = No 1 = Yes

F7. Has a current alcohol problem?

F8. Uses non-prescribed drugs?

F9. With whom do you spend most of your free time:

- 1 - Family 3 - Alone
 2 - Friends

F10. Are you satisfied with spending your free time this way?

- 0 - No 1 - Indifferent 2 - Yes

F11. How many close friends do you have?

FAMILY/SOCIAL RELATIONSHIPS

Direction for F12-F26: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

F12. Mother

F13. Father

F14. Brothers/Sisters

F15. Sexual Partner/Spouse

F16. Children

F17. Friends

Have you had significant periods in which you have experienced serious problems getting along with:

PAST 30 DAYS IN YOUR LIFE

0 - No 1 - Yes

F18. Mother

F19. Father

F20. Brothers/Sisters

F21. Sexual partner/spouse

F22. Children

F23. Other significant family _____

F24. Close friends

F25. Neighbors

F26. Co-Workers

Did any of these people (F18-F26) abuse you: 0 = No, 1 = Yes

30 LIFE DAYS

F27. Emotionally (make you feel bad through harsh words)?

F28. Physically (cause you physical harm)?

F29. Sexually (force sexual advances or sexual acts)?

How many days in the past 30 have you had serious conflicts:

F30. with your family?

F31. with other people?
(excluding family)

FOR QUESTIONS F32-F35 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

F32. Family problems

F33. Social problems

How important to you now is treatment or counseling for these:

F34. Family problems

F35. Social problems

INTERVIEWER SEVERITY RATING

F36. How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

F37. Patient's misrepresentation?
 0 - No 1 - Yes

F38. Patient's inability to understand?
 0 - No 1 - Yes

--

Comments

--	--	--

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems?

* P1 In a hospital

* P2 As an Opt. or Priv. patient

P3. Do you receive a pension for a psychiatric disability?

--

0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes

PAST 30 IN
DAYS YOUR
LIFE

P4. Experienced serious depression

P5. Experienced serious anxiety or tension

P6. Experienced hallucinations

P7. Experienced trouble understanding, concentrating or remembering

P8. Experienced trouble controlling violent behavior

P9. Experienced serious thoughts of suicide

P10. Attempted suicide

P11. Been prescribed medication for any psychological emotional problem

P12. How many days in the past 30 have you experienced these psychological or emotional problems?

FOR QUESTIONS P13 & P14 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

P13. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

--

P14. How important to you now is treatment for these psychological problems?

--

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient:

0 - No 1 - Yes

P15. Obviously depressed/withdrawn

--

P16. Obviously hostile

--

P17. Obviously anxious/nervous

--

P18. Having trouble with reality testing thought disorders, paranoid thinking

--

P19. Having trouble comprehending, concentrating, remembering.

--

P20. Having suicidal thoughts

--

Comments

INTERVIEWER SEVERITY RATING

P21. How would you rate the patient's need for psychiatric/psychological treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

P22. Patient's misrepresentation?
0 - No 1 - Yes

P23. Patient's inability to understand?
0 - No 1 - Yes

Appendix J – Confidentiality and Patient Consent to Treatment Forms

TOADS Evaluation Form – Patient and Counselor
to be completed upon intake and every 90 days thereafter

Name of Referring Clinician _____		Telecare Counselor: _____	
Appointment Purpose (circle one): Evaluation for telecare, Ongoing care		Patient Telecare Setting (circle one below) Out-Patient, Rural Clinic, Hlth Dept, School, Mobile Unit, Other:	
Consult Location	Refer Location	Yr month day	Pt.Initials
# of Patient Hospitalizations in last 6 months _____ # of Emergency Room visits in last 6 months _____ # of Skilled Nursing /Rehab admits last 6 mos. _____		Age: <18 18-64 65+	
<input type="checkbox"/> Fresno County <input type="checkbox"/> Kings County <input type="checkbox"/> Madera County <input type="checkbox"/> Tulare County <input type="checkbox"/> other		Circle Encounter type: PP TC OT (PP=patient present; TC=telecare counseling session; OT = other encounter: detail: _____)	

Questions 1-6 to be completed by patient or designee

1. This is the first time I have been seen as a patient in a telecare network ?
 yes no (if you answer "no" then answer
 1a. My last telecare session was _____
- 1b) Have you been in the hospital since your last telecare visit? yes no 1c) I have been hospitalized _____ times since then.
 1d) I was hospitalized for _____ mental health _____ other (detail): _____
2. If telecare were not available for my problem today, I would have...
 driven for treatment sessions
 not gone to treatment
3. If telecare was not available and I had to travel for treatment, I would have
 driven my own car I would have driven _____ miles one way
 taken a free ride in someone else's car
 paid for a taxi, bus or other transport
4. If I had to travel for treatment (check all that apply)
 I would have lost time from work
 My companions would have lost time from work How many companions? _____
 I would have paid for meals while I was away from home
 I would have paid for a hotel to spend the night
 I would have other expenses (please specify) _____
5. The telecare counselor was able to address what was bothering me today – give a brief answer detailing how you were helped today:
 Yes, because _____ No, because _____
6. Overall, I was satisfied with today's telecare counseling encounter, I feel better because (give a brief reason in the box below)
- 6a. I prefer to get reminders of my telecare counseling sessions and telecare related appointments by:
 Telephone or cell phone call Text Message Instant Message Email Other: _____
 Comments or Suggestions? _____

QUESTIONS 7, 8, 9 TO BE COMPLETED BY Addiction Couneslor

7. The telecare counseling session encounter was successful (detail reasons in box below)
8. If you felt it was not successful, please state your insights as to why (in box below)
9. Payor Medicaid Medicare Commercial No Insurance Other _____

PROMESA BEHAVIORAL HEALTH: TELECARE OUTPATIENT ALCOHOL DRUG SERVICES (TOADS)
CONSENT TO PARTICIPATE IN TELECARE/TELEMEDICINE FOR TREATMENT OF SUBSTANCE ABUSE

Patient's Name: _____ Medical Record No.: _____

1. I understand that my health care provider, _____, wishes me to engage in a telemedicine consultation with Promesa Behavioral Health.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection. I understand that I am being referred to telecare substance abuse counseling upon the conclusion of my physical exam and recommendation of my practitioner. I understand that while a patient in the telecare substance abuse network that I will be seen regularly by the supervising clinician or psychiatrist. I agree to these regular psychiatric consultations in addition to regularly scheduled sessions with an addiction counselor via telecare.
7. I understand that in order to participate in telecare substance abuse counseling, I have to have an internet-enabled cell phone or access to telecare videoconferencing facilities that have been established by Promesa Behavioral Health.
8. I understand that I have to participate in an assessment and telecare training in order to receive counseling services through the telecare network of Promesa Behavioral Health.
9. I understand that billing will occur for the telecare services I receive. I understand the cost of treatment I will receive through telecare and I agree to these costs.
10. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit and in telecare counseling sessions under the terms described herein.

Patient's signature

Date and Time

Promesa staff signature

Date and Time

TOADS Evaluation Form – Consulting Clinician/Psychiatrist

Encounter Start time _____

Encounter Stop time _____

Code _____

Consultant Location Referring Physician Location Yr month day Patient's Initials

Clinician's Name _____ Specialty _____ Location _____

1.	How many times you have conducted clinical services on the telecare network?				
2.	The purpose of today's encounter <input type="checkbox"/> Consultation <input type="checkbox"/> See own patients via telecare <input type="checkbox"/> Med check <input type="checkbox"/> Assign patient to telecare counseling <input type="checkbox"/> Ongoing care <input type="checkbox"/> Patient progress in telecare review				
3.	Was a definitive diagnosis established? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
4.	Technology adequate to make diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
5.	In-person visit required for diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
6.	Was a definitive treatment plan established? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
7.	Patient disposition: <u>(Select up to three choices)</u> <input type="checkbox"/> Return to referring clinicians' care <input type="checkbox"/> Refer to telecare for ongoing counseling <input type="checkbox"/> I will manage the patient's care <input type="checkbox"/> Additional testing needed <input type="checkbox"/> Discharge patient from care <input type="checkbox"/> Patient will see me in person <input type="checkbox"/> Other (specify) _____			Patient Age Category <input type="checkbox"/> Less than 18 years old <input type="checkbox"/> 18-64 <input type="checkbox"/> More than 65 years old	
8.	Clinical decision-making was successfully accomplished				
	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
9.	Overall, I was satisfied with the telecare referral for this patient.				
	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree

If you felt it was not successful, please let us know why. _____

Any other important items regarding this encounter? _____

P.O. Box 1161
607 N. Douty Ave.
Hanford, CA 93230
Telephone: (559) 584-9033
Fax: (559) 584-9038
E-mail: pdm@promesabehavioral.org



PATIENT TREATMENT CONTRACT FOR BUPRENOPHINE SUPPORTED THERAPY

Patient Name _____ **Date** _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®, Klonopin®, or Xanax®), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature _____ Date _____

*Valium® is a registered trademark of Roche Products Inc.

†Klonopin® is a registered trademark of Roche Laboratories Inc.

‡Xanax® is a registered trademark of Pharmacia & Upjohn Company



P.O. Box 1161
607 N. Douty St.
Hanford, CA 93232
P: (559) 584-9033
F: (559) 584-9038

Patient information and consent to treatment with Suboxone

Suboxone® (a tablet with buprenorphine and naloxone) is an FDA approved medication for treatment of people with opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications that include counseling, groups and meetings.

If you are dependent on opiates – any opiates - you should be in as much withdrawal as possible when you take the first dose of buprenorphine. If you are not in withdrawal, buprenorphine can cause severe opiate withdrawal. For that reason, you should take the first dose in the office and remain in the office for at least 2 hours. We recommend that you arrange not to drive after your first dose, because some patients get drowsy until the correct dose is determined for them. Some patients find that it takes several days to get used to the transition from the opiate they had been using to buprenorphine. During that time, any use of other opiates may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opiates will have less effect. Attempts to override the buprenorphine by taking more opiates could result in an opiate overdose. You should not take any other medication without discussing it with the physician first. Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths.

The form of buprenorphine (Suboxone®) you will be taking is a combination of buprenorphine with a short-acting opiate blocker (Naloxone). It will maintain physical dependence, and if you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine, it could eventually cause physical dependence.

Buprenorphine tablets/film must be held under the tongue until they dissolve completely. You will be given your first dose at the office, and you will have to wait as it dissolves, and for two hours after it dissolves, to see how you react. It is important not to talk or swallow until the tablet/film dissolves. This can take up to ten minutes. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed. If you swallow the tablet/film, you will not have the important benefits of the medication, and it may not relieve your withdrawal.

Most patients end up at a daily dose of 16 mg to 24mg of buprenorphine. (This is roughly equivalent to 60mg of methadone) Beyond that dose, the effects of buprenorphine plateau, so there may not be any more benefit to increase in dose. It may take several weeks to determine just the right dose for you. The first dose is usually 2mg.

If you are transferring to Suboxone® from methadone maintenance, your dose has to be tapered until you have been below 30mg for at least a week. There must be at least 24 hours (preferably longer) between the time you take your last methadone dose and the time you are given your first dose of buprenorphine. Your doctor will examine you for clear signs of withdrawal, and you will not be given buprenorphine until you are in withdrawal.

I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Signed _____ Date _____

Print Name _____

Witness _____ Date _____

PATIENT ACTIVITY LOG

Counselor: _____ Patient I.D. # _____

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: <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	2. * Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. * Report Type: <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 Promesa Behavioral Health, Inc. * Street 1 7475 N. Palm Avenue Street 2 Ste 107 * City Fresno State CA: California Zip 93711-5763 Congressional District, if known: 20		
5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:		
6. * Federal Department/Agency: SAMHSA		
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: Promesa has not hired a lobbyist, nor do we engage in lobbying		
9. Award Amount, if known: \$		
10. a. Name and Address of Lobbying Registrant: Prefix * First Name Lisa Middle Name K * Last Name Weigant Suffix * Street 1 Street 2 * City State Zip		
b. Individual Performing Services (including address if different from No. 10a) Prefix * First Name No Middle Name One * Last Name Lobbies for Promesa 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: Carol Scroggins		
*Name: Prefix Ms. *First Name Lisa Middle Name K * Last Name Weigant Suffix		
Title: CEO Telephone No.: 559.439.5439 Date: 06/13/2011		
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

Project/Performance Site Location(s)

Project/Performance Site Primary Location I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: **Promesa Behavioral Health, Inc.**

DUNS Number: **9615707640000**

* Street1: **7475 N. Palm Avenue**

Street2: **Ste 107**

* City: **Fresno** County: **Fresno**

* State: **CA: California**

Province:

* Country: **USA: UNITED STATES**

* ZIP / Postal Code: **93711-5763**

* Project/ Performance Site Congressional District: **CA-D20**

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: **Promesa Behavioral Health/Promesa Dependency & Rehab**

DUNS Number: **9615707640000**

* Street1: **607 N. Douty**

Street2:

* City: **Hanford** County: **Kings**

* State: **CA: California**

Province:

* Country: **USA: UNITED STATES**

* ZIP / Postal Code: **93232-1161**

* Project/ Performance Site Congressional District: **CA-D21**

Additional Location(s)

[Add Attachment](#)

[Delete Attachment](#)

[View Attachment](#)

CHECKLIST

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

Type of Application: New Noncompeting Continuation Competing Continuation Supplemental

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

Included NOT Applicable

1. Proper Signature and Date on the SF 424 (FACE PAGE)
2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690)
 - Civil Rights Assurance (45 CFR 80)
 - Assurance Concerning the Handicapped (45 CFR 84)
 - Assurance Concerning Sex Discrimination (45 CFR 86)
 - Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)
3. Human Subjects Certification, when applicable (45 CFR 46)

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

YES NOT Applicable

1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)
3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)?.....
4. Have biographical sketch(es) with job description(s) been provided, when required?.....
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?
6. Has the 12 month narrative budget justification been provided?
7. Has the budget for the entire proposed project period with sufficient detail been provided?
8. For a Supplemental application, does the narrative budget justification address only the additional funds requested?
9. For Competing Continuation and Supplemental applications, has a progress report been included?

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

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

Prefix: Ms. First Name: Lisa Middle Name: K
 Last Name: Weigant Suffix:
 Title: CEO
 Organization: Promesa Behavioral Health, Inc.
 Street1: 7475 N. Palm Avenue
 Street2: Ste 107
 City: Fresno
 State: CA: California ZIP / Postal Code: 93711 ZIP / Postal Code4: 5763
 E-mail Address: lweigant@promesabehavioral.org
 Telephone Number: 559.439.5439 Fax Number: 559.439.5411

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

Prefix: Dr. First Name: Herbert Middle Name: A
 Last Name: Cruz Suffix: M.D.
 Title: Chief of Medical Services
 Organization: Tele-Care/Promesa Dependency and Rehabilitation
 Street1: 907 N. Douty Street
 Street2:
 City: Hanford
 State: CA: California ZIP / Postal Code: 93232 ZIP / Postal Code4: 1161
 E-mail Address: hacruzmd@sbcglobal.net
 Telephone Number: 559.584.9033 Fax Number: 559.584.9038

HHS Checklist (08-2007)

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

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

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

Previously Filed with: (Agency)

on (Date)

INVENTIONS

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

EXECUTIVE ORDER 12372

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

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

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

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

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

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

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

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

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

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

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

Debarment and Suspension – Title 2 CFR part 376.

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

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

Environmental Tobacco Smoke – Public Law 103-227.

Program Fraud Civil Remedies Act (PFCRA)