

ABSTRACT: ACCESS TO RECOVERY (ATR Ohana)

Hawaii, a previously ATR-funded state, will expand from Oahu to at least one neighbor island as "ATR Ohana" (family). Adding clinical treatment and serving substance using adolescents and extended family members will improve recovery for entire families. Clients experiencing health disparity, HIV/AIDS patients and methamphetamine clients with dental disease, expand target populations that include native Hawaiians, National Guard, and drug court clients. Pacific Islanders, child protective services, and re-entering offenders remain important target populations to ATR Ohana. Faith- and cultural-based providers will expand partnerships program-wide, and ATR Ohana will formalize referral pathways to treatment and recovery with various institutions whose clients struggle with controlled substances.

ATR Ohana will serve 8,362 clients age twelve (12) and older at an average cost of \$1,091.72 per client. 1,236 clients will be served in the first year, 2,800 served during each of the second and third years, and 1,526 clients served in the fourth year.

ATR Ohana will use Hawaii's existing electronic voucher management system (VMS) to reimburse providers on a fee-for-service basis, ensuring genuine client choice from an expanded network of faith-based providers and cultural healers not previously funded through public funds. ATR Ohana will use place-based strategies to bring treatment and recovery to clients in remote locations. ATR Ohana will enhance client compliance and effective provider practices using "real time" outcomes measures from the VMS and incentives.

ATR Ohana will supplement existing high intensity treatment with lower levels of clinical services, and require care coordination from all provider agencies, emphasizing the importance of collaboration between treatment and recovery providers. ATR Ohana targets clients who may be in need of treatment, but do not recognize their need, such as family members of identified clients who also abuse controlled substances. Incorporating the recommendations of stakeholders from all counties and disciplines, ATR Ohana will enhance existing treatment services by offering substance abuse education, Motivational Enhancement and Recovery Check-ups, and expand recovery service reimbursements for transportation, individual and group peer-based education and mentoring, spiritual and cultural support, child care, sober activities, and care coordination.

Implementation of treatment and recovery services will commence within 90 days with full project implementation by 6 months. Project staff will monitor key implementation and outcome measures to ensure quality of care; to prevent waste, fraud and abuse; and to maximize the efficiency and effectiveness of service delivery.

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Dear Mr. [Name]

I have your letter of the 15th and am glad to hear that you are well.

I am well at present and hope these few lines will find you the same.

I have not much news to write at present.

I have been thinking of you very much lately and wondering how you are getting on.

I have not much news to write at present.

I have been thinking of you very much lately and wondering how you are getting on.

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BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

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. TI-10-008	93.275	\$	\$	\$ 2,933,000.00	\$	2,933,000.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		\$ 0.00	\$ 0.00	\$ 2,933,000.00	\$ 0.00	2,933,000.00

SECTION B: BUDGET CATEGORIES

Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY		Total (5)
	(1)	(2)	
a. Personnel	\$	\$	\$
b. Fringe Benefits		\$ 266,650.00	266,650.00
c. Travel		102,100.00	102,100.00
d. Equipment		50,052.00	50,052.00
e. Supplies		4,819.00	4,819.00
f. Contractual		5,570.00	5,570.00
g. Construction		97,900.00	97,900.00
h. Other		0.00	0.00
i. Total Direct Charges (sum of 6a-6h)		2,366,453.00	2,366,453.00
j. Indirect Charges	0.00		0.00
k. TOTALS (sum of 6i and 6j)	\$	\$ 2,933,000.00	\$ 2,933,000.00

7. Program Income	(1)	(2)	Total
	\$	\$	\$
		\$ 0.00	0.00
		\$ 2,933,000.00	2,933,000.00

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program

	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Access to Recovery (TI-10-008)	\$			
9.	\$		\$	0.00
10.				0.00
11.				0.00
12. TOTAL (sum of lines 8-11)	\$	0.00 \$	0.00 \$	0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 2,933,000.00	\$ 733,250.00	\$ 733,250.00	\$ 733,250.00	\$ 733,250.00
14. Non-Federal	0.00				
15. TOTAL (sum of lines 13 and 14)	\$ 2,933,000.00	\$ 733,250.00	\$ 733,250.00	\$ 733,250.00	\$ 733,250.00

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

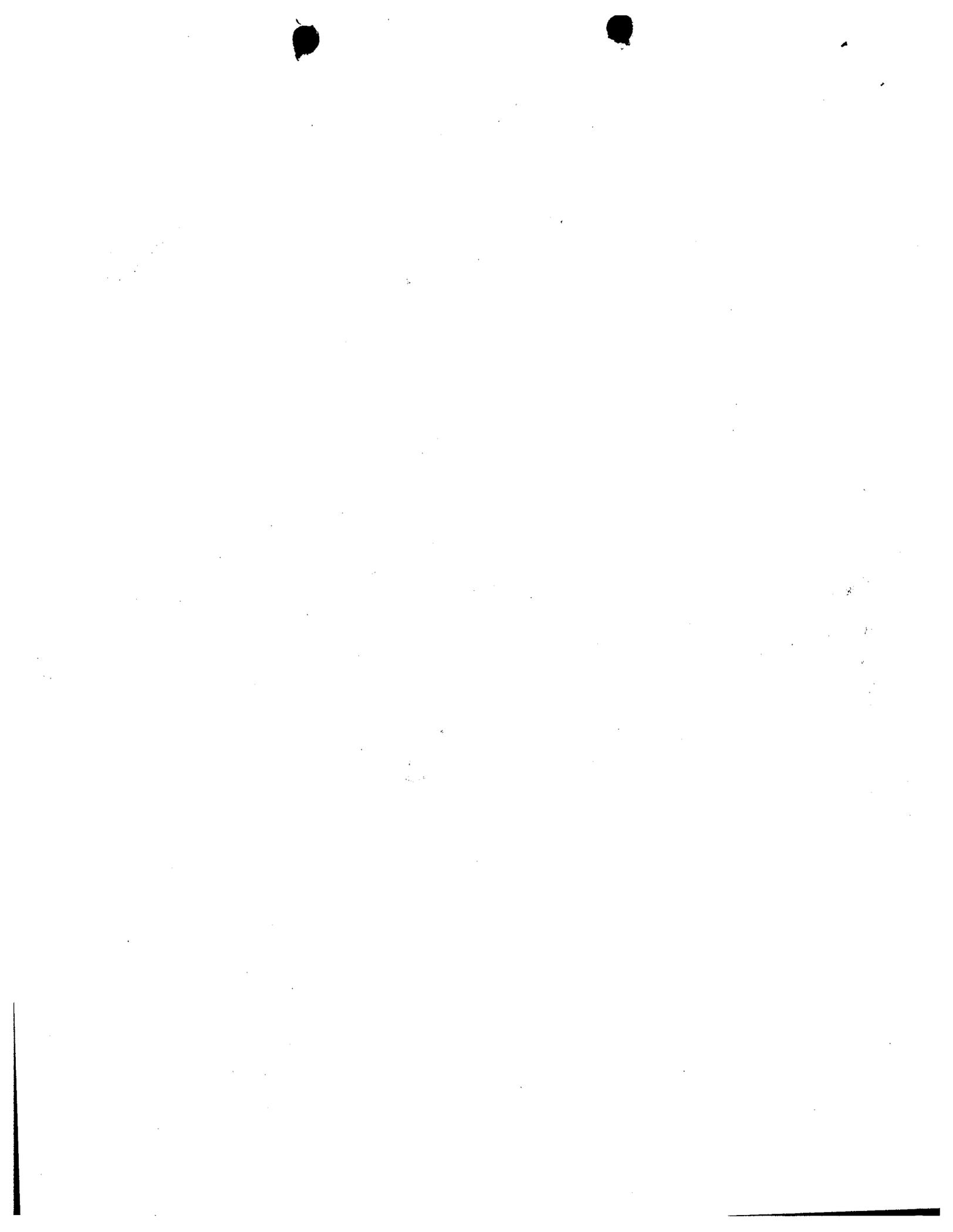
	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Access to Recovery (TI-10-008)	\$ 2,933,000.00	\$ 2,849,000.00	\$ 2,824,360.00	\$ 2,873,150.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16-19)	\$ 2,933,000.00	\$ 2,849,000.00	\$ 2,824,360.00	\$ 2,873,150.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:
 As required, \$2,333,592 (80% of \$2,933 million budgeted) is for Voucher System
 22. Indirect Charges:
 The \$39,456 (10.7% indirect cost rate) is applied to the Total Personnel Costs.

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REV



Project Narrative

Section A: Statement of Need

Current System

The State of Hawaii currently funds clinical substance abuse treatment services, hereafter referred to as "treatment," through the Department of Health, Alcohol and Drug Abuse Division, hereafter referred to as "ADAD". The Single State Authority (SSA) in Hawaii is Division Chief Keith Yamamoto. ADAD provides no direct services to those with substance use disorders (SUD), hereafter referred to as "clients," and distributes allocated funds through competitive purchase of service contracts. The Web Infrastructure for Treatment Services (WITS) electronic voucher management system, hereafter referred to as "VMS," is used to oversee contracted services

ADAD treatment contractors serve clients in all four counties of the state. Substance abuse screening instruments vary between agencies, but the Addiction Severity Index (ASI) is the prescribed adult SUD assessment tool and the Adolescent Drug Abuse Diagnosis (A.D.A.D.) is the prescribed adolescent SUD assessment tool for ADAD contractors. Paired with patient placement criteria (PPC) using the American Society for Addiction Medicine (ASAM), clients are then referred to the corresponding levels of treatment intensity. Clients unable to pay for treatment and who have no other form of insurance are eligible to have the cost paid for by ADAD through its contracted provider agencies. Most treatment contracts consist of Federal block grant funds and State General Funds.

Hawaii is a 2007 Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) Access to Recovery (ATR) II grantee. Prior to ATR II, Hawaii had no formal coordinated recovery oriented system of care (ROSC) for substance abusers. ADAD committed all ATR II funds to developing recovery support services (RSS) and promoted connections to treatment providers, building the foundation for an integrated ROSC on Oahu. ATR II supported treatment by linking ADAD contractors with non-traditional faith-based and community organizations (FBCOs) already serving the needs of clients. By building upon Federal block grant and State General Funds that support treatment, ATR enhanced the likelihood that clients would be retained in a full episode of treatment, an indicator correlated with future success in sobriety. (NIDA <http://www.drugabuse.gov/PODAT/faqs.html>)

RSS providers assisted clients with getting assessed for treatment, facilitated referral to treatment, encouraged engagement in treatment, and mentored clients as they re-entered their community after being discharged from treatment. They created bridges across silos of influence and advocated for clients who were eligible for other benefits, such as low-income housing assistance, food stamps, mental health counseling, and veteran benefits, and met the client's needs without relying solely on ATR funding. RSS helped clients: 1) put food on the table; 2) link with 12-step, legal services, and spiritual support; 3) identify, secure, and sustain safe, affordable housing; 4) access primary health and emergency dental care; 5) receive employment readiness training, and 6) engage safe,

affordable child care that facilitated employment and assisted client efforts to reunify with children in the custody of the Department of Human Services (DHS).

Culturally responsive RSS included Native Hawaiian conflict resolution, Ho'oponopono, (Pukui & Elbert, 1986); Lomilomi, Hawaiian restorative massage; La'au Lapa'au, cultural herbal healing for one's ills (Gutmanis, 2003); and Acupuncture, a healing method of relieving pain (Stux, Berman, and Pomeranz, 1988).

ADAD funds eighteen (18) agencies offering treatment to adults at forty-three (43) sites and eleven (11) adolescent treatment programs, primarily located on school campuses. The greatest portion of treatment funds are spent on residential services, followed by outpatient services (Department of Health and Center on the Family, 2010). Project staff enlisted, screened, authorized, and trained an ATR network of forty-one (41) FBCOs, distributing over \$5.7 million of funds to thirty-seven (37) RSS providers, sixty-four (64) percent of which deliver faith-based or culture-specific services through outreach and place-based services.

Nature and Prevalence of Problem

Not all levels of treatment or elements of ROSC are available on all islands. When treatment is available, some clients have difficulty accessing the appropriate level of care because they lack the resources to pay it. Wait lists for residential treatment are used at five (5) of six (6) ADAD funded facilities, who report they were at full capacity every month during State Fiscal Year (SFY) 2009. The remaining facilities report they were near capacity across SFY 2009 (Nakano, 2010). Lower levels of treatment are overburdened as well. Clients who are court ordered to participate in substance abuse education classes for operating a vehicle under the influence of intoxicants (OVUII) encounter waitlists of up to six (6) months for substance abuse educational classes from non-ADAD funded treatment providers (Oto, 2010).

Despite successful efforts to offer meaningful choice to ATR II clients, the needs of clients in Hawaii outpaced the capacity of funding. Requests to make ATR II services available outside Oahu could not be accommodated due to limited resources. ADAD chose to concentrate on establishing the Oahu network, improving Oahu RSS providers' ability to become sustainable without reliance on public funding. While the current RSS network has made initial strides in this direction, they are not entirely independent from system support, particularly when faced with the great need that exists for their services.

Neighbor island needs for treatment and RSS were emphasized recently when community providers from neighbor islands traveled, at considerable personal expense, to attend a multi-day ATR sponsored ROSC Roundtable and Capacity Building training presented on Oahu in December 2009. These neighbor island FBCOs are committed to establishing ROSC in their communities, but lack comprehensive models or expertise to do so independent from public resources and technical assistance.

Access to primary medical services is also a system gap. Over seventy-five (75) percent of Hawaii ATR II expenditures were committed to assisting those in recovery from

addiction to methamphetamine, hereafter referred to as "meth," a population with significantly compromised dental health. When ATR temporarily extended dental services to meth addicts during ATR II, based on anecdotal reports of need, the demand for primary dental care and emergency dental procedures outpaced the capacity of the grant. Project staff had no alternative but to discontinue dental services to ATR II clients who arguably needed the services to manage infection and salvage remaining teeth.

ATR II dental providers report that clients using their services demonstrated follow through rates on appointments at the same frequency as the general public, a level of compliance that is unusual in this population. Care coordinators reported that dental service clients sustained abstinence and gained employment despite no requirement for a minimum period of sobriety preceding their approval for the service.

Hawaii's landmass is separated by ocean channels spanning as much as 85 miles, requiring prohibitively expensive privately chartered boat or commercial air travel to access services. When services are available in neighbor island communities, access to frequent and dependable public transportation to get to services is not. In cases where it is necessary for clients to travel to Oahu for higher levels of treatment, donations from a faith community, from family, or from community elders who can ill afford the cost may be the only means for paying travel costs. When availability to services are limited, this significantly delays the client's access to vital services, compounding the client's hardship.

Neighbor island residents who are able to access a treatment slot off island or on Oahu often have no local support network and may use General Assistance resources from the State to cover room and board to sustain themselves as they step down to non-residential treatment. Without adequate treatment available in their local communities, they are unable to safely return home where they might live with family members during their recovery. Displaced, they struggle to find employment and are dislocated from the support of their local faith or cultural community.

Incidence of meth abuse in Hawaii has risen thirty-three (33) percent between 2008 and 2009 according to Diagnostic Laboratory Services, a drug testing company in Hawaii ("Crystal Meth Use Up From 2008," 2010). A similar trend was noted with admissions to treatment for meth addiction rising nineteen (19) percent during the past year, as recorded in the number of treatment admissions (State of Hawaii, December 2009). Despite attention on the issue of combating meth abuse by Hawaii's elected officials (Hawaii Drug Control Program, 2010), the complex challenges facing the population of Hawaii, including homelessness, poverty, and displacement, contributes to high rates of substance use.

ATR II funding allowed for pilot project implementation on Oahu. Broader state-wide implementation during 2010 ATR (ATR III) will require expanded resources to provide technical assistance and to fund FBCO treatment and RSS providers on at least one additional neighbor island.

Overcoming the isolation of neighbor island services for clients in Hawaii presents a particular challenge for ATR III's expansion efforts. Expanding treatment services will require cultural sensitivity as well. Neighbor island communities have distinct cultural influences and hierarchies; protocols or historic prohibitions about embracing western healing practices; and are geographically isolated from resources that have been traditionally concentrated in the urban center of the state, the City and County of Honolulu on the Island of Oahu, a sensitive local issue. Nevertheless, ADAD is committed to honoring its Mission, "to promote a statewide culturally appropriate, comprehensive system of services to meet the treatment and recovery needs of individuals and families". ATR III will make recovery support services available to a wider geographic area than during ATR II, and will do so in a manner that respects the unique needs of diverse neighbor island communities.

Project staff will work through key neighbor island contacts hosting requests for information (RFI) focus groups to help local communities recognize existing ROSC elements and identify gaps in their service delivery system. Their unique local perspective, in combination with ATR's capacity to expand distribution of funding for treatment and recovery services will help build a ROSC that is appropriate to local communities.

Project staff anticipate that geographic expansion will be implemented in stages. Some communities possess sophisticated service delivery systems enabling them to quickly implement expanded ATR III services. To expedite ATR III implementation, project staff are already collaborating with treatment providers statewide, and have secured commitments from executive directors of several multi-island treatment agencies for expansion of their services to include ATR III clinical components. Current ATR II providers with existing programs on neighbor islands are willing to participate in ATR through a formal memoranda of understanding (MOU). Project staff anticipate that ATR III treatment services and expanded RSS services will be operationalized on Oahu within 90 days and on at least one neighbor island within 180 days of the notice of award (NoA). Further expansion of services to additional neighbor islands will be dependent on availability of resources.

During ATR II, ADAD anticipated that adults involved with the DHS Child Welfare Services (CWS) system would have the most need for and interest in ATR RSS. Despite the continued anecdotal information that the need is great in this population, referral of CWS clients to ATR remains low. ATR II expanded to include clients in treatment, those involved with the criminal justice system, individuals who were military veterans, and clients involved with mental health services, and ATR II experienced a surge. ATR II did not anticipate the great volume of those in need related to the expanded target populations, and as a result, had to restrict scope of service to meth clients only. ATR II has exceeded its target number of clients served and continues modest enrollment of 160 clients monthly. Over 350 wait list clients express immediate need for ATR services. The need for enhanced treatment and for expanded eligibility for recovery support services is anticipated to continue until ATR III implementation. Current wait-listed clients eligible for ATR II services will also be eligible for ATR III, providing an immediate pool of clients ready to enroll in and benefit from expanded services.

ATR III will be rebranded as "ATR Ohana." Ohana is the Native Hawaiian word that refers to family, including nuclear family, extended family, and surrogate family members. ATR Ohana will expand to include family members of identified clients who are also using substances, ages 12 and over.

The name, ATR Ohana, conveys this expanded focus for ATR III. Expanding the target population for ATR Ohana is more culturally consistent with Hawaiian values, which emphasize care for members of one's family, with local communities providing mutual aid and free exchange of resources, first exhausting those options before seeking public or charitable resources. Substance using family members of clients were not eligible for ATR II. Anecdotal reports from the ATR II provider network indicate that for every treatment client identified and eligible for ATR Ohana, at least one additional member of that client's family was also abusing substances.

Family members of National Guard soldiers will also be eligible for ATR Ohana services. Discussions are currently underway between ADAD and local representatives of the Counter Drug Officers of the Hawaii National Guard, with assurances that a more formal MOU will be signed once Hawaii receives its NoA.

While ATR II collaborated with human immunodeficiency virus and/or acquired immune deficiency syndrome (HIV/AIDS) educators working with transgender individuals, expansion of the partnership with other HIV/AIDS educators will be implemented through ATR Ohana.

ATR Ohana will expand by including treatment, which was not part of ATR II. Treatment services under ATR Ohana will be extended to Oahu and at least one neighbor island. Project staff have identified agencies that can promptly implement treatment on Oahu, and are working with the network of treatment providers for prompt implementation on at least one neighbor island within 180 days of NoA.

ADAD is in discussion with the Driver's Education Administrator and the National Guard Counterdrug Officer to increase the availability of ASAM Level 0.5, Early Intervention services for clients unable to pay for this court-ordered intervention. ATR Ohana will be able to provide assessment services for clients who have no other resources, and can pay for the tuition to OVUII classes for those in need of the service, but who have no resources to pay for them. As a result of the partnership between the National Guard, the Driver's Education Administrator, the Department of Justice, and ATR Ohana, system capacity will expand. National Guard OVUII train-the-trainer classes will be provided by the National Guard Counterdrug Officer to FBCO providers at no cost to the FBCO or to ATR Ohana. This is an important expansion of services, since clients on wait lists for OVUII classes face delays up to six (6) months before an opening is available. In addition to this expansion of low intensity outpatient clinical treatment, ATR Ohana will expand to include Recovery Support Services Questionnaire (RSSQ) assessment will be part of ATR Ohana's service array, along with the use of recovery check-ups (RC). Both are new elements to Hawaii's treatment system.

RSS, currently available only on Oahu, will be expanded to at least one neighbor island through ATR Ohana. Services that will be continued from the current ATR grant initiative include housing, transportation, individual and group-based delivery of education and training, spiritual support, cultural practices, child care, sober support activities, gap fund, and care coordination. ATR Ohana resources will enable expansion of meth related dental services to promote oral hygiene and to assist with infection control where no other resources exist to pay for the services. Dental services were only available for a brief time during ATR II.

To estimate the need for treatment services, ADAD conducted a statewide survey of adults in 2004. The results indicate that 85,468 adults need some level of treatment for SUD; 59,459 of this number reside on Oahu and 26,009 reside on neighbor islands. While most of those who reported needing treatment were on Oahu, neighbor islands reported substance abuse rates that indicate treatment services are needed statewide. The need for expanded clinical treatment services in Hawaii is evident in the long wait periods to access services, and the limited availability for some levels of service in neighbor island communities. Hawaii also has inadequate and fragmented treatment and recovery support services in remote island communities.

Native Hawaiians represent over forty-six (46) percent of treatment admissions (Hawaii State Department of Health and Center on the Family, 2010), a disproportionate representation from the demographic for the State where only twenty-three (23) percent of the resident population report they identify as native Hawaiian or Pacific Islander (NHPI) (U.S. Census, 2000). Meth and alcohol abuse are major factors impacting native Hawaiians served by treatment and social services agencies (Alcohol and Drug Treatment Survey, 2010). Thirty-seven (37) percent of Hawaii's homeless population consider themselves to be native Hawaiian (Hawaii Policy Academy on Chronic Homelessness, 2004), and the homeless in Hawaii report that substance abuse is one of the top factors contributing to their homelessness. According to the US Conference of Mayors, one of the most common contributing factors in homelessness is substance abuse (US Conference of Mayors, 2008). In their 2006 study, they concluded that individuals from racial groups that would be considered minorities when compared with the general population of the United States are overrepresented among the homeless (US Conference of Mayors, 2006). In Hawaii, a disproportionate number of NHPI are homeless and need treatment.

An estimated ten (10) percent of National Guard returning from deployment to Iraq and Afghanistan exhibit signs of trauma from their combat experience, and meet the criteria for Posttraumatic Stress Disorder (PTSD) (Levin, 2006), a condition that may contribute to not only the stress faced by veterans, but also impacts the health and well-being of their family members. Since 2001, Hawaii has a large military community, both regular military and National Guard members, deployed to, and returning from, Iraq and Afghanistan. The scope of need for substance abuse services among veterans and their family members will continue to be assessed and clarified during ATR Ohana. Meeting the treatment need of this population is a high priority for the State of Hawaii.

ATR II Client Satisfaction Survey results show that for the period between August 2008 and October 2009, of one hundred-forty (140) clients surveyed, twenty-four (24) percent of clients report that ATR services were helpful for their long-term sobriety, and sixty-nine (69) percent rated the value of ATR services as "critical" to their recovery. Peer-to-peer recovery support services were selected by thirty-four (34) percent of clients, one of the most frequent choices by ATR II clients (SAMHSA CSAT, December 2009). Clients indicated that RSS was a vital component of their recovery.

The people of Hawaii who depend upon State or Federal funding to cover residential treatment are faced with five (5) of six (6) publicly funded treatment facilities on Oahu operating at full capacity. As a result, ADAD is unable to ensure prompt access to subsidized residential treatment for indigent clients. RSS providers are generally able to provide immediate services to clients despite limited grant funding. During the highest rates of enrollment in ATR II, only one (1) in seven (7) RSS providers temporarily ceased accepting client referrals because they had reached their agency's maximum capacity.

First time offenders presenting to the 1st Circuit Court on Oahu for OVUII are routinely ordered to participate in substance abuse education classes, but the need for these classes far out-paces system capacity. Currently the county has a six (6) month wait lists for the service. OVUII are not funded by ADAD. Formal partnership with a stakeholder group of treatment and recovery professionals, such as with the National Guard Counterdrug Officer, will help bridge service gaps identified in ATR II. National Guard representatives have reported capacity to provide no-cost training to clinicians who can, in turn, increase the number of OVUII classes available, providing prompt expansion of treatment.

Neighbor island representatives initially report that there are "no RSS services available to clients in their communities." Further discussion suggests the more accurate picture is that local providers are unaware of the capacity of non-traditional RSS providers to accommodate clients transitioning out of treatment when linkages between treatment and FBCO have not been formalized. Clients in recovery are already being assisted by FBCOs who receive limited or no funding to do so. Neighbor islands require technical assistance (TA) available through ATR Ohana to recognize, develop, and formalize their local ROSC. Four (4) current ATR providers operate in neighborhood communities without ATR funding for their efforts, four additional treatment providers who are collaborating with ATR RSS on Oahu already provide limited treatment services in neighbor island communities, and have expressed interest in expanding their service array to neighbor islands.

There is a need for expanded publicly funded treatment in Hawaii, both on Oahu and on neighbor islands. The need for RSS exceeds the capacity of the non-traditional altruistic FBCO to adequately address, and treatment providers willing to expand their services to meet the greater demand report that fiscal constraints and limited technical savvy stymie their efforts to address the problem without public guidance and resources. The capacity of the FBCO, while not formally recognized, appears to be underutilized on neighbor

islands, and with technical assistance from ATR Ohana, may enable agencies to meet the challenge.

By adding treatment through ATR Ohana, ATR will expand system capacity making services available for individuals assessed at the lower ASAM levels at reasonable costs, and quickly increasing treatment options to clients earlier in the progression of their disease. RC, an inexpensive adjunct to treatment is emerging as a best practice, but is not used by clinical treatment providers in Hawaii. Treatment providers express willingness to expand their clinical service array if funding is made available for RC.

FBCOs report they have capacity to serve more clients. By linking traditional treatment with FBCO services and supporting those services through ATR Ohana, ATR can maximize the client's capacity to successfully transition between clinical treatment and re-engagement in their community. On neighbor islands, where FBCOs are not engaging clients in treatment settings, linkage can be facilitated through ATR Ohana, especially when clients are discharged from treatment on Oahu and returning to homes on a neighbor island. Supporting the existing, albeit fragmented, neighbor island ROSC is the most cost effective, culturally appropriate way of meeting the client's needs through ATR Ohana.

ADAD is uniquely positioned to effectively implement these expansions to alleviate system gaps. By creating the expectation that treatment providers include culturally relevant components in their treatment programs, ADAD has nurtured the readiness of clinical partners to welcome RSS into their array of "in-house" services. A limited amount of cultural components are being funded through ADAD substance abuse prevention and treatment (SAPT) block grant funds alongside State General Funds in RFP for treatment services. Non-traditional RSS providers recognize the important contribution being made by treatment agencies and report that they are willing to collaborate with treatment professionals. Clinical professionals are beginning to facilitate client contact with RSS providers while the client is still in treatment, minimizing the likelihood that clients discharged from treatment will be "lost on the way" to their first post-treatment recovery appointment. Clinicians provide valuable care coordination to clients with complex needs, such as dual diagnosis or other medical issues that impair their ability to sustain recovery. The ATR Ohana focus on care coordination will help avoid supplantation of other funded services.

Thirty-eight (38) percent of those eligible for RSS under ATR II self-identified as NHPI, a population with high rates of displacement from their traditional homes as a result of historical and continuing social inequalities (Shapiro, 2004). The NHPI rates of enrollment on neighbor islands are expected to meet or exceed those numbers as ATR Ohana expands beyond Oahu. These high utilization rates of ATR II services by NHPI suggest that ATR's implementation is culturally responsive to and effective in accommodating the needs of NHPI. This may also suggest that NHPI are not effectively being identified, engaged, or served through more traditional service systems, and are gaining access to available services guided by ATR RSS providers. By bridging the gap

in disparity through culturally relevant programs and services, ATR is enhancing the ability of NHPI to experience health and wellness.

Until recently, inclusion of faith-based content in any publicly funded treatment services was not an option for clients. Previous ATR grantees had demonstrated that treatment programs are able to successfully incorporate spiritual content with western evidence-based practices. By inviting FBCO treatment professionals affiliated with native Hawaiian culture to become ATR Ohana providers, the disparity can be narrowed between native Hawaiians interested in engaging with clinical treatment and the resources available to them that are culturally responsive to their spiritual needs.

Another population to be served by ATR Ohana will be individuals whose health is impaired or at risk because of HIV/AIDS. While issues related to HIV/AIDS are not exclusive to the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population, "research has shown that LGBT alcohol, tobacco and other drug use is 2 to 4 fold higher than in the broader heterosexual community" (Queensland Association for Healthy Communities, 2009). This increased likelihood of substance use, particularly when the substance is meth, places some individuals within the LGBTQ community at higher risk for HIV/AIDS (Halkitis, et al, 2001). ATR Ohana will promote linkages between clients whose behaviors while under the influence of substances may have, or continue to, place them at high risk for HIV infection and development of AIDS.

According to the Pew Center on the States, which scored states on policy responses to dental health needs, Hawaii scored an "F", the lowest ranking, for addressing challenges in the area of dental care among youth (Pew, 2010). Hawaii's commitment to including limited meth-related dental services as part of ATR Ohana helps to address infection for clients with no other means to access critical primary oral medical care to remediate, at least in part, their disparity in access to the health care system.

ATR II provided only RSS, since sufficient publicly funded treatment existed at that time. Since ATR II was originally implemented, ADAD has faced severe funding cuts, while demand for publicly funded treatment has grown. Publically funded treatment on neighbor islands is insufficient to meet the need, and RSS can be effective in assisting clients whose enrollment in treatment is delayed, by engaging clients in RSS until a treatment opening becomes available. ATR has an opportunity to enhance the existing, but insufficient treatment system in Hawaii. ATR Ohana will cast a wider net, engaging individuals who need treatment services, particularly at lower levels of intervention, and who might otherwise be unserved by the existing treatment system.

Treatment and RSS service availability expanded through ATR Ohana will help clients engage in treatment closer to their home, and will extend the scope of services provided on Oahu and to at least one neighbor island. This will expand ATR's partnership with local FBCOs in the broader geographic area. ATR Ohana will enhance the client's choice by ensuring that clients have at least two or more options in each service category, at least one to which the client will have no religious objection. By adding lower ASAM levels of treatment, project staff will increase the likelihood that individuals with SUD

will engage in treatment earlier in their disease progression. Project staff will promote coordinated care, implemented through the VMS, which will also reduce supplantation and minimizes the likelihood of waste, fraud, and abuse of limited resources. These efforts have already begun, with project staff engaging local communities in discussion of targeted system elements in a way that is sensitive to and responsive toward the unique community's needs.

Enhancements to Existing Voucher Management System

Hawaii's VMS will be used to reimburse providers on a fee-for-service basis. ATR II providers were successfully compensated through the VMS and this will continue during ATR Ohana. Since Hawaii has an operational VMS, project staff will avoid costly start up. Managing ATR Ohana data through the existing VMS will facilitate referral between ADAD treatment providers and ATR Ohana providers, allowing tracking of client movement across the system, ensuring that supplantation is avoided, and enhancing the likelihood that clients will be indentified who qualify for other system services, expediting delivery of ancillary services.

Data captured through the VMS will be linked to outcomes measures that are required by the Government Performance Results Act (GPRA). Current VMS contractors provide electronic data hosting and uploads of all grant required client demographics, national outcome measures (NOMs), and voucher related data within SAMHSA CSAT required timelines. The VMS contractors will implement enhancements to ensure that client screening, assessment, referral, vouchering, tracking, reimbursement and data management of both client demographics and fiscal processes honor security of all client data mandated by the Health Insurance Portability and Accountability Act (HIPAA) and the U. S. Department of Health and Human Services Code of Federal Regulations, Title 42, Part 2 (42CFR) which regulates confidentiality of alcohol and drug abuse patient records. All requested WITS enhancements will be operational within 90 days of NoA.

Hawaii has the components, capacity and expertise to immediately expand service options through ATR Ohana. Electronic referral of clients to ATR Ohana will be available to a broader array of social service agencies in the community, and will commence within 90 days of NoA. Project staff will monitor service utilization through the VMS to ensure quality of care, prevent waste, fraud and abuse, and maximize the efficiency and effectiveness of service delivery, while monitoring utilization rates of expanded services across a broader geographic area.

Project Narrative

Section B: Proposed Approach to Meet Program Goals

Number of Clients

ATR Ohana will serve 7,500 clients over the age of 11 during the grant period at an average cost of \$1,400 per client. 1,406 clients will be served in the first year, 2,344 served during each of the second and third years, and 1,406 clients served in the fourth year. This figure is based on the rates of referral using the most restrictive eligibility criteria from ATR II. During the busiest period of ATR II, monthly enrollment ranged from 400 to 600 clients per month. Average client enrollment across the three years of ATR II was 79 clients monthly. Unique circumstances contributed to delayed implementation of ATR II and an unanticipated surge in enrollment, and suggest that a significant number of clients are eligible for ATR services over the amount anticipated by ATR II. ATR Ohana will commit to enrollment averaging 154 clients per month.

This 200% increase from the number of target clients for ATR II to the in the target number of clients for ATR Ohana will be accomplished at 30% reduction in cost per client when compared to the ATR II target enrollment and client costs. This significant cost savings per client is a result of a more accurate understanding of the reimbursement rates for comparable services available locally, reflects consolidation of two high-cost ATR II services into one, all-inclusive reimbursement package (Housing Mentoring and Housing Subsidy), and includes low ASAM levels of treatment rather than a full array of more expensive interventions.

Plan to Meet Target Number

Technical assistance related to locating, identifying and enrolling eligible clients received under ATR II remains relevant in ATR Ohana. Because of the limited eligibility period for clients enrolled under ATR II, many of these individuals continue to need additional recovery support services. 350 clients currently waitlisted for ATR II services will be eligible for ATR Ohana and can be enrolled promptly, providing an immediate base of clients. Approximately fourteen (14) percent of ATR II clients have returned to use, underscoring the chronic nature of the disease of addiction. These clients are eligible under ATR Ohana. ATR Ohana clients will be encouraged to invite substance using family members to be screened for eligibility.

Clients enrolled in ADAD treatment services have been referred infrequently to ATR II. By including lower ASAM Level clinical services and formalizing referral pathways through MOUs, ATR Ohana anticipates more robust referrals from treatment providers.

Drug court clients, offenders re-entering community settings, and dually diagnosed clients were late additions to the list of those eligible for ATR II services. Referrals from these stakeholders are expected to remain high or increase. Stakeholder groups operating on neighbor islands have provided letters of intent to sign MOUs with ADAD, formalizing their commitment to refer clients to ATR Ohana. These stakeholders represent organizations that provide direct services to over 79,000 clients annually.

These stakeholders also report that a majority of their clients struggle with SUD and would be eligible for referral to ATR Ohana. Many of these individuals have family members who would also benefit from treatment and recovery services. Successful capture of as little as three (3) percent of the 79,000 potentially eligible individuals each year will be sufficient for ATR Ohana to exceed the proposed target client numbers.

Multiple levels of fiscal oversight are built into the State fiscal system. Project staff will ensure that the ATR Ohana budget and accounting processes comply with State and Federal fiscal reporting (FFR) requirements to SAMHSA and the Office of Grants Management (OGM) in a timely manner. Broader fiscal oversight of Federal grant fund expenditures occurs at multiple levels of the State fiscal system, including the Department of Accounting and General Services (DAGS) and the Administrative Services Office (ASO). Grant funds are tracked in the VMS, minimizing the likelihood of duplicate billing and system alerts will inform project staff about potential problematic trends in billing and service utilization.

Project staff will monitor rates of client enrollment monthly, along with voucher data and utilization rates as reflected in the Services Accountability Improvement System (SAIS) website and as extracted from VMS data. During ATR II, project staff utilized these methods to justify expanded scope of service, and used information from SAIS to strategically reduce the scope of services in Year 3. During ATR Ohana, superior performance by providers can be identified through the VMS and will shape how incentives are awarded. ATR II project staff learned to regularly monitor data trends for forecasting purposes. Reviews alerted project staff to the high rates of un-redeemed vouchers, leading to system wide review of inactive cases, and focus on improving the promptness with which clients were engaged by providers. Other trends revealed delinquent client engagement by providers, prompting technical assistance and corrective actions that improved system-wide GPRA follow-up compliance rates. Similar efforts will be continued during ATR Ohana.

Plan to Ensure Collection and Upload of Mandated Data

Six (6) month follow-up GPRA outcome measures, captured through VMS were reported each month to ATR II stakeholders through the monthly newsletter, *Spotlight on ATR*. By reporting outcomes data to Oahu stakeholders, project staff provided project transparency and raised awareness in the community, particularly among stakeholders, of valuable partnerships between treatment providers and FBCO RSS providers. The VMS features a home page that utilizes alerts that inform both project staff and provider agencies to problematic client records. The VMS also has an announcements section that project staff have utilized to distribute information about VMS procedures, enhancements, notices for training, resource sharing among providers, information regarding funding opportunities, and ATR project announcements from SAMHSA or OGM. This strong emphasis on frequent, candid communication between project staff and ATR II FBCOs and other community stakeholders helped ATR Ohana emerge with a strong provider network and more defined ROSC despite implementation, execution, staffing, and funding challenges.

When challenges were identified, outcome data, procedures and documents that illustrated and clarified the nature of the challenge were shared with RSS providers. This allowed collaborative decision making on critical issues requiring provider input to resolve. Project staff were able to effectively liaise between the State and the provider network on several implementation challenges that were successfully resolved, which improved grantee performance. Collaborative discussions included: realistic reimbursement rates, enhancement of system services most in demand, and prompt identification of procedures that impeded implementation efforts. As a result, project staff were able to meet the needs of clients, providers, stakeholders, and SAMHSA.

Project staff requests to a variety of stakeholders prompted increased referral for enrollment and initiated discussion between project staff and key ROSC stakeholders that strengthened coordination between treatment and RSS. RSS providers reported a correlated change occurred with clients demonstrating increased empowerment by making efforts to advocate for their unique needs with the intake unit staff. These clients also were empowered to speak directly with project staff and did so to express both support for and concern about various aspects of project implementation. Communication enabled project staff to prevent fraud, eliminate wasteful practices, and reduced the likelihood of abuse of system resources. This open management style allowed the ROSC to become invested in project outcomes and enabled project staff to implement ATR II with sensitivity to the community. A similar level of effort, openness, collaboration, and responsiveness will continue during ATR Ohana, as no change in key staff is anticipated and stakeholders have expressed their intention in continued partnership with ATR.

Results of VMS intake, GPRA, assessment, and referral to service providers are electronically recorded in the VMS. Successful completion of the Intake GPRA record must occur before access to any other system function is enabled. Data is, and will continue to be, uploaded daily to SAMHSA, as specified in the VMS contracts. Assessors will collect Intake GPRA at enrollment. Providers delivering care coordination will be directed to collect six (6) month follow-up GPRAs within (30) days prior to the official due date for the record. When clients have not completed the six (6) month follow-up by the due date, the client record will be flagged in the WITS system and billing permissions will be temporarily suspended for all agencies working with the client until the follow-up is uploaded. Clients, who complete their 6 month follow-up within the 30 days prior to the due date, will receive incentives of up to \$20 in value. Clients who complete their 6 month follow-up within the 30 days following the due date will receive incentives of up to \$10 in value. Clients who do not complete their follow-up GPRA within the eligible period may be discharged from ATR Ohana. Discharge GPRA data will be captured when the client has completed all services. Timely documentation will be a stipulation in the MOU, along with requirements for compliance with GPRA mandates. All providers will be required to complete GPRA collection training. Current providers have been trained in GPRA collection and new providers will be required to complete the training within 60 days of their MOU activation. New providers will have their enrollment capped at 50 clients until they complete GPRA training. Providers who do not comply with training requirements within set time-limits may have their VMS access privileges suspended until they comply with mandatory training requirements.

Approach to Implement Vouchers

Organizational Management

ATR Ohana will utilize the existing VMS and VMS contractor. ATR II contracts for data hosting, enhancements and maintenance of the VMS. The VMS processes reimbursements for funded services and has the capacity to draw down funds from multiple funding streams. The VMS contract specifies that federally mandated data be collected promptly and uploaded daily to ensure compliance. Service providers will be required to enter collected data within 72 hours of data collection. When GPRA data is entered into the VMS more than 7 days post collection, cost for client incentives delivered to the client for that GPRA interview will be assessed to the provider agency as having been distributed inappropriately, since SAIS may reject the data. This will discourage care coordinators from collecting GPRA data, but not enter the data into the VMS system as required.

During ATR II, the onus for completing the GPRA follow-up was placed solely on the care coordinators, and incentives of up to \$228 were authorized to be paid for completion of the follow-up record. Financial incentives to care coordinators did not prove effective in promoting uniform compliance with Federal mandates. System-wide billing for other ATR II services continued regardless of compliance with GPRA follow-up. By making continued billing for any ATR Ohana services contingent on completion of the follow-up, project staff can better assure that clients utilizing any ATR Ohana system service will be prompted to complete the follow-up GPRA by various providers whose reimbursement is tied to the client's compliance with the mandated reporting.

Clients who were invited to complete the follow-up GPRA generally expressed willingness to do so, but were inconsistent with their follow through. Client incentives, disclosed during the intake process, reiterated during frequent contacts with provider agencies, and included in promotional materials about ATR Ohana may encourage clients to self direct their efforts to cooperate with this important grant requirement. Clients also indicated that transportation to centralized care coordination units, separate from their selected provider location, presented hardship. By assigning care coordination and GPRA follow-up to the service provider working with the client, this barrier to GPRA compliance will be minimized.

Referral Entities

Clients may self-refer for screening and enrollment in ATR Ohana. ROSC stakeholders may make direct referral into the VMS if they designate a staff who will be trained and authorized by project staff. Clients may be referred for screening and assessment using a referral form transmitted electronically to an assessor. ACCESS Line, a statewide 24-hour crisis hotline, already fields calls for ATR II and has committed to renewing their existing MOU to continue throughout ATR Ohana.

Existing statewide entities that have committed to signing an MOU with ADAD to formalize referral pathways to ATR Ohana include: Adult Mental Health Division (AMHD) (through ACCESS Line), the Department of Justice (DOJ) (through

Interagency Council on Intermediate Sanctions and through the First Judicial Circuit Court), University of Hawaii (UH) John A. Burns School of Medicine (through Hawaii AIDS Education and Training Center) and UH Myron B. Thompson School of Social Work (through North Shore Mental Health), AIDS Community Care Team, Hawaii National Guard, Hawaii Department of Public Safety (through the Department of Corrections (DOC)), Island STAR, and The Institute For Family Enrichment (TIFFE). Over thirty other FBCOs that represent mental health providers, substance abuse treatment providers, and RSS provider agencies representing 79,000 clients served on the islands of Oahu, Maui, Molokai, Kauai, and the Big Island of Hawaii have expressed their intent to formalize referrals to ATR Ohana through MOUs.

While DHS was the primary target population during ATR II, and ATR Ohana will continue to serve this population, the number of referrals from this source alone will be insufficient to allow ATR Ohana to reach its target client number. DHS has embedded referral to ATR II in their case workers' intake protocols, and ATR Ohana project staff will continue to provide training and technical assistance to DHS case workers about referral to ATR Ohana and about the potential benefit to their clients from ATR Ohana treatment and recovery services.

VMS Enhancements

No VMS enhancements are needed to implement ATR Ohana, but project staff have requested some enhancements regarding security of client records and to automate prompts for system features. All requested enhancements will be operational within 90 days of NoA. VMS enhancements from ATR II remain in place, allowing ATR Ohana to realize the benefit from continued use of those enhancements.

Outreach and Enrollment of FBCOs

ATR II FBCOs have expressed intent to sign MOUs to be ATR Ohana service providers. Over sixty (60) percent of ATR II providers were FBCOs, and similar proportions of FBCOs represented in the ATR Ohana provider network are anticipated.

ADAD treatment and RSS providers have participated in Requests for Information (RFI) sessions that helped shape ATR Ohana. This inclusive approach has engendered ownership and will help expedite efforts to attract, authorize, train, and execute MOUs for ATR Ohana. The ATR Ohana provider directory will be significantly larger and more diverse than was available to clients during ATR II. Community "Talk Story" sessions, such as the initial ROSC Roundtable discussions held in December, 2009, during Year 3 of ATR II, have kept the dialogue open with key stakeholders regarding the design and implementation of ATR Ohana.

During the December ROSC Roundtable, project staff and FBCO stakeholders improved the foundation for a public-private partnership. Participants have committed to continue the process of raising awareness of recovery in Hawaii, to continue system coordination, and to accept ownership of sustaining the ROSC independent from public funding. By equipping ROSC participants with outcome measures from ATR II, project staff encouraged the FBCO treatment and recovery network to make services and strategies

funded through ATR Ohana key elements in their service delivery to clients and to link providers with individuals or organizations that will champion their efforts, ensuring client choice beyond Federal funding or political initiatives.

This broader stakeholder support will expand ATR Ohana options to ensure client choice from among at least two providers in each service category, at least one to which they have no religious objection. When choice is not possible due to extreme or remote service delivery circumstances, FBCO and secular services will be promoted by requesting that faith-based service providers make available faith-neutral or secular versions of services. Project staff will intensify efforts to locate, engage, and secure additional service providers to which the client has no religious objection, and may provide increased incentives to agencies that create satellite locations for delivery of services to more remote locations.

Eligibility Criteria

Hawaii statutes shape the minimum requirements for becoming a contracted ADAD provider. Fair procurement practices require providers to be selected through a competitive purchase of services process driven by a formal request for proposal (RFP) process that concludes with awarding contracts to preferred agencies. The process is lengthy, complex, and may be difficult for smaller non-traditional service provider agencies with limited resources to compete successfully. The contracting process is prohibited by the SAMHSA's ATR RFP.

ADAD stipulates that staff performing higher level clinical services in its contracted programs must be certified as a Certified Substance Abuse Counselors (CSAC) or have a master's degree in behavioral health. All ATR Ohana treatment providers will produce proof of current CSAC status. Assessment providers will be required to complete training in the ASI, A.D.A.D., and ASAM PPC, and RSSQ, or to produce proof of prior training related to use of these instruments, and must make recommendations for levels of treatment based on ASAM PPC. All providers, including RSS providers, must comply with training in GPRA protocols, and periodic re-training as appropriate. This process will not penalize FBCO CSACs.

Individuals who apply to deliver cultural healing practices or cultural activities or culturally based content will be approved to provide ATR Ohana services based on the following criteria, taken directly from language currently used to determine provider eligibility:

When the cultural practice is one that is regulated, licensed, or certified by the State of Hawaii with a minimum industry standard (e.g., Lomilomi, acupuncture), that industry standard shall be considered the minimum acceptable standard of regulation, license or certification by the ATR Project for authorization to provide this service. Additionally, where there is an industry standard or association that is generally recognized as the arbiter of quality, providers agree to abide by that industry standard for quality of service in their provision of services. Cultural Practice providers shall submit a letter from an established organization in the community that can attest to the provider's expertise in the content area for which

this agreement is being made. The letter shall be on organizational letterhead, be signed by a dually authorized officer or designee of the organization, and state that the practitioner is a provider of or is recognized as a practitioner of the proposed Cultural Practice.

ATR Ohana provider agencies will provide proof of screening for criminal record and sex offender status. While a criminal record does not automatically exclude one as an ATR provider, it will trigger closer scrutiny to determine the potential risk the staff may pose to clients. Agency staff who are listed as sex offenders will be prohibited from working with juveniles. Scope of duties for that individual may be further restricted by project staff if there are concerns that the staff may pose a risk to vulnerable clients. Agencies that do not remain in compliance with established discipline standards that ensure client safety and well-being will have their capacity to deliver ATR services suspended, and risk cancellation.

Enabling FBCOs to Compete

To accommodate ATR II grant requirements, ADAD negotiated exceptions to usual procurement rules. Procurement through an MOU may be used for ATR and this exemption will be requested to continue during ATR Ohana. Hawaii requires, at a minimum General Excise Tax clearance (GET), a vendor identification number (VID), proof of business location, and general liability insurance. Operating within the VMS requires internet access using high speed connection, use of Internet Explore to access the server, and personal computer (will not operate on Apple-based software). ADAD requires a completed application form, relevant insurance coverage (e.g., auto or general liability insurance), and clarification of the terms of services. Verification of all required documentation will precede authorization of an MOU. Providers must be able to produce evidence of current status of all eligibility requirements when requested by project staff during the duration of the grant initiative.

Project staff have identified a non-profit FBCO internet technology (IT) agency that donates computers and office equipment to other FBCOs who do not have the funds to upgrade their IT operations to meet the specifications of ATR Ohana. This partnership expedites FBCOs in securing approval as ATR providers. ATR does not pay this FBCO for any services it provides, but does link the IT agency with FBCOs who need TA to upgrade their agency's technology capacity.

FBCOs will receive TA from project staff in completing the ATR Ohana provider application process, including securing a VID. Information about getting proof of GET clearance will be provided, along with additional technical assistance as needed to complete the ATR Ohana provider application.

Reporting requirements include documentation of sufficient service delivery details to justify compensation for ATR Ohana services. At a minimum, service documentation will include the date, times, location, service category and/or sub-code, relevant content, units of service, the name of the staff delivering the service, progress toward treatment goals, and name of individual documenting the note. Documentation is required to be

submitted within 72 hours of service delivery. Documentation submitted more than 30 days delinquent may not be paid, since vouchered services may have expired and funds re-assigned to other clients. These are redemption requirements for all vouchers, regardless of agency type or service code, including those previously unable to compete successfully for Federal funds.

Direct face-to-face outreach was on-going throughout ATR II, and will continue during ATR Ohana to ensure inclusion of a broad variety of service providers, including FBCOs. Invitations will be extended to the current list of Hawaii CSACs, a group of over 630 individuals, many of whom have never successfully competed for public funds to pay for their services.

Project staff will continue to evaluate enrollment of ATR Ohana providers to ensure that FBCOs are not penalized solely for their status as an FBCO. During ATR II, a wide range of competency levels were noted among RSS providers. Enrollment efforts will continue to appeal to a wide range of provider agencies, but project staff are more informed about where FBCOs are likely to struggle when interacting with State government or with SUD clients. Increased training, TA, and frequency of communication across all provider agencies will improve system-wide service provider competencies.

The project staff will meet monthly with ATR Ohana treatment providers. Monthly provider forums, network-wide trainings, e-mail announcements, postings in the VMS, monthly newsletters, and community presentations will continue during ATR Ohana. Project staff are accessible during the work week by phone, internet, mail and drop-in appointment from 7:45 AM to 4:30 PM at the ADAD office, and will make after hours or weekend appointments as needed. The ATR Ohana Project Director is the primary liaison with providers to ensure direct collaboration. Technical assistance and provider development is addressed by other project staff.

ATR Ohana has received letters of intent from seventeen (17) treatment providers who have expressed intent to partner with ATR Ohana for delivery of treatment services, and of these, nine (9) already provide, or have expressed interest in providing, faith or cultural content in their programming. ADAD affirms that no screening of applicant agencies will occur that rule out participation on the basis of religious character or affiliation. Participant agencies will be given the opportunity to disclose their faith and cultural affiliation and service content in their program description. Faith or cultural content in the clinical service provider's program will be allowed, but does not exempt clinical providers from complying with the clinical eligibility requirements to comply with the credentialing, assessment, and ASAM Level treatment content that ADAD requires of its treatment providers.

Provider Eligibility Process

Providers in Hawaii occasionally disclose their faith or cultural content of programming. FBCOs have an active presence in the non-ADAD funded treatment community, and

some culture healers provide culture-based content in partnership with ADAD treatment contractors.

During ATR II, project staff determined that substantial TA and extended lengths of time were needed to assist FBCOs to complete ATR II provider applications. The original document was simplified to two (2) pages and was accepted with no supporting documents. Additional documentation and verifications were collected using TA matched to the FBCO's sophistication. The Treatment and Recovery Support Services Coordinator is the designated key staff to facilitate completion of all documentation and training for FBCOs in ATR Ohana.

ATR's 24-hour website provides information for both clients and providers to access important programmatic information, eligibility requirements, service categories, and contact information for project staff. ACCESS Line, a 24-hour crisis hotline in Hawaii, partnered with ADAD, through a formal MOU, and provided general ATR II eligibility information to callers who indicated that substance abuse contributed to their crisis.

Clients are assisted in their choice of providers during intake and across their ATR Ohana enrollment by service providers who will be equipped with a provider directory of agencies and services available through ATR Ohana. Client choice is further informed by promotional resources provided to them by FBCOs. These resources may include brochures, calendars of events, outlines of service content, and locations of satellite offices. Directory content continues to be expanded. Directory information is organized alphabetically, by geographical region, and by service. Providers have additional resources and human services directories, independent from ATR Ohana, that inform clients about services available to them other than those funded by ATR Ohana.

Maintenance of the provider directory is assigned to the Treatment and RSS Coordinator. ATR II project staff struggled to provide timely directory information to clients. Designating a project staff to update and distribute the most recent version of the provider directory will ensure that current information is provided.

Translators are available in many agencies to assist clients whose primary language is not English. To date, all translation needs have been met by the care coordinator staff, and ATR II has received no requests to translate provider directory information into another language. This TA would be made available should the need arise.

Client satisfaction surveys were used during ATR II, and responses to those surveys have been captured into a data base. A provider report card (PRC) document has been developed to capture and clarify for clients a variety of provider performance areas, informing the client's selection of the provider. The PRC will be implemented as part of ATR Ohana.

Client Eligibility Criteria

ATR Ohana clients will be screened for eligibility using the CAGE-AID and the CRAFFT, which will be embedded in the VMS. Positive score on either document will indicate that the client is eligible for further assessment and enrollment in ATR Ohana.

Clients will be eligible for clinical service vouchers based on assessment using the ASI for adults, and the A.D.A.D. for adolescents. All clients will be eligible for RSS service vouchers based on determinations using the RSSQ. ATR Ohana will supplement, but not supplant other funding sources. Clients with health insurance or other resources to pay for clinical services must exhaust those options before ATR Ohana funds will pay for clinical services. Clients eligible for RSS from existing social service agencies must exhaust those options before ATR Ohana funds will pay for RSS.

ATR Ohana will include: 1,500 (20%) adolescents, 375 (5%) National Guard and family members, 1,875 (25%) clients involved with drug court or other criminal justice agency, and 750 (10%) clients with compromised health, i.e., dental problems, HIV/AIDS, or other dual-diagnosis, and 3,000 (40%) who identify meth as a drug of choice.

Policies and Procedures to Ensure Assessment and Client Choice

ATR Ohana clients will be screened for eligibility, assessed for level of care using the VMS, which will then enable referral to available and appropriate treatment and RSS. When clients are referred without the appropriate screening, a screening will be completed by the assessor to determine eligibility. Pre-existing ASI, A.D.A.D. or RSSQ may be accepted by the assessor as proof of eligibility for level of service. Physical proof of that document must be presented to waive the assessment requirement, and information from the pre-existing document must be uploaded to the VMS in order to enable further referral to ATR Ohana services. Clients will complete a new assessment when they are unable to substantiate their claim of pre-existing assessment. Assessors will re-assess clients when the existing data is more than twelve (12) months old, or when significant changes to the client's using pattern have occurred since the previous assessment.

Referral to treatment and/or RSS will be based on the best match between the client's assessed need and available service providers, while respecting client preferences. Level of care needs may change over the client's recovery with respect to intensity or category of need. When clients express choice for higher or lower level of care than assessed, assessors may request written consent to discuss case details with a treatment or RSS provider of the client's choice to determine whether the client may be stabilized and treated effectively at the alternate level of care.

Clients may determine post-referral that the service provider selected is not a sufficient match with their unique needs and may request referral to an alternate service provider. Providers will assist the client by exploring the client's perspective on the mismatch, and if the provider is unable to resolve the issue, or if the client refuses efforts to resolve the issue, clients will be referred to the Treatment and Recovery Support Coordinator who will assist the client with selecting an alternative provider. Clients will be encouraged to

authorize information exchange between providers to minimize the potential for abuse of resources or unnecessary repetition of services.

Ensuring Referral and Transition to Appropriate Service Providers

Once clients are referred by the assessors to the client's choice of an authorized provider for a selected service using the VMS, assessors will follow up on the VMS referral with a phone call to the provider informing them that a referral has been made and will issue a letter via e-mail or U.S. Postal Service informing the provider of the referral. A copy of that communication will remain in the client's file at both agencies, and the assessor will request confirmation that the provider received the notification within two (2) business days. If no confirmation is received within two (2) days, the assessor will contact the client to offer them referral to an alternate provider if available. If no alternate provider is available, the assessor will attempt to contact the service provider again. If no contact or confirmation can be secured within 24 hours, the case will be referred to the Treatment and Recovery Services Coordinator who will investigate the nature of the problem and assist the client with contacting an alternate provider.

Clients will be given contact information for their selected service provider and encouraged to actively pursue contact with them. Failure on the part of the client to follow through on contacting the provider agency or the assessor does not excuse either agency from ensuring that the client is served. During ATR II, FBCOs demonstrated significant efforts to engage clients in services. This high level of effort toward engaging, and tracking clients will be expected during ATR Ohana as well.

Meth clients, in particular, struggle with short term memory loss, health issues, and stigma related to their disease. Some may have difficulty self-directing or independently negotiating the service delivery system without high levels of structure, assistance, and advocacy on the part of ATR Ohana assessors and providers. This was evident during ATR II, when care coordinators with the highest staff-to-client ratio experienced high frequency of contact. Familiarity with care coordinators generally earned those agencies higher marks on client satisfaction surveys, and those clients were easier to locate and reported higher levels of sobriety at six months post enrollment. By assigning shared care coordination responsibilities among local ROSCs working with the client, ATR Ohana will simplify the demand on clients so they make additional appointments or travel during office hours to distant locations to remain in compliance with ATR Ohana enrollment expectations. ATR Ohana clients will be given an appointment card for their next care coordination appointment, and will be given written documentation that specifies their choice of provider, their next appointment date, time, location, and name of individual they are to meet. Whenever possible, ATR Ohana providers will be encouraged to include a picture of the agency staff, to assist meth clients and others who have difficulty with short term memory, auditory processing, or other memory issues, comprehend and comply with future appointments.

Ensuring Genuine, Free, and Independent Choice

As demonstrated in ATR II, Hawaii has been effective in engaging a balanced ratio of FBCO and secular provider agencies. Every service category was populated with more

than two providers. (See Attachment 1 - ATR II Provider Directory) The list of committed ATR Ohana provider agencies will offer clients similar freedom of choice. Clients will be free to transfer between selected provider agencies. When there is limited choice in a service area, project staff will solicit alternate service providers in that category in that geographic region to enroll in the ATR Ohana network, and/or will provide technical assistance to other providers in the area to assist them with development of appropriate alternatives for the service category in their geographic area of choice.

Measures of Client Satisfaction

Client satisfaction surveys were implemented in ATR II, and an updated, simplified document will be implemented during ATR Ohana. Data from the survey will be incorporated in PRCs that inform clients about how their peers view various providers' capacity and competence. The VMS contractor is developing a client satisfaction survey that is expected to be available during ATR Ohana. This instrument will be embedded in the VMS, and will be implemented during ATR Ohana once it is available. Hawaii's ATR Ohana provider network and project staff facilitated SAMHSA CSAT's ATR II Cross Site Evaluation survey of clients. Project staff awaits the results of those responses, with the intent to learn from the anonymous feedback that is gathered.

Four (4) Year Implementation Plan

For further information regarding the four-year plan for implementing ATR Ohana, including specific milestones with target dates for their achievement and the parties responsible for achieving milestones, please see Attachment 5 of this application.

Project Narrative

Section C: Readiness to Expand

Ability to Implement Within Three (3) Months

Hawaii's existing VMS, which manages client information, issues and tracks vouchers for reimbursement, and automates daily reporting of all required SAMHSA data points, will differentiate between ATR II and ATR Ohana funding streams. This is an important point to emphasize, since there will be approximately a one (1) month overlap between the two grant periods. All contracted enhancements to manage this overlap of funding periods will be fully operational within 90 days of NoA.

Expanded treatment and RSS categories will be available within 90 days. This prompt expansion will be possible because of the current relationship that ADAD has with existing service providers statewide, some of which are FBCOs. As entities are existing partners with ADAD, their staff have been trained in both VMS and have service delivery competencies in treatment and/or RSS. Updated MOUs for all service categories will be signed within 90 days of NoA.

Enhanced client enrollment via VMS will be available within 90 days. Training to community social service providers on procedures for directly referring clients into the VMS will be developed. The first training will be completed within 90 days of NoA. Client referral to ATR Ohana will be implemented within 90 days of NoA. During ATR II, Hawaii experienced a demand for recovery support services that exceeded funding capacity. Existing providers have created wait-lists of eligible clients, facilitating prompt client enrollment. Upload of Federally mandated GPRA data will commence within 90 days of NoA, and is incorporated in the VMS service contract.

Project staff have received written commitment from numerous institutions, agencies and programs willing to sign MOUs establishing referral pathways, stipulating how ATR Ohana will partner with each entity, and projecting the number of referrals they will be able to make. (See Attachment 1)

Current Capability to Implement VMS

ATR currently makes eligibility determinations based on the CAGE-AID screening instrument. A positive score enables VMS enrollment in ATR II. In ATR Ohana, the CRAFFT will be added to the VMS as the screening instrument to determine eligibility for those ages 12 years to 18 years. The VMS records intake GPRA data, documenting eligibility. Further eligibility for treatment and RSS service categories is determined using the ASI, A.D.A.D. and RSSQ, which will also be recorded in the VMS.

ADAD currently certifies substance abuse treatment providers, and project staff will make eligibility determinations for RSS providers. ADAD will enforce eligibility determinations for both treatment and RSS providers. Current FBCOs were provided TA to ensure compliance with eligibility requirements and project staff will continue to assist new FBCOs with completing the required eligibility documents and procedures. ADAD

manages the current VMS through contracts for data hosting, upload of federally mandated data, program enhancements, and TA to staff and providers.

Existing VMS monitoring software assists project staff with identifying and tracking key measures related to management of grant funds. These reports are regularly extracted from the VMS and monitored for project performance and emerging trends. These details have informed staff's decisions regarding adjustments in project implementation, enabling project staff to meet key grant targets. Project staff set and enforce reimbursement rates through the VMS. Maximum caps on provider services and costs per client are automated through the VMS. Automated collection and reporting of client data and voucher details to SAIS is managed in real-time through the VMS.

Expertise with interpreting VMS data was gained during ATR II, and additional QA measures were identified and tracked to improve prevention of and detection of waste fraud and abuse using the VMS. These insights guided project staff toward changes to procedures and prompted additional training and TA to provider staff.

The experiences gained and lessons learned in ATR II have informed the shape of acceptable standards and practices for ATR Ohana service providers. FBCOs have developed interventions that are correlated with positive client outcomes. Project staff and provider groups have collaborated on identifying and documenting quality practices. These protocols, with demonstrated effectiveness, efficiency, and accountability, are being incorporated into the ATR Ohana procedure manual. The completed 2010 revision of the ATR Ohana Provider Manual will be ready for distribution to providers within 90 days of NoA.

Treatment and RSS providers will be required to complete a minimum level of training in ATR Ohana procedures and demonstrate competency in each area of content prior to their agency being authorized to deliver reimbursable services. Each agency will, in turn, have a designated Senior Agency Staff (SAS) responsible for on-going training content and updates, and will be responsible to see that agency staffing changes will not affect service delivery. Regular VMS and ATR Ohana procedural training will be offered no less than twice-yearly, and staff trained in-house by that agency's SAS will be required to attend the next available project staff training opportunity.

SAMHSA TA was used extensively during ATR II, a contributing factor in the sharp turn-around in the performance of ATR II. Webinar and place based training opportunities from SAMHSA will continue to be utilized to assist with prompt implementation and effective execution of ATR Ohana.

ADAD monitors and sanctions purchase of service treatment contracts, and ATR II monitors and sanctions RSS providers in Hawaii.

RSS providers in ATR II conducted client screening and assessment of both treatment and RSS needs that determined eligibility for ATR II and related service categories. By expanding to include treatment in ATR Ohana, project staff will continue this service.

The CAGE-AID and CRAFFT will be used to screen for eligibility to enroll in ATR Ohana. The ASI or A.D.A.D. will assess clinical need, and the RSSQ will identify client eligibility for RSS categories.

The current VMS is able to issue vouchers for treatment and RSS. Through contracted enhancements for ATR Ohana, all screening and assessment tools will be embedded into the VMS, ensuring that referral to treatment and recovery providers is driven by assessed need and client choice.

Project staff have developed the ATR II Provider Directory. For ATR Ohana, this directory will be merged with a PRC and published on the ATR Ohana website for public information.

Potential Operational Problems

Continued exemption from Hawaii's usual procurement and fiscal reimbursement processes will be required to use MOUs to formalize ATR-Provider relationships and to expedite vendor payments during ATR Ohana. Project staff will begin the process of continuing to secure those exemptions and will secure required approvals within 90 days of the NoA.

While current project staff have verbally committed to remaining in their positions during the operationalization of ATR Ohana, unexpected staff changes may occur during the grant period. Project staff participate in frequent team meetings, and are becoming familiar with the responsibilities and job duties of each key staff position. In the event that a key staff position is vacated, an immediate request to refill that position will be submitted by project staff, and hiring efforts will commence. Federally funded project staff are exempt from State hiring restrictions.

Hawaii DOH is currently determining a preferred version of electronic health records (EHR) management software for the division. Regardless of the program selected, ADAD will retain the current VMS throughout ATR Ohana. The VMS has capacity to share data with other EHRs that are under consideration, and ATR Ohana should not be negatively impacted by the final DOH decision.

During ATR II, ADAD worked with DHS at the administrative and middle management levels to embed protocol for screening and referral of eligible clients to ATR II. Project staff conducted multiple trainings with DHS staff to answer questions and distribute information. ATR client benefits were stressed, along with information on how referrals could benefit the worker. Referral rates from DHS remained low. After consultation with the SAMHSA GPO, Hawaii requested an expansion in scope to including clients in treatment. A second expansion in scope included clients within 2 years of discharge from treatment. A sharp surge of client enrollment required reductions in services to effectively manage grant funds for the duration of ATR II.

As a result, project staff recognized that it is insufficient to establish referral pathways programmatically or through training alone. Client targets may need to be closely

tracked, periodically adjusted, and vigorously promoted. Partnership with stakeholder institutions must take place at the highest levels of administration and be supported by direct service providers as well as promoted by mid-level supervisors to ensure that client targets are met when populations are narrowly defined. ATR has linked across traditional silos of influence to ensure clients transfer between system components, facilitating service delivery through collaboration among various ROSC elements. Direct appeals to line staff were most effective in producing client referrals to ATR II. ATR Ohana will benefit through formalization of these partnerships and referral pathways with treatment and RSS FBCOs, with the DOC, with AMHD, with the National Guard, and with primary care providers.

The MOU process significantly eases eligibility criteria for FBCOs to deliver treatment services when compared to the usual service procurement process, and will enable treatment providers to deliver services to ATR clients, expanding ATR Ohana's Provider Directory. A significant number of providers already deliver faith or cultural content in their services, and this will increase client choice in Hawaii once treatment is added to ATR Ohana services.

By expanding to at least one additional neighbor island for RSS, ADAD will be ensuring that clients are not forced to relocate to Oahu for supported recovery. Similar to the pilot implementation on Oahu, client choice is likely to be limited during start up of ATR Ohana, but will be assured over time as project staff meet, engage, and enroll a variety of FBCOs and treatment providers in the expanded jurisdiction.

When choice is limited, providers will be encouraged to provide their services with optional faith content if no other choice is available to clients. Recruitment efforts to ensure choice will require significant commitment of administrative funds, because of the need for inter-island air travel. The cost for this administrative expense has been allocated in the proposed budget.

ATR Ohana is not designed to meet all the needs of eligible clients in Hawaii. Service categories were based, in part, on input gathered from neighbor island contacts who are likely to understand local client needs and system gaps. ATR Ohana will be promoted as an option for clients when other resources have been exhausted. Accurate screening and assessment-driven authorization for treatment and recovery referrals, along with project-wide promotion of alternate services available to the client will minimize excessive demand for ATR Ohana services. In most extreme circumstances, a reduction in scope or service array may be negotiated with SAMHSA's GPO, ensuring that grant targets are not compromised.

Project staff recognize that legitimate need for services will far outpace the capacity of ATR to enroll and deliver program services. By utilizing TA provided by SAMHSA, Altarum, and the Center for Faith-based and Neighborhood Partnerships (CFNP) during ATR II, project staff developed the expectation that there may, from time to time, be episodes where clients experience a wait period before enrollment slots become available. In both wait-list episodes during ATR II, clients tolerated wait periods, existing service

delivery was uninterrupted, and after brief delays (less than 90 days in most cases), ATR resumed client enrollment for the full range of ATR services and for full periods of eligibility. While wait-listing is not optimal, this tool proved essential for prudent management of limited grant funding. An additional lesson learned is that project staff will need to implement a VMS "life-time" expenditure cap per client to more effectively manage grant funds.

Potential conflicts of interest will be avoided by allowing clients to be screened for and referred to ATR Ohana electronically from a variety of community based social service agencies who will receive no compensation for that referral. This will reduce the likelihood that agencies will have conflicts of interest when screening clients for ATR eligibility. Referring agencies do not conduct assessments, and only assessors are able to make initial referrals to the service provider network once the client has completed enrollment. As part of the intake process, assessors will ensure that clients are not coerced into choosing a particular provider agency, but have free choice among available providers. Assessors will not be allowed to bill for any other service category under ATR Ohana, minimizing the likelihood that conflict of interest would influence their determination regarding levels of care or service provider referrals.

Other Project Partners

FEI, one of the current WITS VMS contractors for ATR II, will continue to be a partner with ADAD throughout ATR Ohana, providing data hosting, system enhancements and maintenance, and daily upload of mandated GPRA and voucher data. FEI will also develop a WITS Operator's Manual for use in training ATR Ohana Providers.

Steve Okano, the University of Hawaii (UH) WITS IT consultant, will continue to be a WITS VMS contractor for ATR Ohana, providing TA to project staff and provider agencies, either directly through training, or indirectly through management of the WITS Help Desk for provider agencies. Access to this contractor's CITRIX "GoTo" Distance Learning Platform will benefit ATR Ohana as project staff will be able to deliver frequent training content to remote neighbor island FBCOs.

The following seven (7) institutions have committed to formalizing partnership with ADAD through MOU for referral of clients to ATR Ohana: Department of Public Safety, DOH AMHD ACCESS Line, First Judicial Court, Hawaii National Guard, Interagency Council on Intermediate Sanctions (ICIS), UH John A. Burns School of Medicine, and the UH Myron B. Thompson School of Social Work. These entities will have direct referral capacity to screen and refer clients, via electronic VMS, to ATR Ohana assessors.

The following current ATR II RSS providers have committed to formalizing their continued partnership with ADAD through MOU for referral of clients and for delivery of treatment and/or RSS services to clients in ATR Ohana: CARE Hawaii, Charles A. Patterson, LLC, Counseling & Spiritual Care Center of Hawaii, Gateway Educational Services, Hale Naau Pono, Hale Oiaio, Helping Hands Hawaii, Hope Chapel, Hope Incorporated, Kulia Na Mamo, Makana O Ke Akua, North Shore Mental Health (NSMH), Oahu Counseling, Ohana Family of the Living God, Path Clinic, PDMI-Care

Inc., Poailani, Salvation Army Family Treatment Services, STARR, Starting Over in Recovery, The Inspirational House, The Institute For Family Enrichment, Windward Baptist Church Rebuilders Addiction Ministry, Women In Need, and WorkNet, Inc. Of these twenty-five (25) providers, sixteen (16), or sixty-four (64) percent, are faith-based or culture-based providers.

The following potential treatment providers have committed to formalizing their partnership with ADAD through MOU for referral of clients to ATR Ohana: AIDS Community Care Team, Aloha House, Big Island Substance Abuse Council, Hina Mauka, Hope, Help, and Healing Kauai, Island Star, and Ka Hale Pomaikai. Of these six (7) providers, at least four (4), or sixty-seven (57) percent, already include, or have expressed interest in including, faith-based or culture-based content in their programming.

TJ Mahoney, a DOC contractor, has committed to formalizing partnership through MOU for referral of clients to ATR Ohana. Together Strengthening Our Community Services (T-SOCS), an emerging administrative services organization for FBCOs, has committed to formalizing partnership through MOU for referral of clients to ATR Ohana.

These institutions, agencies, and FBCOs are existing stakeholders in Oahu's ROSCs, or represent agencies who have expressed willingness to be active in the development of ROSCs on neighbor islands. They serve over 79,000 individuals annually, as stated in their letters of intent, and provide a wide range of publically and privately funded services to clients with SUD, many whom may not currently be engaged in the traditional treatment system. (See Attachment 1 for the complete list of agencies, client numbers, and islands of operation)

Project Narrative

Section D- Management, Staffing, and Cost Controls (20 points)

Program Management

ADAD manages project staff within the Kapolei office under the supervision of the Division Chief, Keith Yamamoto. ADAD manages the VMS through contractors. The VMS has automated controls in its programming to ensure the prevention and detection of waste, fraud and abuse. VMS prevents duplicate billing for the same service by multiple providers, for multiple billings for the same service on the same day, and for overlapping periods of time for the different services. All keystrokes in the VMS are captured to facilitate complete program audit. The VMS fiscal module allows ATR to recoup overpayments or inappropriately claimed funds through adjudication and reverse-charge invoicing. VMS reduces the likelihood of system abuse by preventing duplicate enrollment of the same client by assigning an unique client identifier generated using the client's name, date of birth, and gender.

The VMS facilitates program audits by providing remote access for project staff, promotes quality of service delivery to clients by tracking client movement through the system, allows oversight of client enrollment levels at each agency, issues alerts on delinquent client records, and generates reports on the frequency and duration of client contacts and promptness of voucher redemption.

The VMS manages multiple funding sources through contract modules that manage distinct funding streams to ensure clients access only the services for which they are eligible. This allows project staff to identify and prohibit supplanting of existing funding. Through the VMS, project staff will monitor enrollment and expenditures, and set expiration dates for vouchers that are short term, enabling project staff to avoid the experience of "runaway enrollment" and high encumbrance of vouchers without correlated prompt redemption of those vouchers, as was experienced during ATR II. Grant management tools distributed by SAMHSA during ATR II are being used by project staff to manage close out of ATR II, and versions of these tools were used for planning enrollment and expenditures for ATR Ohana. VMS Reports will assist with fund management by providing real-time data to project staff and will promote favorable service practices, demonstrate efficacy of ROSC practices, and enhance FBCO sustainability.

Project staff will provide VMS training to ATR Ohana providers. During ATR II, project staff learned that frequent repetition will be required before FBCOs are able to demonstrate competence using system features. ATR II providers required extensive remedial level TA on basic computer operations, including use of Windows operating systems, accessing and using Internet Explorer, word processing and accounting software and spreadsheets. By the end of ATR II, all provider agencies were able to use the VMS to engage clients and to bill for and document client services independent of project staff direction. A similar level of training and TA will likely be necessary during ATR Ohana as it expands its provider network to include FBCO treatment and RSS agencies not

familiar with VMS. Project staff have directed VMS contractors to create an Operator's Manual for ATR Ohana that is user-friendly and can be updated by project staff as system enhancements are incorporated.

Available Resources

ADAD contributes a significant amount of in-kind resources for ATR Ohana. No less than five (5) percent in-kind level of effort (LOE) will be provided to project staff by the Division Chief, facilitated by project staff placement in the same office. Project staff use major office equipment, receive administrative support, access to internet technology, utilities, and other work place conveniences essential to project operations as in-kind contributions. All desks, computers, and supplies purchased through ATR II administrative funds will remain designated for ATR Ohana project operations.

Despite serious budget reductions during the period of ATR II, ADAD sustained these in-kind supports to project staff. ADAD was unable to negotiate an exception to state worker furloughs during the current budget year, and as a result, project staff experienced periods of furlough alongside tenured state co-workers with minimal disruption to project management.

ATR Ohana benefits from cost-sharing through ADAD's VMS. Collaboration with VMS contractors is partially in-kind, along with in-kind support from UH through periodic placement of social work interns under the supervision of the ATR II Project Director. Formal MOUs for VMS contracts will continue during ATR Ohana with VMS TA provided between 5 and 15 hours weekly, averaging twenty (20) percent LOE by ADAD's VMS consultant. On-going VMS TA will be delivered by VMS contractors to project staff and providers to ensure monitoring of billing practices, completeness of documentation, and auditing of providers for accountability, prevention, detection and reduction of waste, fraud, and abuse.

Project staff will utilize an existing distance learning platform to facilitate cost-effective expansion of ATR Ohana. The cost for this element of program management is in-kind and training content through this platform will be ready to implement within 90 days of notice of award.

ADAD considers the existing trained and operational provider network a valuable resource for ATR Ohana. These VMS competent stakeholders will enable project staff to implement ATR Ohana promptly.

VMS contractor fees for hosting client data, automating compliance with required data-uploads and reporting requirements of the grant, creation of the Operator's Manual, and ongoing enhancements will be included in the twenty (20) percent of grant funds allowable for administration of ATR Ohana.

Other Agencies with Roles and Responsibilities

ATR Ohana provider network and stakeholder groups, as formalized through MOUs, will be essential to ensuring that clients eligible for ATR are identified and promptly referred

for services. VMS enhancements will include automated protocols that will allow direct referral into VMS by various social service agencies without requiring those referral agencies to be ATR Ohana providers. Screening and referral to assessment will be guided by VMS alerts that guide the referral agency staff through an automated screening, then allowing referral to ATR Ohana assessors when the screen is positive, indicating that the client is eligible for ATR Ohana services.

MOUs with assessors will define procedures for enrolling eligible clients to ensure compliance with grant mandates, such as collection of intake GPRA data and completion of treatment and RSS assessments. Referral to treatment and RSS provider agencies will only be allowed by the VMS after assessments have been completed. Provider agencies that receive the client referral will use the VMS to document, bill for, and capture required grant data.

While the VMS contracting feature will manage multiple funding streams available to ADAD, preventing supplanting of existing funding, project staff will take measures to further ensure that no supplanting of existing funding occurs. FBCOs will receive frequent information about existing community resources. Provider agencies will be directed to exhaust alternate funding sources prior to billing ATR Ohana for treatment or RSS services. Communication about available community resources to the provider network is essential to assist them with remaining up-to-date on the rapidly changing options available to clients from a variety of service provider agencies. During ATR II, project staff and RSS providers shared information through various means of communication about existing community resources available to clients, minimizing supplantation of funds.

During ATR II, project staff provided extensive public education and outreach to the community to help social service providers identify eligible clients. This effort was effective at helping stakeholders accurately target clients eligible for ATR II, as demonstrated by the high rate of completed enrollment for clients referred to ATR II. Over eighty-nine (89) percent of those referred to ATR II were eligible for enrollment. Expansion of community education to stakeholder groups will be used to ensure that multiple partners continue to accurately identify, screen, and refer those eligible for services to ATR Ohana. This high level of accurate pre-screening of eligible clients by a diverse stakeholder group during ATR II suggests that project staff can be more confident about expanding direct VMS referral to ATR Ohana, allowing social service stakeholders to expedite client referral, minimizing delay in accessing treatment and RSS services.

Project staff will be able to monitor and provide corrective assistance to RSS and treatment agencies struggling to utilize VMS. Project staff will replicate community "talk story" sessions that were effective during ATR II to outreach directly local FBCO providers encouraging them to identify their unique non-traditional service provider networks already in place in their communities. Project staff will foster collaboration among interested parties to formalize referral pathways ensuring partnerships that benefit clients and all elements of the ROSC. These sessions, facilitated by project staff will occur in the local community, will be hosted by a trusted member from an agency with

experience doing business within that community, and will be framed as an opportunity for the State to learn about existing resources, rather than framed as directive or focused on forcing change to existing community practices.

As experienced during ATR II, western-based approaches sometimes have limited applicability for non-traditional providers doing business with the State or providing services to clients. Alternate structures of authority may involve securing the endorsement, if not the participation, of community elders, prior to entering into official or formal agreements and MOUs. Additionally, local community practice is most effective when it is client centered, focuses on inclusion and support for the client rather than on removal or isolation of the client from family and community, and recognizes that in Hawaii, nearly everyone is related through extended families. This strong attachment to extended families must be respected, eschewing traditional definitions of what constitutes the boundaries of the family unit. ATR II enjoyed success on the island of Oahu. Already, project staff are receiving requests for services to be expanded into neighbor island communities. This word-of-mouth publicity will work to spark interest and participation in initial community forums in expanded ATR Ohana jurisdictions and will establish communication and referral pathways for delivery of future VMS TA.

Managing Provider Performance

Avoiding provider performance problems is more efficient than correcting them through monitoring and oversight. To ensure reliability, the State of Hawaii requires minimum documentation of an entity's business viability before approving any entity as a vendor for services procured through the state. Periodic on-site review of these business documents, GET clearance, general liability insurance, and documentation in client records will be conducted by project staff. Oversight of the day-to-day operations will reside at the agency level, and be the responsibility of the primary signatory of that agency's MOU with ADAD.

Early and frequent training supported by sample forms was not effectively implemented during ATR II. Project staff have fully developed relevant training content that can be replicated during ATR Ohana. Mastery of training content will be required prior to agencies being authorized to promote themselves as ATR Ohana providers.

On-going provider performance will be evaluated through desk review of VMS data uploads, which track a range of service elements including wait time until a client is served, frequency of service, length of service delivered, and escalation or decline in frequency of services across time.

Provider agencies are held fiscally accountable for the return of incorrectly distributed funds. ATR II has established the expectation that no supplantation will be tolerated, and that all funds expended on behalf of the client must be documented and justified, and will be verified by hands-on site visit reviews of client records along with independent confirmation on a random basis with clients to confirm that funds are expended legitimately, accurately and promptly.

When performance difficulties were identified during ATR II, project staff learned that technical assistance using sample scenarios was necessary to help providers recognize and make accurate, fiscally responsible decisions about client eligibility for services. In rare cases, when provider documentation was incomplete, project staff identified and documented the problem, and then implemented escalating corrective actions, use of incentives, and applied restrictions on VMS access and client enrollment. Insufficient improvement in provider performance resulted in temporary or permanent suspension of the MOU.

Previous ATR Grant Experience

Hawaii successfully implemented ATR II, earning a performance bonus during Year 2 of the project, and was recognized for accomplishments by SAMHSA CSAT at the National Grantee Meeting in Baltimore in 2008. Despite implementation delay, ATR II was able to encumber all Year 1 and 2 service dollars by the end of Year 2, expending 100 percent of Year 1 funds and 70 percent of Year 2 funds by September 2009. Project staff also managed per client expenditure within the proposed per capita target of \$1,950 per client, averaging expenditures by the end of Year 2 of \$1,946 per client. Project staff negotiated exceptions to State protocols, demonstrating the viability of alternate pathways of delivering fee-for-service to clients, while providing choices including FBCOs. The exceptions and exemptions required to implement an innovative project such as ATR II requires lengthy lead time to ensure that mandated State protocols are respected. Project staff have initiated requests for the required exemptions, minimizing the likelihood of repeating the delayed implementation time that occurred during ATR II.

Qualifications of the Key Staff

The project staff listed below were involved in the successful implementation of ATR II. They will be designated as key project staff during ATR Ohana as listed below:

Single State Authority (SSA)

Keith Yamamoto, MPA (Division Chief)

- Provides statewide oversight and management of substance abuse services
 - substance abuse prevention,
 - intervention
 - treatment
- Administrator
 - DHS Office of Youth Services (OYS) - Maintained statewide services for youth at-risk of involvement with juvenile justice
 - State Department of Labor and Industrial Relations - Managed various school-based vocational education and career development programs.

Project Director

Bernie Strand, MSW, CSAC – Hawaii; MSW, LAT - Wyoming

- 5 years experience in ATR implementation
- Treatment Services Coordinator for ATR I grantee (Wyoming)
- Project Director for ATR II grantee (Hawaii)
- 20 years direct practice in prevention and treatment settings
 - Primary medical care setting
 - Residential mental health setting

- Medically managed inpatient SUD treatment facility
- School social work K-12
- Teacher K - graduate level, including community education
- Experienced in institution-based delivery of human services
 - FBCO non-profits
 - Private sector for-profits
 - Public sector (i.e., city, county and state)

Treatment and Recovery Support Services Coordinator

JoHanna Mechergui, PhD, CSW – Michigan (Service Developer)

- 4 months experience in ATR implementation
- Educational Administrator (Principal)
- Educational Specialist
 - Learning Disabilities
 - Special Education
 - Speech Pathology
- K-12 Teaching Certification
 - Hawaii
 - Michigan
 - New Jersey
- International multi-cultural experience
- Local cultural competency

Information Technology (IT) Coordinator

Allan Sagayaga, MEd in Counseling and Guidance (Quality Assurance Monitor)

- 5 months experience in ATR implementation
- QA experience with publicly funded housing programs
- Data tracking and audit experience
- Hawaii Public Housing Authority
 - Experience with contracts and procurement
 - Managed grievance hearings
 - Developing resident associations and advisory boards
- Vocational rehabilitation counselor
- School Counselor and coach

Fiscal Coordinator

Enrique "Mike" Palma, BA (Accountant)

- 2 years experience in ATR implementation
- Experienced with State fiscal processes and migrating data between disconnected information management systems
- Over 30 years fiscal management
 - Private for profit
 - State government
 - Non-profit social service agencies.

These qualifications, experience levels, and familiarity with ATR II will allow ATR Ohana key staff to implement the 2010 ATR grant promptly.

Ability to Collect and Report GPRA Data

The current VMS collects and reports required GPRA data daily, including data on client outcomes and the costs and redemption rates of vouchers, to SAMHSA. While occasional upload problems were experienced during ATR II, project staff identified the issues, collaborated with VMS contractors to resolve the incidents and successfully resumed direct data upload to SAMHSA promptly.

Regular Monitoring of VMS

Specific VMS reports track problems with data upload, facilitating the ability of project staff to promptly determine the issue, to specify the date of the error, and to locate where in the VMS technical problems occurred. This close collaboration with VMS contractors will continue throughout ATR Ohana, building on the technical knowledge gained in ATR II, and minimizing similar technical difficulties.

ATR Ohana will contract VMS services, which includes creation of specialized data reports that include the cost per service, per client, per agency, per reporting period, and cumulative implementation data. Client outcomes as reported by SAIS are reviewed no less than weekly to compare posted data with VMS data. This ensures integrity of uploads and accuracy of reporting project performance. VMS reports also shape quality improvement efforts. Review of SAIS data is authorized for all key staff. During ATR Ohana, VMS Reports will be available to provider agencies to assist them in their own quality improvement efforts. These efforts reduce unutilized service categories, while offering detailed per capita utilization rates and outcome measures to provider agencies. By identifying agencies whose enrollment trends increase, project staff are able to identify needed areas for expansion of service categories. This has also triggered increased audits to look for potential waste or abuse of project resources. While concerns were raised about potential fraud in agencies with high client enrollment, no incidents of fraud were confirmed during the course of quality assurance site reviews, or targeted client surveys conducted by project staff.

SAMHSA's grants management tool kit provided spreadsheets that facilitate forecasting and tracking of enrollment and expenditures during ATR II. These tools have been used in planning ATR Ohana activities, enabling project staff to project reasonable targets for the 2010 ATR Grant. Monthly tracking of expenditures against anticipated targets will alert project staff to emerging trends, and analysis of those data shifts will guide project staff to initiate corrective actions to ensure managed implementation. In combination with VMS reports, project staff will use a variety of measures to track redemption rate of vouchers, including reissuance of un-redeemed funds, ensuring prompt and full expenditure of grant resources.

Recommended program adjustments will be identified by project staff in collaboration with clinical and RSS providers, and informed by clients and stakeholder groups. Suggestions will be reviewed by ADAD and discussed with the GPO and relevant

consultants. Adjustments that are most likely to provide empirical results demonstrating improved service delivery, including cost-effectiveness, will be promoted. ATR Ohana will promote emerging evidence-based practices, such as RC, which are not currently funded by ADAD, by including such practices in the treatment service array for ATR Ohana. This will encourage treatment providers to use emerging models of effective, efficient low-cost interventions.

Incentives for Positive Outcomes

Maximum capacity for client enrollment will be raised when provider agencies demonstrate quality service delivery and the ability to increase staffing patterns to accommodate higher levels of client enrollment. Efforts that contribute to ATR Ohana achieving 80 percent completion rates for the GPRA six-month follow-up will be recognized in the monthly newsletter. Outstanding contributions from the provider network will be recognized and rewarded with certificates and designations as "Senior Provider" for those demonstrating outstanding competencies. Monetary incentives proved ineffective with motivating ATR II FBCOs, but recognition by project staff of individual and agency accomplishments and contributions were valued by FBCOs.

During ATR II clients who had frequent contact and reported close relationship with their service provider were likely to report higher levels satisfaction on survey instruments, were engaged and responsive to provider contacts, and reported higher levels of sobriety in their six-month GPRA follow-up. As a result, project staff have adjusted ATR Ohana's care coordination model to promote sustained relationship with service providers who coordinate client care. These providers are the designated agencies for conducting six (6) month GPRA follow-up, and will complete them in familiar sites convenient to clients.

Reimbursement Rates for Vouchered Services

ATR II reimbursement rates were based on best estimates of comparable services available through state procurement or through comparable private service providers. Project staff considered several factors in setting ATR Ohana rates, including competitive rates of compensation in Hawaii, review of reimbursement rates used by other ATR states when Hawaii has no comparable usual and customary charge in a specific service category, and compensation rate set with respect to compensation for a comparatively desirable or similarly valued service in the community.

In cases where the reimbursement rates were determined to be too low to attract quality service providers, project staff increased reimbursement rates until competent service providers elected to participate. In other cases, where reimbursement rates or quantity of units for service exceeded the usual demand for that service, units pre-authorized for that particular service were reduced, and special requests to extend vouchers were considered on a case-by-case basis.

During ATR II the rate of compensation required to engage agencies able to provide centralized client intake exceeded fifty (50) percent of the total available service dollars for the average client. This left restricted funding for the client's choice of services and

defined a maximum period of service delivery, bounded by the length of pre-negotiated monthly minimum payments to the central coordinating units. As a result of this arrangement, project staff implemented a seven-month maximum period of ATR II eligibility for clients. Time-limited ATR eligibility was insufficient to meet the needs of many clients, but did underscore the urgency of prompt service delivery, and built in a need for RSS providers to empower client self-sufficiency. Setting a maximum period of ATR eligibility also had the unintended consequence of discouraging referral to ATR II by stakeholders who waited to refer clients "until they really needed" services. At times, this meant that clients presented for ATR when their level of crisis was high, or after clients had exhausted alternative service options, and were in immediate jeopardy of being homeless, incarcerated, or permanently separated from dependent children by DHS.

ATR Ohana will no longer provide guaranteed monthly reimbursement for any vouchered service. ATR Ohana clients will have service delivery capped fiscally, and clients can access services that do not supplant other funding at any time in their sobriety once enrolled in ATR Ohana. Clients may select services based on their changing recovery needs, prioritized to address one-at a time, if necessary.

Proactive Management to Reduce Health Disparities

During ATR II, Hawaii had a high proportion of clients reporting meth use. Meth clients remain a target population for ATR Ohana. Native Hawaiians are disproportionately represented in several target groups, including clients involved with DHS, Drug Court, and primary healthcare providers. Hawaii National Guard has identified a need for its service members and their families' members to receive treatment and RSS. This target group is being served by ATR II, and will continue throughout ATR Ohana. Discussion is underway with representatives of the National Guard to include ATR Ohana eligibility information regarding impaired family members during regularly scheduled briefings about social services available to soldiers' family members.

During ATR II, project staff acknowledged significant oral hygiene needs affect recovering meth clients. ATR II temporarily partnered with community dentists, providing exams, cleaning, X-rays, and infection control to meth clients in recovery. Dental providers exhausted Medicaid funding before accessing ATR to provide essential dental care to meth clients, where dental services to indigent meth clients were not available. By facilitating comprehensive resolution of compromised dental health issues for meth clients, project staff learned that ATR II meth clients were more likely to complete multi-step treatment plans than non-enrolled meth users, were invested in learning to care for their prosthetics, reported improved nutritional habits, and were no more likely to "no show" for dental care appointments than the non-addicted dental patient. Dentists reported satisfaction with their opportunity to provide preventive dental health education to clients aimed at preserving their existing teeth, and encouraged clients with children to access early preventive dental care for their children.

Project staff have collaborated with the Dental Health Division (DHD) to identify a list of reasonable dental care services for meth clients, to set reimbursement rates, and to define

criteria for approving dentists as ATR Ohana providers, ensuring that this health disparity is addressed during ATR Ohana.

Ethnic population categories for ATR Ohana that are usually combined in NOMs are disaggregated and captured in the VMS. Project staff are reviewing these data to determine whether trends may be present regarding SUD frequency among Pacific Islander populations.

Improved Efficiencies

Services categories will be re-evaluated yearly and the utilization patterns of available services will drive their continued presence on the menu of available ATR Ohana services. This will most effectively ensure ATR Ohana responds to the client and ROSC needs throughout ATR Ohana. Feedback from client satisfaction surveys will be reported back to the provider agency and reflected in PRC distributed to clients enrolling in ATR Ohana underscoring the importance of client choice in the ATR Ohana.

Care coordination will be delivered through the client's treatment and RSS providers. By distributing the responsibility for care coordination among providers, ATR will increase the likelihood that clients have at least one provider ensuring that clients access existing community resources before utilizing grant funded services. VMS will alert all provider agencies working with the client when there are multiple ATR Ohana service providers, prompting provider staff to speak with the client about coordinated services. ATR providers will have the ability to secure client consent and make direct electronic referral to other treatment and RSS, minimizing the disincentive for clients to choose freely from resources because of the need to travel to a separate care coordination agency.

ATR Ohana will improve efficiency by combining two previous services, Housing Support and Housing Subsidy through use of clean and sober houses affiliated with treatment facilities. These facilities already provide program driven content that combines both cost of housing and a mentoring toward independence through skill building in budgeting, housing maintenance, and pro-social community living skills.

More automated VMS protocols, paired with a VMS Operator's Manual will reduce the direct supervision and frequent re-training required during ATR II, freeing up project staff to attend to other grant management duties. Bundling related service areas into broader categories of Individual or Group services, and allowing treatment and RSS providers to tailor content to client needs will minimize the number of distinct voucher categories and reduce the TA required to interpret service category content in many unique client situations.

While face-to-face meetings and trainings with new FBCO provider agencies will be critical for establishing partnerships on neighbor islands, training content may be delivered effectively to neighbor island provider agencies through distance learning technology as the grant period progresses. Project staff anticipate using distance learning technology more frequently with senior provider agencies and during later years of the ATR III.

Management within Reasonable Costs

Average expenditure per client for ATR Ohana will be \$1,400, well within the range suggested by SAMHSA in the RFP. This amount includes both treatment and RSS. Project staff will control costs by funding only low level ASAM services and braiding ATR with existing SAPT Block grant funds to enhance the existing continuum of care. ATR Ohana will provide only services with demonstrated need, desirability to the client, interest from the provider community, and demonstrated efficacy.

Average cost of treatment services will be relatively low and well within SAMHSA recommendations because ATR Ohana will only authorize lower ASAM levels of service reimbursement. The high rate of FBCO enrollment compared with the representation of secular, traditional service provider agencies will help project staff continue to ensure that a significant portion of ATR funds are expended toward FBCO. All ATR Ohana service category costs are set within the authorized ranges outlined in the 2010 ATR Grant RFP.

As a current grantee, Hawaii recognized in advance the challenge of implementation of such an innovative project within our isolated island community. Whereas other grantees may have large areas of implementation that requires extensive travel, few, if any, require travel by commercial air every time that face-to-face community outreach, provider training, and culturally responsive development of recovery oriented systems of care are needed. This is the situation for Hawaii, which is proposing to expand implementation during ATR Ohana beyond Oahu to at least one (1) neighbor island community.

In Hawaii, round trip air travel to some islands costs as much as \$800 per trip (Hana, Maui), while most air fare averages \$300 per staff, per trip. To maximize the benefit of each travel, contact with neighbor island providers will be coordinated and condensed into multi-day contacts, necessitating overnight travel in every instance. This adds significant cost to ATR Ohana's administrative costs for lodging and per diem, particularly in Hawaii's tourist-based economy. While on neighbor islands, project staff will require car rental and funds to purchase gasoline for travel between the airport and remote community locations. Fuel costs in these remote communities may be as much as \$5.00 per gallon. Each of these circumstances add administrative costs for expansion during ATR Ohana.

A second consideration involves moving from VMS operations during ATR II to ATR Ohana VMS. Because of the overlapping schedule for the two projects, extra costs are assessed by the VMS contractor to ATR II grantees. The VMS will be providing "dual hosting" for that period of time, and dual GPRA uploads and other data complications raise the cost to the contractor, who, in turn, passes that on to the grantee.

In Hawaii, ATR II was able to cost-share much of the original VMS developmental costs with other parts of the Alcohol and Substance Abuse Division, keeping start up costs low. Budget constraints will not allow similar accommodation during ATR Ohana. The VMS enhancements identified for ATR Ohana will smoothly transition Hawaii's system

between the ATR II and the ATR Ohana modifications. ATR Ohana will implement automated protocols that ensure confidentiality of client records and enhance prevention and detection of waste, fraud, and abuse. Costs to accommodate recovery support services assessments, which are required during ATR Ohana, will present ATR Ohana with significant expense over and above what was needed to implement VMS and assessment during ATR II.

The estimated VMS enhancements, including Operator's Manual, and distance training for providers, constitute 3.5 % of the entire budget for ATR Ohana. This is a significant commitment of authorized percentage for administrative budget, and would leaving insufficient administrative budget for project staff to most effectively implement expansion to at least one neighbor island community.

As a result, Hawaii is requesting special exception to the maximum cap of 20% administrative costs in budget allocations across all four years of ATR Ohana. Hawaii requests an increase to allow 25% admin costs as averaged across the life of the grant. While VMS costs will be front-loaded in Year 1, and lower in subsequent years, costs of travel and lodging to neighbor islands is expected to remain static, or increase during the same period of time.

While ADAD has concerned that, under the current administrative budget limitation of the grant, Hawaii is at significant disadvantage for implementing the highest quality of expansion efforts when compared to mainland peers, ADAD is nevertheless committed to expanding ATR Ohana and the ROSC model beyond Oahu to neighbor island communities.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

March 1, 2010

Dear ATR III Applicant:

As you are aware, the Access To Recovery (ATR) Request for Application (RFA) calls for information regarding the performance of a previously funded ATR grantee. Given that you have been the recipient of an ATR II grant award, the following information is being provided to you for your application submission, should your state or tribe decide to apply. Please provide this letter as Attachment VI of your application.

The data presented below reflect your ATR II performance:

Hawaii ATR II Data

Target Rate * (Yr 1)	Target Rate* (Yr 2)	Dollars Expended** (Yr 1)	Dollars Expended** (Yr 2)
21.5%	185.4%	18.4%	100.0%

*Source: Services Accountability Improvement System; Run Date: 1/4/2010

**Source: Financial Status Report (FSR) Year 01 and Year 02

Thank you for your interest in applying to this program.

Sincerely,

Anne M. Herron, MS, CRC, CAC, NCACII
Acting Director
Division of Services Improvement

Supporting Documentation

Section F – Literature Citations.

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Section G: Budget Justification

**Alcohol and Drug Abuse Division
SF 424A: Section B for 01 Budget Period**

Personnel (a)					
Job Title	Name	Annual Salary	Level of Effort	Salary Being Requested	
Project Director	Bernie Strand		1.0 FTE	67,492	
IT Coordinator (Quality Assurance Monitor)	Allan Sagayaga		1.0 FTE	57,708	
Treatment & RSS Coordinator (Service Developer)	Jo Hanna Mechergui		1.0 FTE	57,708	
Fiscal Coordinator (Accountant)	Mike Palma		1.0 FTE	51,318	
Secretary	To be hired		1.0 FTE	32,424	
Personnel Sub-Total (424A, Section B, 6.a.)					266,650
Fringe Benefits (b)					
	(38.29%)				
Personnel Sub-Total (424A, Section B, 6.b.)					102,100
Total Personnel Costs					\$368,750
Travel (c)					
In-state travel					
Airfare			\$	9,600	
Lodging and Meals			\$	7,272	
Rental Car			\$	3,480	
Mileage			\$	9,000	
Total In-state travel			\$	29,352	
Out-of-state required travel for grantee meetings					
Airfare			\$	10,500	
Lodging and Meals			\$	6,700	
Excess Lodging			\$	2,700	
Transportation			\$	800	
Total Out-of-state travel			\$	20,700	
Travel Sub-Total (424A, Section B, 6.c.)					\$ 50,052
Equipment (d)					
Laptop Computers			\$	2,000	
Desktop Computers			\$	2,000	
Software			\$	819	
Equipment Sub-Total (424A, Section B, 6.d.)					\$ 4,819
Supplies (e)					
Office Supplies			\$	5,570	
Supplies Sub-Total (424A, Section B, 6.e.)					\$ 5,570
Contractual Costs (f)					
WITS Web-based System			\$	97,900	
Contractual Costs Sub-Total (424A, Section B, 6.f.)					\$ 97,900



Construction (g)	N/A			0
Other (h)				
Puncher System (77%) - Assessment, treatment, case management and recovery services			\$2,284,152	
Printer & Publications			\$ 3,000	
Communication:			\$ 6,430	
Training			\$ 23,430	
Program Promotion			\$ -	
Other (Incentives & Access Line)			\$ 49,440	
		Other Sub-Total (424A, Section B, 6.h.)		\$2,366,452
Total Direct Charges (424A, Section B, 6.i.)				\$ 2,893,543
Indirect Costs (j)				
10.7% of total personnel costs			\$39,456	
(copy of negotiated indirect cost rate agreement is attached)				
		Indirect Costs Sub-Total (424A, Section B, 6.i.)		\$39,456
TOTAL (424A, Section B, 6.k)				\$ 2,933,000
		Program Costs	80%	\$2,333,592
		Administrative Costs	20%	\$ 599,408



Supporting Documentation
Budget Table for ATR Ohana

Table 1. Personnel Budget

Budget Category	Name	LOE*	Annual Salary	In-kind Costs	Year 1 Budget	Year 2 Budget	Year 3 Budget	Year 4 Budget
Personnel (Must list 4 key staff)								
SSA/Tribal Organization Administrator (all in-kind—5-10% LOE)								
Project Director								
IT Coordinator (Quality Assurance Monitor)	Bernie Strand	1.0 FTE	67,492		\$ 67,492	\$ 67,492	\$ 67,492	\$ 67,492
Treatment & RSS Coordinator (Service Developer)	Allan Sagayaga	1.0 FTE	57,708		\$ 57,708	\$ 57,708	\$ 57,708	\$ 57,708
Fiscal Coordinator (Accountant)	Jo Hanna Mechergui	1.0 FTE	57,708		\$ 57,708	\$ 57,708	\$ 57,708	\$ 57,708
Secretary	Mike Palma	1.0 FTE	51,318		\$ 51,318	\$ 51,318	\$ 51,318	\$ 51,318
	To be hired	1.0 FTE	32,424		\$ 32,424	\$ 32,424	\$ 32,424	\$ 32,424
	<i>If salary increases over years, you need to provide us a copy of the policy.</i>							
	Total Personnel Costs							
Fringe (38.29%)					\$ 266,660	\$ 266,660	\$ 266,660	\$ 266,660
Benefits								
Total Fringe Costs					\$ 102,100	\$ 102,100	\$ 102,100	\$ 102,100
Travel (Justify the Purposes)					\$ 102,100	\$ 102,100	\$ 102,100	\$ 102,100
In-state travel								
Out-of-state required travel for grantee meetings					\$ 29,352	\$ 29,352	\$ 29,352	\$ 29,352
					\$ 20,700	\$ 20,700	\$ 20,700	\$ 20,700
	Other							
Total Travel Costs					\$ 50,052	\$ 50,052	\$ 50,052	\$ 50,052

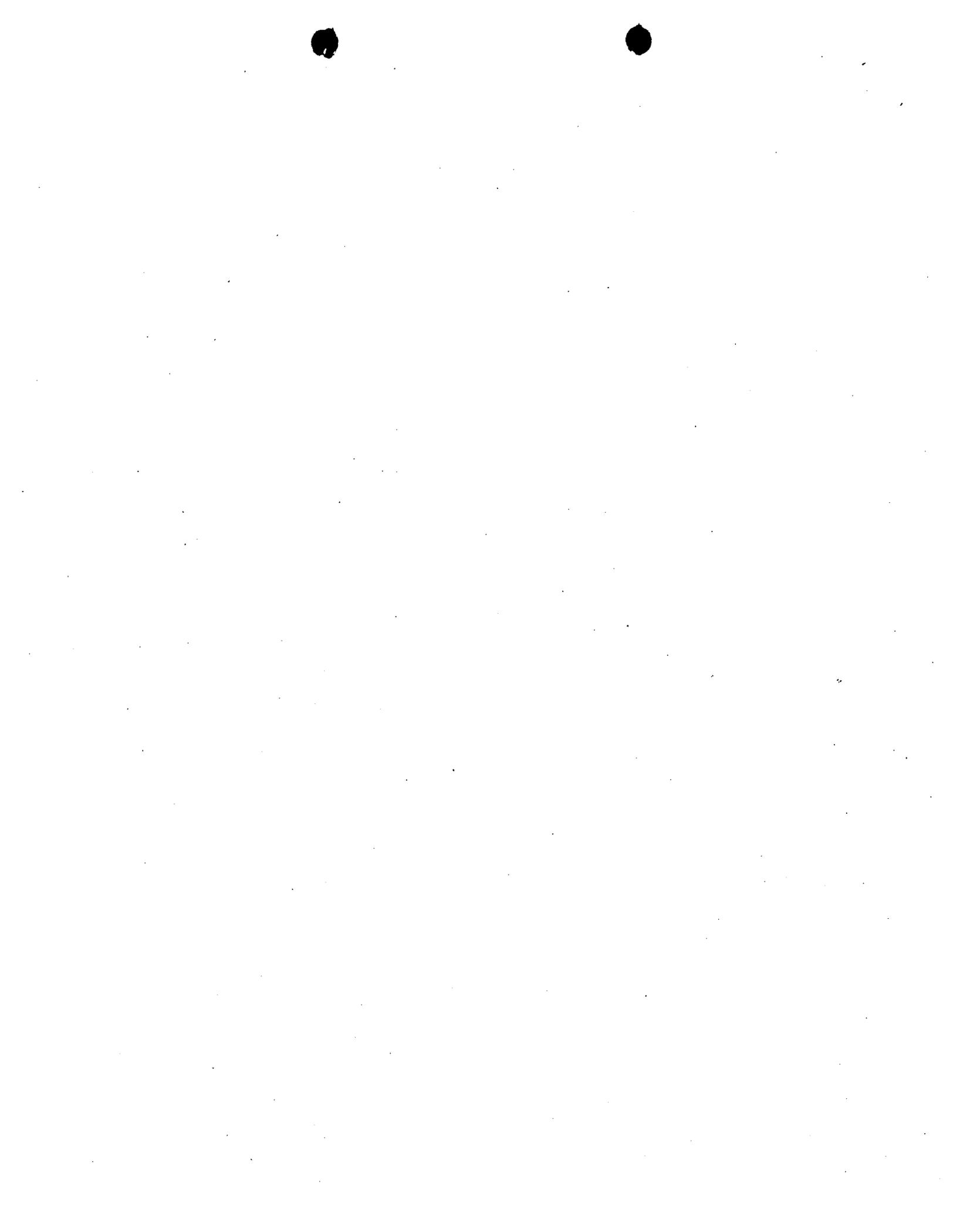
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Budget Table for the ATR Ohana

Table 2. Project Budget

	Year 1 Budget	Year 2 Budget	Year 3 Budget	Year 4 Budget
Equipment				
Equipment	4,818	0	4,000	0
Total Equipment Costs	4,818	0	4,000	0
Supplies				
Supplies	5,570	8,162	8,162	9,684
Total Supplies Costs	5,570	8,162	8,162	9,684
Contracts				
Consulting and Professional Services (WITS Web-Based System)	97,900	66,060	66,060	66,060
<i>(Grantees may not contract out assessment and vouchers. Only the implementation and maintenance of the voucher management system may be contracted out.)</i>				
<i>(Need to breakdown by tasks & person in detail; Clearly state the purposes of the contract. SAMHSA reserves its right to request a copy of your contract.)</i>				
Total Contracts Costs	97,900	66,060	66,060	66,060
Other				
Voucher Pool – electronic vouchers (Need to list the major services broken down by clinical and recovery support service provided, etc. Please provide this information in Table 3.)	2,284,152	2,153,240	2,133,849	2,223,402
<i>(Need to list any costs associated with methamphetamine issues. Please provide this information in Table 4.)</i>				
Printer & Publications				
Communications	3,000	12,000	12,000	12,000
Training	6,430	6,180	6,180	6,180
Program Promotion	23,430	18,000	18,000	32,000
Other (Incentives & Access Line)	0	13,892	3,217	0
	49,440	112,000	112,000	61,040
Total Other Costs	2,366,462	2,316,312	2,285,046	2,334,622
Total Direct Costs	2,893,643	2,808,396	2,782,070	2,829,168
Indirect Costs (10.7 %)				
(For future years if the rate expires provide estimates)	39,466	40,884	42,290	43,982
Total	2,933,000	2,849,000	2,824,360	2,873,160





Budget Table for the ATR Ohana

Table 4. Clients Served/Voucher Pool Breakdown for Year 1 of the Grant

Modality or Service Type	Average Cost using ATR Funds	In-kind Costs	Number of Clients	Total Cost
Clinical Services				
Assessment				
Recovery Check-Ups	\$180	110%	1,360	244,800
ASAM Level I.0	\$240	50%	618	148,320
ASAM Level 0.5	\$360	35%	411	147,960
High intensive outpatient ASAM Level II.1 - IOP	\$100	50%	619	61,900
Care coordination	\$1,200	90%	111	149,850
Recovery Support Services	\$200	100%	1,236	247,202
Transportation				
Education	\$300	70%	823	246,900
Child Care	\$320	50%	618	197,760
Gap Fund	\$480	15%	87	41,760
Dental	\$200	10%	62	12,400
Peer-based mentoring	\$250	40%	530	132,500
Housing	\$400	75%	927	370,800
	\$600	35%	470	282,000
Total				2,284,152

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Section G: Budget Justification

**Alcohol and Drug Abuse Division
SF 424A: Section B for 01 Budget Period**

Personnel (a)				
Job Title	Name	Annual Salary	Level of Effort	Salary Being Requested
Project Director	Bernie Strand		1.0 FTE	67,492
IT Coordinator (Quality Assurance Monitor)	Allan Sagayaga		1.0 FTE	57,708
Treatment & RSS Coordinator (Service Developer)	Jo Hanna Mechergui		1.0 FTE	57,708
Fiscal Coordinator (Accountant)	Mike Palma		1.0 FTE	51,318
Secretary	To be hired		1.0 FTE	32,424
Personnel Sub-Total (424A, Section B, 6.a.)				266,650
Fringe Benefits (b)	(38.29%)			102,100
Personnel Sub-Total (424A, Section B, 6.b.)				\$102,100
Total Personnel Costs				\$368,750
Travel (c)				
In-state travel				
Air (2 Staff Round Trips @ \$300 X 12 Trips + \$2,400 Additional for checked bags)			\$ 9,600	
Lodging (2 Nights @ \$84 X 2 Staff X 12 Trips)			\$ 4,032	
Meals (2 Staff @ \$45 Each X 12 Trips X 3 days)			\$ 3,240	
Rental Car (One Car @ \$100 X 2 Days X 12 Trips + \$90 Gasoline (400 Miles @ \$4.50/gallon) X 12 trips traveling 400 miles each trip)			\$ 3,480	
Mileage (500 miles X 3 staff X 12 months X \$0.50 mileage reimbursement (Oahu))			\$ 9,000	
Total In-state travel			\$ 29,352	
Out-of-state required travel for grantee meetings				
Air (5 Staff Round Trips @ \$950 X 2 Conference trips + \$1,000 Additional for checked bags)			\$ 10,500	
Lodging (5 Staff X 5 Nights Each Staff @ \$84 X 2 Conferences, + Excess Lodging Fees average \$50 per day X 5 Staff X 5 Nights Each Staff X 2 conferences)			\$ 6,700	
Meals (5 Key Staff @ \$45 X @ 6 Days X 2 Conferences)			\$ 2,700	

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Shuttle to Lodging (5 staff X \$80 Round-Trip Shuttle X 2 Conference2)			\$ 800		
Total Out-of-state travel			\$ 20,700		
	Travel Sub-Total (424A, Section B, 6.c.)			\$ 50,052	
Equipment (d)					
One Laptop Computer \$2,000 (amortized across 4 years)			\$ 2,000		
One Desktop Computer \$2,000 (amortized across 4 years)			\$ 2,000		
Software			\$ 819		
	Equipment Sub-Total (424A, Section B, 6.d.)			\$ 4,819	
Supplies (e)					
Office Supplies			\$ 5,570		
	Supplies Sub-Total (424A, Section B, 6.e.)			\$ 5,570	
Contractual Costs (f)					
Web-based System enhancements + WITS Hosting (1st Yr \$97,900; 2nd Yr \$66,060, 3rd Yr \$66,060, 4th Yr \$66,060)			\$ 97,900		
	Contractual Costs Sub-Total (424A, Section B, 6.f.)			\$ 97,900	
Construction (g)					
	N/A				0
Other (h)					
Voucher System (75%) - Assessment, treatment, case management and recovery services			\$2,284,152		
Copier Lease Rental: cost of lease + metered usage			\$ 3,000		
Communication:			\$ 6,430		
Monthly Telephone & Fax service costs \$38 X 12 X 5 staff =			\$ 2,280		
Air Cards \$50 X 2 staff + 65 X 12 X 2 staff =			\$ 1,660		
Cell Phones @ 12 months service X \$65 X 3 staff + \$50 each for 3 cell phones =			\$ 2,490		
Training: facilities rental, training materials (4 ROSC Events Yearly X \$2,928.75- Oahu, 4 ROSC Events Yearly X \$2,928.75- one neighbor island			\$ 23,430		

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Program Promotion			\$	-
Other (HePS - Incentives 1236 X average \$19 per incentive)			\$	23,484
Other (ACCESS Line client hotline services @ average of \$21 per client X 1,236 clients)				\$25,956
	5			
	Other Sub-Total (424A, Section B, 6.h.)			\$2,342,968
Total Direct Charges (424A, Section B, 6.i.)				\$2,893,543
Indirect Costs (j)				
10.7% of total personnel costs			\$39,456	
(copy of negotiated indirect cost rate agreement is attached)				
Indirect Costs Sub-Total (424A, Section B, 6.i.)				\$39,456
TOTAL (424A, Section B, 6.k)				\$2,933,000
		Program Costs	80%	\$2,333,592
		Administrative Costs	20%	\$ 599,408

Detail Rev



Supporting Documentation

Section G – Budget and Narrative Justification, Existing Resources, Other Support (Revised)

Summary: Of the total \$11,479,510 budgeted for all four (4) years of the 2010 ATR Grant, the allocation is as follows: Year 1 - \$2,933,000.00, Year 2 - \$2,849,000.00, Year 3 - \$2,824,360.00, and Year 4 - \$2,873,150.00. Of the \$2,933,000.00 budgeted in Year 1, \$2,333,592 (80%) is allocated for the direct client services and \$599,408.00 (20%) is allocated for the administrative costs. Non-reoccurring costs (\$36,909) are for equipment purchases (computers and software for staff, communications costs for cell phones, remote wireless internet devices, and enhancements to the WITS system) incurred in Year 1. These costs are reallocated in Years 2 and 3 to cover increased costs for salaries as determined through collective bargaining agreement, and to allow for program promotion to ensure sharp increases in client enrollment are achieved.

Personnel

The Project Director will provide full-time (2,080 hours annually) project oversight and is classified under the Hawaii State Civil Service System according to the HGEA-AFSCME Collective Bargaining Agreement for the Unit 13 (Professional and Scientific) category at the salary schedule for the SR 28E level. The full-time Project Director, who is responsible for development, implementation, coordination, and monitoring of a standardized statewide voucher system and carrying out day-to-day operational activities, will exercise supervisory responsibility over 5 staff engaged in project implementation. Adjustments in salary costs for Year 2, Year 3, and Year 4 budgets are determined through collective bargaining agreement.

The Treatment and Recovery Support Coordinator (Service Developer) will provide full-time (2,080 hours annually) Service Development and serves as the point of contact for provider agencies seeking to enroll as treatment and recovery support providers, the individual responsible for assisting providers with compliance of all applications requirements, is the staff primarily responsible for outreach to potential providers, arranging and providing training and developmental instruction for providers, and for resolving complaints where arbitration is needed to coordinate client care. This position is also responsible for the development, distribution, and maintenance of provider directories, program manuals, and screening and assessment instruments for collecting client outcomes data and surveys related to client satisfaction and stakeholder experience with ATR Ohana. The position will be classified under the Hawaii State Civil Service System according to the HGEA-AFSCME Collective Bargaining Agreement for the Unit 13 (Professional and Scientific) category at the salary schedule for the SR 26D level. Adjustments in salary costs for Year 2, Year 3, and Year 4 budgets are determined through collective bargaining agreement.

The Information Technology (IT) Coordinator (Quality Assurance Monitor) will provide full-time (2,080 hours annually) monitoring of project data, utilization rates, compliance of provider agencies, and monitors trends in service delivery that may indicate potential for waste, fraud, and abuse of project resources. These duties are managed through desk audit of the voucher management system (VMS) and on-site monitoring to vendors who utilize the VMS to claim fees for services provided to clients, verifying that billing is accurate, allowable, and supported by documentation that complies with various laws and regulations regarding protected health



information and confidentiality of substance abuse treatment records, making recommendations for VMS enhancements and operational protocols that improve system efficiency and prevent, detect, and interrupt fraud, waste, and abuse related to system resources. This project staff will document all incidents of client complaint, along with necessary corrective actions. The position will be classified under the Hawaii State Civil Service System according to the HGEA-AFSCME Collective Bargaining Agreement for the Unit 13 (Professional and Scientific) category at the salary schedule for the SR 26D level. Adjustments in salary costs for Year 2, Year 3, and Year 4 budgets are determined through collective bargaining agreement.

The Fiscal Coordinator (Accountant) works full-time (2,080 hours annually) to ensure that expenditures are consistent with the budget and that costs are allocable to approved budget categories and cost elements. The Accountant independently performs day-to-day operations of fund management and ensures accountability and effectiveness in the use of grant funds, and tracking of fiscal processes across usual departmental boundaries when fiscal software does not interact with the VMS. This position provides training and programmatic recommendations to providers regarding sound fiscal accounting practices to ensure tracking and accountability of project funds, and provides trend analysis to project staff and vendors to assist with prompt, complete expenditure of funds. Fiscal coordinator reviews billing and uploads voucher data, via VMS, to SAIS as mandated by the grant, and disbursing fee-for-service payments with detailed invoices. The position is classified under the Hawaii State Civil Service System according to the HGEA-AFSCME Collective Bargaining Agreement for the Unit 13 (Professional and Scientific) category at the salary schedule for the SR 22F level. Adjustments in salary costs for Year 2, Year 3, and Year 4 budgets are determined through collective bargaining agreement.

The Secretary works full-time works full-time (2,080 hours annually) to assist project staff with creation of required reports, correspondence, and other required grant related files. The Secretary receives and prioritizes messages for project staff when they are in the field and provides assistance to staff in the field by accessing and reporting information that is essential to their project duties. This position is the primary link between staff in the field and staff in the ADAD offices. The Secretary assists project staff with compliance with all required documentation for personnel, including ensuring that adequate supplies are always on hand. This staff assists project staff with collating results of surveys and other information gathering instruments to assist in project improvement efforts, and will assist with dissemination of periodic IT based communication to providers and stakeholders. The position is classified under the Hawaii State Civil Service System according to the HGEA-AFSCME Collective Bargaining Agreement for the Unit 3 (Professional and Scientific) category at the salary schedule for the SR 8 level. Adjustments in salary costs for Year 2, Year 3, and Year 4 budgets are determined through collective bargaining agreement.

^bFringe Benefits

The composite *fringe* benefit rate of 38.29% has been approved by the U.S. Department of Health and Human services for use during fiscal year 2010.

^cTravel



In-state *travel* is budgeted based on cost of air travel, lodging, meals and incidentals, and rental car expenses. Two (2) project staff will travel round-trip at the cost of \$300 for twelve (12) trips each, along with checked-baggage fees for a maximum of \$100 per staff, per trip, to expand ATR Ohana to at least one (1) neighbor island; to provide face-to-face technical assistance to new provider agencies; and to perform quality assurance monitoring on-site with provider agencies. Each of these twelve (12) expansion trips will include lodging for two (2) nights at \$84 per night, per staff, meals at the per diem rate of \$45 per day per staff, per trip, for three (3) days. Staff will share a rental car for two (2) days on each trip, at the cost of \$100 per day, with \$90 budgeted for gasoline, which may average as much as \$4.50 per gallon in remote locations. Estimated driving distance on each trip is 400 miles.

Mileage costs to reimburse key staff for grant related travel using their personal vehicles is budgeted at 500 miles each for three (3) staff, each month, for twelve (12) months at the reimbursement rate of fifty cents (\$0.50) per mile on Oahu.

Out-of-state travel is budgeted based on grant requirement for travel to the mainland by key staff to one (1) or more national grantee meetings or mandatory trainings per year. Five (5) staff will travel twice round-trip at the cost of \$950 for five (5) trips, along with checked baggage fees at maximum of \$100 per staff each trip. Each of these staff will incur cost of lodging for five (5) nights at \$84 per night, per staff, per trip, with excess lodging fees averaging \$50 per night, per staff, per trip, for the mandatory travel. Budget includes per diem per staff for the grantee meeting at \$45 per day, per staff, for six (6) days per trip to accommodate travel time. Round-trip transportation from the airport to meeting sites is budgeted at \$80 per staff per trip.

^dEquipment

Equipment costs include purchase of one (1) laptop computer at \$2,000 to facilitate field access to VMS, and one (1) desktop computer at a cost of \$2,000 for the ATR Secretary, and software purchase and permissions for project staff at a cost of \$819.

^eSupplies

Project *supplies* include cost of paper, toner, ink, postage and other expendables and are based on current run-rates for these items, with adjustments for expanded service areas. Postage is calculated to accommodate the cost of certified mail and stamps to facilitate correspondence with and delivery of reimbursement checks to providers.

^fContractual Costs

Hawaii Web-based Infrastructure for Treatment Services (WITS) system
Costs associated with implementation of enhancements for ATR WITS include:

Tier 3 User Support - Interface with State support staff on all user and technical issues.
Costs are budgeted at \$47,520 in each of the four years of the project.



STATE OF HAWAII

SCHEDULE OF DELIVERABLES

The STATE's Notice to Proceed to September 30, 2012

1. Enhance HI-WITS with ATR Software Enhancements.

Contract Item	Deliverable	Invoice Date	Invoice Amount
1	Work Order Items (270 consulting hours)	Monthly-Only completed and accepted Work Order Item(s)	\$7,980.00
Total Cost for ATR Software Enhancements			\$7,980.00

2. Support and Maintenance of ATR Software Enhancements.

Contract Item	Deliverable	Invoice Date	Invoice Amount
2	Support and Maintenance	Notice to Proceed	\$47,520.00
Total Cost for Support and Maintenance of ATR			\$47,520.00

3. Hosting of ATR Software Enhancements.

Contract Item	Deliverable	Invoice Date	Invoice Amount
3	Hosting Period	Notice to Proceed	\$10,560.00
Total Cost for Hosting of ATR			\$10,560.00

TOTAL \$66,060.00

Source of Funds:
S-12-203-H-000396-12-578

Exhibit "A"



Hosting - Highly secure hosting environment; biometric access required; monitored 24/7; fully redundant uninterruptible power supplies; network redundancy; cages and racks require access codes/biometrics; multiple inline firewalls; internet connectivity (10 mbs); and nightly database backup. Cost is budgeted at \$11,040 in each of the four years of the project.

WITS Reports - Access to the entire WITS database for Ad-Hoc reporting needs at \$17,500 in the first year of the project, and will decrease by over fifty percent in each of the subsequent.

WITS Operator's Manual - Full user documentation delivered after phase 1 development items are finalized will be in the form of a user-friendly Operator's Manual, and is budgeted as a one-time fee of \$10,000.

Implementation - ATR experts guides States through critical ATR Ohana decision-making process, Gap Analysis, documenting program Business Rules, Program and Policy Consulting as a one-time fee of \$11,840.

Construction

None.

Other

Voucher Pool. Cost to *voucher* treatment and recovery support services for 8,362 individuals at an average cost of \$1,091.72 per client across four years. This reflects client enrollment in Year 1 at 1,236, Year 2 at 2,800, Year 3 at 2,800, and Year 4 at 1,526. This includes assessment, low intensity and high intensity outpatient treatment services, care coordination, and recovery support services. The total direct client services amount budgeted is \$9,128,923 for the total grant period. Of this cost, \$2,333,592 is budgeted for Year 1. Of this amount, \$1,000,032 is allocated for Treatment Services and \$1,333,560 is allocated for Recovery Support Services (RSS). This proportion of treatment (42.9%) to RSS (57.1%) represents a cost-effective mix of clinical treatment and recovery support services that will be necessary to achieve ATR Ohana goals for the project.

Print and Publication. Copier lease rental includes cost of being a lessee and metered usage.

Communication. Monthly telephone and Fax services are calculated at the rate of \$38 per month, per five (5) staff, per twelve (12) months. These charges also include cost of two (2) wireless internet access "air cards" for two (2) staff at the rate of \$50 per device, with access charges of \$65 per month for twelve (12) months per device, and three (3) cell phones at \$50 per device, with access charges of \$65 per month per device.

Training. *Training* costs include facilities rental and training materials for four (4) recovery oriented system of care (ROSC) events yearly on Oahu and four (4) ROSC events yearly on at least one (1) neighbor island at the cost of \$2,928.75 per event.



Other. This category includes the costs for direct services to clients which are not considered fee-for-services since they can not be procured through the WITS electronic voucher management system.

ACCESS Line. ACCESS Line is a 24-hour crisis hotline available to those with inquiries about ATR eligibility and enrollment. Referral and screening services provided through MOU with the Department of Health, Adult Mental Health Division are delivered at a cost of \$21 per client. The cost for ACCESS Line services in Year 1 is \$25,956. This cost is not voucherable through the VMS, but represents direct services to clients.

Incentives. Incentives purchased through the Hawaii e-Procurement System will include gift cards and other certificates for goods and services, and will be utilized as client incentives to promote engagement and compliance with treatment and recovery plans. Costs are calculated at an average one-time cost of \$19 per client served. The cost for incentives in Year 1 is \$23,484. This cost is not voucherable through the VMS, but represents direct services to clients.

Direct charges. Total direct charges for Year 1 are \$2,893,543. This figure represents 80% of funds spent on client services, and 20% of funds spent for administration costs. This is within the proportional allocation for the direct service budget mandated in the 2010 ATR RFP.

Indirect cost rate. The indirect cost is \$39,456 based on the 10.7% rate agreement with Department of Health and Human Services (DHHS).

Total. Throughout the four-year project, the total budget is \$11,479,510. An average of 80% (\$9,128,923) is budgeted for program costs and an average of 20% (\$2,350,587) is budgeted for administrative costs for the four years. Year 1 budget (\$2,933,000) reflects allocation of 80% (\$2,333,592) allocated to direct services and 20% (\$599,408) allocated to administrative costs.

Ø Pg 60

Aloha Roger,

Attached to this e-mail are the items and clarifications you have requested that are required for further review of Hawaii's application for the SAMHSA Access to Recovery: (RFA No. TI-10-008)

Attached is the scanned document of the signed form called "ASSURANCE of Compliance with SAMHSA Charitable Choice". The signatory is Keith Yamamoto, SSA for Hawaii.

RE: E) Supplies:

1. "Laptop Computer" costs in the amount of \$2,000 needs to be further justified and explained as to why this is a crucial part of the program for such a high dollar amount.

One (1) laptop computer is needed to facilitate field work on the Web Infrastructure for Treatment Services (WITS) voucher management system (VMS) for the ATR Fiscal Coordinator (Accountant). The need for field access to the VMS was not anticipated during the 2007 ATR Grant period, and lack of this resources hampered the Fiscal Coordinator's ability to ensure timely processing and expenditure of payments to vendors during periods of furlough were access to State offices and desktop terminal was restricted. This item will also expand capacity for the Fiscal Coordinator to provide direct field training and fiscal auditing of ATR providers. The cost for this item is estimated based on actual costs for similar equipment that was purchased during Year 1 of the 2007 ATR Grant, and is being used regularly and extensively by other ATR staff during daily field-based interactions with ATR provider organizations. This cost also includes programming the laptop unit with operational software, reflects an estimate that accounts for inflation of tech equipment since Year 1 costs of the 2007 ATR Grant, and reflects shipping costs passed along to consumers for items that are shipped to and sold in the state of Hawaii.

2. "Desktop Computer" costs in the amount of \$2,000 needs to be further justified and explained as to why this is a crucial part of the program for such a high dollar amount.

One (1) desktop computer is needed to equip the ATR Secretary with internet access and technical capabilities similar to the technical capacity other ATR Ohana staff. The cost for this item is estimated based on actual costs for similar equipment that was purchased during Year 1 of the 2007 ATR Grant, and is being used regularly and extensively by other ATR staff during daily operations. This cost also includes programming the laptop unit with operational software, reflects an estimate that accounts for inflation of tech equipment since Year 1 costs of the 2007 ATR Grant, and reflects shipping costs passed along to consumers for items that are shipped to and sold in the state of Hawaii.

H) Other Costs:

1. Please provide a revised Voucher Service Table 4 - for the amount of \$2,284,152. The table that was provided reflects the amount \$2,333,592.

REV



The revised document is attached to this e-mail.

2. Please provide an itemized detailed breakdown budget of all costs included under "Training" for the amount of \$23,430.

Costs in this category are estimated based on an average of actual costs incurred for training events during the 2007 ATR Grant. Training costs have ranged between \$150 to over \$4,000 per event. Several ATR training events have been provided with no expenditure of ATR Grant funds. For example, ATR Monthly Provider Forums have often been presented with limited expenditure of ATR Grant funds by coordinating training events at facilities that are periodically available at no cost. These facilities are limited in size, and generally available only episodically for small group trainings or meetings (church basements, etc.). ATR will also maximize training efforts for this limited amount of funding by tapping local experts as trainers rather than paying for mainland experts wherever possible.

Training funds will cover the cost of periodic facility rental, when ATR staff are unable to arrange facility usage at no cost, such as initial outreach and recruitment meetings with potential ATR providers in the proposed expanded service area of at least one neighbor island. Costs in this category will include facility rental, and conference services (audio-visual equipment use, tech support, set-up) and are expected to also pay for facility rental for proposed quarterly Recovery-Oriented System of Care (ROSC) Roundtable meetings of stakeholders on Oahu and on at least one neighbor island. Limited funds may be expended to attract expert trainers on specific topics that need to be addressed related to best practices, such as the recent LifeRing Training held on Oahu, and for trainings related to on-going sustainability efforts, such as the recent state-wide Grant Writing Clinic for ATR providers and stakeholders that followed-up on Technical Assistance provided by SAMHSA CSAT.

We anticipate that there will be no less than four (4) quarterly ROSC Roundtable events yearly on Oahu and on at least one neighbor island. Past expenses for ROSC events have ranged between \$1,000 and \$4,000. ATR has estimated that an average cost of \$11,715 can be maintained during Year 1 of the ATR Grant on Oahu by having ATR co-sponsor ROSC events with other local stakeholders who can share a portion of training costs, and by coordinating all monthly ATR provider meetings with local facilities that are often available at minimal, or no, cost to ATR.

Training costs for neighbor island provider recruitment and training are estimated for the same amount, \$11,715, for Year 1. ATR staff will coordinate with existing ADAD treatment provider agencies to maximize the potential for use of their existing spaces at no cost, and is proposing to use distance teaching technology to maximize training efforts while maintaining training expenses that do not exceed this amount in Year 1. Budget expenses are anticipated to cover the cost of quarterly ROSC events on a neighbor island as well. Since no existing administrative service organization has yet been identified to share the cost for Year 1 ROSC training, ATR anticipates that the entire cost for the quarterly ROSCs may need to be covered in ATR's Year 1 budget.

INDIRECT COSTS:

Rev 1



Please submit a copy of Office of the Governor, State of Hawaii most recent Indirect Cost Rate Agreement or Cost Allocation Plan negotiated with the Division of Cost Allocation reflecting the 10.7 % rate being charged to SAMHSA for Indirect Costs in the amount of \$39,456. If you are unable to provide a copy to me, you will not be allowed to charge any indirect costs to the grant; therefore you would need to submit a revise budget with out any Indirect Costs being requested.

A copy of that document is attached to this e-mail.

This correspondence is being sent to you from the ATR Project Director, Bernie Strand, and the form, "Assurance of Compliance with SAMHSA Charitable Choice Status and Regulations SMA 170", has signed by the Single State Authority (SSA) for the State of Hawaii, Keith Yamamoto, Division Chief for the Hawaii Department of Health Alcohol and Drug Abuse Division.

Please acknowledge that this E-mail has reached you no later than COB, Wednesday August 25, 2010.

If you have any questions feel free to contact me.

Thank you

Roger George

Grants Management Specialist
Division of Grants Management
1 Choke Cherry Road
Room 7 - 1081

Rockville, MD 20857 - (OVERNIGHT 20850)

✉: Roger.George@samhsa.hhs.gov

☎: (240)276-1418

☎: (240)276-1430

Rev.



Supporting Documentation

Section H - Biographical Sketches and Job Descriptions

Biographical Sketch

ATR Project Director, Bernie Strand

MSW, Master of Social Work, 1995 from the University of Michigan, Ann Arbor, with concentration on Interpersonal Practice, with sub-majors in Administration and Community Organization.

BSW, Bachelor of Social Work, 1993 from the University of Wyoming, Casper College Campus, with extensive coursework in psychology and education.

AA, Associate of Arts, Addictions Specialist, 1991, from Casper College, Casper, Wyoming.

CSAC, Certified Substance Abuse Counseling, No. 1519-10, from the State of Hawaii, expiring January 26, 2012

LCSW, Licensed Clinical Social Worker, No. 260, from the State of Wyoming, expiring on August 20, 2010.

LAT, Licensed Addictions Therapist, No. 176, from the State of Wyoming, expiring on August 20, 2010.

Ms. Strand is the current Project Director for Hawaii's \$8.2 million ATR II Project implementation serving adults in the City and County of Honolulu, Island of Oahu. Previously, Ms. Strand assisted an ATR I grant recipient, the State of Wyoming, to successfully achieve all target goals. All elements of the ATR related treatment and recovery oriented system of care was sustained after completion of ATR I without reliance on future ATR funding. This was achieved through multiple public-private partnerships and community ownership of the system of care that emerged in the community. These experiences provide Ms. Strand with broad ATR implementation experience.

Ms. Strand brings 20 years direct practice in prevention and treatment settings including primary medical, residential mental health, medically-managed inpatient SUD treatment, and school social work. Ms. Strand has special expertise in working with a variety of target groups and vulnerable populations including children and adolescents, families, survivors of trauma, individuals with substance use disorders, severe and profound mental illness, developmental disabilities, and those diagnosed with Autism Spectrum Disorders.

Ms. Strand brings other practical experience to the position from other work settings including law enforcement and marketing. Ms. Strand has been a field instructor for more than ten (10) years with four different institutions of higher learning, was active in the National Trauma Team Network, has been active in local chapters of the Association of Play Therapists, and has contributed to the body of knowledge and professionalism in her disciplines through active participation in a variety of teams and coalitions in the

areas of prevention, treatment, criminal justice, child protection, and recovery oriented systems of care.

Among her most valued achievements and honors are being gifted with an eagle feather by the Ojibwa Tribal Medicine Man, in Janesville, Wisconsin in 2008, leading the ATR II team that earned performance incentive bonuses of over \$100,000 for the State of Hawaii in 2009, several honors and awards related to theatrical performances in community theater, and numerous awards and publications related to her writing.

Job Description

Title: Project Director: Exempt from Civil Service

Description of Duties and Responsibilities: Ensures compliance with project and agency goals, policies and procedures, and Federal and State laws, rules, regulations and guidelines. The Project Director works with administrators and staff of participating agencies to ensure the application of sound clinical approaches throughout project implementation, serving as the point of reference and assuming the lead in clinical issues. Specific responsibilities for the position are as follows:

- Serves as the primary contact with the Center for Substance Abuse Treatment (CSAT) project officer, performs all reporting to CSAT, service providers and other affected agencies.
- Assumes the lead throughout project planning, implementation, monitoring and evaluation. The Project Director will be responsible for the direction and integration of the voucher program with the Information Technology (IT) system, management of service delivery, prevention of waste, fraud and supplantation, development of new faith-based and alternative services, and monitoring the quality of care.
- Supervises staff during utilization review of IT-generated statistics, reports, trends and voucher data. Reviews will evaluate indicators of the quality of care, potential waste, fraud, abuse and inappropriate supplantation of funds from alternative funding sources.

Qualifications for Position: Education: Graduation from an accredited university with a master's degree in public health, public administration, planning, social work, or related field.

Supervisory Relationships: Reports to Single State Administrator (SSA)

Skills and Knowledge: Knowledge of principles and practices within the field of public health and pertinent Federal and State laws, rules and regulations. Skills in computer word processing software; familiarity with database and spreadsheet applications desirable. Ability to read and comprehend complex technical materials, write reports, organize work, express ideas orally and in writing, and use analytical methods and tools; English grammar and statistics.

Prior Experience: Four and one-half years of specialized experience consisting of progressively responsible professional experience in public health, human services or other related fields.

Personal Qualities: Must be physically, mentally and emotionally able to perform the duties of this position effectively.

Travel and special conditions: Must be able to travel interstate at least twice annually, and be able to travel intra-state as project expands to neighbor islands.

Salary: \$62,424 - \$67,492, commensurate with experience.

Hours per day or week: 40 hours, one (1.0) full time equivalent (FTE)

Biographical Sketch

Treatment and Recovery Support Services Coordinator, Dr. JoHanna Mechergui (Service Developer)

PhD, Doctor of Philosophy in Educational Administration

MEd, Master's of Education with special focus in Speech Pathology, Special Education, and Educational Specialist with a major focus in Learning Disabilities

BS, Psychology

Teaching Certificate, K-12 in Michigan, Hawaii, and New Jersey

Administrative Certification for Secondary and Elementary Principal in New Jersey

Bachelor Level Certified Social Worker in Michigan.

Ms. Mechergui is an internationally experienced educator, and has assisted individuals from a variety of cultures in expanding their academic learning and professional growth. She brings to ATR her positive multinational attitude and a unique ability to inspire awareness in others. She believes that this atmosphere promotes understanding, empathy and effective interactions with her team and with developing community based service providers. Dr. Mechergui has worked with native Hawaiian and Pacific Island populations on the Islands of Maui, Lanai, and the Big Island, Hawaii, in addition to the Island of Oahu. She has also worked in Saudi Arabia, the United Arab Emirates, and across the United States, from Florida to Washington State, while collaborating with a variety of federal agencies on targeted initiatives.

As a former Educator and Administrator she has taught grades K through 12 as well as at the university level. She has a desire to strengthen, teach, encourage, validate, and exhort students and families to follow their life goals. She addresses issues relating to teaching cognitive skills, thinking, emotional disabilities and insight, with practical experience, and, always, with humor. Her seminars and teaching for students, parents and teachers have helped transform reluctant learners and have equipped educators with powerful tools to dramatically improve students' skills. She has worked as a Speech and Language Pathologist and therapist providing services to people with closed head injuries in an acute care facility as well as a skilled nursing facility. Dr. Mechergui worked to improve the wide range of services for her patients. She was the first female coordinator of Speech-Language/Learning Disability services in the Arabian American Oil Company ARAMCO School District in Saudi Arabia and provided services in Abqaiq, Dhahran, and Ras Tanura School Districts located in the eastern province of Saudi Arabia. She worked in San Juan, Puerto Rico, Copenhagen, Denmark, and Recife Brazil to help transform learners and equip educators. She has worked throughout the United States to provider students with the necessary skills so they could reach their highest potential. She has learned to adapt to a variety of teaching situations, colleagues and others in an educational climate that promoted cultural diversity and multicultural understanding.

Dr. Mechergui worked as a Quality Control Crew Leader for the United States Census Bureau. She assisted in the training, providing classroom and hands-on training using state of the art hand-held computers provided by the census bureau. Her in-depth knowledge of the material enabled her to proficiently train personnel and respond to questions in a professional, knowledgeable manner. She was able to improvise and adapt

the training materials when necessary to engender learning by the team. Due to her demonstrated abilities, she was selected to lead a team of personnel to Lanai, Hawaii on short notice to ensure quality control operations there were completed on time and to standard. She also became part of the Quick Reaction Team that deployed to Maui on short notice to finish quality control operations within the State of Hawaii. This deployment required long hours, attention to detail and adaptability.

Dr. Mechergui is a talented individual who displays initiative, skills and the ability to perform well under fast-paced high demand conditions.

Job Description

Title of Position: Service Developer: Exempt from Civil Service

Description of Duties and Responsibilities: Works with administrators and staff of participating agencies and organizations to implement the project. Specific responsibilities for the position are as follows:

- Supports the Project Director in all aspects of planning, implementation, monitoring and evaluation of the Project. Assures that services providers utilize best practices for substance abuse services; provides expertise in substance abuse treatment, consultative services to improve services, as well as technical assistance to service providers.
- Serves as a liaison to faith-based community organizations (FBCOs) and other service providers in developing, implementing and monitoring the project. Facilitates the development of new or previously under-utilized services and/or providers. Provides technical assistance and support in resolving problems in conjunction with monitoring staff and other team members.
- Develops and recommends policies and procedures for the project; monitors service utilization rates and other trends related to the service system through desk audits and site visits to ensure providers understand rules and procedures, and remain up-to-date on training content. Evaluates provider applications to determine eligibility to act as an authorized provider.
- Composes, edits and finalizes communications, reports, and documents, including requests for proposals, written agreements, and programmatic and fiscal justifications.

Qualifications for Position: Education: Graduation from an accredited university with a master's degree in public health, public administration, planning, counseling, social work, or related field.

Supervisory Relationships: Reports to the Project Director

Skills and Knowledge: Knowledge of principles and practices within the field of public health and pertinent Federal and State laws, rules and regulations. Skills in computer word processing software; familiarity with database and spreadsheet applications desirable. Ability to read and comprehend complex technical materials, write reports, organize work, express ideas orally and in writing, and use analytical methods and tools; English grammar and statistics.

Prior Experience: Experience: Three and one-half years of specialized experience consisting of progressively responsible professional experience in public health, human services, faith-based initiatives, community organization and/or nonprofit management or other related fields, which involved the integration and coordination of clinicians and technical support staff in planning, implementing and evaluating service delivery both qualitatively and quantitatively.

Personal Qualities: Must be physically, mentally and emotionally able to perform the duties of this position effectively.

Travel and special conditions: Must be able to travel interstate at least twice annually, and be able to travel intra-state as project expands to neighbor islands.

Salary: \$51,312 - \$57,708, commensurate with experience

Hours per day or week: 40 hours, one (1.0) full time equivalent (FTE)

Information Technology (IT) Coordinator, Allan Sagayaga, M.Ed.

Biographical Sketch

Internet Technology (IT) Coordinator, Allan Sagayaga (Quality Assurance Monitor)
MEd, Master's of Education in Counseling and Guidance, 1992, University of Hawaii,
Manoa

BA, Psychology, 1988, University of Hawaii, Manoa

Mr. Sagayaga started his public service in the Department of Education as a school counselor. He continued his work in public service in the Department of Human Services, working with disadvantaged public housing residents and was instrumental in helping public housing tenants organize to form the statewide Resident Association.

In addition, he brings nearly 5 years of experience with him to ATR in the procurement and monitoring of statewide service contracts. He was involved with processing grievance hearing requests submitted by residents of public housing, coordinating and consulting with hearing officers and residents. Provided planning, development, and training to public housing residents, including practices for responsible fund management. Mr. Sagayaga assisted with communication efforts to increase awareness about, and participation with, resident groups and governing associations. Coordinated Resident Advisory Board's recommendations and comments on the Public Housing Plan (PHA Plan)

As a case manager for clients with educational, social and/or psychological barriers that prohibited them from entering the workforce, Mr. Sagayaga consulted with case workers, employers, government staff and with physicians and mental health professionals on the condition and treatment plans for clients.

Mr. Sagayaga is a talented photographer and videographer.

Job Description

Title of Position: Quality Assurance Monitor: Exempt from Civil Service

Description of Duties and Responsibilities: Works with project staff and Alcohol and Drug Abuse Division (ADAD) employees and the external Evaluators to monitor system utilization, provide monthly reports to the Service Utilization Review Committee and recommend corrective actions. Specific responsibilities for the position are as follows:

- Supports the Project Director in all aspects of planning, implementation, monitoring and evaluation of the Project.
- Generates and analyzes provider utilization reports voucher management practices and redemptions, and documentation of client data through the WITS VMS and WITS Reports, and SAMHSA's SAIS website. Responsible for conducting desk audit and on-going systematic review of provider agencies performance and data outcomes in relation to costs expended system-wide.
- Monitors trends and analyses efficiencies through comparative analysis of data patterns in the VMS including outcomes by modality, provider, demographics, and other data.
- Contributes to reports, documents, and newsletters by submitting content related to quality improvement, and prevention and detection of waste, fraud, and abuse.

Qualifications for Position: Education: Graduation from an accredited university with a master's degree in public health, business administration, public administration, planning/analysis, or related field.

Supervisory Relationships: Reports to the Project Director

Skills and Knowledge: Knowledge, skills and abilities: Knowledge of principles and practices within the field of public health and pertinent Federal and State laws, rules and regulations. Skills in computer word processing software; familiarity with database and spreadsheet applications desirable. Ability to read and comprehend complex technical materials, write reports, organize work, express ideas orally and in writing, and use analytical methods and tools; English grammar and statistics.

Prior Experience: Experience: Three and one-half years of specialized experience consisting of progressively responsible professional experience in public health, human services or other related fields, which involved the integration and coordination of quantitative data in planning, implementing and evaluating service delivery, preferably in a managed care setting.

Personal Qualities: Must be physically, mentally and emotionally able to perform the duties of this position effectively.

Travel and special conditions: Must be able to travel interstate at least twice annually, and be able to travel intra-state as project expands to neighbor islands.

Salary: \$49,344 - \$57,708, commensurate with experience

Hours per day or week: 40 hours, one (1.0) full time equivalent (FTE)

Biographical Sketch

Fiscal Coordinator, Enrique "Mike" Palma III (Accountant)
BS, Accounting, 1976, Far Eastern University, Philippines

After retiring with 21 years at Bank of America as Accountant, Financial Analyst, Internal Auditor, and Compliance Manager, he spent the next 10 years working in similar capacities for private industry and in public health service delivery agencies. Mr. Palma is multi-lingual, being fluent in English, Spanish, Tagalog and Visayan.

As Project Accountant for Waianae Coast Comprehensive Health Center, he was familiar with a how various fiscal systems, including public and foundations interact to best ensure fiscal sustainability of social service agencies. He prepared and maintained the budget, forecasts, fiscal monitoring, resource management, and cash flow projections for the various capital and construction projects. Manage and oversee the project timelines, contracts, GL, A/R, grant payments, bank reconciliations, loan contracts, credit lines, financial reporting, and variance analysis

Mr. Palma has provide consultations regarding budget, forecasting, government grants, cash management, AP, G/L, internal controls, and cost-effectiveness using variance & trend analysis to FBCOs to assist them with improving fiscal practices, managing assets, and designing and implementing project management and quality assurance regarding fiscal practices.

Job Description

Title of Position: Accountant: Exempt from Civil Service

Description of Duties and Responsibilities: serves as the lead in overseeing budgeting and fiscal monitoring of project services. The position is responsible for ensuring financial integrity of the Project, in particular the management of resources, prevention of waste, fraud and supplantation. Specific responsibilities for the position are as follows:

- Develops, installs and modifies fiscal policies and procedures for service provision. Monitors expenditure of Project funds to ensure compliance with funding restrictions; prepares financial reports on expenditures and obligations.
- Ensures that project expenditures are consistent with project budget and that costs are allocable to approved cost categories and cost elements. Performs day-to-day operations of cash management; ensures accountability and effectiveness in the use of Project funds.
- Verifies financial data submissions for accuracy, completeness and consistency; verifies information with vendors and secures missing information; provides technical assistance to public and private nonprofit agencies in the collection and verification of financial data.
- Conducts fiscal monitoring of service providers through desk reviews, expenditure reports and other financial documents submitted by vendors, as well as through on-site audits of fiscal operations and records.

Qualifications for Position: Education: Graduation from an accredited university with a master's degree in accounting, business administration or other related fields.

Supervisory Relationships:

Skills and Knowledge: Knowledge of principles and practices within the field of accounting and pertinent Federal and State laws, rules and regulations; theories, principles, practices and techniques of accounting and/or auditing; principles and methods of data collection and analysis; and business writing. Skills in computer spreadsheet applications and financial data analysis; skills in word processing software applications desirable. Ability to read and comprehend complex technical materials, write reports, organize work, express ideas orally and in writing, and use analytical methods and tools; English grammar and statistics.

Prior Experience: Experience: Two and one-half years of professional accounting and/or auditing experience consisting of work involving budgeting and accounting for publicly-funded organizations, preferably in organizations with multiple funding sources; understanding and applying policies and procedures; and equipment and staffing requirements.

Personal Qualities: Must be physically, mentally and emotionally able to perform the duties of this position effectively.

Travel and special conditions: Must be able to travel interstate at least twice annually, and be able to travel intra-state as project expands to neighbor islands.

Salary: \$45,57632 - \$51,318, commensurate with experience

Hours per day or week: 40 hours, one (1.0) full time equivalent (FTE)

Supporting Documentation

Section I: SAMHSA Confidentiality and Participation Protection Requirements and Protection of Human Subjects Regulations

Client confidentiality and exposure to risks arising from participation will be protected as specified in the provisions of 42 CFR, Part II and other State statutes and internal procedures pertinent to protecting clients. The specific elements of protection are addressed below.

1. Protection of Clients and Staff from Potential Risks. Since the treatment intervention is psycho-educational in nature and the assessment/evaluation activities are primarily interviewer-administered self-report confidential interviews, the primary risks associated with participation would arise from illegal disclosure of client identity or confidential information. While outside agencies or individuals may require a client to participate, from the perspective of the project, all participation is voluntary, without penalty or loss of any benefits otherwise due to the client as a result of their election to terminate participation. Thus, clients may elect not to participate in treatment, in which case they may be at risk for consequently suffering harmful consequences of continuing untreated alcohol and/or drug use and other high risk behaviors.

Confidentiality will be protected by using the procedures specified in 42 CFR, Part 2 and 45 CFR, Parts 160 and 164 (HIPAA) regulations. Sample confidentiality agreements for staff and contractors and informed consent forms are included below. From previous projects in which ADAD and its contractors have participated, consent forms will be modified to the specifics of the evaluation required for the Access to Recovery Voucher Grant. Also included as required in Appendix 3 are existing forms currently in use, including ADAD Privacy Notice, ATR Ohana Referral Form, ATR Ohana Assessor Enrollment Checklist, RSS Plan, and Sample Consent for Release of Confidential Information. This project will also make use of standard formats mandated as part of the GPRA data collection strategy.

All reasonable efforts will be made to explain to clients, verbally and in writing, using the informed consent form, any and all of the potential risks of electing not to participate or to terminate treatment as well as the requirements and procedures to protect their confidentiality and privacy. In addition to specifying the name and general description of the project, the voluntary nature of client participation, and conditions and procedures for any potential disclosures of information, contact information on individuals providing oversight of potential risks and harm to clients will be provided so they will have the information on whom to contact and the way to reach them in the event clients feel at risk or have been harmed in any way. Individuals whom clients can contact will include the Project Director, the Evaluator, the Single State Agency Chief and its Institutional Review Board.

2. Fair Selection of Participants. The target population for this project is adults and youth age 12 and older who abuse controlled substances. Several demographic groups

are at higher risk for serious health, employment, and educational problems related to substance abuse. These include meth addicts, HIV/AIDS patients, military veterans from the Iraq and Afghanistan wars and their families, families involved with child welfare services and/or drug courts, youth, and offenders re-entering the community. Referrals for assessment and referral to appropriate services can be voluntary, or can be made through a variety of social service agencies in the community. Clients will not be excluded on the basis of race, ethnicity, religion, sexual preference, HIV status or any other prejudicial basis. All clients referred to the project that are not appropriate for this program will be referred and assisted in obtaining treatment services in other programs associated with ADAD or elsewhere.

The population may include numerous individuals who will be mandated by the criminal justice system to seek treatment and recovery services, as well as HIV positive individuals and persons with co-occurring mental disorders for which additional specialized services are available in collaboration with several agencies as described in the proposal narrative.

3. Absence of Coercion. As stated above, while outside agencies or individuals may require a client to participate, from the perspective of the project, all participation is voluntary, without penalty or loss of any benefits the project otherwise offers to the client as a result of their election to terminate participation. Clients who are court ordered with requirements for reporting back to the court from the agency are fully informed of the court's requirements and the limits imposed on agency reporting by Federal law and State statutes. Any and all such disclosure of information is conducted with full knowledge and written consent of the client under the restrictions of the signed informed consent forms and all provisions of the 42 CFR, Part 2 and 45 CFR Parts 160 and 164 (HIPAA) regulations.

4. Data Collection. Clinical data will be collected directly from the clients and their collaterals. All clinical data will be maintained in confidential case records, and, as described above, all clinicians will be bound by written agreement to protect the confidentiality of clients in adherence to Federal law and State statutes.

The pre-existing treatment protocols include scheduled and random urine drug screens of clients as described in the treatment protocols in the narrative of the proposal and as governed by the consent and confidentiality forms and guarantees included in Appendix 3. Evaluation data will be collected only from clients and process data (e.g. length of stay) reported by services providers. The assessment/evaluation instruments, even those mandated by the RFA or variously recommended by SAMSHA are included in Appendix 2 (e.g. GPRA, ASAM, ASI, A.D.A.D.). These interviewer-administered but self-report instruments are the sole form of evaluation data collected on clients.

5. Privacy and Confidentiality. All clinical and evaluation data will be collected directly and exclusively by Hawaii State Certified Substance Abuse Counselors (CSAC's), case managers and/or counselors or others permitted under state law. Data will be entered and stored electronically in some instances by those same individuals and in other instances

by trained data entry personnel informed of relevant Federal and State confidentiality and privacy regulations and laws, with written agreements to protect client confidentiality. Once entered, any hard copies of data not required in the client's clinical file will be stored in a locked fireproof file cabinet, until such time as the electronic data is sufficiently and securely backed-up electronically. Electronic files used for research analyses and/or evaluation will have security and research standards consistent with regulations as set by 42 CFR, Part 2 and 45 CFR Parts 160, 162 and 164 (HIPAA) and will identify clients only by number, and the linkage between client numbers and names will be maintained only in confidential client-based clinical files. Access to clinical data will be electronically restricted exclusively to clinicians and providers requiring the data to deliver and report services. All such approved user accounts on the IT system will be password protected. Again, all confidentiality, privacy and security will be protected under the strictly enforced prescriptions of all the confidentiality, privacy and security regulations consistent with 42 CFR, Part 2 and 45 CFR Parts 160, 162 and 164 (HIPAA).

6. Adequate Consent Procedures. As stated above, all reasonable efforts will be made to explain to clients, verbally and in writing, using informed consent forms, the potential risks of electing not to participate or to terminate treatment as well as the requirements and procedures to protect their confidentiality. This project will require numerous consent forms as specified in Section 1 above. Prior to registering a client in the IT system supporting the voucher-based system of care, informed consent will be obtained to search for any previous entries and enter and maintain the client's name and identifying information in the system. This consent will specifically authorize the appropriate release of information as needed to those providing services to the client. This consent will also inform clients of their right to withdraw their permission at any time, and that their permission will automatically expire after one-year of the client making no use of services. Authorization for treatment will be collected by treatment service providers (see attached sample).

The sample informed consents are located in Appendix 3 below. They specify the name and general description of the project as well as the type and purpose of the participation solicited from the client. The informed consent will include information on the purposes for which the data will be used to maximize the efficiency and effectiveness of treatment and recovery services as well as the requirements and procedures to keep the information confidential. The informed consent will specify the voluntary nature of client participation, conditions and procedures for any potential disclosures of information, any perceived risks resulting from participation in the project or the election to refuse treatment, and contact information on individuals providing oversight of potential risks and harm to clients will be provided so these clients will have the information on whom to contact and the way to reach them in the event that clients feel they are at risk or have been harmed in any way. Those individuals whom clients may contact will include the Project Director.

Informed consent forms will be read and explained, and questions to clarify any unclear issues will be solicited from the client, before obtaining the signature of the client. Other

consents to be used in this project are included in Appendix 3 and explicated in the narrative of the project and the appendix.

7. Risk/Benefit Discussion. The Potential Benefits of this project far outweigh the potential risks posed to clients. The project itself provides an opportunity to demonstrate and test the efficacy of a voucher-based system of care addressing alcohol and drug use, abuse and dependence in a variety of at-risk populations, and to simultaneously provide data supporting the GPRA evaluation strategy. The significance of addressing substance abuse in these target populations is underscored in the preceding narrative and the related citations indicated in Section F of the application.

These benefits will not be realized without potential risks to clients, but especially in light of the potential benefits of the project, those risks appear to be so minimal that no harm to participants is anticipated. One of the greatest potential sources of harm would be for clients who refuse or terminate treatment who may thus continue pre-existing patterns of alcohol and drug use and other related risky behaviors, and, as a result, suffer serious physical, mental, legal and/or social consequences. The informed consent procedures will attempt to alert clients to this potential source of risk. The other greatest potential source of harm would occur in the event that staff made an illegal disclosure of confidential information. Mere disclosure of client status could result in stigmatization and/or prejudicial action against the individual. Given the potentially serious nature of such an occurrence, great lengths will be taken as specified above in training staff and informing clients on the necessity of maintaining confidentiality and privacy. Staff will be 1) informed and bound by written confirmation of knowledge of the regulations governing confidentiality and privacy; 2) aware of the potential risks to clients and penalties to staff for failing to follow those regulations; 3) in agreement to fully protect the confidentiality and privacy of clients; and 4) to conform to all legal and procedural requirements in order to do so.

Given these considerations, the potential benefits are significant; the potential risks to clients are minimal with rigid procedures and safeguards, many of which are already in place, to protect clients from those risks. Consequently, the potential benefits appear to far outweigh the potential risks of the project.

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE Division Chief
APPLICANT ORGANIZATION Hawaii Department of Health Alcohol and Drug Abuse Division	DATE SUBMITTED August 25, 2010



Access to Recovery
 Department of Health and Human Services
 Substance Abuse and Mental Health Services Administration
 Center for Substance Abuse Treatment

Notice of Award

Issue Date: 09/29/2010

Grant Number: 1H79TI023123-01

COPY

Program Director:
 Keith Yamamoto

Project Title: ATR Ohana

Grantee Address	Business Address
HAWAII STATE DEPARTMENT OF HEALTH Department of Health 415 South Beretania Street Honolulu, HI 96813	HAWAII STATE DEPARTMENT OF HEALTH ATR Project Director 801 Kamehaha Boulevard, Room 360 Kapolei, HI 96707

Budget Period: 09/30/2010 – 09/29/2011

Project Period: 09/30/2010 – 09/29/2014

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of \$2,932,999 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to HAWAII STATE DEPARTMENT OF HEALTH in support of the above referenced project. This award is pursuant to the authority of Sec.501(d)(5), 509, PHS Act 42U.S.C. Sec.290aa(d)(5), 290bb-2 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Kathleen Sample
 Grants Management Officer
 Division of Grants Management

See additional information below



SECTION I - AWARD DATA - 1H79TI023123-01

Award Calculation (U.S. Dollars)

Salaries and Wages	\$268,650
Fringe Benefits	\$102,100
Personnel Costs (Subtotal)	\$368,750
Supplies	\$10,389
Consortium/Contractual Cost	\$97,900
Travel Costs	\$50,052
Other	\$2,368,462
Direct Cost	
Indirect Cost	\$2,893,543
Approved Budget	\$39,456
Federal Share	\$2,932,999
Cumulative Prior Awards for this Budget Period	\$2,932,999
	\$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	\$2,932,999

SUMMARY TOTALS FOR ALL YEARS	
YR	AMOUNT
1	\$2,932,999
2	\$2,849,000
3	\$2,824,360
4	\$2,873,150

* Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number: 93.275
 EIN: 1996000449A4
 Document Number: 10TI23123A
 Fiscal Year: 2010

IC	CAN	Amount
TI	C56T507	\$2,932,999

TI Administrative Data:

PCC: ATR / OC: 4145

SECTION II - PAYMENT/HOTLINE INFORMATION - 1H79TI023123-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support - Telephone Number: 1-877-814-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III - TERMS AND CONDITIONS - 1H79TI023123-01



This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

- a. The grant program legislation and program regulation cited in this Notice of Award.
- b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
- c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
- d. The HHS Grants Policy Statement.
- e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – TI Special Terms and Condition – 1H79TI023123-01

REMARKS:

This Notice of Award (NoA) reflects a reduction in total costs from \$3,500,000 to \$2,932,999 as accepted by the Authorizing Representative.

SPECIAL CONDITION(S) OF AWARD:

Please submit the following by October 31, 2010:

Please submit required form:

1. "SF-424A Budget Information", this must be completed and submitted with the revised amount being requested.

Failure to comply with the above stated condition may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

SPECIAL TERM(S) OF AWARD:

1. This NoA reflects the target number of clients to be served over the four year ATR Grant project period:

01 Year - 1,238
02 Year - 3,120
03 Year - 3,035
04 Year - 1,528

Total Clients to be served over the project period: 8,917

2. Grantees are expected to maintain four key staff on the grant project: Project Director, Treatment/Recovery Support Services Coordinator, Information Technology Coordinator, and Fiscal Coordinator. The Project Director is required to commit a minimum of 75% level of effort on the project. In addition, the Authorizing Representative is required to devote 5-10% level on effort on the project in-kind.
3. No more than 20% of the total grant award can be used for administrative cost.
4. Grantees must be able to identify and report about clients, including those from restricted environments (such as criminal justice system, etc.).



5. SAMHSA will be partnering with Federal Departments and other Federal programs such as Department of Labor, Department of Justice, and SAMSHA's Screening, Brief Intervention, Referral to Treatment (SBIRT) Program. These partnerships could include clients being served under these initiatives that have substance abuse treatment and recovery support service needs and are eligible for ATR vouchers. Technical assistance will be provided to support your efforts.

6. SAMHSA encourages Access to Recovery implementation as soon as possible. This ATR grant must be implemented by January 15th, 2011. Implementation is defined as 1) serving clients, 2) having successfully passed the SAMHSA upload certification process for the client tool, the voucher information, and the voucher transaction data, and 3) electronically transferring the data mentioned in 2. There will be a 2 week grace period. If 1, 2 and 3 are not completed by the end of January 2011, your grant funds will be restricted (placed on high risk status). This means that the ATR funds will be restricted and may not be drawn down without prior approval and supporting documentation. Grant fund restriction will remain in effect until your project implements as defined above. When 1, 2 and 3 are accomplished the restriction on funds will be immediately lifted.

STANDARD TERMS OF AWARD:

- 1) This grant is subject to the terms and conditions, included directly, or incorporated by reference on the Notice of Award (NoA). Refer to the order of precedence in Section III (Terms and Conditions) on the NoA.
- 2) The grantee organization is legally and financially responsible for all aspects of this grant, including funds provided to sub-recipients.
- 3) Grant funds cannot be used to supplant current funding of existing activities. Under the HHS Grants Policy Directives, 1.02 General – Definition: Supplant is to replace funding of a recipient's existing program with funds from a Federal grant.
- 4) The recommended future support as indicated on the NoA reflects TOTAL costs (direct plus indirect). Funding is subject to the availability of Federal funds, and that matching funds, (if applicable), is verifiable; progress of the grant is documented and acceptable.
- 5) By law, none of the funds awarded can be used to pay the salary of an individual at a rate in excess of the Executive Level I, which is \$199,700 annually.
- 6) "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b).
Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with (42 CFR 2). The grantee is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.
- 7) Accounting Records and Disclosure - Awardees and sub-recipients must maintain records which adequately identify the source and application of funds provided for financially assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The awardee, and all its sub-recipients, should expect that SAMHSA, or its designee, may conduct a financial compliance audit and on-site program review of grants with significant amounts of Federal funding.
- 8) Per (45 CFR 74.36 and 45 CFR 92.34) and the HHS Grants Policy Statement, any copyrighted or copyrightable works developed under this cooperative agreement/grant shall be subject to a royalty-free, nonexclusive and irrevocable license to the government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. Income earned from any copyrightable work developed under this grant must be used a program income.
- 9) A notice in response to the President's Welfare-to-Work Initiative was published in the Federal Register on May 16, 1997. This initiative is designed to facilitate and encourage grantees and their sub-recipients to



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hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the notice is available electronically on the OMB home page at <http://www.whitehouse.gov/omb/fedreg/omb-not.html>.

10) Program income accrued under the award must be accounted for in accordance with (45 CFR 74.24) or (45 CFR 92.25) as applicable. Program income must be reported on the Financial Status Report, Standard Form 269 (long form).

Program income accrued under this award may be used in accordance with the additional costs alternative described in (45 CFR 74.24(b)(1)) or (45 CFR 92.25(g)(2)) as applicable. Program income must be used to further the grant objectives and shall only be used for allowable costs as set forth in the applicable OMB Circulars A-102 ("Grants and Cooperative Agreements with State and Local Governments") and A-110 ("Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations").

11) Actions that require prior approval must be submitted in writing to the Grants Management Officer (GMO), SAMHSA. The request must bear the signature of an authorized business official of the grantee organization as well as the project director. Approval of the request may only be granted by the GMO and will be in writing. No other written or oral approval should be accepted and will not be binding on SAMHSA.

12) Any replacement of, or substantial reduction in effort of the Program Director (PD) or other key staff of the grantee or any of the sub-recipients requires the written prior approval of the GMO. The GMO must approve the selection of the PD or other key personnel, if the individual being nominated for the position had not been named in the approved application, or if a replacement is needed should the incumbent step down or be unable to execute the position's responsibilities. A resume for the individual(s) being nominated must be included with the request. Key staff (or key staff positions, if staff has not been selected) are listed below:

SSA : Keith Y. Yamamoto @ 5-10% level of effort in kind
 Project Director: Bernie Strand @ 100% level of effort
 Treatment/Recovery Support Services Coordinator: Johanna Mechergui @ 100% level of effort
 IT Coordinator: Allan Sagayaga @ 100% level of effort
 Fiscal Coordinator: Enrique Palma @ 100% level of effort

13) Refer to the NoA under Section II (Payment/Hotline Information) regarding the Payment Management System and the HHS Inspector General's Hotline concerning fraud, waste or abuse.

14) As the grantee organization, you acknowledge acceptance of the grant terms and conditions by drawing or otherwise obtaining funds from the Payment Management System. In doing so, your organization must ensure that you exercise prudent stewardship over Federal funds and that all costs are allowable, allocable and reasonable.

15) No HHS funds may be paid as profit (fees) per (45 CFR Parts 74.81 and 92.22(2)).

16) RESTRICTIONS ON GRANTEE LOBBYING (Appropriations Act Section 503).

(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

17) Where a conference is funded by a grant or cooperative agreement the recipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):



Funding for this conference was made possible (in part) by (insert grant or cooperative agreement award number) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

18) This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://samhsa.gov/grants/trafficking.aspx>.

19) Grantees must comply with the requirements of the National Historical Preservation Act and EO 13287, Preserve America. The HHS Grants Policy Statement provides clarification and uniform guidance regarding preservation issues and requirements (pages I-20, "Preservation of Cultural and Historical Resources"). Questions concerning historical preservation, please contact SAMHSA's Office of Program Services, Building, Logistics and Telecommunications Branch at 240-276-1001.

20) Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs promotes efficient delivery of quality health care through the use of health information technology, transparency regarding health care quality and price, and incentives to promote the widespread adoption of health information technology and quality of care. Accordingly, all grantees that electronically exchange patient level health information to external entities where national standards exist must:

A) Use recognized health information interoperability standards at the time of any HIT system update, acquisition, or implementation, in all relevant information technology systems supported, in whole or in part, through this agreement/contract. Please consult <http://www.hhs.gov/healthit> for more information, and

B) Use HIT products (such as electronic health records, personalized health records, and the network components through which they operate and share information) that are certified by the Certification Commission for Healthcare Information Technology (CCHIT) or other recognized certification board, to ensure a minimum level of interoperability or compatibility of health IT products (<http://www.cchit.org/>). For additional information contact: Jim Kretz (CMHS) at 240-276-1755 or jim.kretz@samhsa.hhs.gov; Richard Thoreson (CSAT) at 240-276-2827 or richard.thoreson@samhsa.hhs.gov; or Sarah Wattenberg (OPPB) at 240-276-2975 or sarah.wattenberg@samhsa.hhs.gov.

21) If federal funds are used by the grantee to attend a meeting, conference, etc. and meal(s) are provided as part of the program, then the per diem applied to the Federal travel costs (M&IE allowance) must be reduced by the allotted meal cost(s).

22) By signing the application (PHS-5161-1) face page in item #21, the Authorized Representative (AR) certifies (1) to the statements contained in the list of certifications* and (2) provides the required assurances* and checking the "I AGREE" box provides SAMHSA with the AR's agreement of compliance. It is not necessary to submit signed copies of these documents, but should be retained for your records.

*The documents are available on the SAMHSA website at <http://www.samhsa.gov/Grants/new.aspx> or contained within the Request for Applications (RFA).

REPORTING REQUIREMENTS:

1) Financial Status Report (FSR), Standard Form 269 (long form) is required on an annual basis and must be submitted for each budget period no later than 90 days after the close of the budget period. The FSR 269 is required for each 12 month period, regardless of the overall length of the approved extension period authorized by SAMHSA. In addition, a final FSR 269 is due within 90 days after the end of the extension. If applicable, include the required match on this form under Transactions (#10 a-d), Recipient's share of net outlays (#10 e-i) and Program Income (q-t) in order for SAMHSA to determine whether matching is being provided and the rate of expenditure is appropriate. Adjustments to the award amount, if necessary, will be made if the grantee fails to meet the match. The FSR must be prepared on a cumulative basis and all



program income must be reported. Disbursements reported on the FSR must equal or agree with the Final Payment Management System Report (PSC-272). The FSR may be accessed from the following website at <http://www.whitehouse.gov/omb/grants/sf269.pdf> and the data can be entered directly on the form and the system will calculate the figures and then print and mail to this office.

2) A final report is due no later than 90 days from the end of the budget/period.

3) The grantees must comply with the GPRA requirements that include the collection and periodic reporting of performance data as specified in the RFA or by the Project Officer. This information is needed in order to comply with PL 102-62 which requires that SAMHSA report evaluation data to ensure the effectiveness and efficiency of its programs.

4) Submission of audit reports in accordance with the procedures established in OMB Circular A-133 is required by the Single Audit Act Amendments of 1996 (P.L. 104-156). An audit is required for all entities which expend \$500,000 or more of Federal funds in each fiscal year and is due to the Clearinghouse within 30 days of receipt from the auditor or within nine (9) months of the fiscal year, whichever occurs first, to the following address:

Federal Audit Clearinghouse
Bureau of the Census
1201 E. 10th Street
Jeffersonville, IN 47132

Failure to comply with the above stated terms and conditions may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

INDIRECT COSTS:

If the grantee chooses to establish an indirect cost rate agreement, it is required to submit an indirect cost rate proposal to the appropriate office within 90 days from the start date of the project period. For additional information, please refer to HHS Grants Policy Statement Section I, pages 23-24.

SAMHSA will not accept a research indirect cost rate. The grantee must use other-sponsored program rate or lowest rate available.

Please contact the appropriate office of the Division of Cost Allocation to begin the process for establishing an indirect cost rate. To find a list of HHS Division of Cost Allocation Regional Offices, go to the SAMHSA website www.samhsa.gov, then click on "grants"; then click on "important offices".

All responses to special terms and conditions of award and postaward requests must be mailed to the Division of Grants Management, Office of Financial Resources (OFR), SAMHSA below:

For Regular Delivery:
Division of Grants Management,
OFR, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

For Overnight or Direct Delivery:
Division of Grants Management,
OFR, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

CONTACTS:

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