Response to questions from the Montana State-Tribal Relations legislative meeting from April, 2008:

1. --when should tribal governments have agreements in place with ATR;

Tribal governments should have agreements with the Rocky Mountain Tribal Access to Recovery whenever they choose to do so.

RMT ATR includes an application process. Tribal chemical dependency programs/Tribal Health Departments/or Tribal governments may apply to participate in RMT ATR at their discretion.

-2.-define "fee for service";
Fee-for-service is a standard business model where services are unbundled and paid for separately. In Health insurance and the health care industry, fee-for-service involves when doctors and other health care providers receive a fee for each service, such as office visit, test, procedure or other health care service.

In the case of the Rocky Mountain Tribal Access to Recovery grant, fee-for-service refers to the pre-authorization process, using an electronic voucher system. Clients choose the services from a list that their Tribe authorizes. These services are pre-authorized through the electronic voucher system. After the client accesses the services, the Tribe or other Provider invoices RMT ATR the fee for the service they provided. This fee is then electronically transferred to the financial institution and account identified by the Tribe.

3.--are you training tribal program staff regarding Medicaid reimbursement;
RMT ATR is not at this time funded by SAMHSA to provide training to tribal program staff on Medicaid reimbursement.

-4-what are your reporting requirements;

1. Financial Status Report (FSR) is due within 90 days of the expiration of the budget period.
2. The grantee must comply with the ATR GPRA requirements that include collection and periodic reporting of performance data. 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. (see below)
3. Grantees are required to submit quarterly reports about the progress of the grantee toward meeting goals and objectives of the grant, which is in addition to the GPRA data submitted electronically. (Appendix A)
4. Grantees may be required to provide additional reports or information about their ATR program. As of June, 2008, these additional reports include a weekly report of the number of individuals served; number of individuals served who have used methamphetamine in the 90 period prior to intake into the ATR; number of providers enrolled in the program to provide services to the clients in the ATR payment system; number of Faith Based and Community Organizations among the providers.

Overview of the GPRA taken from SAMHSA website:
1. The Government Performance and Results Act (GPRA) of 1993 holds all Federal agencies accountable for achieving program results. Under GPRA law, the Substance Abuse and Mental Health Service Administration and its three centers, including the Center for Substance Abuse Treatment (CSAT), from which the ATR grant is funded, are required to set program-specific targets, to measure

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Website: http://www.tribalrecovery.com Email: epimasis@mtwytlc.com

program performance on a regular basis against those targets, and to report annually to Congress on the Centers' results.

CSAT's primary mission is to bring effective alcohol and drug treatment to every community.
The number of people served reflects the extent to which CSAT funding has supported the provision of service.
-5.-what types of data are you collecting, what is done with the data;
CSAT has a set of GPRA goals and a standard set of output measures has been identified to correspond with these goals.

These measures are the basis of the reporting requirements for the RMT ATR project.

Each of the Tribal and Urban Indian Substance Abuse programs which participate in RMT ATR are required to collect a uniform set of data from each individual who chooses to participate in RMT ATR, and who consents to the interview, at intake and six months after intake.

The GPRA measures and the interview include each client's perception of the following measures:

a) their employment;
b) their living environment;
c) their involvement with the criminal justice system;
d) their access to services;
e) their use of substances in the month prior to the interview
f) their level of social connectedness;
g) whether they were still in services for substance abuse treatment.

The data from the voluntary confidential interview is entered by the interviewer into the GPRA web-based database. The data is anonymous when entered and does not identify the individual client.

6. do participating tribes get the data back (or have access to it?) Participating tribes have access to the GPRA data without any client-identifying information attached. The Tribes have access to cumulative data of their tribal programs and of the entire RMT ATR data.

Historical data repositories such as the Indian Health Service, States, and Centers for Disease Control have not allowed Tribes to access their own data directly.

7.--what are the outcome and/or performance measures;

2. Outcome measures for RMT ATR.

RMT ATR is required by SAMHSA to serve at least 2,553 individuals over the three year ATR project.

RMT ATR is required to spend a minimum amount of $686,515 on methamphetamine related issues.

Expansion of treatment capacity and consumer choice, resulting in increase in recovery options for clients. Increase in numbers and types of providers of clinical treatment and recovery support services is a performance measure.

--8.do the participating tribes have any input into the process;
Elected Tribal Leaders are the Governing Body for the grantee, the Montana-Wyoming Tribal Leaders Council.

Participating tribes make up the Technical Advisory Team for the grant. Input from the participating Tribal Chemical Dependency Programs began at the onset of the grant application, and continues.

The RMT ATR project represents the consensus of this group. They maintain oversight of the technical aspects of the project.

9.-who is responsible for liability issues;
Liability issues do not change as a result of this funding.
Each participating organization is responsible for its own conduct. The chemical dependency counselors are responsible for following the standards of their own professional practice. The chemical dependency programs are responsible for their own programs. The Montana-Wyoming Tribal Leaders Council is responsible for its actions. Service Providers for RMT ATR are each responsible for their own actions.

-10.-overall, what are the cultural aspects of this project?

Each tribal community has its own set of cultural traditions. Cultural issues are inherent in substance abuse treatment.

Ethnic and racial disparities persist in substance abuse treatment and access to treatment.

The Tribes are the true "experts" on the cultural aspects involved in substance abuse recovery within our reservations---and this idea is the guiding principle of the ATR design. ATR is supporting the efforts of each tribe to most effectively define culturally based recovery efforts (through collaboration with CD directors, Tribal based clinicians, and leadership).

The individual Tribes define their own cultural components of the ATR. The RMT ATR respects the sovereignty of each Tribe. Applicants to be service providers for any of the participating Tribes are only enrolled as RMT ATR providers after the Tribal program chooses them. The clinical treatment and recovery support services to be provided with ATR funds are specific to each Tribe. Each Tribal program determines the services as well as the providers.
RMT ATR authorizes whatever a Tribe decides is the appropriate activity for their Tribe. RMT ATR does not define it for them. RMT ATR does not represent itself to anyone on behalf of the Tribes.

Questions about ATR activities on any reservation, by the Tribe or Tribes, should be directed to the individual tribal program.

More information is available on the FAQ page of the RMT ATR website:
www.tribalrecovery.com

Appendices:

1. SAMHSA Access to Recovery (ATR) 2007 Fact Sheet
2. SAMHSA Brochure: Reducing Substance Abuse in America
3. ATR Quarterly report format

QUARTERLY REPORT TEMPLATE AND GUIDELINES*

CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

2007 COHORT OF ATR GRANTS

Grantee Organization: _____

Project Name: _____

Grant Number: H TI _____

CSAT Project Officer: _____

Reporting Period: _____

Project Director: **Submission Date:** _____

*Refer to Appendix A for instructions and guidance.

I. PERSONNEL INFORMATION:

Instructions: Please complete the tables below and note any changes that occurred during this reporting period, including contact information, level of effort, salary, etc.

Note: Any changes to the four key staff require prior approval from a SAMHSA Grants Management Officer.

Required ATR Key Staff				
	Project Director	**Treatment Coordinator**	**Financial Coordinator**	**Information Technology Coordinator**
Mark with X if any Changes Occurred				
Name				
Organization				
Telephone				
Email Address				
Address				
Fax Number				
Level of Effort				
Annual Salary				
SAMHSA Funding of Salary				
In Kind Contribution of Salary				

	Non-key staff hired this Quarter	Staff Vacancies that Occurred this Quarter
Name		
Position/Title		

II. PROGRAM INFORMATION

II.A. Strategic Implementation

List the following information:

Target Population:

Geographic Target Areas* (such as region, county, city, etc.):

** Insert map of target areas if available*

II.B. Strategic Planning:

II.B.1 What is your strategy and plan for developing/enhancing your voucher management system to meet your program goal? Detail any experienced or anticipated delays and your efforts to address those delays.

II.B.2 Describe your strategic plan for reaching your annual client targets and spending your grant dollars. Include objectives, steps, and timelines for achieving your targets. Detail any experienced or anticipated delays and your efforts to address those delays.

II.B.3 What is your marketing and outreach plan to recruit ATR providers, including timelines, targets, and milestones? Detail any experienced or anticipated delays and your efforts to address those delays.

II.B.4 What is your marketing and outreach plan to recruit ATR clients?

II.B.5 Describe strategies in place to obtain six-month GPRA follow ups.

II.C. Policy and Procedural Changes

Detail any policy and procedural changes that relate to:

- Program management:
- Administering or monitoring the client satisfaction survey (including changes to the instrument):
- Administering or monitoring client choice:
- Preventing and detecting fraud, waste, and abuse:

II.D. Cultural Competency

What are your strategies for ensuring culturally competent services? Report any changes, challenges and new successes this quarter.

II.E. Fraud, Waste, and Abuse

II.E.1. Identify which and how many programmatic monitoring efforts have taken place this quarter to prevent or detect fraud, waste, and abuse. (Please check all that apply)

Yes (please check)	# of times	
___	___	Programmatic audits
___	___	Fiscal Audit
___	___	Cross-checking payment systems for duplicate payments
___	___	Review of provider billing practices
___	___	Electronic tracking
___	___	Unique voucher identifiers
___	___	Client satisfaction surveys
___	___	Other (If other, describe)

II.E.2 Please report all incidents that required ***investigations to determine*** whether fraud/waste/abuse occurred during this reporting period.

II.E.3 Please report all ***substantiated*** cases of fraud/waste/abuse. Include how you detected the issue and what actions were taken to resolve the situation.

II.F. Partnerships/Collaborations with other programs

List and describe any formal or informal partnerships, collaborations, MOUs, etc. with Federal, State, or Local agencies or other grant/funded programs. If few or none to report, describe plan and timeline for establishing those partnerships.

II.G. Technical Assistance (TA) Needs

Challenges and TA Needs		
	Detail Concern/Challenge	**If TA is needed, describe purpose of TA and proposed dates for the TA**
Overall Program Management		
Fiscal Management		
Target Population or Target Area		
Service Array		
VMS Development/ Enhancement		
Marketing and Outreach—Providers		
Marketing and Outreach—Clients		
GPRA Data/Data Collection Systems		
Methamphetamine Related Needs *(Services, Clients, Providers, Data Collection)*		
Needs Related to Faith- & Community-Based Organizations (FBCO)		
Partnership Outreach *(with other Federal Agencies)*		
Client Retention		
Assuring Client Choice		
Other		

III. DATA TABLES

Table 1: Overall Program Data						
Client Information		**Financial Information as of End of Quarter**				
Year 1 Client Target Number	**Total Number Served through End of Quarter**	**Year 1 Funding/ Award Amount**	**Administrative Costs**	**Vouchers**		
				$ Linked to active vouchers*	**$ paid vouchers**	**Remaining funds****

$ Linked to active vouchers = $ of all vouchers issued - $ of paid vouchers - $ of expired vouchers

***Remaining funds= Total Award Amount-(Administrative Costs)-($ linked to active vouchers)-($ paid vouchers)*

Table 2: Methamphetamine Data						
Client Information		**Financial Information as of End of Quarter**				
Year 1 Meth. Client Target Number	**Total Number Meth. Clients Served through End of Quarter**	**Year 1 Meth. Funding/ Award Amount**	**Meth. Administrative Costs**	**Vouchers**		
				$ linked to Active Meth. vouchers	**$ paid Meth vouchers**	**Remaining Meth. funds**

Table 3: Enrolled Providers (unduplicated)			
	# of New Additions	***Total # at end of reporting period***	***% of Enrolled Providers who are FBO/Secular***
FBO			
Secular			
Total			

Table 4: Active Providers*** (unduplicated)			
	# of New Additions	***Total # at end of reporting period***	***% of Active Providers who are FBO/Secular***
FBO			
Secular			
Total			

****Active providers refer to those who have received and redeemed vouchers by the end of the reporting period.*

Table 5: Enrolled Providers (duplicated)****		
	# of New Additions	***Total # at end of reporting period***
Clinical Treatment		
Recovery Support Services		

Table 6: Active Providers (duplicated)		
	# of New Additions	***Total # at end of reporting period***
Clinical Treatment		
Recovery Support Services		

*****The term "duplicated" means that some providers may be counted twice if they provide both clinical treatment and recovery support services.*

Please mark the appropriate option with an X.

Table 7: Structure of Vouchers	
Services are bundled in all vouchers	
Services are never bundled	
Some services are bundled in vouchers and some are not	
Other (please specify):	

Table 8 Voucher Life and Caps for non-Methamphetamine Services			
		Amount of Voucher Range	
Most Often Used Services	Length of Voucher Life	*Minimum*	*Maximum*
1.		$	$
2.		$	$
3.		$	$
4.		$	$
5.		$	$
Voucher Life and Caps for Methamphetamine Services			
		Amount of voucher range	
Most often used services	Length of Voucher Life	*Minimum*	*Maximum*
1.		$	$
2.		$	$
3.		$	$
4.		$	$
5.		$	$

Table 9 Average Cost Per Client as of End of Quarter (Based on Discharge Data)	
Average Cost Per Methamphetamine Client	$
Average Cost per non-Methamphetamine Client	$

IV. ACCOMPLISHMENTS

IV.1 Please detail accomplishments made this quarter that pertain to:

Development/Enhancement of the VMS:

Provider outreach and recruitment, especially to Faith- and Community-based and methamphetamine providers:

IV.2 What promotional materials have you developed/used (e.g., flyers, e-alerts, FBO directory, power point presentations, videos, website, etc) and where have they been disseminated?

IV.3 What TA has been offered to providers, if any?

IV.4 Please summarize results of the client satisfaction survey to date.

IV.5 Describe any successfully-resolved challenges you achieved this reporting period

IV.6 Please provide 1-2 client or provider success stories from this reporting period. Please note that client success story submissions must include a release form signed by the client. See Appendix B for success story outline and client authorization form.

V. ADDITIONAL SUBMISSIONS

V.1 Share with us information you gave to others about your project, (e.g., newsletter, marketing
materials and tools; newspaper, TV, or radio coverage; public presentations; presentations at local, state, or national conferences; and publications).

V.2 Please submit an updated provider list with the quarterly report.

Appendix A

Quarterly Report Guidelines

Background and Purpose of Report:
Quarterly reports are required by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health services Administration (SAMSHA) in response to the reporting requirements outlined in the Terms and Conditions of Award for your grant. This requirement was discussed in the Guidance for Applicants (GFA) under the reporting requirements section of the terms and conditions of support. In this section, SAMHSA stated:

> *"Interim and final progress reports and financial status reports will be required as specified in the Public Health Services (PHS) Grants Policy Statement requirements.*
>
> *To permit compliance with the Government Performance and Results Act, grantee will be required to supply necessary data about certain grant process and/or outcome activities or results in their regularly scheduled program progress reports..."*

Quarterly reports are a means of regular communication between the grantee and CSAT/SAMHSA about the progress of the grantee toward meeting the goals and objectives of the grant, which is in addition to the Government Performance and Results Act (1993) (GPRA) data submitted electronically. Quarterly reports allow grantees to inform CSAT about progress, problems, and successes including problem resolutions. They also are used for reporting major changes in staffing or project goals and technical assistance needs.

Overview of the Report Sections:

I—Personnel Information

Key Staff names, contact information, work effort information.

II—Program Information

Strategic implementation; strategic planning; policy and procedural changes; cultural competency; fraud, waste, and abuse; partnerships/collaborations with other programs; concerns, challenges, and technical assistance needs.

III—Data Tables

Client, fiscal, and provider data; structure of vouchers; services and caps; average cost per client.

IV—Accomplishments

Voucher management system; promotional materials; technical assistance offered to providers; client satisfaction survey results; resolved challenges, and success stories.

V—Additional Submissions

Information given to others about the project; and updated provider list

Instructions and Guidance:

- The Project Director is responsible for submitting the quarterly report.
- The report must be **electronically** submitted via **email** directly to your Government Project Officer and copied to CSAT/SAMHSA's onsite support staff.
- The report should be completed in Microsoft Word using the most recent template you receive from CSAT/SAMHSA.
- If you need clarification to complete the report, you may contact your Government Project Officer.
- The report is due the last working day of the month following the end of the previous quarter. The quarterly report is due **no later** than 30 days after the end of a quarter. The reporting periods and due dates are listed below:

Quarterly Reporting Periods and Due Dates	
Reporting Period	**Due Date**
First Day of Grant – December 31, 2007	January 31, 2007
January 1, 2008 – March 31, 2008	April 30, 2008
April 1, 2008 – June 30, 2008	July 31, 2008
July 1, 2008 – September 30, 2008	October 31, 2008
October 1, 2008 – December 31, 2008	January 31, 2009
January 1, 2009 – March 31, 2009	April 30, 2009
April 1, 2009 – June 30, 2009	July 31, 2009
July 1, 2009 – September 30, 2009	October 31, 2009

SAMHSA.gov
The Substance Abuse & Mental Health Services Administration

SAMHSA.gov

SAMHSA Access to Recovery (ATR) Grants

2007 ATR Factsheet

BACKGROUND: President Bush proposed a new substance abuse treatment initiative, Access to Recovery, in his 2003 State of the Union Address. The program was launched in August 2004 when the President announced the first three year Access to Recovery grants to 14 states and one tribal organization to provide people seeking drug and alcohol treatment services with vouchers to pay for a range of appropriate community-based clinical treatment and recovery support services. Since then, approximately $300 million in funds have been awarded and more than 170,000 people with substance abuse problems have received treatment and/or recovery support services, exceeding the three-year target of 125,000 people.

After a competitive grant review of 40 applications, 24 new 3-year Access to Recovery grants were awarded in September 2007 to: Louisiana, Hawaii, Missouri, New Mexico, Oklahoma Cherokee Nation, California, Alaska Southcentral Foundation, Inter-Tribal Council of Michigan, Indiana, Illinois, Connecticut, Tennessee, Oklahoma, Montana Wyoming Tribal Leaders Council, District of Columbia, California Rural Indian Health Board, Arizona, Rhode Island, Washington, Ohio, Iowa, Texas, Colorado, and Wisconsin. Just under $100 million is expected to be awarded each year, for three years to help the grantees increase access to clinical treatment and recovery support services for an estimated 160,000 individuals.

Too Many Americans Do Not Receive Help. In 2006, 21.1 million of the 23.6 million people needing treatment for an illicit drug or alcohol use problem did not receive treatment. Of the 21.1 million, only 940,000 reported that they felt they needed treatment for their drug or alcohol use problem, including 314,000 people who knew they needed treatment, but were unable to find care.

Addiction Treatment Works; Recovery is Real. With treatment, even hard-to-reach populations reduce their illegal drug use by nearly half. Further, addiction treatment reduces criminal activity by 80%. Treatment markedly increases employment and decreases homelessness; results in substantially improved physical and mental health; and reduces risky sexual behaviors. When tailored to the needs of the individual, addiction treatment is as effective as treatments for other illnesses, such as diabetes, hypertension, and asthma.

***ACCESS TO RECOVERY*:** establishes a Grantee-run voucher program for clinical substance abuse treatment and recovery support services built on the following three principles:

Consumer Choice. The process of recovery is a personal one. Achieving recovery can take many pathways: physical, mental, emotional, or spiritual. With a voucher, people in need of addiction treatment and recovery support will be able to choose the programs and providers that will help them most. Increased choice protects individuals and encourages quality.

Outcome Oriented. Success will be measured by outcomes, principally abstinence from drugs and alcohol, and includes attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care, and retention in services.

Increased Capacity. *Access to Recovery* increases the number and types of clinical treatment and recovery support service providers (including faith-based and community organizations) eligible to receive Federal funding and expands the array of services available including medical detoxification, inpatient and outpatient treatment modalities, residential services, peer support, relapse prevention, case management, and other recovery support services.

HOW IT WILL WORK: The selected grantees have designed their approach and targeted efforts to areas of greatest need, areas with a high degree of readiness, and to specific populations, including adolescents. Critically, Grantees are using the new funds to supplement, not supplant current funding and are building on existing programs, including SAMHSA's Substance Abuse Prevention and Treatment Block Grant, for which the President has requested $1.759 billion in FY 2008. The SAPT Block Grant, with its required State maintenance of effort, provides the basic national addiction treatment infrastructure.

For more information, contact SAMHSA's Office of Communications - Phone: (240)276-2130

Last Update: 9/20/2007

Reducing Substance Abuse in America: Building the Nation's Demand Reduction Infrastructure A Framework for Discussion

The Programs: Facilitating Recovery

Healing America's Drug Users

Access to Recovery

Chief among SAMHSA's substance abuse treatment priorities is a focus on facilitating recovery. A key addition to the demand reduction infrastructure is the Access to Recovery (ATR) Program. Thousands of people seek treatment each year and sadly, many are unable to find care. With the leadership of the President, access to recovery is now a reality for thousands of Americans. ATR expands consumer choice through a unique voucher program aimed at increasing recovery options by focusing on both clinical treatment and other recovery support services. States (including eligible tribes and territories) take the lead on implementation of the Access to Recovery Program because Governors are key to ensuring a coordinated approach among various State departments.

ATR is built on three principles:

Free and Open Consumer Choice. Achieving success in recovery takes many pathways. With a voucher, people in need of addiction treatment and recovery support are able to choose the programs and providers that will help them most. Increased choice protects individuals, encourages quality, and allows individuals to select the program that best fits their needs, including faith-based treatment programs as approved by the State.

Outcomes. ATR measures success by outcomes such as abstinence from drugs and alcohol, attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care, and retention in services.

Increased Capacity. Access to Recovery supports treatment for approximately 50,000 people per year and expands the array of services available including medical detoxification, inpatient and outpatient treatment modalities, residential services, peer support, relapse prevention, case management, pre-employment counseling, employment coaching, recovery coaching (including stage-appropriate recovery education, assistance in recovery management and telephone monitoring), family support services including marriage education, parenting and child development services, and other recovery support services.

Success Story

Wisconsin issued the first Access to Recovery voucher to a 41-year old mother from Milwaukee in December 2004. Her addiction and related felony conviction had become roadblocks to getting a job and raising her children. This single mother chose an agency which provides residential clinical treatment and recovery support services that will allow her one-year old baby to live with her in treatment once she is ready for re-unification. She worked with her Access to Recovery Coordinator to develop her own unique Recovery Support Team which includes her service providers, probation officer, church members, family members and others to help her achieve and then sustain recovery. When asked to describe the impact of the Access to Recovery program she describes the program as "an angel on her shoulder."

Treating People with Co-occurring Mental and Substance Use Disorders

According to SAMHSA's 2004 National Survey on Drug Use and Health, an estimated 4.6 million people experienced co-occurring mental and substance use disorders during the year. Nearly half of the adults with co-occurring disorders received no treatment for either problem, and only 6 percent received treatment for both. The resulting human and societal costs are high. People with co-occurring disorders are at greater risk for HIV/AIDS, homelessness, contact with the criminal justice system, violence, and suicide. To better serve individuals in need, states and communities must strengthen their systems to address both substance abuse and mental health disorders.

In a landmark 2002 Report to Congress, SAMHSA recognized that people in need with co-occurring disorders are the *expectation*, not the exception, in substance abuse and mental health treatment systems. In this report, SAMHSA outlined its commitment to ensure that States and communities have the incentives, technical assistance, and training they need to effectively serve people with co-occurring disorders. To this end, SAMHSA has awarded Co-occurring State Incentive Grants to help States develop or enhance their infrastructure to provide accessible, comprehensive, and evidence-based treatment services to people with co-occurring substance use and mental disorders. SAMHSA has also established the National Co-occurring Center for Excellence, published a new Co-occurring Treatment Improvement Protocol (TIP 42), and held policy academies to encourage the development of State action plans.

Co-occurring Center for Excellence

SAMHSA created the Co-occurring Center for Excellence (COCE) as a vital link between the agency and States, communities, and providers. COCE provides the technical, informational, and training resources needed for the dissemination of knowledge and the adoption of evidence-based practices in systems and programs that serve persons with co-occurring disorders.

COCE's Mission is to:

Receive, generate, and transmit advances in substance abuse and mental health treatment that address mental health and substance use disorders at all levels of severity that can be adapted to the unique needs of each client Guide enhancements in the infrastructure and clinical capacities of the mental health and substance abuse service systems Foster the infusion and adoption of evidence- and consensus-based treatment and program innovation into clinical and organizational practice.