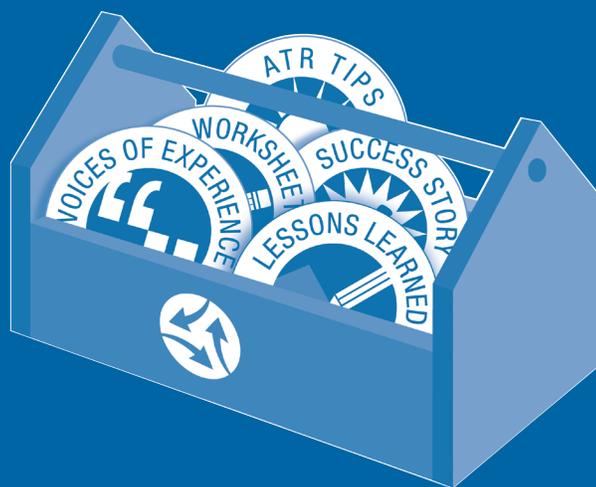




# ACCESS TO RECOVERY

## ACCESS TO RECOVERY IMPLEMENTATION TOOLKIT VOLUME 1 • PHASE 1



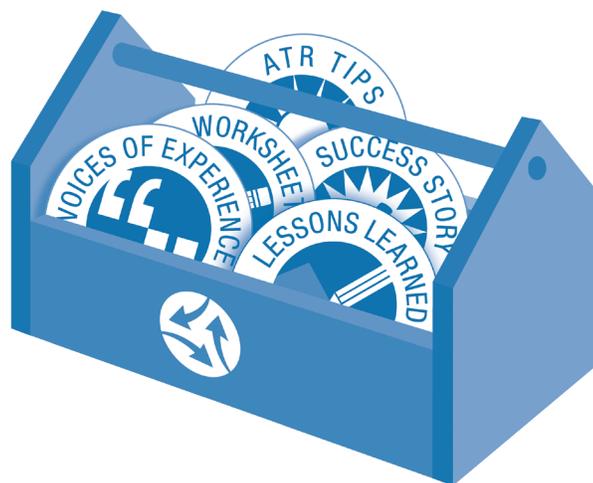
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Center for Substance Abuse Treatment  
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# ACCESS TO RECOVERY IMPLEMENTATION TOOLKIT

## VOLUME 1 • PHASE 1



U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment / Division of Services Improvement

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# 1

## Introduction

The Access to Recovery Program is a SAMHSA initiative which expands capacity, offers clients a choice of services, and increases the array of faith-based and secular community service providers within systems of care. Funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (SAMHSA/CSAT), the program's grant projects provide vouchers to clients for purchasing substance use disorder clinical treatment and recovery support services.

# Introduction

The Access to Recovery (ATR) Implementation Toolkit consists of three workbooks prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) ATR program. The workbooks are meant as planning, implementation, and operational tools to assist the Single State Authority and tribal program officials and their project management teams.

SAMHSA also hopes the information contained in the workbooks is useful to others interested in learning about ATR's provision of services using vouchers and the integration of diverse services within a single collaborative system. The workbooks include many lessons learned by grantees in the first two ATR cohorts from 2004 to 2007 and from 2007 to 2010.

## Rationale for the workbooks

Building and operating an ATR project are complex endeavors because the SAMHSA program introduces numerous innovations to State and tribal systems of care. Project management teams face such challenges as:

- Organizing the system of care around the client, rather than around the providers of services, emphasizing client choice in recovery planning and selection of services;
- Expanding the system of care to include new providers and new types of services that together constitute a more holistic array of services;
- Introducing new administrative and decision processes, with special emphasis on improving projects based on client outcomes and project performance data; and
- Introducing an indirect payment method, using vouchers that are expended by clients for services of their choosing.

In addition, some of the jurisdictions housing ATR projects may wish to incorporate some or all of the new program's features into their established systems of care. As the comments of project leaders from cohorts 1 and 2 reveal in the workbook pages, ATR enabled them to introduce innovations into their State or tribal systems. Usually, ATR features have been adapted by the larger systems because they have produced improvements—documented by data—in client outcomes or quality of services.

High levels of management skill and understanding are required to plan and conduct an ATR project. This ATR Implementation Toolkit aims to assist cohort 3 grantees in designing projects to meet these and other challenges. It is meant to increase understanding of the Federal program in a manner that facilitates implementation of integrated community projects.

## Introducing the workbooks

The workbooks are unusual in that they do not tell system authorities and project management teams how to conduct ATR projects. That guidance is provided in the SAMHSA Request for Applications (RFA).

Instead, the workbooks raise questions that ATR managers need to consider as they plan, implement, operate, and close out the project. The questions are quite comprehensive and have been phrased so as to spur thinking and consideration of factors involved in the various project phases. They are also designed to stimulate discussion among the State or tribal system director and members of the management team.

Teams from different jurisdictions will answer questions differently, depending on a number of variables such as the particular target populations selected, the types of alcohol and other drug problems and needs for care in their communities, and the types of referral and provider networks they are able to create. Irrespective of these differences, answering the questions posed in each chapter can help the management team to create a successful project that fits its local, State, or tribal situation.

The workbooks have been prepared for management teams in State and tribal settings that are quite diverse in their capacity to plan and implement the many tasks required of an ATR project. Some States and tribal grantees—particularly those with previous ATR experience—may find that some of the information and worksheet queries are already familiar and that only a few sections provide helpful guidance. Other State and tribal entities may benefit from the majority of chapters and worksheets.

The concepts embodied in ATR are sufficiently new and different that simply reading through the chapters may help broaden and clarify understanding. The worksheets are intended to stimulate thinking that is particularly relevant to individual State and tribal environments. The workbooks strive to present information, concepts, suggestions, and lessons learned that can benefit every reader irrespective of system strengths, organizational knowledge, and previous exposure to ATR.

## The three phases of ATR

The workbooks cover ATR activities conducted during three different periods of time, as designated in Exhibit 1, *ATR Project Phases*.

Topics are presented, to the fullest extent possible, in the order that project planning, implementation, operations, transfer of remaining clients into other programs, and close out will occur. Intensive planning in all areas of project activity will occur concurrently in the project startup phase of 4 months for new grants and 3 months for previously funded grants. Ideally, even sustainability planning will be considered at this stage to help ensure that data are collected throughout all parts of the implementation phase to help pave the way for implementation of ATR elements in jurisdictional systems of care.

The first volume of the toolkit pertains to phase 1, startup. During this phase, project planning and infrastructure building are particularly intense and driven by the RFA requirements (see page 9 of the RFA). All the activities you identified in your grant application implementation plan must be completed. Key staff must be hired, and four project components must be in place and ready for service delivery to start: (1) financial system, (2) information management system, (3) provider network, and (4) referral processes to ensure client flow. Exhibit 2, *SAMHSA Requirements for Startup Phase*, on the following page, spells out the accomplishments to be achieved during phase 1.

Exhibit 1. ATR Project Phases		
Phase	New Grants	Previously Funded Grants
Phase 1: Startup	Year 1, months 1–4	Year 1, months 1–3
Phase 2: Implementation and operations	Year 1, month 5 through end of grant, year 4	Year 1, month 4 through end of grant, year 4
Phase 3: Sustaining ATR innovations and closing out projects  1. Implementation of ATR project features in jurisdictional system of care or continued project funding.  2. Close out of grant with SAMHSA Grants Management Office.	Year 4, approximately month 4, through expenditure of final vouchers and cessation of ATR services, coinciding with end of year 4. Clients are served until the end of year 4; those remaining in the program at the end of the year and still requiring services are transferred into appropriate programs. All project funds are expended by the end of the project.	

## Keeping clients at the center

In the new systems of care emerging under ATR, networks are created to deliver services that enable clients to sustain recovery. Partners in the networks include referral organizations, intake and assessment staff, care coordinators, and treatment and recovery support services providers. Networks typically include public, private, faith-based and secular community organizations, and referral institutions such as correctional systems or child and family services. Clients receive services not just during acute treatment crises but also prior to treatment and during the initiation, stabilization, and maintenance of recovery.

## Exhibit 2. SAMHSA Requirements for Startup Phase

### Financial system

- Fully functional electronic voucher management system (VMS).
- Fiscal and cost accounting mechanisms to track voucher implementation.
- Oversight methods pertaining to standards and clear procedures to monitor, prevent, and remediate fraud.
- Voucher reimbursement system for services defined in the continuum of care.

### Information technology (IT) system

- Management information system to track performance and outcomes.
- IT capacity to upload performance data to SAMHSA.
- Development of client follow-up system for finding and interviewing clients 6 months after intake.
- Initial uploading of Government Performance and Results Act information to the SAMHSA system.

### Provider network development

- Activities to attract, develop, and sustain new clinical treatment and recovery support services providers, with at least three information and orientation meetings held with potential providers in each targeted region.
- Outreach to and partnership with grassroots faith-based and secular community organizations or other entities new to the single State or tribal authority.
- Development of eligibility determination process for clinical treatment and recovery support services providers.
- Identifying and determining eligibility of new clinical treatment and recovery support services providers.
- Definition of specific services defined in the continuum of care.
- Development of infrastructure and sustainability planning in enrolled faith-based and secular community organizations.
- Steps for establishing certification of treatment and recovery support services providers.

### Client flow

- Eligibility determinations for clients.
- Design and management of a client intake and assessment system.
- Establishment of client referral pathways through collaborations with other large institutional systems such as the criminal justice system.
- Development of memoranda of understanding or other formal mechanisms to solidify client referrals.
- All necessary steps preceding the enrollment of clients and delivery of services.

ATR's networks of care provide comprehensive and integrated services that:

- Enable clients to take steps toward recovery in the pre-recovery stages of problem identification and engagement with recovery processes.
- Provide care coordination assistance that supports clients in initiating and stabilizing recovery by engaging in:
  - Treatment, if necessary because of the severity of the substance use disorder (SUD).
  - Recovery support services.

## ATR in the context of the current health care environment

The design of ATR projects is consistent with several important and current societal initiatives within health care.

- There has been movement by the Obama Administration, Congress, and Federal agencies to foster the establishment of community- and place-based integrated health care systems that include grassroots faith-based and secular organizations providing a variety of support services, as well as established public and private professionally directed clinical services.
- New health care reform measures are likely to bring many new clients to SUD services.
- There is an increasing demand for electronic information systems that enable SUD systems managers and staff to make decisions based on data and to communicate and interact more effectively with other areas of health care.
- The scientific community has an increased understanding of most SUD as chronic in nature.
- Movement is underway within key areas of the SUD field to establish recovery-oriented systems of care (ROSC).
- Interest has increased in the contributions that can be made by stage-appropriate recovery support services throughout the course of recovery.
- Expansion of service capacity to meet more unmet needs of Americans is a continuing theme.

Established as a presidential initiative in 2004, ATR can be seen now as an early innovator. Its emphases on creating new structures for SUD systems of client-directed care and providing an expanded array of services in a network of provider organizations are consistent with the trends of 2010.

In many respects, ATR projects also can be viewed as one step toward the development of systems modeled after conceptual frameworks for ROSC. Fully functioning ATR projects offer a wide range of services that support client-directed recovery. These are offered by diverse providers in the ATR system of care and in referral organizations. ATR projects introduce a new payment mechanism—the voucher—that is expended by the client for services of his or her choice. In the new systems of care created in ATR projects, treatment staff, recovery support services providers, and referral organizations work together, integrating services and serving the same clients. Care coordinators, in a newly defined role, help clients negotiate a complex system of services. The challenge to ATR project managers is to create and coordinate this wide array of service providers, lead them through the innovations and systems change processes inherent in ATR projects, and build an integrated system that provides holistic care to clients recovering from SUD.

## ATR PRINCIPLES

Three major principles have served as the basis for the ATR program from its inception and they inform this toolkit.

- **ATR is client-driven.** ATR projects use a wide range of services to meet the recovery needs of all clients. The use of a voucher system helps to facilitate client choice of both the services to be received and the provider giving them.
- **ATR is outcomes-driven.** For this reason, grantees are required to collect data and track them electronically. Collecting client outcomes data is the basis for improving ATR project management and bettering the services provided, and it can help detect problems, such as fraud, waste, or abuse in the network. Ultimately, the data will undergird the development

of best practices in recovery-oriented care and serve as proof that ATR facilitates and supports the process of recovery.

- **ATR emphasizes the expansion of capacity.** This requires an increase in both the range and types of services that can be offered and in the number of clients whose needs can be met. Engaging stakeholders at the outset of program planning and maintaining their engagement throughout the entire grant cycle can help ensure that new services fit the needs of target populations.

The goals of this toolkit are to help grantees build their ATR projects based on these three principles and understand how these principles inform every aspect of ATR.

# 2

## Planning Systems Changes Using Your ATR Grant



# Planning Systems Changes Using Your ATR Grant

## Key Concepts

- An ATR project is a systems change project that includes broad community involvement.
- Managing an ATR project is grounded in understanding the change process and the scope of changes to be made.
- ATR managers can be viewed as change agents.
- Many changes will occur simultaneously.
- Effective management teams will find ways to identify and resolve problems early in the different parts of the changing ATR project system.
- Having a systems change advisory group will make it easier to manage the project and the change process.
- Fostering communication among managers and obtaining feedback from the components of the system, including community representatives and the advisory group, are the most essential tasks of management.

ATR changes are wide-ranging—from introducing vouchers to emphasizing recovery to finding ways of sharing information electronically among network partners and with the Substance Abuse and Mental Health Services Administration (SAMHSA). A notable innovation is the integration of State- and tribally funded services with new grassroots provider organizations.

Instead of waiting until the 4-year grant is almost over and defining sustainability just as a search for continued funding, ATR projects are encouraged to focus on the goal of implementing appropriate ATR components into the larger systems of care within which the projects are located. Getting this idea entrenched early creates expectations that will smooth the transition 4 years from now. More important, starting early allows for observation of ATR activities to determine which project features warrant establishment in your jurisdiction's system of care.



Reflecting on their experiences in two ATR cohorts, project directors agree that implementing an ATR project can be seen as a task of organizational change. They emphasize the importance of viewing the ATR project as a systems change initiative. Many of them describe the

ATR experience as the creation of a new system—or network—of care, with the ATR management team functioning as the linchpin that holds it together.

SAMHSA suggested the formation of a grant planning team to advise the grant-writing process. Your grant may have used the Single State Authority community advisory group in this capacity or created a special group just for this purpose. This stakeholder group can continue to advise the ATR project over the 4 years of the grant, while working within the State or tribal system of care to recommend and advise on the implementation of changes stemming from ATR. It can play an important role in decisions about importing ATR elements into the broader system. It will be important to ensure broad representation of community stakeholders.

The first requirements of ATR managers are to (1) understand that systemic changes will be made, and (2) involve a broad range of community stakeholders in defining these changes and communicating them to the community at large. Community stakeholders can help ensure that the system of care you develop provides the types of services needed and desired by the community. They can help you explain the changes and the reasons for them to officials in your State or tribe. As the changes are being implemented, you need to communicate often with the people making them, as well as the recipients of ATR services and the community. You want early feedback on how the changes are working so that corrections can be made as soon as possible.

This chapter is built around six management topics:

1. Understanding the system changes required by an ATR project.
2. Preparing for the changes.
3. Thinking about systems.
4. Directing and managing the ATR project system.
5. Ensuring that your systems function as designed.
6. Gaining support for sustainability.

The chapter starts with the topic of change, because change—the predominant theme of ATR—is difficult and hard to manage.

People and organizations resist change, partly because the change process produces stress. Even if we believe in and want to make a change, it is still difficult. Managing people throughout the change process presents many challenges to ATR project directors and the members of their management teams.

Worksheets to help you plan for and manage change begin in Section 2, *Managing the project and helping people and organizations change*.

## Section 1. Understanding the changes to be made by an ATR project

ATR was introduced to bring multiple changes into systems of care. As described in Exhibit 1, *Explicit Systems Changes Introduced by ATR*, systems changes are expected in virtually every facet of administration and service delivery.

Further, managers of ATR projects have found that making one change leads to others. Making required changes like client choice and reporting client outcomes requires changes in the finance and information systems. The change to a focus on the client involves working with diverse stakeholders, both inside and outside the substance use disorder (SUD) field. For example, in some cases, the introduction of ATR was the first instance in which long-time treatment providers in the State- and tribally funded and faith-based communities met each other, although both had been working in the same community for many years.

By bringing together treatment and recovery support services providers from different communities and referral organizations, ATR projects have created integrated service networks. Most State and tribal systems believe these integrated service systems are an important advance toward providing holistic care for individuals in or seeking recovery. Organizations with different funding streams are working together, many for the first time.

At the end of ATR I, grantees identified a wide range of stakeholders who had some involvement and interest in the project as collaborators or supporters. The players who emerged as most influential and critical to success varied across the grants, depending on differences in State and tribal structures and circumstances.

ATR is operating within an overall climate of change, influenced by many convergent trends, including the impetus to establish recovery-oriented systems of care (ROSC), a notion consistent with ATR's focus on the client. Considering ATR in the context of these trends will help give project managers an overall perspective for the changes to be undertaken. Even though the achievements already realized by this convergence of forces are "huge," the changes have come about only through well-managed, complex processes.

## Exhibit 1. Explicit Systems Changes Introduced by ATR

- **Expansion of services:** Services other than clinical treatment are introduced into systems of care. Multiple recovery needs and strengths are supported through the delivery of recovery support services.
- **Expansion of providers:** New SUD services are delivered by recovery support services providers and in some cases by community treatment providers who are new to the system of care. Many of them have long provided services in the community but have not previously operated as part of a publicly funded treatment system. Because recovery support services are often available from agencies outside the SUD system, many other organizations may also become part of ATR networks, including providers of transitional housing, job training and employment, community reentry, family and children, primary health care, legal, and transportation services.
- **Introduction of client choice:** ATR projects involve clients in directing their own care and give them choices among appropriate providers.
- **New payment mechanism:** Giving clients direction of their care and choice among providers means that services need to be reimbursed using a preauthorized form of payment that clients can present to providers. This led to the development of voucher systems. After providers deliver preauthorized services to the clients, they submit the vouchers for service reimbursement.
- **Increased interaction among administration and service providers:** To design the financial and information systems needed to support vouchering and the reporting of data, the financial and information systems managers work collegially with provider organizations.
- **New client assessment processes:** To provide choice, a new approach to assessment is needed that assists clients with selecting stage-appropriate care from providers in the system. Many projects have established a care coordinator to aid clients' decisions.
- **New project assessment requirements:** ATR projects must assess their performance and submit project performance data on specified accountability measures to SAMHSA.
- **Increased reporting of outcomes data:** ATR projects are expected to report outcomes data more frequently than usual.

## Section 2. Managing the project and helping people and organizations change

### Goals

- Learning about the change process.
- Identifying the five stages of change through which people and organizations cycle until a change becomes stabilized.
- Understanding these stages to help you direct your project's changes. (See Exhibit 2, *Stages of Change and Management Strategies to Support People in Each Stage.*)

People and organizations go through these stages of change in ongoing spiraling cycles. Organizations and systems can lapse into former patterns of thought and behavior. Even when the old ways are not working well, people often resist adopting new ways and structures because the old ones are more familiar. As you initiate your change processes, expect some setbacks and roadblocks along the way.

### Themes

- Listen for the reasons people are resistant to change.
- Understanding their reasoning will help you develop change management strategies.
- Involve stakeholders who are working within the current system and those working to change it.
- Engage key stakeholders early so you have time to help them understand and accept the coming changes.
- Use managers to communicate with people at all levels to:
  - Explore organizational problems.
  - Reduce concerns.
  - Help people develop increased understanding of the changes and their purposes.
  - Increase motivation for change.



When you begin managing a change initiative, ask yourself, “Is my plan relevant, timely, clear, credible, multifaceted, and multidirectional?”

Adapted from SAMHSA, The Addiction Technology Transfer Center Network. (2004). *The Change Book: A Blueprint for Technology Transfer*, p. 14. Kansas City, MO.

## Exhibit 2. Stages of Change and Management Strategies to Support People in Each Stage

Stage of Change	Management Strategies
<p><b>Precontemplation—</b> People and organizations tend to be content with things as they are—that is, the status quo. They aren't thinking about change.</p>	<p>Consciousness-raising or needs assessment tools may help reveal problems.</p>
<p><b>Contemplation—</b> People and organizations are thinking about change, but they often have ambivalent thoughts or feelings. They think, "It might be a good idea, but ..."</p>	<p>People and organizations thinking about change can be overwhelmed with too much information. They need just enough to make them interested. Provide "tastes" of the topic to build interest. Try to "tip" the decisional balance. Helping people identify "pros and cons" might help them move toward change.</p>
<p><b>Preparation—</b> People and organizations are getting ready to make a change. They think, "Something needs to change if we are going to fix this problem."</p>	<p>Movement to the "action" stage of change is not smooth. Preparation becomes an important step. Be sure the language describing the change is clear. Help develop a change plan.</p>
<p><b>Action—</b> People and organizations are actively changing. They think and speak resolutely, "We are changing our practices by ..."</p>	<p>Supporting people and organizations during change is important. Avoid the common error of getting people and organizations to buy into change and then failing to provide support once the action stage is reached. Provide information in a "user-friendly" fashion. Encourage questions and help solve problems. Have frequent interpersonal contact—mentoring during this stage is important.</p>
<p><b>Maintenance—</b> The behavior change has been made and people are working to maintain it. They ask questions like, "How is the change working? Can we improve it even more?"</p>	<p>A focus on maintaining the new behavior is important so that people and organizations follow through and don't just move on to the next "innovation." Continue communication (updates, newsletters, Web sites, listservs, telephone trees, interpersonal contact). Encourage communication and problem solving.</p>
<p>Adapted from Addiction Technology Transfer Center. (2004). <i>The Change Book—A blueprint for technology transfer</i>, second edition, pp. 62, 63.</p>	

## Tools you can use

- *The Change Book*, produced by the Addiction Technology Transfer Center to assist treatment programs in implementing research results, can be very useful to managers preparing to implement an ATR project. This section of the workbook draws heavily from that document and its accompanying workbook, which can be downloaded from [http://www.nattc.org/pdf/The\\_change\\_Book\\_2nd\\_Edition.pdf](http://www.nattc.org/pdf/The_change_Book_2nd_Edition.pdf).
- Take advantage of the many tools available to help you and your key stakeholders to evaluate your community's readiness for change. One valuable resource is the "Community Readiness Model," developed by Linda Stanley and Ruth Edwards at Colorado State University. The materials are available online at no cost at <http://www.triethniccenter.colostate.edu/communityreadiness.shtml>.

## Considerations for success

- The earlier you engage stakeholders in working toward a common understanding, the greater your chances for success, which increase greatly when key stakeholders develop a shared understanding of the changes ahead. Identify and recruit stakeholders as change agents to help you.
- Look for change agents in and outside your current system.
- Be realistic. Recognize that the change process will be messy. Those working in the existing system may have good reasons for thinking current constraints are insurmountable and the proposed changes impossible.
- Remember that practitioners and administrative staff alike are working in ways they view as effective and are comfortable in their roles.
- Anticipate that attempts will be made at all levels to maintain the status quo. Some people will feel threatened; others will just feel uncomfortable. Resistance usually dissipates with increasing familiarity and when the desired changes are achieved.
- Remember also that a single change can occur at different levels, with barriers to change at each level: the client level, the practitioner level, the administrative level.

## Understanding and discussing the stages of change

*The ATR project management team has to initiate and oversee many types of changes in the startup period of several months.*

*Consider the following questions.*

1. What strategies and processes will help us create change energy and movement toward change in our community? How do we prepare to implement these processes?

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2. How can we adapt the stages of change theory to plan and facilitate movement in initiating our ATR project?

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3. What strengths can we access within our management team that will help us make progress?

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4. How can we use prior successes with change to leverage the ATR initiative?

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5. What strengths inherent in our community will also help our change initiative make progress?

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6. Which of the key elements outlined in Exhibit 3, *Key Elements in Achieving Change*, are in place and what do we need to do to achieve any that remain?

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“Our finance manager actually was most helpful in overcoming resistance from treatment providers for two reasons. First, he just has a natural understanding of change at the systems level and can help people see the broad view. Second, he’s held a number of front-line service jobs in the past, and he knows how hard it is sometimes for front-line workers to understand the rationale for changes that go beyond their area of knowledge and expertise.”

—An ATR Project Director

### Exhibit 3. Key Elements in Achieving Change

Transforming your system to match ATR requirements is a collaborative effort on many levels. Key elements for making the transitions as smooth as possible include:

- Policies that provide incentives for adopting the ATR project;
- Managers and staff who understand and support the proposed innovations;
- Managers and staff who understand, support, and can clearly explain client-centered care;
- Staff willing to adapt their service designs to focus on individual client strengths and self-direction;
- Supervisors skilled in implementing new practices;
- Opinion leaders who endorse the proposed systems changes;
- Service providers with knowledge, skills, and attitudes consistent with the delivery of the proposed new services;
- Continuing staff input and feedback; and
- Continuing client input and feedback.

## Getting ready to manage change

Consider the following questions.

1. What skills and qualities does our management team need to lead this change initiative?

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2. What steps does the management team need to take to ensure that each member of the team understands the full scope of changes required?

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3. What training, management consultation, brainstorming, conversations, and the like do we need to help us get on a firm footing to lead change?

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4. What new or revised communication approaches and methods are needed to support the change initiative and each other?

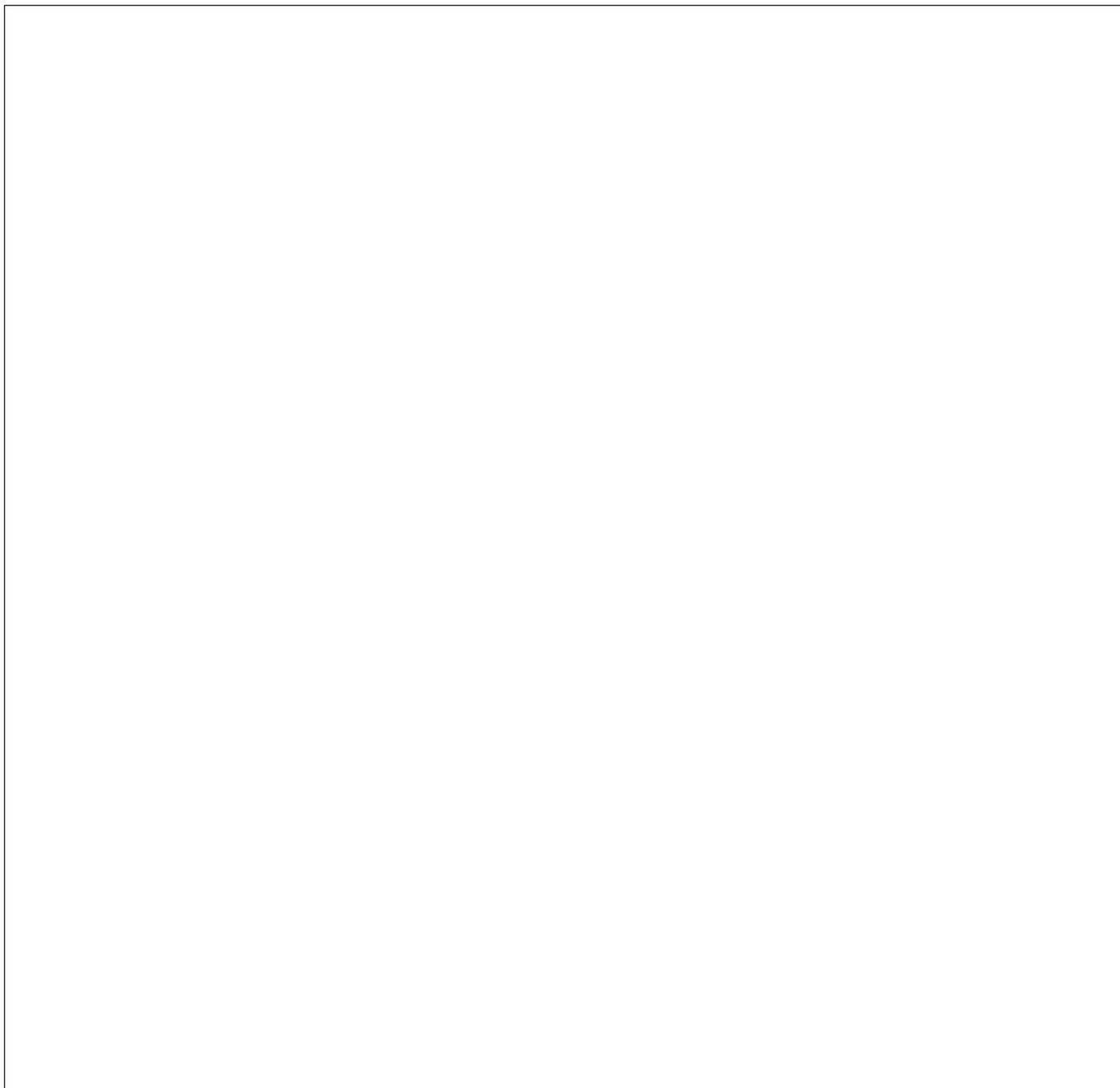
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5. To visualize the ATR project, sketch out all its parts to show the interdisciplinary relationships among managers in different areas of responsibility.



Managers need to have the mind-set of building something new.

## Explaining ATR changes to your project managers and staff

Consider the following questions.

1. What are a few marketing approaches we might consider to “sell” the ATR project to other managers and staff? Who can help us carry out this marketing task?

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2. Who can we identify to solicit support from in spreading the word about ATR? Which particular segment of the project can the people we have identified work with? Who are the influential opinion shapers in our organization?

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3. What are some organizations in other fields of work in our community that have successfully made changes? What discussions do we need to initiate in order to learn firsthand how they did it?

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With access to earlier ATR cohorts, you can turn to real examples of innovations that have been achieved, some of which have been incorporated into the agencies hosting ATR projects. One of the best ways of preparing to educate your managers and staff about the changes ahead of you is to contact project directors of ATR I and ATR II projects.



“There are usually no ‘A-ha’ moments until after a change is in place. As a manager of change, you can’t let that discourage you.”

—An ATR Project Director

## Overcoming resistance and barriers to the adoption of change

Consider the following questions.

1. How can we be sure to get the information about change out in time—before people hear about it through the “grapevine”?

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2. What dialogues do we need to initiate so the management staff can become comfortable with the change initiative?

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3. What tips can we give staff and providers in our system of care that will help them become better educated about the change?

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People brought in early often become your best advocates.

Resistance often arises simply because people didn’t find out about the change soon enough. Discuss ATR changes at the earliest possible moment.

The time to call your first community meeting to introduce ATR and its changes is as soon as you and your management team are able to converse about the changes and explain them.

Beginning at this point also helps you gain skill in articulating the details and clarifying understanding; plus, you become more able to talk about what lies ahead.

4. What incentives are appropriate to offer ATR management team and staff? Others throughout our jurisdiction? Current provider organizations?

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5. What support will people need in the early stages and throughout the change initiative?

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6. How can we help people overcome their resistance?

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## Section 3. Time for systems thinking

Introducing client-centered care is an immense task. The amount of systems change that occurs as a result of an ATR project can be significant and requires engagement with many different systems.

Thinking about the different systems will help you to quickly identify the real causes of organizational problems and to figure out where to work to solve them. In addition, attention to feedback is an essential part of systems thinking. Asking for and receiving feedback will help you look for other solutions, rather than wasting resources on an approach that isn't working.

### Considerations for success

As an ATR manager, you deal with many systems, including:

- Your ATR project.
- The existing system of care (your “host” system, the State or tribal organization with the grant).
- Providers’ systems.
- Referral systems—systems in which SUD clients receive services, such as transitional housing or child and family support.
- The recovery community and its organizations.
- The faith-based community.
- Other institutional systems, such as:
  - Primary health care providers.
  - Community clinics.
  - Criminal justice systems, including corrections and drug courts.
  - Child and family services.

A system can be formal or informal. Examples are the formal State or tribal health care system tasked with providing services to the residents of the State or the members of the tribe and the informal, unorganized residents of the community who are seeking treatment and/or recovery support services.

Whether formal or informal, the system comprises (1) an infrastructure, (2) relationships, and (3) communication processes.

## Fostering change in other systems

ATR sets in motion changes in other systems. When practitioners and managers in other institutions agree to work with ATR, they are agreeing to change their systems to accommodate involvement with your project and with SUD clients. Many of them will have to make legal and financial changes in their operations to be able to work “across systems.” You will be asking stakeholder organizations to make changes in order to accommodate a working relationship with the ATR project. For example, you may ask a bureau of licensure or a health insurer to make an exception to its requirements in order to use vouchers to pay for recovery support services.

Some systems in your community, such as family reunification services, already treat and serve SUD clients. If you recruit these as recovery support service providers, your finance system will have to make arrangements for them to be paid via vouchers. Conversely, grassroots organizations will need to make bold changes, because many will have to acquire or expand existing computer systems to be eligible for reimbursement through ATR.



A SAMHSA grantee, White Bison, describes systems as follows:

*A system is an entity that comprises both content (ideas, roles, and definitions) and process (ways of doing things) and is complete in itself.*

Characteristics of a system include the following:

- It has a life of its own, distinct from the lives of components (or individuals) in it.
- It is a being greater than the composite of all its components (or workers).
- It has a tradition, a way of doing things, and unwritten norms and expectations.
- It has the capacity to continually change and self-organize.



“The question that systems analysis asks is: Why is this going to work? The difficulty of ATR is that it must produce two products—recovery and a network—either of which alone is difficult, but to build an ATR project, they must be produced at the same time. Our challenge is to develop a system that can produce both of these products, but to remember that the program product exists only to serve the client, to produce the recovery product.”

—An ATR II Project Director

## Feedback: The oil to make the ATR project system run smoothly

*Consider the following questions.*

1. Can we sketch out the complexity of our ATR system, highlighting how the subsystems are interconnected and interdependent?

2. What are the goals of each of our subsystems? What is the shared goal and intention that bind them together?

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3. What practices do we need to administer for communication, cooperation, and collaboration among our internal systems?

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4. What feedback mechanisms do we need, both internally and externally?

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5. Because clients are an important subsystem within our ATR project, what practices will ensure that they are integrated into the system and that all parts of the system work for them?

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“We intend to develop ‘alumni groups’—people in recovery who have successfully passed through our ATR program. These groups will give us feedback on what we’re doing. We want them to be co-equal stakeholders in the program.”

*—An ATR I and II Project Manager*

6. Similarly, an ATR project includes subsystems such as grassroots and established community organizations and community leaders, as well as interested individuals. How will we communicate with and include them?

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7. What steps should we take to market ATR concepts and practices to our State or tribal system of care?

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## Section 4. Directing and managing the ATR project system

Your management approach and methods will be influenced by institutional customs and requirements, as well as by your accustomed style and approach to management.

Most ATR projects have found that a management team is necessary due to the complexity of the systems being managed. (See discussion of management team members in Exhibit 4, *Who's on the Management Team?*)

The management team will be responsible for setting up project infrastructure (the components or subsystems of the project) and for supporting personnel in all project components as they carry out changes and develop innovations.

This section contains suggestions and worksheets that may be valuable to ATR project management teams as they begin working together to manage the project.

### Goals

- Recognizing that you are building a project system within your State or tribal system of care. Elements and processes from your project may be incorporated into your host system when your project ends.
- Considering ATR requirements in relation to your State or tribal system and your community's strengths and needs.
- Supporting people who are making the changes and developing innovations to improve client outcomes.

### Themes

The ATR project management team will have to divide its attention among numerous tasks.

- Focusing on the client and establishing a client-centered system of care.
- Educating team members on the interrelatedness of roles and responsibilities.
- Ensuring that all managers understand the project and that the team has a cohesive view of the challenges ahead, including:
  - Selecting referral and provider organizations.
  - Establishing client intake, assessment, and vouchering.
  - Designing an appropriate financial system.
  - Establishing an automated information system for voucher management, outcomes data collection, and reporting to SAMHSA.
  - Deciding whether to accomplish all tasks internally or use an administrative services organization for some of them.
  - Creating a selection process for referral and provider organizations.

- Creating and developing new provider networks.
- Orienting and training referral and service providers.
- Testing all systems with a few clients.
- Being ready to accept clients at the time specified in the grant.

## Considerations for success

- **Because of the complex nature** of making changes and introducing client-centered innovations, overall project management and management of the ATR components (subsystems) must focus on quality.
- Managers need to be completely informed and in agreement about the changes and innovations to be accomplished in order to avoid generating confusion.
- Many managers and staff may initially have difficulty accepting and adjusting to the new system focus expressed in client-centered care, which gives the client authority over the determination of services to be received. They will need your support and patience as you introduce them to this new approach.
- Transparency is therefore a topmost consideration—for the benefit of managers themselves as well as of all individuals and groups involved in the ATR project.
- Clarity in communication is essential.
- **Major innovations and changes** that need to be explained and discussed throughout the project include:
  - Conceptualization of a system of different provider organizations coordinated by ATR.
  - Focus on recovery, recovery management, and client-directed care.
  - Inclusion of recovery support services, such as welcoming grassroots faith-based and secular community organizations as partners.
  - Establishing new types of relationships with referral organizations, which are considered partners in the ATR project.
- **Client-centered care** as defined by ATR may be a brand-new concept to people on your management team, in your State or tribal system, and to current providers and their organizations. Be prepared to explain it many times.
  - Clients are to have genuine, free, and independent choice of treatment and recovery support services appropriate to the level of care they need.
  - Clients determine what services they will obtain with their vouchers.



“Prepare to explain ATR over and over to all the groups and individuals involved. Just when you think they understand, you may have to explain it all again.”

—An ATR Project Director

- Diverse recovery support services will be available from new providers joining the system of care.
- The care coordinator, a new position, will assist the clients in choosing appropriate services and help them navigate the system of care.



Get printed policies and procedures (P&P) out early to help give everyone a grounding in the new project. Prepare to add to the P&P during the startup phase. This management task is important. It helps people know what page they are on and what is expected of them.



Grantees report that cooperation from a number of State entities, particularly those that support financial systems, is essential. One-on-one meetings with other agencies are needed to explain how the voucher system differs from current systems and the implications of vouchers for system operation. Because the voucher concept is new to all parts of the system, it may need repeated explanation. Making the distinction between vouchers and current payment systems is critical. In addition, support from the governor and legislature is essential, both to secure additional State funding and to pass any legislation needed to successfully implement the program.

SAMHSA. (2007). *Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services. A Start-Up Guide*, p. 12. Prepared under contract no. 277-00-6400; Task Order no. 277-00-6403 by American Institutes for Research.

## Exhibit 4. Who's on the Management Team?

Your management team is required to include four key staff members, as outlined on page 8 of the RFA:

- Project director.
- Treatment and recovery support services coordinator.
- Information technology (IT) coordinator.
- Fiscal coordinator.

You may find that other positions are important, as well.

In the first two ATR cohorts, a typical management team often included some of the following positions:

- Intake services manager.
- Care coordination manager.
- Trainer.
- Deputy project director.
- Deputy managers.
- Administrative manager (often working with new provider organizations to help them with administrative and organizational development).
- Regional directors.

In a number of projects, the fiscal and IT coordinators were not accustomed to working directly with service providers. In ATR, this is necessary. ATR fiscal coordinators found it necessary to become educated about the actual services in order to establish costs and to design the voucher payment methodology. Similarly, the ATR IT coordinator had to work with the providers, if only to provide technical support in the use of computers for data entry. The IT coordinators also found they needed information directly from providers to set up data-reporting systems on client outcomes and service delivery. Collaboration among managers becomes routine because of the conceptual design of the ATR program, in which many components from different systems are combined into one system.



**Engagement of grassroots providers is key ... Engagement of these providers is built on relationships and requires lots of face time, listening, seeking input, attending to complaints, eliciting feedback, and clarifying expectations.**

SAMHSA. (2007). *Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services. A Start-Up Guide*, p. 12. Prepared under contract no. 277-00-6400; Task Order no. 277-00-6403 by American Institutes for Research.



**“When we first started working in ATR, the treatment providers resented us. Then they discovered how we could support their clients during treatment. Next, they found out we were bringing clients into treatment. Now, they look to us for this assistance. It’s become routine.”**

—Member of recovery community organization in an ATR provider network



## Sorting out management team responsibilities

Consider the following questions.

1. What interrelated roles and responsibilities do we need to map out for members of our ATR project team?

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2. Who will be in charge of marketing the project to recruit and engage providers?

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3. Who will be in charge of identifying organizations to refer clients to ATR?

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4. Who will handle the identification of screening and assessment organizations and/or defining ATR screening and assessment processes?

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5. Who will create a system of care coordination and define the role of care coordinators for our project to ensure that each client has continuity of service from referral to discharge?

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6. Who will coordinate the activities of an increasingly diverse provider network that offers a variety of services to clients?

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7. Who will develop an automated data management system to support vouchers?

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8. Who will develop a financial management system to support vouchers?

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9. Who will collect Government Performance and Results Act data at intake? At 6-month follow up? Who will collect client and outcomes data throughout the project?

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10. Who will prepare job descriptions, including skills and qualities needed for each job?

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11. Who will develop the curricula and train staff and providers so they learn the infrastructure of the ATR project and develop the skills needed to meet its requirements?

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12. Who will train providers in the use of the automated data management system?

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## Building the management team for your ATR project

Consider the following questions.

1. What adjustments, if any, do we need to make in the vision of the management team that we presented in our grant application?

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2. What team-building activities do we need to plan and conduct?

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3. Who will develop a policies and procedures manual for our project and update it as needed?

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4. Should we consider contracting some activities out to an administration services organization (ASO)? What considerations are involved in making this decision and in working with an ASO if we choose to use one?

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5. Which specific project areas or activities will need support from the management team?

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Not all ASOs perform the same activities, but they are often in charge of operations, the voucher management system, and fiscal management.

Weigh the pros and cons of contracting an ASO.

Although this approach will free ATR project staff of administrative duties, it incurs cost, limits direct staff knowledge of the ATR project, and may introduce communication problems between staff and the ASO.

In spite of these challenges, some ATR projects have given all responsibility for services to an ASO. Others have contracted out building a management information system or recruiting community providers.



## Introducing a client-centered focus and a recovery perspective

Consider the following questions.

1. To what extent are our management team and staff ready to focus on client choice? What impact will this change in focus have on us?

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2. How will we emphasize client choice through ATR practices, policies, and procedures?

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3. To what extent are providers in our community ready to focus on client choice? What impact will this change in focus have on them?

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4. What means will we use to explain client choice and client-directed care? Systemwide meetings? Community meetings? Town halls? Focus groups? Media such as project manuals, brochures, etc.?

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One ATR grantee has established a good working relationship with the criminal justice system and has developed vouchers that clients from criminal justice programs may present for services. The grantee anticipates that the relationships will become good referral sources for the project's chosen clientele.

SAMHSA, ATR Program, cohort II grant projects. Technical assistance provided by Altarum Institute Technical Assistance Contractor under Task Order No. HHSS28320070001/HHSS28300001T.

5. What educational and promotional elements do we need to incorporate to highlight the value and achievements of faith-based and recovery community organizations?

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6. Are people in our system and community starting to talk about ROSC? Recovery capital? Recovery strengths? Do we need to ask them to begin developing localized definitions of these terms?

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**Managers can help treatment providers understand their role among other providers within a recovery-based system.**

ATR focuses on client recovery, fully embracing treatment when needed. However, treatment providers accustomed to leading systems of care may find it difficult to shift to a new role as an equal partner on a recovery team that includes the client and recovery support services providers. Managers will need to help them see the benefits of a recovery focus.

Offering recovery support services instead of assigning all clients to treatment whether needed or not allows treatment providers to focus on the clients who most need their help.

Treatment providers may not realize that recovery support services providers can work closely with them to bring numerous benefits to both treatment and the clients.

- Recovery support services providers can help prepare people who need treatment to seek it, often bringing them to treatment's door sooner than if they were left to their own resources during the preparation stage.
- They can help people stay in treatment by providing support services—for example, meeting clients at the end of an outpatient session and taking them to meetings or socializing with them.
- They can support people leaving treatment by offering an array of service options, including socialization, which is so important during early recovery.

## Section 5. Making sure the ATR project systems are ready for implementation

In the final weeks of phase 1, you will want to take every precaution to make sure that all system components are ready for implementation. Grant funds may not be used to conduct pilot tests, but there are steps you can take to make sure the ATR system you have developed is able to provide choice, issue vouchers, and deliver services in phase 2.

To be sure your project is fully prepared to be up and running on day 1 of phase 2, the implementation (service delivery) phase, your management team and selected members of the service delivery teams can take final steps using such techniques as “walkthroughs” of procedures and the creation and use of checklists covering final steps prior to implementation.

### Goals

- Ensuring that the implementation requirements spelled out on page 6 in the introduction to the toolkit can be met.
- Seeing that everyone with roles and responsibilities in the ATR system is prepared for client entry and service delivery to begin.
- Reviewing procedures, roles, responsibilities, forms, and data reporting.
- Having financial processes in place and understood.

### Themes

- Your ATR project is a complex system that requires administrative and support personnel and service providers to work together every day. It will be important to bring people together from all parts of the project to walk through the new procedures involved.
- A flexible, problem-solving mind-set is important as you support your staff, referral organizations, and providers in preparing to deliver ATR services.
- Teamwork is the name of the game. Now is the time to function as a team, with management, administrative components, and service providers actively communicating and interacting with each other.

## Considerations for success

- As the end of phase 1 approaches, consider holding daily meetings of key staff to make sure details do not slip through the cracks; the best time to get all staff together is likely to be first thing in the morning.
- Ask everyone to describe the planning and implementation hurdles they are facing as well as notable progress being made in preparing to deliver ATR services.
- Involve your staff and a few representative end users (intake personnel, providers, etc.) in an activity to help the IT staff understand the users' requirements of the information system. Have them role-play the various tasks involved in a client's referral to the system, vouchering, and determination of choice, as well providers' reporting information required for reimbursement to be made.
- Checklists correlated with implementation requirements spelled out on page 6 in the introduction to the toolkit can be helpful.
- Role-play or detailed review of procedures, roles, forms required, data reporting, and all other steps related to actual delivery and reporting of services can be very useful.



Service providers, referral organizations, the IT system, and the financial team all have to work together in a well-designed ATR project. One successful ATR project set up a role-play of real-life procedures that have to be conducted by staff when clients present themselves to intake, receive vouchers, make service choices, and go to the providers chosen. Members of the administrative and service delivery teams, including providers, enacted “what-if” situations.

The “what-if” role plays also gave personnel a clearer understanding of how ATR procedures differ from the jurisdictional processes normally followed.



## 9 Preparing for project implementation

Readying the project service delivery system, VMS/MIS, and financial system to meet the requirements of clients, systems users—referral organizations, providers, and cooperating institutions—and SAMHSA

*Consider the following questions.*

1. Within the context of a project that contains service elements not previously present in the typical jurisdictional system of care, what steps can we take to ensure that members of our ATR management, financial, IT staff and service providers, intake and assessment team, and referral organizations understand their roles and responsibilities well enough to receive clients on day 1 of phase 2?

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2. How will we ensure that our communication systems are adequate to the task ahead of us?

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3. What steps will we take to prepare referral organizations, providers, and cooperating institutions to function in the client-centered ATR system?

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4. What techniques, such as role-play or scenario development, will we use?

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5. What processes will our management team use to be sure that administrative and service components understand the new requirements that differ from current ways of working?

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6. What team-building activities might we need?

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## Conducting a final check of system components

Use the lists below to check progress in each area at your morning meeting or in your work throughout the day. You may want to make copies of these pages, so you can use new ones as needed. In each area, indicate problems and solutions. This list is keyed to the required systems that must be operating at the beginning of phase 2.

### Project Management

ATR Component	Problems	Solution
Development of Policies and Procedures Manual for all project functions		
Establishment of management team: <ul style="list-style-type: none"> <li>• Members.</li> <li>• Schedule of meetings.</li> <li>• Requirements for member participation.</li> <li>• General meeting practices (e.g., review of financial reports, client referrals, provider recruitment, program function status).</li> </ul>		

## Financial System

ATR Component	Problems	Solution
<p>Electronic VMS:</p> <ul style="list-style-type: none"> <li>• Client record creation.</li> <li>• Voucher creation.</li> <li>• Voucher redemption.</li> <li>• Payment processes.</li> <li>• Report to SAMHSA.</li> </ul>		
<p>Fiscal and cost-accounting mechanisms</p> <p>Keeping record of services by:</p> <ul style="list-style-type: none"> <li>• Clients, by admit date.</li> <li>• Provider.</li> <li>• Voucher.</li> </ul>		
<p>Oversight methods:</p> <ul style="list-style-type: none"> <li>• Periodic monitoring schedule of providers.</li> <li>• Comparison of invoice to service plan schedule.</li> <li>• Service notes to invoice comparison schedule.</li> </ul>		
<p>Rate development and determination process based on:</p> <ul style="list-style-type: none"> <li>• Standard definitions.</li> <li>• Comparability to other funders in the same community.</li> </ul>		
<p>Voucher reimbursement verification based on voucher issuance, approved rate, and client attendance records</p>		

## Management Information System

ATR Component	Problems	Solution
<p>System to track performance and outcomes:</p> <ul style="list-style-type: none"> <li>• Performance to be tracked.</li> <li>• Number of client admissions per month.</li> <li>• Service dollars expended each month, based on date of admission.</li> <li>• GPRA follow-up rate.</li> <li>• Cost per client.</li> <li>• Average cost per client.</li> <li>• Average cost per client type.</li> <li>• Number of clients using all voucher services.</li> <li>• Number of clients completing program.</li> <li>• Number of clients achieving desired goals.</li> </ul>		
Capacity to upload performance data to SAMHSA		
Capacity to determine providers needed by geographic area		
Maintenance of complete services directory by type, location, and provider		
Client follow-up system		

## Provider Network Development

ATR Component	Problems	Solution
Development of provider outreach plan: <ul style="list-style-type: none"> <li>• Recruiting new clinical providers.</li> <li>• Recruiting new recovery support services providers.</li> <li>• Recruiting faith-based and secular community organization providers.</li> </ul>		
Development of provider application		
Eligibility determination for clinical treatment providers		
Eligibility determination for recovery support services providers		
Infrastructure and sustainability planning and training for grassroots providers		

## Client Flow

ATR Component	Problems	Solution
Client eligibility determinations		
Client intake tracking procedures		
Client intake and assessment system and processes		
<p>Established client referral pathways:</p> <ul style="list-style-type: none"> <li>• Identification of referral source outreach staff (e.g., liaisons, key contacts).</li> <li>• Development of orientation/training plan for referral sources.</li> <li>• Development of referral source resources (e.g., who to contact with questions, what ATR offers, ATR eligibility criteria).</li> </ul>		
Development of memoranda of understanding or other formal agreements with providers and referral organizations		



# 3

Identifying Target Populations' Needs, Designing Service Menus, and Creating Provider Networks



# Identifying Target Populations’ Needs, Designing Service Menus, and Creating Provider Networks

## Key Concepts

- Get an early start on building and nurturing a network that includes treatment organizations, new secular and faith-based recovery support service providers, and referral organizations.
- Take steps to encourage collaboration and integration of treatment and recovery support services so clients are supported in their recovery.
- Be prepared to offer training and organizational development help that builds on the unique and inherent strengths of secular and faith-based community providers.
- Help everyone involved become familiar with the recovery orientation.

At its heart, ATR network development is about strengthening existing partnerships and creating new ones with service providers that support long-term recovery. The shape and scope of your new network of referral organizations and providers will emerge as you collect and review data to identify the particular populations your project will serve, these populations’ unique needs for treatment and recovery support services, and the strengths and limitations of your existing partnerships.

Your partners will include treatment organizations, faith-based and secular community groups delivering recovery support services, and other service providers—creating an integrated system of community-wide care that embraces a better quality of personal and family life in recovery. Supporting recovery over the long term may introduce concepts that are new to many in your current system, such as recovery planning and recovery management (see Exhibit 1, *How Recovery Plans Differ from Treatment Plans*, and Exhibit 2, *Recovery Management*).



Conducting a community needs assessment can help you determine what recovery support services you need to provide. The substance use disorders among individuals in your community, along with environmental factors, will help determine the kinds of services needed. You can recruit and engage specific types of RSS providers based on the client needs identified in your assessment. Be sure your assessment collects information from people in the community who are in recovery. They can provide significant, firsthand insight into the types of services your clients may need.

In this chapter you will learn how the composition of the referral and provider network must meet the needs of your ATR target populations. New partners and relationships are essential for making the change to a recovery-oriented system of care (ROSC). You will assess current networks, identify new faith-based and secular community providers to expand participation and enhance client choice, market your ATR project, recruit new providers that fill critical gaps in services, and plan and begin the training that providers will need to participate effectively in the network.

**Exhibit 1. How Recovery Plans Differ from Treatment Plans**

<b>Recovery Plan</b>	<b>Treatment Plan</b>
Developed by the client	Developed by the treatment professional
Often prepared collaboratively by the client and a care coordinator, who assists clients in achieving their own goals	Prepared by an expert professional for a client
Focuses holistically on many domains, including physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality, as well as the resolution of alcohol and other drug problems	Focuses primarily on alcohol and other drug problems and leaves problems in other domains to other systems
Sets recovery goals and an action plan for steps toward achievement of recovery goals in numerous domains of importance determined by the client	Focuses on maintenance of sobriety
Builds on strengths of the client and uses recovery capital	Focuses on overcoming pathologies and weaknesses
White, W., Kurtz, E. (2006). <i>Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches</i> . Northeast Addiction Treatment and Technology Center, Substance Abuse and Mental Health Services Administration, 6.	

**Exhibit 2. Recovery Management**

- The provision of engagement, stabilization, education, monitoring, support, and reintervention technologies to maximize the health, quality of life, and level of productivity of people with alcohol and other drug problems.
- Management is the responsibility of the person with the disorder.
- The primary role of the professional is that of a recovery consultant.
- Three stages in the recovery process are recognized:
  - Engagement and recovery priming, sometimes called a period of pre-recovery.
  - Recovery initiation and stabilization.
  - Recovery maintenance.
- The client may receive treatment and/or recovery support services in any of these stages.
- Continuing research is moving toward more clearly and specifically delineating the stages of recovery.

White, W., Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Northeast Addiction Treatment and Technology Center, Substance Abuse and Mental Health Services Administration, 6.

## The New Emphasis on Recovery

In their focus on long-term recovery, ATR grantees are implementing new approaches to care that are consistent with current trends occurring throughout health care. The new approaches are characterized by:

- A shift from acute care to continuing care to support long-term recovery.
- Integration of treatment and recovery support services.
- Greater focus on what happens before and after treatment.
- Transition from professionally directed treatment plans to client-directed recovery plans.
- Greater emphasis on the physical, social, and cultural environment in which recovery succeeds or fails.
- Emphasis on recovery capital and recovery management.
- Increased use of recovery coaches and a variety of recovery support services roles.
- Integration of paid and volunteer recovery support services providers with treatment providers.
- Use of people in recovery as peers in recovery support services roles.



“Individuals will have a menu of stage-appropriate choices that fit their needs throughout the recovery process.... Systems will adapt to the needs of individuals, rather than requiring individuals to adapt to them. They will be designed to support recovery across the lifespan. The approach to substance use disorders will change from an acute-based model to one that manages chronic disorders over a lifetime.”

—SAMHSA. (2007). National Summit on Recovery: Conference Report, p. 7,8. DHHS Publication No. (SMA) 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at [http://pfr.samhsa.gov/report\\_notice.html](http://pfr.samhsa.gov/report_notice.html).



# Section 1. Assessing service needs of your target populations

## Goals

- Identifying ATR target populations' needs for service.
- Assessing strengths and needs of the community.
- Planning a comprehensive services menu.

## Themes

- Undertake assessment and base decisions on the findings.
- Look for provider strengths to build on.
- Emphasize collaboration and integration of services.

## Considerations for success

- Solicit information regarding service needs from members of your target populations, providers already serving them, community residents, and other stakeholders. A community needs assessment can be very helpful.
- Once you have a good understanding of the types of needs among your target populations, you can begin to define the types of treatment and recovery support services and providers, as well as referral organizations, that need to be included in your network.
- Assess the strengths and gaps in services and resources that can support recovery in your target communities.
- Use your stakeholders to help gather information about service needs and to identify providers and referral partners.
- Recognize that recovery has stages and client service needs can shift from stage to stage. Stakeholders, such as people in recovery, can help you identify recovery support services appropriate to your clients' different recovery stages.



Given its focus on life context, one tool required for effective recovery planning and the provision of recovery-oriented care is adequate knowledge of the local community, including its opportunities, resources, and potential barriers. Community mapping is a process that allows community leaders and people in recovery to uncover the resources and capacities of public, private, and grassroots organizations, identifying available and untapped or overlooked resources.

Connecticut Department of Mental Health and Addiction Services. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*.

- Assess the capacity of existing treatment and recovery support services to match levels of need (low, moderate, high intensity) to levels of service to ensure access and choice for everyone in the target population and to identify critical gaps in the service continuum.
- Be willing to expand, revise, or reassess the target population to ensure that project goals are met. A review process should be in place from the earliest point in ATR programming.
- If you decide to change the target populations identified in your grant application, you will need to obtain approval from SAMHSA.



A grantee initially intended to serve civil and criminal justice clients, but quickly found it difficult to enroll eligible clients into the project. With technical assistance, the grantee expanded its ATR target population to include those “at risk” for entering or reentering the criminal justice system, such as individuals in the State-funded treatment system who were at risk due to active drug use.



“We think that recovery support services have great value for adolescents. But they’re possibly the hardest population to work with—most of them are coerced into services by a probation officer or parents, and they want to do only what they absolutely have to do. In our State, they can be very hard to reach because they can access services without parental consent. This means we can’t call them at home to track them down—this would compromise their confidentiality.”

*—The manager of an ATR project that serves adolescents*

## Assessing the uniqueness of the ATR target population

Consider the following questions.

1. What do we know about the recovery capital among clients in the target population? What types of data do we need to help us identify the strengths and assets they can bring to the recovery process? (See Exhibit 3, *Assessing Strengths and Needs of Your Target Population[s]: Conducting a Community Assessment.*)

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2. What do we know about our selected target population’s needs that will affect network planning and development of services (e.g., transportation, child care, reentry services)? How will we collect these data?

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3. What are the unique considerations of culture, gender, sexual orientation, age, race and ethnicity, and religion that define the selected target population? How will we collect these data? How will these considerations relate to service needs? How will our findings be communicated to stakeholders?

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4. How are these considerations and needs likely to affect service delivery and client outcomes? What are the implications for network development? How can we avoid service gaps and overlaps?

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5. How will we determine the types and levels of services that our target population will need? (See Exhibit 4, *Mapping Community Resources.*)

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## **Exhibit 3. Assessing Strengths and Needs of Your Target Population(s): Conducting a Community Assessment**

### **What is a community assessment?**

A community assessment is a tool or plan developed to identify the needs of people in a community, as well as strengths and resources that can be used to meet them.

### **What are some reasons an ATR project might conduct a community assessment?**

- To determine what services are needed.
- To find out what services are currently being offered.
- To discover what individuals, groups, and organizations are offering services.
- To map out service locations.
- To discover resources and areas of strength from which to anchor new services and new providers.
- To gain understanding of geographical access and transportation availability.
- To map existing recovery housing.
- To locate recovery-friendly employers and businesses.

### **How can a community assessment inform an ATR project?**

- Program design: Determine services needed by a project's target population(s) and configure service menus.
- Provider network organization: Link needed services with assigned providers and eliminate duplication of services.
- Program review: Evaluate the effectiveness of the program.
- Program improvement: Identify, strengthen, and realign components that are not working.

### **What components of a community assessment should be included?**

- Focus on assets and needs. Uncover and use hidden resources, foster engagement and empowerment, emphasize community-grounded solutions, and build and strengthen relationships and community support.
- Various means of gathering information: Include a mix of key informant interviews, community observation, questionnaires, focus groups, and public forums.
- Diverse stakeholders and constituent representatives: Include individuals and family members in recovery, clients currently accessing services, treatment and RSS providers, indigenous community leaders, opinion leaders, elected and agency officials, businesses, educators, and others.

### **What steps are involved in conducting a community assessment?**

- Determine the purpose and value of the data you plan to collect.
- Establish when you want to use the data.
- Define exactly what you want and need to know and identify gaps in your knowledge.
- Identify methods and sources to obtain the data.
- Determine who will collect the data.
- Set limits on the scope of the assessment.
- Collect, synthesize, analyze, and review the data.
- Use your findings to inform program design and network organization.
- Report your findings to the community.

## Exhibit 4. Mapping Community Resources

Mapping community resources and capacity will help create a solid foundation for developing a provider network that serves the ATR target population and supports a ROSC. When mapping community resources, ATR grantees are encouraged to focus on strengths—as well as needs—to avoid program development that centers on weaknesses.

Communities often have a limited understanding of their resources. By mapping a community's strengths and weaknesses, you can determine whether the current service system is using all available resources, where there are gaps in resources, and where overlaps and duplications occur. This important effort requires careful planning and the willingness of the ATR team to go beyond traditional methods.

Six steps can result in effective community resource mapping.

- 1. Involve diverse stakeholders in the process.** ATR staff, individuals from the private and public sectors, and community members can all contribute to and benefit from resource mapping.
- 2. Create a forum where stakeholders can learn about and participate in the mapping process.** Assist stakeholders with understanding that identifying community capacities and assets is an important step toward building a strong network of services and a comprehensive system of care.
- 3. Set up a planning team to inventory the community's traditional and nontraditional services.** Enlist team members who either are or want to be connected with facilitating recovery. Involving community members will improve the quality of data collection and create opportunities to learn about ATR's change strategies. Perhaps most important, it will build understanding and trust in the ATR goals and its efforts to provide a full continuum of care.
- 4. Take inventory of nontraditional services—assets and capacities largely under community control and influence.** These resources will include the talents of peer educators, mentors, and coaches; recovery centers; faith-based organizations; self-help groups; and other recovery support providers who are part of informal yet vibrant systems at the community level.
- 5. Take inventory of traditional services—assets and capacities offered largely by public and private organizations.** These resources will include capabilities of public and private treatment providers. In addition, it will be important to identify other service providers that include educational institutions, hospitals and clinics, civic organizations, employment agencies, legal services groups, children and family service organizations, and libraries, among others.
- 6. Create the resources map and put it to use.** Conduct an assessment to determine how effectively the resources are aligned with target audience needs and locales. Seek input from the planning team to determine priorities for strengthening the resources map and translate results into the network outreach and recruitment plan.

Adapted from: W.K. Kellogg Foundation. *Community Partnership Toolkit: Mapping Community Resources*. Available at <http://www.wkkf.org>.

## Meeting the needs of the stages of recovery

Consider the following questions.

1. What is our understanding of stage-appropriate services and how will it influence our approach to network development? (See Chapter 2, Exhibit 2, *Stages of Change and Management Strategies to Support People in Each Stage.*)

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2. Identify and list the stage-appropriate services provided in our current network. How well are they provided? Are there missing services to be added?

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3. How will we determine our priorities for closing any gaps in stage-appropriate services?

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4. How will we coordinate clients' care and make sure they get help in navigating services? (See Exhibit 5, *Coordinating Care for Clients.*)

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Recovery-oriented systems of care offer a continuum of care, including pretreatment, treatment, and continuing care and support throughout recovery. Individuals have a full range of stage-appropriate services from which to choose at any point in the recovery process.

## Exhibit 5. Coordinating Care for Clients

Care coordinators play a key role in ATR projects, working with clients after intake and assessment and through their enrollment in the system of care, to help ensure that clients receive appropriate services. The term care coordinator was preferred by most ATR I and II projects to avoid confusion with clinically trained case managers already working in the jurisdiction.

The care coordinator may or may not be clinically trained; clinical training is not a requirement. The job slot may be filled, for example, by a person in recovery who is familiar with recovery processes and the types of services clients need at different stages of their recovery.

Here is a job description from an ATR II grant that details the responsibilities of the care coordinator.

**Care coordinators** must complete the training provided by the Single State Authority prior to providing services. They must be at least 18 years old, have a high school diploma or equivalent, if in recovery have a minimum of 2 years sobriety, and be supervised by the program director. Care coordinators may provide services within certified agencies or credentialed recovery support service provider agencies.

**Care coordinators** are assigned to a participant upon admission to a recovery support provider. Care coordinators are responsible for the following:

1. Meeting with the participant face-to-face to develop the recovery support plan (billable for care coordinators as “Peer Counseling, Individual”);
2. Preparing, implementing, monitoring, and evaluating the participant’s recovery support plan;
3. Documenting recovery support services provided on the recovery support service summary;
4. Meeting with the participant face-to-face (billable) or by telephone (nonbillable) no less than one time each week and completing documentation regarding each meeting;
5. Establishing linkages with other service systems and programs serving the participant; acting as a liaison between the participant and the other systems, and advocating for the participant’s needs with the systems;
6. Working in collaboration with other agencies that may meet the needs of participants;
7. Maintaining a current list of resources appropriate to the participants being served;
8. Assisting participants in their transition between levels of care;
9. Documenting all services they provide, indirectly and directly, to participants and updating information as needed; and
10. As deemed appropriate, assisting with collection of GPRA discharge and 6-month follow-up data for 90 percent of the clients they serve.

Training for care coordinators is essential. The grantee included the following topics in an hour training course conducted by the SSA training staff:

- Concept of care coordination.
- Strengths-based/person-centered concept and evidence-based care model.
- Engagement.
- Goal attainment.
- Collaboration.
- Documentation.
- Supportive counseling.
- Boundaries.
- GPRA data collection, as deemed appropriate.

## Section 2. Understanding the ATR network

### Goals

- Understanding the ATR network’s role and significance.
- Understanding how the ATR network differs from existing systems.
- Ensuring the inclusion of a broad range of treatment and secular and faith-based community providers.

### Themes

- Get started early.
- Services need to match the stages of recovery.
- New provider partners are required.
- Keep building and nurturing the network.
- Relationship building is an ongoing, core activity.

### Considerations for success

- Start early to plan for network development. Focus your efforts on the goals of client-centered services, client choice, services expansion, and sustainability.
- ATR requires that you build a new network or expand your existing one to include a range of partners that vary in size, vision, mission, and organizational structure, among other elements.
- Begin with the array of treatment and recovery support services you will need to satisfy a comprehensive services menu.
- Faith-based and secular community groups will be joining the treatment agencies in your network. Most likely these have been important sources of recovery support services for members of your target population. They are now key partners in your new integrated ROSC.
- Treatment agencies, other service systems, and recovery support service providers often work independently. They will need your help to improve the communication and linkages that are essential to client choice, integrated service delivery, and recovery under ATR.

- Prepare treatment providers and other stakeholders for network development and the change to a client focus by engaging them from the beginning, articulating the vision of where you want to go, and inviting them on the journey as partners through regular communications and participation in work groups, planning efforts, and making decisions.
- Be prepared to experience some opposition, criticism, or resistance from established stakeholders and policy makers as you embrace new partners and begin to empower clients who have been stigmatized and previously lacked a voice in their own care.
- Help everyone understand that you are shaping a new system of care.
- Your network planning emphases will evolve over time to reflect changing client choices.

## The role and significance of the ATR network

Consider the following questions.

1. How can we recognize and honor the role and significance of providers in our existing system of care?

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2. What is our current perspective on the role and significance of the provider network and its development for our ATR project? What are the most significant differences between this new network and our current one? (See Exhibit 6, *Models of Traditional Treatment and a Recovery-oriented System of Care* and Exhibit 7, *Values to Guide ATR Network Development*.)

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3. How much planning and consideration have we already given to network development? What has been accomplished so far?

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4. What priority are we willing to place on and resources will we devote to network development, including during the three phases of the ATR project—startup, delivery of services, and closeout—and beyond, while ensuring sustainability of ATR elements?

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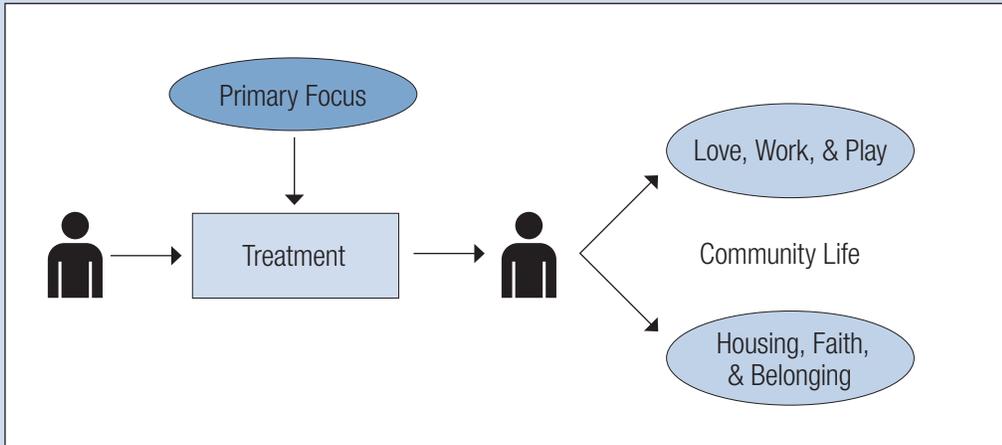
5. What criteria will we use to identify and select a team of staff members (or an administrative services organization) to have primary responsibility for network planning, development, and maintenance? Who are we considering for these roles and why?

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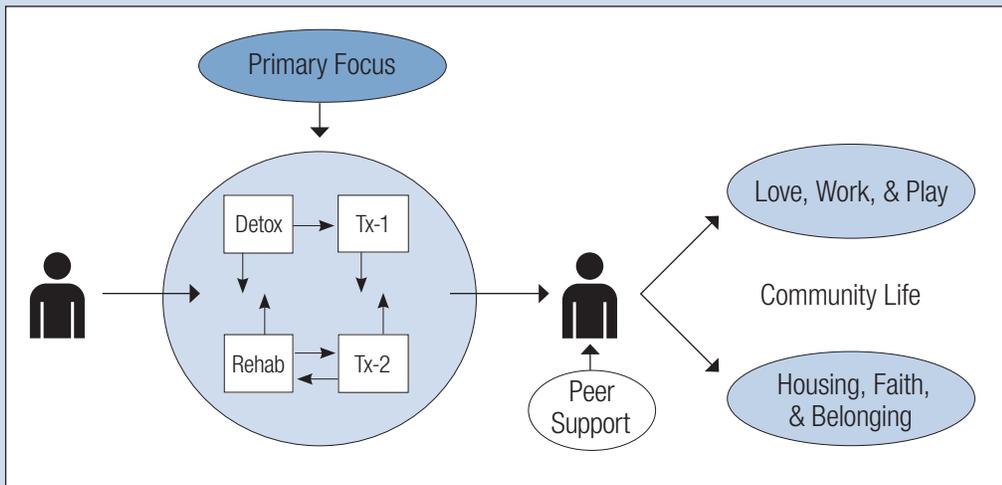
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**Exhibit 6. Models of Traditional Treatment and a Recovery-oriented System of Care**

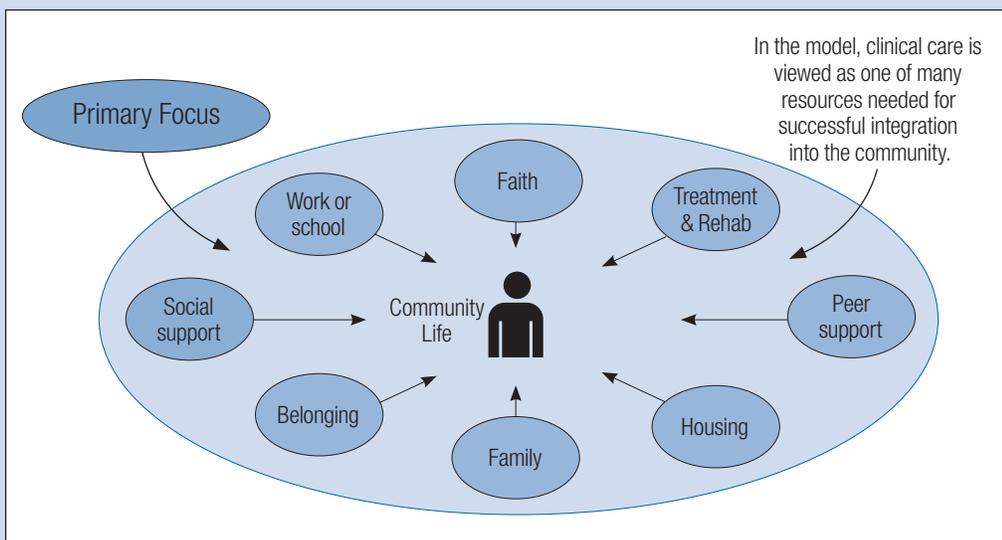


Service System Progression

**Model 1:**  
Effective treatment



**Model 2:**  
Continuity of care



**Model 3:**  
Recovery-oriented system of care

Dr. Arthur Evans

*continued*

Exhibit 6. Models of Traditional Treatment and a Recovery-oriented System of Care, cont.



This model of a recovery-oriented system of care was presented by Dr. H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director, Center for Substance Abuse Treatment at a 2009 meeting of ATR grantees.

## Exhibit 7. Values to Guide ATR Network Development

**Hope:** Sustained recovery and its rewards are possible for individuals, families, neighborhoods, and communities.

**Respect:** Treat all system stakeholders with courtesy and appreciation of their unique strengths and contributions, negotiate rather than dictate, gain trust by giving trust.

**Strength:** Build on existing assets, emphasizing past traditions of commitment, innovation, and excellence; recognize and celebrate transformation efforts.

**Transparency:** Make the criteria upon and process by which decisions are made visible to all people affected by them (i.e., picture-window decisionmaking).

**Inclusion:** Involve in the process of making it the people who will be affected by a decision; cultivate mutual learning, interdependence, and reciprocity of support.

**Fidelity:** Make only promises you can keep and keep the promises you make.

**Honesty and Candor:** Tell the truth; when wrong, promptly admit it and make amends (e.g., “I made a mistake; it is my responsibility to correct it; I will correct it.”).

**Forgiveness:** Expiate and let go of the past; expect some regression to old styles of interacting, promptly acknowledge such regression, and correct it.

**Consistency and Endurance:** Stay on message and sustain the effort. Transformation, like recovery, is not an event but a prolonged process.

Adapted from Lamb, R., Evans, A. C., Jr., & White, W. L., (2009). *The Role of Partnership in Recovery-Oriented Systems of Care: The Philadelphia Experience*.

## Preparing to build a recovery-oriented ATR network

Consider the following questions.

1. What criteria will we use to identify gaps in the conceptualization and offering of services in our existing provider network?

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2. What education do we need to provide to our current provider network regarding the focus on clients?

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3. What plans do we have for involving “peer” participants (people in recovery who offer services) in our network? What outreach will we plan to invite and include recovery community organizations in our network?

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4. What strategies can we use to advance communications and cooperation between treatment and recovery support services providers?

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5. How can we facilitate integration between our current network providers and other service organizations (e.g., public health, mental health, employment)? What will we need to change?

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6. How can we proactively deal with political concerns, laws, regulations, or other elements that might affect changing the existing network? What actions, if any, must we take now?

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7. What plans do we need to make in order to develop a provider network that has the desired types of services?

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## 5 Opening the network to new partners

Consider the following questions.

1. What do we know and/or need to learn about the community organizations that deliver faith-based or secular recovery support services? How can we prepare to become partners with them in an integrated system of care?

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2. How do we identify and engage new treatment and recovery support services providers from the community?

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3. What requirements for participation can community organizations anticipate as they prepare to become providers in our ATR system of care?

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**ATR TIP** In ATR, American Indian recovery support services providers are sometimes classified as “faith-based organizations.” However, past tribal grantees have emphasized that this term doesn’t really fit such providers. Those who offer culturally and spiritually based practices for American Indians would describe themselves as “culturally based organizations.”

## Section 3. Identifying and marketing to potential network partners

### Goals

- Identifying new and diverse service providers.
- Communicating ATR principles and goals to new service providers.
- Preparing providers in the existing network for change.

### Themes

- Engage new partners to meet clients' holistic needs.
- Recognize that knowledge of the target population(s) is essential.
- Ensure genuine client choice of both treatment and recovery support services.
- Engage diverse and culturally relevant providers.
- Cultivate the assistance of community stakeholders to identify and market to new recovery support service providers.
- Remember that outreach to potential providers and key stakeholders must begin early and continue.

### Considerations for success

- For most clients, SUD can be classified as a chronic condition.
- Client needs change over time and an expanded network of providers is needed to respond effectively.
- A diverse network of providers will ensure client choice and a continuum of services that support long-term recovery.
- Your potential partners may find that an ATR network is an unfamiliar concept. Treatment providers, for example, may not be accustomed to working with faith-based and secular community organizations and for-profit corporations. Similarly, participating in a government-funded project will be new to many of the grassroots groups. For many grantees, working with an expanded network that includes faith-based and secular community groups will be a new experience.

*Define and choose critical new partners:*

- The type, number, and location of providers that will make up your network must be responsive to the unique needs of the target population. Assess your existing provider agreements to provide a baseline for the direction your ATR network-building activities need to take.

- Recovery support services are a vital link between treatment systems and the communities in which people live. These services extend the continuum of care for clients by facilitating their entry into an integrated and expanded service system.
- Recovery support services are often delivered by faith-based and secular community organizations. Typical secular community organizations include recovery community organizations, service groups, and nonprofit organizations. Faith-based organizations may include churches, outreach ministries, mosques, synagogues, independent spiritual groups, and faith-based recovery groups.
- Ideally, your provider network will meet the holistic needs (physical, emotional, social, and spiritual) of your unique target population. Key providers to consider are those that deliver recovery support and peer support services, provide culturally appropriate services, and seek to close gaps such as child care, family services, and community reentry services.

*Explain and market the network:*

- Cultivate a commitment among your ATR project staff and current providers to cooperate with new providers who may have different ideas, visions, and backgrounds.
- Develop and communicate clear ATR project goals, core values, and principles for the delivery of services and development of recovery orientation.
- Strive to communicate ATR project information simply and clearly without the use of acronyms, technical or bureaucratic language, or vague terms. Preparing and disseminating a glossary of terms and acronyms may be helpful.
- Consider developing and communicating to providers an understanding of the concept of return on investment to encourage participation in the network.
- Engage project staff and consultants with experience in planning and conducting cost-effective and targeted outreach and marketing efforts to providers at the community level.



## Defining new network partners

Consider the following questions.

1. How does our current configuration of services fit with our target population(s)' needs?

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2. What types of services appear to be missing from our provider network based on this assessment?

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3. How do we define and describe recovery support services and peer recovery support services? Which ones will be important for our network? (See Exhibit 8, *Examples of ATR-Funded Recovery Support Services*.)

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4. What specific criteria will we use to identify potential new partners?

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5. How do we ensure that new providers are culturally diverse and responsive to the gender, age, race and ethnicity, sexual orientation, and other characteristics of our target population(s)?

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6. How will we identify new treatment providers for the ATR network? Do we already have contacts in place or do we need to develop them? How do we identify these contacts?

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7. How will we identify new recovery support service providers for the ATR network? Do we already have contacts in place or do we need to develop them? How do we identify these contacts?

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8. What challenges can we anticipate when the existing network is expanded and changed?

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9. What are our strategies for meeting anticipated challenges?

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## Exhibit 8. Examples of ATR-Funded Recovery Support Services

The following types of recovery support services may be funded by the ATR grant.

- Transportation to and from treatment, recovery support activities, employment, etc.
- Employment services and job training.
- Case management/individual services coordination, providing linkages with other services (legal services, Temporary Assistance for Needy Families, social services, food stamps, etc.).
- Outreach.
- Relapse prevention.
- Housing assistance and services.
- Child care.
- Family/marriage education.
- Peer-to-peer services, mentoring, coaching.
- Self-help and support groups, such as 12-step groups, SMART Recovery, Women for Sobriety, etc.
- Life skills.
- Spiritual and faith-based support.
- Education.
- Parent education and child development.
- Substance abuse education.

Definitions of each of these types of service are provided on pages 68–70 of the Request for Applications, Number TI-10-008, available on the SAMHSA Web site.

## Explaining and marketing ATR to potential providers

Consider the following questions.

1. What are the most important messages and information about our ATR project that we want to share with potential providers? How will we tailor our messages and information in order to recruit the providers we want into the network? (See Exhibit 9, *Return on Investment: A Marketing Concept for ATR Provider Recruitment* and Exhibit 10, *Examples of ATR Network Marketing Materials*.)

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2. What specific organizations and individuals should be involved in explaining and marketing the ATR network and its purpose to potential secular and faith-based providers?

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3. What marketing strategies will we implement to effectively reach these providers? What are the key elements of the marketing plan?

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4. Who can help us develop a marketing plan to inform potential providers about the ATR network? What providers already in our network can we enlist in such an effort?

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5. What types of marketing (such as pamphlets, fact sheets, presentations), aimed at diverse audiences, do we need to reach potential network partners? Where can we find resources that suggest models and/or offer templates we can use or modify? (See Exhibit 10, *Examples of ATR Network Marketing Materials*.)

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6. What are the most effective venues for rolling out marketing strategies to recovery support services and treatment providers?

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## Exhibit 9. Return on Investment: A Marketing Concept for ATR Provider Recruitment

Return on investment (ROI) is a term widely used in the business world, yet applicable to many other environments. It is appropriate to ATR grantees, in particular, when you are marketing to new providers to encourage their participation in the network. Quite simply, ROI acknowledges that participation in an ATR network is a true partnership, with all parties sharing in its challenges and rewards.

When marketing ATR to provider organizations, especially those new to the concept and goals of ATR, it is helpful to describe your program's purpose and attributes, the providers' potential role, and the challenges and benefits—or ROI—that providers may accrue. The decision to join your network may be easier if you describe what partners will receive in return for their participation.

The value of ROI to ATR provider recruitment is illustrated by returning to a traditional business context for a moment. Most businesses do not enter into partnerships merely for the sake of doing good work. They seek something in return for their investment of time and resources. Similarly, ATR grantees need to clarify for potential providers what they can anticipate in return for their participation or “investment” in the ATR network.

The following are examples of ROI that ATR providers have received. You may identify additional returns that can attract new providers to your network.

- Expanded access to individuals who need the provider's services.
- Additional revenue to support program enhancements and expansion.
- Additional revenue stream that stabilizes program finances.
- Reduced per client cost as the client base expands.
- Technical, managerial, and leadership training for staff and volunteers.
- Strengthened infrastructure, such as improved reporting and financial management systems.
- Heightened visibility in the community.
- Enhanced awareness of and connections with other community service providers.
- Enhanced workforce as a result of skill development.
- Increased confidence in organizational management skills and capacity.
- Increased ability to document client outcomes.
- Improved technologies and methods of communication.

## Exhibit 10. Examples of ATR Network Marketing Materials

### ATR Talking Points for Potential Network Providers

Fill in the blanks with information about your project.

#### (Telephone and One-on-One Meetings)

**Note:** The following information is designed to inform potential network providers about the ATR project in \_\_\_\_\_. It should be expanded and modified to fit specific State programs and circumstances.

#### What is Access to Recovery?

Access to Recovery (ATR) is a federally funded program designed to help those recovering from substance use disorders. It gives individuals a choice in recovery avenues by providing payment vouchers for a variety of treatment and recovery support services. In \_\_\_\_\_, approved ATR services include:

#### Treatment Services [revise as appropriate]

- Medical detoxification.
- Inpatient substance abuse treatment.
- Outpatient treatment (including intensive outpatient treatment).
- Medication management.
- Individual counseling.
- Group counseling.

#### Recovery Support Services [revise as appropriate]

- Housing:
  - Transitional housing.
  - Sober housing.
  - Recovery living centers or homes.
  - Supported independent living.
  - Short-term, emergency, or temporary housing.
  - Housing assistance or management.
- Education and employment training.
- Transportation.
- Child care.
- Culturally appropriate support services such as indigenous healing.
- Life skills training (budgeting, communications, conflict resolution).
- Family and marital counseling and/or education.
- Peer and non-peer mentoring and coaching.
- Faith-based counseling and support.
- Other services.

*continued*

*Exhibit 10. Examples of ATR Network Marketing Materials, cont.*

**Fast Facts**

- ATR I was launched August 2004.
- ATR III is a federally funded 4-year grant program.
- ATR is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.
- \_\_\_ received an ATR grant in 2010.
- ATR is built on four main principles:
  - Consumer choice: the process of recovery is a personal one.
  - Outcomes oriented.
  - Increased capacity.
  - Sustainability.

**Who does ATR serve?**

ATR serves \_\_\_ individuals living in \_\_\_.

**How can an organization benefit from participating as an ATR provider?**

- Improved client outcomes—Research indicates that individuals who participated in both treatment and recovery support services had better long-term recovery outcomes than people who used either service alone.
- Additional funding—Approved providers receive reimbursement for services through the ATR program. This reimbursement is provided once approved services are rendered to ATR clients and claims are submitted through the voucher management system.
- Inclusion of faith-based services—The ATR program recognizes that spirituality and/or faith can significantly affect the recovery of some individuals. Because ATR focuses on client choice, faith-based providers are permitted to deliver services that include spirituality in the recovery process.

**Who can be a service provider?**

Eligible ATR service providers include organizations providing approved services to \_\_\_ clients served by the \_\_\_ ATR program, including grassroots faith-based and secular community organizations.

*continued*

*Exhibit 10. Examples of ATR Network Marketing Materials, cont.*

**Requirements for Providers**

- Provide ATR-allowable services.
- One-year experience providing the allowable service in the community.
- Registration with Secretary of State (if lawfully required).
- Compliance with local occupancy and zoning laws.
- Legally required business licenses.
- Organizational mission statement.
- Board of directors.
- Code of ethics.
- Liability insurance.
- Proof of appropriate drivers licenses and auto insurance (if transportation is applicable).
- Client database and filing system reports of specified data.
- Participation in training.
- Participation in random on-site visits (case file service and fiscal auditing).
- Confidentiality policies and procedures.
- Policies and procedures manual.
- Fiscal management practices and a system consistent with accepted accounting principles.
- 501(c)(3) tax exemption filing, if a nonprofit organization.
- Adequate staffing.
- IBM-compatible computers with:
  - Windows XP or Vista, Version 7.
  - Internet access.
  - Virus protection.

**How can an organization access more information?**

- Send an e-mail to: \_\_\_\_\_.
- Refer to the Web site [www.\\_\\_\\_\\_\\_.org](http://www._____.org).
- Attend a meeting in your community. Refer to [www.\\_\\_\\_\\_\\_.org](http://www._____.org) for a meeting calendar.
- Request a one-on-one meeting with an ATR representative by calling: \_\_\_\_\_.

## Section 4. Engaging and integrating partners to create an ATR network

### Goals

- Securing the enrollment of new partners in the network.
- Assisting new and existing network partners in working collaboratively.

Both treatment and recovery support service providers are required under ATR for client choice and improved client outcomes. When potential partners are identified as critical and relevant to the needs of the target population, the ATR grantee needs to invite and encourage them to join the network. The new service organizations can then engage with other network participants in the coordinated delivery of client care.

In many areas, faith-based and secular community groups have operated separately, with limited interaction with treatment organizations and other service organizations. ATR provides the opportunity to embrace recovery support services and help integrate them with treatment and other service providers. As previous ATR grantees have demonstrated, the benefits of these new integrated networks are increasingly evident in clients' lives.

Your ATR network will need not only new providers, but also an infrastructure that supports formal and informal working relationships and strong referral processes, if clients are to benefit. The desired flow of clients to appropriate network service providers can be generated and enhanced by well-developed and innovative procedures and communication protocols.

### Themes

- Convey that both treatment and recovery support service providers are valuable and necessary participants in the network.
- Establish standards of care based on service-appropriate measures.
- Simplify and streamline application procedures.
- Collaborate with established, trusted community leaders and stakeholders.
- Encourage formal and informal communication among partners.
- Use written memoranda of understanding (MOUs) to ensure clarity and consistency of working relationships and agreements across the network.
- Demonstrate to network participants that services integration improves client outcomes.

## Considerations for success

- Highlight and focus on the strengths among your ATR managers and existing and potential network providers, such as common values, principles, and a desire to support client-directed recovery.
- Identify and enlist help from community contacts willing to assist in engaging new grassroots faith-based and secular providers in the network.
- Develop a sound provider engagement plan and materials such as enrollment forms, a project overview, project expectations, and a statement of provider and client benefits.
- Share with potential providers your vision for ATR, your commitment to the project, and its main principles (person-centered, strengths-based, culturally responsive, outcomes-oriented).
- Simplify your network enrollment and approval procedures to reduce delays and avoid cumbersome processes that can discourage new providers.
- Meet directly with potential new providers to review project information and expectations, and respond to questions, comments, and concerns regarding network enrollment.
- Provide technical assistance to new providers to complete the enrollment procedures.

### *Build a network that supports integrated service delivery:*

- The integration of treatment and recovery support services requires different tools and training, as well as new collaborations and coordination among providers.
- Integrated and collaborative care optimizes recovery outcomes and improves cost effectiveness.
- Building a client-centered system of care must be done in a way that avoids an “us and them” polarization between professional and indigenous community services. Instead, answer this question: “What service(s) do individuals and families need at a particular moment in time?” The network is a community where all types of service providers are available as needed. Relationships among providers can be complex and often include informal understandings and agreements on multiple levels that can complement and/or complicate formal processes. Work to clarify and institutionalize these relationships through written MOUs.



Evaluations of eight State systems showed that clients who direct their own care express greater satisfaction with their services. Moreover, participants stated that quality of care either remained steady or improved as a result of the consumer-directed system.

SAMHSA. (2008, June). *Quantitative Analysis of ATR I Evaluations*. Prepared by Altarum Technical Assistance Team under Task Order HHSS2832070001/HHSS28300001T.

- Support and encourage the development and implementation of written MOUs between providers to build a more cohesive care network, expand the range of available services, and facilitate referrals and follow-up. These MOUs are most likely to lead to an integrated delivery system if they include these essential elements: (1) names of organizations entering into the MOU; (2) parties to be served; (3) responsibilities of each provider, including referrals and services; (4) points of contact and staff governed by the MOU; (5) pertinent financial information; (6) reporting; (7) duration of the agreement; (8) termination clause; and (9) executive signatures.
- Provide assistance to new and existing providers in the network to develop negotiating skills that can overcome obstacles to MOU development and implementation.
- Encourage service providers to create or expand referral linkages across multiple service sectors to strengthen the overall system of care.
- Recognize that referrals are client-driven. Also recognize that client outcomes are enhanced when referrals to recovery support service providers are made as clients enter the system of care.



“The thought of getting discharged was so terrifying to me I almost didn’t want to get well. But my case manager and

I made sure that I had people and places I could go to for support when I needed it—and these folks had been involved in our work all along. It made a huge difference in my feeling good about taking the next step.”

—An ATR client



## Enrolling potential partners in the ATR network

Consider the following questions.

1. What elements will we include in our provider engagement plan? Who will prepare it?

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2. Who can help us engage new faith-based and secular community groups in the ATR network? Are there providers in our existing network that can act as ambassadors in these efforts?

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3. What types of strategies (such as on-site meetings, community presentations, leadership groups, email or Web-based announcements) should be developed and implemented to give us the best chance of reaching and engaging faith-based and secular community providers in the network?

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4. How can we develop simple enrollment applications and other procedures that encourage rather than discourage new providers to join the network? What kinds of questions, procedures, approval processes, or other aspects of enrollment could be problematic for them and how can we avoid them?

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5. What processes can we consider and develop to assist potential providers in filling out applications?

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6. What types of follow-up and ongoing activities should we plan and carry out to support newly enrolled network providers? What processes do we need to establish to support regular communication among providers in the network?

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7. How will we monitor progress toward our provider engagement goals? What type of contingency plans will be in place if we are failing to meet our goals?

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## Creating memoranda of understanding

Consider the following questions.

1. What is the status of memoranda of understanding among our current network providers? How effective are the MOUs in strengthening client linkages to services and in enhancing outcomes? What should they include?

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2. How can we encourage network providers to improve their MOUs to strengthen the process of linking clients to the right services, including recovery support services, and to enhance outcomes?

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3. What types of obstacles currently exist in our system to developing effective MOUs? How can these obstacles be reduced or removed? What training and/or walkthroughs on MOUs do we need to develop to help new providers?

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4. What would a model MOU look like in our provider network? (See Exhibit 11, *Sample Memorandum of Understanding* and Appendix L, *Sample Memorandum of Understanding*, on page 82, of SAMHSA ATR Request for Applications No. TI-10-008.)

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5. Do we have written provider agreements in place? What is specified in them (cost per service unit, confidentiality and reporting requirements) and what are the implications for services integration and network development?

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## Exhibit 11. Sample Memorandum of Understanding

### Memorandum of Understanding

NO. B23-56-9-09-1234

This agreement is entered into by and between the San Bando Family and Services Administration, the Division of Mental Health and Addiction, (hereafter referred to as “DMHA”) and the San Bando Department of Correction (hereafter referred to as “DOC”), and is executed pursuant to the terms and conditions set forth herein. In consideration of those mutual undertakings and covenants, the parties agree as follows:

#### I. PURPOSE

This Memorandum of Understanding (“MOU”) is entered into by DMHA and the DOC in order that, under a grant from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT), the DMHA may provide increased chemical dependency recovery services to certain committed individuals who are being or who have been released from correctional facilities, are re-entering the community, and who are in need of the services provided by the San Bando Access to Recovery program (ATR). The parties agree to the division of responsibilities as outlined in Sections IV, V, VI, and VII.

#### II. AUTHORITY

The DMHA enters into this MOU pursuant to the authority found in NA 45-34-98(7). The San Bando DOC enters into this MOU pursuant to the authority found in NA 23-54-34(1).

#### III. TERM OF AGREEMENT

This MOU shall become effective July 1, 2010, and shall remain in effect through September 30, 2013.

#### IV. RESPONSIBILITIES OF THE DMHA

The DMHA shall have the following responsibilities:

- a) The DMHA shall provide chemical dependency recovery (“services”) to the following three target populations:
  1. Methamphetamine-consuming individuals.
  2. Women who are pregnant or who have dependent children.
  3. Individuals re-entering the community from correctional facilities.
- b) The service shall be paid for through ATR vouchers provided by the DMHA to services providers.
- c) The services available through the ATR vouchers shall be the following:
  1. Detoxification.
  2. Transportation.
  3. Relapse prevention.
  4. Addiction education.

*continued*

*Exhibit 11. Sample Memorandum of Understanding, cont.*

5. Housing assistance.
  6. Peer coaching services.
  7. Family and marital counseling.
  8. Employment services.
  9. Faith-based and/or secular community organization support.
  10. Parenting support services.
  11. Parenting education.
  12. Supportive education.
  13. AOD screening.
  14. Care coordination.
  15. Clinical assessment.
  16. Outpatient treatment.
  17. Independent treatment of co-occurring disorders.
- d) The DMHA shall ensure that all San Bando ATR program service providers deliver culturally sensitive services to the greatest extent appropriate.
- e) The DMHA shall be responsible for training all DOC staff in the policies and procedures of the San Bando ATR program with special emphasis on each of the following:
1. Client eligibility.
  2. Client choice.
  3. Referral procedure.
  4. Intake procedure.
  5. Outcome measures.
  6. Non-supplantation policy.
- f) The DMHA shall be responsible for providing any report or information required by SAMHSA concerning the San Bando ATR program; however, the San Bando DOC shall provide the DMHA with the reports and information required under the terms of this memorandum.

**V. RESPONSIBILITIES OF THE SAN BANDO DOC**

The DOC shall have the following referral policies:

- a) Scope of work
1. The DOC shall refer inmates to the ATR program as a part of their release procedure insofar as those re-entering the community are in need of the services provided by the ATR program, as listed above.

*continued*

*Exhibit 11. Sample Memorandum of Understanding, cont.*

2. ATR vouchers shall be provided for inmates who will reside in the following 3 counties upon their release from a State correctional facility: Vanley, Shorum, and West Fallsville counties.
3. San Bando DOC shall identify at least 3,500 inmates being released from State correctional facilities who are in need of chemical dependency recovery services and refer those individuals to the San Bando ATR program.
4. Referred inmates shall meet all of the following qualifications:
  - The inmates shall reside following release in one of the three counties listed in the previous section.
  - The inmate shall have a history of substance abuse.
  - The inmate shall have voluntarily expressed a willingness to participate in the San Bando ATR program.
  - The inmate shall select a care coordination agency from among those available in the county in which the inmate resides or will reside following release.
5. The San Bando DOC shall establish release protocols that provide the ATR care coordinators the ability to conduct the ATR intake interview prior to the inmate's release from a State correctional facility.
6. During the period immediately preceding an inmate's release from a State correctional facility, the San Bando DOC shall refer to the ATR program inmates who meet the above requirements and who have participated in the following DOC programs:
  - The Recovery from Addiction Program (RAP).
  - The Sober and Purposeful Life Program (SPLP).
  - Any other DOC chemical dependency programs or therapeutic communities.

In addition, the San Bando DOC may refer to the ATR program other inmates in the general population of a State correctional facility who are being released if the inmate otherwise meets the referral requirements contained in this MOU.

7. The San Bando DOC shall provide all referred inmates with a list of approved care coordinators for the ATR program in the county where the inmate will reside following release and shall allow the inmates to select a care coordinator from that list.
  8. The San Bando DOC shall assure that no one influences the inmates' selections of a care coordinator from a care coordinator list.
  9. The San Bando DOC agrees to provide the ATR care coordinator selected by an inmate with access to the inmate prior to the inmate's release from the State correctional facility.
- b) Administrative and funding terms, requirements and limitations
1. The San Bando DOC acknowledges and agrees that no funds will be paid to the San Bando DOC for the purpose of performing the work related to the ATR program as outlined in the preceding scope of work.

*continued*

*Exhibit 11. Sample Memorandum of Understanding, cont.*

2. Each quarter, the San Bando DOC shall provide the DMHA with projections of the individuals to be referred to the ATR program in each successive 6-month period, including the following:
  - Name
  - Facility at time of release
  - County of release
  - Date of release
  - Sample matching data
  - Re-entry coordinator and contact information
3. The San Bando DOC shall provide quarterly reports of the following to the DMHA:
  - A comparison of (1) the recidivism rate of individuals referred to the ATR program with (2) the recidivism rate of a matched sample of individuals not referred to the program.
  - The associated savings to the jurisdiction of San Bando.

#### VI. MUTUAL RESPONSIBILITIES

Each party shall cooperate with the other party and meet with the other party as necessary to further the objectives of this memorandum.

Each party agrees to meet regularly and to provide any information or documentation necessary to fulfill the responsibilities of the DMHA or San Bando DOC under this memorandum.

#### VII. SECURITY AND PRIVACY OF HEALTH INFORMATION

Through this MOU the parties wish to acknowledge their mutual obligations arising under laws and regulations of the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy Regulations effective April 14, 2003, and Security Regulations effective on April 20, 2005; and (2) Confidentiality of Alcohol and Drug Abuse Patient Records (CADAPR). 45 CFR 164. 42 CFR 2.

The DMHA agrees to comply with all requirements of HIPAA and CADAPR in all activities related to the MOU, to maintain compliance throughout the life of the MOU, to operate any systems used to fulfill the requirements of this MOU in full compliance with HIPAA and CADAPR and to take no action which adversely affects San Bando's compliance with either Federal statute.

To the extent required by the provisions of HIPAA and regulations promulgated thereunder, the DMHA assures that it will appropriately safeguard Protected Health Information (PHI), as defined by the regulations, which is made available to or obtained by the DMHA in the course of its work under the MOU. For the purposes of this MOU the term PHI shall include the protections under both 45 CFR 164 and 42 CFR 2. The DMHA agrees to comply with all applicable requirements of law relating to PHI with respect to any task or other activity it performs under this MOU, including the following:

*continued*

*Exhibit 11. Sample Memorandum of Understanding, cont.*

- a) Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the DMHA receives, maintains, or transmits on behalf of the San Bando DOC.
- b) Not using or further disclosing PHI other than as permitted or required by this MOU or by applicable law.
- c) Using appropriate safeguards to prevent use or disclosure of PHI other than as provided by this MOU or by applicable law.
- d) Mitigating, to the extent practicable, any harmful effect that is known to the DMHA.
- e) Ensuring that any sub-contractors or agents to whom the DMHA provides PHI received from the San Bando DOC agree to the same restrictions, conditions, and obligations applicable to such party regarding PHI and agrees to implement reasonable and appropriate safeguards to protect it.
- f) Making available the information required to provide an accounting of disclosures pursuant to applicable law.
- g) At the termination of the MOU the protections in this agreement shall continue to be extended to any PHI maintained by the DMHA for as long as it is maintained.

The parties agree that all terms in this section of the MOU not otherwise defined shall be defined by reference to the same terms in the HIPPA in its implementing regulations.

#### VIII. MODIFICATION

This memorandum may be modified at any time by a written modification mutually agreed upon by both agencies.

#### IX. EFFECTIVE DATE

This memorandum of understanding is effective on the date that both signatories have executed this document. The parties, having read and understood the terms of this memorandum do, by their respective signatures below, hereby agree to the terms and conditions thereof.

#### X. NON-COLLUSION AND ACCEPTANCE

The undersigned attests, subject to the penalties for perjury, that he/she is the agreeing party, or that he/she is the representative, agent, member or officer of the agreeing party, that he/she has not, nor has any other member, employee, representative, agent or officer of the division, firm, company, corporation or partnership representative by him/her, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid, any sum of money or other consideration for the execution of this agreement other than that which appears upon the face of the agreement.

*continued*

*Exhibit 11. Sample Memorandum of Understanding, cont.*

## XI. SIGNATURES

In Witness Whereof, DMHA and DOC have, through duly authorized representatives entered into this agreement. The parties having read and understand the foregoing terms of the Agreement do by their respective signatures dated below hereby agree to the terms thereof.

San Bando Department of Correction

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Commissioner

Date: \_\_\_\_\_

San Bando Division of Mental Health and Addiction

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Director

Date: \_\_\_\_\_

San Bando Budget Agency

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Director

Date: \_\_\_\_\_

## Preparing providers for services integration

Consider the following questions.

1. How do secular and faith-based recovery support providers currently view each other in our community?

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2. What are the key concerns stated by secular and faith-based providers about working together within our system of care? What assistance might they need in order to work cooperatively?

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3. If our treatment, secular, and faith-based providers participated in an integrated recovery-oriented service delivery system, what would be different from what now exists?

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4. What factors are likely to support the integration of recovery support and treatment providers (commitment to client well-being, desire for financial support, similar missions)? How will we build on these factors to support service integration?

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5. What examples of integrated recovery support and treatment providers exist in our State, tribe, or other communities and what can we learn from them? What are other integrated system models that we can evaluate?

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## Preparing the ATR project system for services integration

Consider the following questions.

1. What factors (e.g., different terminology, values, fee structures, and outcome measures; licensing requirements, certification, and credentialing) are likely to impede integration of recovery support, peer recovery support, and treatment services? How can we remove these impediments to support services integration?

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2. How do we ensure that recovery-oriented services are an integrated part of the client’s recovery plan and not “tacked on” to a treatment plan?

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3. What kinds of changes are needed for our network providers to be comfortable with clients choosing the specific services that support their recovery plan?

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4. How can our service array be documented and marketed in such a way that it supports clients in making informed choices?

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5. What standards or eligibility requirements do we need to establish for providers and provider organizations?

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## Section 5. Preparing community partners for network participation

### Goals

As you enroll diverse providers in your ATR network, you may find that secular and faith-based organizations have often been providing recovery support services outside of established provider networks and have significant needs and concerns about their ability to fill the roles and responsibilities of network participants. Frequently relying on volunteer resources and with limited organizational structures, some of these providers will need to develop new skills and capacities if they are to fully and effectively participate as an ATR provider.

Part of the challenge for providers will involve participating in a unique, federally funded project. Perhaps for the first time, service groups will be accountable for the quality of care they provide and for meeting specific data collection, reporting, financial management, confidentiality, and other business and performance standards. These requirements for ATR grantees may be unfamiliar to many providers, especially those delivering recovery support services.

- Identifying the information needs and concerns of new providers.
- Planning the training and technical assistance for new providers.
- Communicating Federal requirements that affect network participation.

### Themes

- Develop clear written policies and procedures with input from providers.
- Assist providers with understanding and adhering to requirements.
- Acknowledge and assist providers with concerns about network participation.
- Explain Federal requirements in simple, straightforward terms.
- Recognize that secular and faith-based provider organizations are likely to need initial and ongoing training and technical assistance on organizational development.

### Considerations for success

- Recognize that current network policies and procedures may need revisions to accommodate recovery support service providers and ATR requirements.
- Ensure that policies and procedures cover:
  - Standards of care appropriate for both treatment and recovery support services.
  - Technology requirements, payment methods, data collection, and reporting requirements.
  - Performance measures that are appropriate for both treatment and recovery support service providers.

- Performance incentives.
- Financial and accounting capacity.
- Adherence to Federal and State regulations such as confidentiality and privacy, drug-free workplace requirements, and nondiscrimination in hiring.
- Develop and include in provider agreements the requirement to adhere to network policies and procedures.
- Assess provider capacity to adhere to network policies and procedures and be prepared to provide technical assistance.
- Be aware that new providers will have varying levels of knowledge about or understanding of HIPAA, CFR 42 Part 2, GPRAs, vouchers, and/or other Federal program requirements that will affect them.
- Develop or adapt training materials that include information on Federal program requirements, targeting providers that operate within different cultures and have varying levels of system capacity and knowledge of Federal programs.
- Plan for training on Federal program requirements in a range of formats (online and on-site, group and individual) to accommodate different learning needs.
- Shift the focus of project guidance from compliance and policing to one of consultation and support. (See Exhibit 12, *Creating a Network Based on Strengths*.)
- Acknowledge the concerns of faith-based providers about Federal regulations and the potential for or perceived effects of these regulations on their missions, values, and service delivery policies and approaches.
- Plan for training and technical assistance resources for providers that deal with their initial and specific concerns about spiritual content of services, documentation, reporting, and payment.
- Plan for training and technical assistance that helps faith-based providers build their infrastructure, such as technology and financial systems development and/or adaptation, business licensing, human resource system support, and other practical considerations.
- Recruit secular and faith-based organizations that already have strong organizational structures to provide training and technical assistance and/or to serve as resource organizations for others.

## Exhibit 12. Creating a Network Based on Strengths

Working together may be a new experience for ATR managers as well as for treatment providers and community organizations. The following tips provide guidance on ways to build stronger partnerships and a strengths-based network.

- Find ways to sustain a continuing dialogue on how different models of ROSC are being implemented and maintained.
- Learn about and focus on the programs and strengths of each partner and how these strengths contribute to clients' recovery. Listen for themes that can provide connecting points for strong service collaborations.
- Be clear about the activities that the ATR program cannot condone. For instance, faith-based organizations may not criticize or dishonor other faiths. Recovery support service providers may not diagnose clients.
- Work together to outline the responsibilities of each provider.
- Understand the infrastructure challenges of all participating providers. Some community organizations, for instance, may depend on volunteers who work only part time. This might mean that communication must occur when they are open for business.
- Be flexible in scheduling meetings and trainings to accommodate different work hours and workforce needs.
- Allow sufficient time for learning, particularly during the early program period, because many new providers will not have had to input data into a shared database or provide other formal reports.
- Walk through new processes together in the beginning. Treatment providers, for example, may see how simple practice changes will lead to smoother integration with community organizations.
- Make time for networking activities in which ATR managers and service providers meet and learn from each other.
- Never underestimate the importance of communication. Keep it open at all times. Invite questions. Seek in all ways to achieve mutual understanding.

## Establishing and adhering to network policies and procedures

*Consider the following questions.*

1. What are the key elements of our current network policies and procedures?

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2. What modifications will we need to make to our existing network policies and procedures to accommodate new network partners? Who should be involved in the process of making them?

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3. Do we have standards of care for recovery support services? What help do we need in developing such standards?

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4. How will we measure the delivery of recovery support services against these standards?

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5. What types of consequences and responses will we have in place if providers do not or cannot meet the standards of care?

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6. How do we plan to encourage and reward high-quality performance by providers?

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7. How will we assess the capacity of potential providers to meet and adhere to our policies and procedures?

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8. Can we anticipate the technical assistance providers will need regarding our policies and procedures?

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## Training providers to work in a federally funded setting

*Consider the following questions.*

1. What do our new providers need to know about key Federal requirements, which may be unfamiliar to them, including HIPAA, CFR 42 Part 2, GPRA, vouchers, and project documentation?

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2. What kinds of concerns or misunderstandings might be expected from new providers regarding these ATR requirements?

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3. Which Federal requirements might mean that providers will need to make significant changes or accommodations and what will those changes and accommodations be?

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4. How can we foster peer partnerships to strengthen the capacity of new providers to understand and meet Federal program requirements?

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## Providing organizational development and training for community organizations

*Consider the following questions.*

1. What do we know about the organizational strengths and challenges of secular and faith-based providers in our communities? Who can help inform us?

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2. What are the most likely organizational development needs of the community organizations in our ATR network (e.g., policies and procedures, human resources, accounting, leadership training)?

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3. What types of training and technical assistance resources are most needed and currently available to meet the organizational needs of our community providers? What new resources are likely to be needed and how will we secure them?

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4. What special considerations must we take into account to plan for secular and faith-based organization training (greater frequency, smaller groups, specific modalities)?

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5. What specific training do we need to develop in response to the needs of our new community providers?

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6. How do we expect their organizational development and training needs to change over time?

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# 4

## Building Your Voucher and Information Management System



# Building Your Voucher and Information Management System

## Key Concepts

- Understanding your system requirements before developing your voucher and information management system (VMS/MIS) will save you time and help you avoid problems.
- A good VMS/MIS ties together all the parts of a client-focused ATR project.
- Your VMS/MIS design should be driven by your project's needs, but remember that you will use the VMS/MIS to meet SAMHSA's data collection requirements.
- A good VMS/MIS can be accessed from the Internet by project staff, providers, and other partners.
- Feedback and flexibility are key to your MIS design.
- Use data from your VMS/MIS to drive your project management and the decisions you make about treatment and recovery support services.

The strong reliance on electronic information management is a distinguishing attribute of the ATR project because of the importance of staying informed about:

1. The delivery of treatment and recovery support services by different provider organizations.
2. Reimbursement for services provided.
3. Number of vouchers issued and proportion of these vouchers expended.
4. Project performance.
5. Client outcomes.

The IT coordinator and his or her staff are responsible for developing a management information system or acquiring one that:

- Maintains records on clients, providers, and services; and
- Contains a voucher management system (VMS) that can be used throughout the duration of the ATR project to:
  - Create vouchers.
  - Receive reports of voucher-authorized services.
  - Reimburse providers.

- Provides a wide array of reports that assist staff in analyzing:
  - The difference between the dollar value of vouchers issued and the actual costs incurred when vouchers are expended.
  - Clients’ participation in services.
  - Use of vouchers by clients.
- Assists in verifying invoiced services.
- Facilitates reporting data to SAMHSA.

To develop the combined MIS and VMS, the IT coordinator will have to work very closely with (1) the clinical and recovery support services coordinator to obtain descriptions of eligible services, and (2) the financial coordinator to design the VMS and to ensure the system accommodates fiscal and cost accounting controls and procedures.

The most successful ATR programs—like the most successful businesses—use their data to manage more effectively. A business uses a variety of data sources to make decisions that will maximize its profits. ATR projects will make data-driven decisions to maximize both the number of clients who recover successfully from their substance use disorders and the quality of care for all.



Many different terms are used to refer to the MIS. Technically, some of these terms have slightly different meanings, but for day-to-day purposes, most people mean the MIS when they say:

- Information management system.
- Information system.
- Data management system.
- Information technology (IT) system.
- Automated data processing (ADP) system.
- Data system.
- Voucher management system (VMS).
- Electronic data system.

The MIS was set up in ATR projects originally because the projects needed a system to process vouchers, so it was commonly called the voucher management system. Later, projects realized they could use the MIS to produce information on client outcomes and service provision. By that time, they knew the system as the VMS, and they continued to refer to it that way. The system can do far more than process vouchers, but many people still refer to it as the VMS. SAMHSA requires ATR projects to create voucher management systems. Projects have created a VMS alone, a VMS as part of an MIS, or a VMS that includes an MIS.

The amount of data you will collect—from clients, providers, referrers, accountants—requires that you create an **automated data system**. This system will not only collect data, it will also tie together data from different parts of your ATR system and produce data relevant to information needs.

A good VMS/MIS has five key characteristics.

- **Client-focused**—Your VMS/MIS needs to be designed to help the greatest number of clients achieve recovery.
- **Comprehensive**—An ideal system will contain data from all segments of your ATR project, including intake and assessment, care coordination, clinical treatment, and recovery support services providers, clients, finances, and project management.
- **Integrated**—Data must be connected (integrated) so that they support your business practices.
- **Accessible**—Your data system will not effectively support your business practices unless those who need the data or need to submit data can access the system when and where they need to. To accomplish this, your system should be Web-based.
- **Available**—Your data should be able to support decisions made by ATR staff at all levels—from a new client’s recovery coordinator to your statewide project manager. To do this, the system must be user friendly.

This chapter will help you consider these key points as you develop and implement your VMS/MIS. Throughout this chapter, you will be given information and questions to lead you through the planning process for an effective data management system to support your ATR program. Exhibit 1, *Technology Requirements of the ATR Grant*, lists the IT responsibilities outlined in the ATR Request for Applications.



#### Benefits of Using a Voucher Management System

- Greater flexibility is achieved because of its Web-based format and ability to produce real-time data.
- Real-time data keep clients fully informed of their enrollment into the program at initial assessment and give providers up-to-date information on any changes to a client’s service requirements.
- Providers find it easier to file electronic invoices and are reimbursed quicker electronically.

SAMHSA, ATR (2007). *Administrative management models*. Prepared under Contract No. 277-00-6400; Task Order No. 277-00-6403 by American Institutes for Research.

## Exhibit 1. Technology Requirements of the ATR Grant

### Management Information System (MIS)

The IT coordinator is responsible for developing an electronic management information system that can be used to:

- Track performance and outcome.
- Upload performance data to SAMHSA (Training and technical assistance will be offered on data collecting, tracking, and follow-up, as well as data entry).
- Support project management in using data to oversee project activity, interact with services in managerial role, and report to SAMHSA.
- Provide data for use in reports to the community and to make decisions regarding implementation of ATR features in the jurisdictional system at or prior to ATR project closeout.

### Voucher Management System (VMS)

The IT coordinator is responsible for developing and maintaining an electronic voucher management system, which is part of the management information system.

The VMS contains descriptions of service and their associated costs per unit, making it possible for provider organizations to report on services delivered to clients.

The VMS also supports your financial management staff with the information needed to:

- Expend funds to reimburse providers.
- Account for expenditures.
- Continually show the difference between the funds authorized and the amounts used (expended).
- Report on the actual expenditures and percentage (rate) of expenditures.

The VMS enables project managers to:

- Determine how many vouchers can be safely expended to ensure that services are provided to all enrolled clients, maintaining a balance between enrollment and actual expenditures.
- Ensure that vouchers are issued rationally, so that neither too many nor too few are issued throughout phase 2 implementation and phase 3 closeout.
- Ensure that all contract funds are expended over the 4 years of the grant.



Some ATR projects have issued a special voucher good only for assessment once eligibility is established. Vouchers for services are given after assessment has been completed.

Models for intake and assessment also vary. State level projects may centralize intake and assessment. Providers and care coordinators may do assessments and coordinate client choice. Providers may do assessments and provide services. Most grantees use the Addiction Severity Index tool for assessment.

# Section 1. Required VMS/MIS functionalities

## What you need for success

### Goals

- Understanding what your VMS/MIS needs to be able to do and why (see Exhibit 2, *Functional Requirements Development Plan*).
- Understanding the importance of creating a **functional requirements document** as your first step toward VMS/MIS development (see Exhibit 3, *Functional Requirements Document Outline*).
- Recognizing the importance of access levels.
- Understanding how your VMS/MIS will make data easy to use.
- Understanding what it means for a system to be “modular” and approaches to designing a modular VMS/MIS.

### Themes

- VMS/MIS user friendliness streamlines work throughout the ATR network.
- System adaptability supports program changes over time.

### Considerations for success

- Know exactly which data you will need to have available for program use and reporting before you begin designing your VMS/MIS. Consider State and Federal data requirements, including GPRA provider needs; management decision support; financial data; and fraud, waste, and abuse audits.
- Know which of your organization’s business processes the VMS/MIS will need to support as you begin designing it.
- Make sure your technical staff and software designers understand the goals and mission of ATR.
- Develop a thorough understanding of the levels of information access needed by different system users, and don’t allow an individual more access than he or she needs.
- Put yourself in the shoes of a nontechnical user when considering user-interface design.



One grantee built the project’s VMS/MIS from scratch, designing the system’s

Web-based home page to be like a personal computer desktop. After logging in, providers see an automated calendar displaying their upcoming appointments with ATR clients, trainers, and other providers, including links that lead to more details about the event or the clients involved. The interface also has a news column containing ATR project updates. A box in the middle of the desktop alerts the user to which program requirements need to be completed within the next week.

## Exhibit 2. Functional Requirements Development Plan

### General considerations

Your voucher management system is ideally part of a comprehensive automated data management system (called a management information system). Your system must be able to bring together distinct groups of data into a comprehensive tool that both supports the details of each functional area of your program and allows you to combine data when needed. In other words, your management information system needs to be modular, with the ability for the modules to interact and exchange data seamlessly.

You might wish to consider five general requirements as you develop your system.

- It should be Web-based.
- It should be functionally modular.
- Its data domains should be completely integrated.
- It should be secure and allow for different levels of permission.
- It should automate as much data entry as possible.

A Web-based management information system is ideal in an ATR project for several main reasons:

- All users need only a computer and Internet access to use it. This means your providers do not need to purchase, install, and maintain expensive software to be in your ATR network.
- The system is centrally developed, maintained, and updated. This means it can be responsive to changes in your ATR project without the need for updates on dozens or hundreds of individual copies of the software.
- The system does not require a physical presence at a particular location to support staff in widely diverse geographic areas.

Your system needs to be modular because it must be able to work effectively for several types of users who deal with different types of data. Most important, your information system needs to be *client-focused*, but different members of your ATR team and partners in your network look at your clients differently. Your intake and assessment teams will perform assessments and intake GPRA's; your care coordinators will help clients as they select services and providers, based on assessment outcomes, and will issue vouchers; your treatment and recovery support service providers will enter service records as clients receive these various services. You and your staff, as managers of the project, will not generate any of these raw data; instead, you must be able to quickly and efficiently look at an overview of what all of these partners are doing or see a detailed report on what one provider is doing. Even within your own organization, different members of the team will need different information. For example, your financial manager will be focused more on costs and expenditures and less on services. Each area of specialty within the project will view data in ways that best support their area of responsibility.

The system must be integrated because the modules must be able to share information where and as appropriate, although they must be somewhat distinct. For example, your care coordinators and providers should not be able in any way to alter an assessment or an intake GPRA, but they need to be able to see both for their clients. Your care coordinators will also want and need to see their

*continued*

*Exhibit 2. Functional Requirements Development Plan, cont.*

clients' service usage, the level of funding available on their vouchers, and the billing from the providers. Similarly, service providers should not be able to alter a voucher and they have no need to see information on clients other than their own (several laws would likely be violated if they could).

Nonetheless, they must be able to see the voucher to know what services have been chosen by and authorized for their clients. Your ATR organization should not be able to alter an assessment, a GPRA, a voucher (although you might not approve one), or a service record, but members of your staff will doubtless need to see and use all these as part of their responsibilities.

The next important consideration as you develop your information management system might be summed up simply as "need to know." In other words, if a person on your staff or that of any of your provider organizations has no need to access information or perform a function, that person should not be able to do so.

- Your system should be able to accommodate different permission levels.
- At the general level, the Web-based system itself should be secure. Only those authorized may enter it, and to do so should require both a unique user name and a password.
- At the functional level, the system interface itself will provide limitations. When an assessor/intake provider logs into the system, only the interface designed for that provider is available, limiting the functions that can be performed for clients to completing the assessment instrument and the GPRA, for example. Similarly, a treatment provider or a recovery support services provider would have functionality limited by the interface according to the services the organization can and has been approved by the ATR project to provide.
- At the lowest level, the system needs to limit function to what is allowed by an individual permission level. For example, a provider organization that can deliver both clinical and recovery support services might need several permission levels. At the top might be an administrative permission that allows the person with that level to be the primary ATR contact, to register staff in the system and assign user permission levels, to perform other administrative functions such as staff management and updating agency information, and to do all other allowed functions. By contrast, a treatment provider within the organization might be precluded from all administrative functions and not be allowed to enter a record for a recovery support service, but be able to enter clinical services. Some organizations might have staff who enter no data, but have permission to see service records, etc. Their permission level might be "read-only."
- A similar set of hierarchical permission levels can be instituted in the ATR organization, according to function and need. For example, the service coordinator will need access to different data than the financial manager.
- **Such a system of access permissions is vital because it protects your clients, your ATR project, and your provider network.**

The final general consideration for developing your data system is to automate as much of the data entry as possible. The advantages of this are twofold: (1) It eliminates or limits data entry error, and (2) it simplifies data entry for your providers and staff.

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*Exhibit 2. Functional Requirements Development Plan, cont.*

For example, online assessment tools and GPRA interviews save time and increase accuracy and fulfillment rates. When your providers open up a client's record, they should be limited to entering only those services the client has chosen and that the voucher supports. Similarly, a drop-down menu of responses, for example, a calendar from which to select the date of the service, makes inappropriate answers impossible when entering a service record (note however that such devices cannot eliminate inaccurate entries).

Just as a user should not be able to access data or perform a function inappropriate to the user's need, neither should a user be able to enter inappropriate data. This limitation vastly simplifies everyone's work and saves time.

### **Specific functional needs**

Perhaps the easiest way to think about functional requirements in a management information system is to think about data flow, starting with intake and assessment and continuing through management needs and reporting to SAMHSA.

#### **INTAKE AND ASSESSMENT PROVIDERS**

- Online assessment tool(s) module:  
Allows online completion of the assessment and makes it available to other users such as the care coordinator and the providers who will deliver treatment and/or recovery support services.
- Online GPRA interview module:  
Allows the client's intake GPRA to be, upon completion, immediately available to the ATR project, SAMHSA, and the care coordinator and service providers.
- Administrative module:  
Allows the agency's management to perform administrative tasks such as staff management, contact with the ATR project, and update of agency information.
- Service record entry module:  
Allows reporting of completed assessments/intake GPRAs.
- Data sorting and report generation module:  
Allows generation of standard reports (e.g., number of assessments/intakes provided by the agency by unit of time, number of assessments/intakes per staff member), and data sorting capacity to answer specific questions.

#### **CARE COORDINATION PROVIDERS**

- Access to client assessment and intake GPRA:  
Allows the care coordinator to look at the client's assessment and intake GPRA while interviewing the client, to inform conversation with the client about strengths and needs.
- Access to comprehensive, up-to-date database on available providers:  
Allows care coordinator to have an informed conversation with the client about available services and who can deliver them.

*continued*

*Exhibit 2. Functional Requirements Development Plan, cont.*

- Client tracking sheet module:  
Allows completion of detailed client tracking sheet for follow-up purposes and includes client authorization of follow-up attempts.
- Voucher development and completion module:  
Allows care coordinator to develop the voucher as the client chooses services and providers, based on the assessment, and upon its completion, allows submission of the proposed voucher to the ATR project for approval. Also allows care coordinator to work with the client to change the voucher as the client progresses through the ATR system.
- Administrative module:  
Allows the agency's management to perform administrative tasks such as staff management, contact with the ATR project, and update of agency information.
- Service record entry module:  
Allows reporting of voucher development client meetings and other reimbursable client contacts to the ATR project.
- Data sorting and report generation module:  
Allows generation of standard reports (e.g., number of voucher interviews provided by the agency by unit of time, number of client contacts per staff member), and data sorting capacity to answer specific questions.

CLINICAL AND RECOVERY SUPPORT SERVICES PROVIDERS

- Access to individual client voucher and other client-specific data:  
Allows access to baseline data on clients, including assessment, baseline GPRA, and follow-up contact information (provider may update contact information but assessment and intake GPRA are read-only). Allows provider to see what services the client has chosen and are authorized, as well as delivery schedule limitations (e.g., only 3 group sessions/week or voucher expiration date).
- Service record entry module:  
Allows reporting to the ATR project of services delivered to the client.
- Online GPRA interview module:  
Allows the client's discharge GPRA to be, upon completion, immediately available to the ATR project and SAMHSA. If providers are responsible for follow-up GPRA at 6 months, also allows provider to complete it and makes it, upon completion, immediately available to the ATR project and SAMHSA.
- Administrative module:  
Allows the agency's management to perform administrative tasks such as staff management, contact with the ATR project, and update of agency information.
- Data sorting and report generation module:  
Allows generation of standard reports (e.g., numbers of services delivered per voucher by unit of time, number of services delivered by type by unit of time, number of services provided per staff member by unit of time), and data sorting capacity to answer specific questions.

*continued*

*Exhibit 2. Functional Requirements Development Plan, cont.*

## ATR Organization

- **Comprehensive provider network database:**  
This database should be started as the network is being recruited. It needs to include contact information (address, telephone, contact person), the type of organization (e.g., faith-based, secular, grassroots), the services offered and available for authorization, and each provider's resources (e.g., credentialed staff, number of beds). This information will be invaluable to your care coordinators, to your fraud, waste, and abuse monitor, and to other providers in the network when they need to make referrals. The responsibility for keeping this database current should fall largely on the providers themselves, who can access an online form to enter any change in their capacity, contact person, etc. Changes made in this module should automatically be captured in the master database.
- **Services module:**  
Allows your service coordinator and staff to review vouchers, decide if they are appropriate based on client assessment, and approve or disapprove them. Approval might generate an automatic e-mail to the selected provider(s) informing them of a new client. Information on these clients should become available on the provider(s)' interface upon voucher approval. Also allows review of all services provided, by voucher, by provider, and by type within a given unit of time. The care management staff should be able to review all vouchers for appropriate usage and analysis of service availability and effectiveness.
- **Financial module:**  
Allows financial management team to monitor voucher issuance, ensure that funds have been encumbered for each voucher issued, monitor actual expenditures per voucher, compute burn rate and average expenditures per voucher type, monitor expenditures per provider and reimburse services appropriately, compare invoices for any evidence of fraud, waste, and abuse.
- **General management module:**  
Allows oversight of finances and services and general review of operations; allows monitoring and tracking over time of client numbers, spending rate, follow-up GPRA rate; network development; and allows timely downloading of required data and reports to SAMHSA.
- **Data sorting and reports module:**  
Allows development of standard reports to satisfy the needs of the services coordinator, financial manager, and project director; also allows customized sorting to create data reports as questions arise among the management team. This critical area of support for the ATR management team offers the ability to closely monitor all aspects of this complex project, both fiscally and programmatically.



As you face development of your management information system, the list of desired functions might seem endless. Many grantees have found, however, that no matter how carefully thought out their system, it must still be altered and even more functions are likely to be needed as your ATR project becomes fully operational. Above all, this is because things change. SAMHSA may alter some grant requirements. You may find the need to alter your client population(s) or adjust your voucher amounts. Plan ahead. Make your management information system flexible and budget for changes.

### Exhibit 3. Functional Requirements Document Outline

Your functional requirements document will detail exactly how your VMS/MIS will support your business processes and what the system will do functionally. It should be written by your IT manager, in consultation with ATR program managers, before system development begins. You can show the completed document to software companies, in-house IT staff, and/or ASO staff to demonstrate exactly what you need them to create for you. This avoids any unpleasant surprises down the road—like discovering that your brand-new, million-dollar system doesn't fit your needs. The final document should be reviewed and approved by project staff before it is released to technology providers.

This outline was adapted from a functional requirements document template developed by the U.S. Department of Housing and Urban Development. You can find the full document template at <http://www.hud.gov/offices/cio/sdm/devlife/tempchecks/frtemplate.doc>.

- 1. GENERAL INFORMATION:** This section describes the purpose of the document and contains reference material such as a glossary, a list of references, and contact information for people and organizations, etc.
- 2. COMPREHENSIVE PROGRAM DESCRIPTION:** This section describes the organization's business processes as they are now and as they will be under the new ATR program.
- 3. CURRENT SYSTEM SUMMARY:** This section describes your current system—what it can do, why it was developed, pros and cons in the system's functioning, the equipment it uses, etc.
- 4. PROPOSED METHODS AND PROCEDURES:** This section discusses the changes you will need to make to get from what you have to what you need in a VMS/MIS. It also describes the effects these changes will have on users. It details the assumptions in place about the new ATR system and any constraints on its development and use.
- 5. DETAILED CHARACTERISTICS:** This section discusses requirements such as accuracy, timing, and capacity; diagrams how input and output will flow through the system; and describes how the system will be backed up in case of malfunction or failure.
- 6. DESIGN CONSIDERATIONS:** This section describes the overall architecture of the new system in relation to the existing systems it will interact or connect with. It also details the flexibility requirements of the new system that will allow for future modification.
- 7. ENVIRONMENT:** This section details the equipment and software environments in which the new VMS/MIS will be used. It also describes the communications requirements of the software in terms of programming language, compilers, and database systems, etc. It describes how the new system will interface with other systems. Finally, it details the impacts the new system will have on the larger organization operation.
- 8. SECURITY:** This section may be distributed or stored separately from other sections of the functional requirements document, due to the sensitive information it contains. It describes the possible vulnerabilities of the proposed VMS/MIS, as well as necessary control points and safeguards to protect the system. Finally, it details the requirements for monitoring and auditing VMS/MIS function.



In addition to a functional requirements document, you may find it helpful to write *user stories*. These describe specific tasks various users will perform using the MIS. User stories follow the format, “As a [role], I’ll want to [see X using the MIS], in order to [have a certain result].” For example, “As a provider, I’ll want to see what other services my client uses in order to better understand his recovery.” In conjunction with a functional requirements document, user stories can help software developers better understand a computer system’s “big picture.”



## How will we make our system easy to use and flexible?

Answering the questions in Worksheets 1 and 2 will help you complete the functional requirements document, outlined in Exhibit 3.

Consider the following questions.

1. How can we make our ATR data as easy as possible to use?

a. User-interface (screen) design?

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b. Integration of data from different sources into one presentation?

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c. Convenient navigation throughout the system?

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d. Exportability?

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e. Methods of data entry?

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f. Sorting?

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2. How can we build a flexible VMS/MIS that can be easily modified?

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3. What modular components need to be built into the overall design to ensure flexibility?

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One grantee set aside \$30,000 a year for VMS/MIS modifications—expecting them and ready for them. Because it had this money on hand, and a VMS/MIS built from scratch by in-house engineers, it had great adaptability in the system. Throughout the course of the ATR project, the grantee found it needed to respond very quickly to changes required to the VMS/MIS—whether due to changed grantee requirements from SAMHSA, burn rate, or other circumstances. The flexibility built into the VMS/MIS has helped it make these rapid adaptations.

WORKSHEET  
**2**

## How can we design our system to aid data usage and reporting?

Consider the following questions.

1. What kinds of reports and for whom might we need to generate them based on our data?

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2. What levels of data and system access might be needed by:

a. ATR IT staff?

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b. ATR fiscal staff?

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c. ATR program management?

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Not every VMS/MIS user has the same needs. Different “permission” levels should be built into the system and each person’s login should tell the system what level of permission that user has. For example, the ATR project’s IT staff need not only access to every aspect of the system, but also the ability to change any part of the system in response to management decisions. Provider staff and assessors need access only to their specific clients’ information and the ability to add service records and client data. ATR management needs to see every aspect of the system, but doesn’t need to change it. Provider management needs to manage staff and other aspects of the specific agency or organization, but doesn’t need access to other organizations’ information.

d. Providers and assessors?

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e. Provider management?

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3. What restrictions on data access need to be in place?

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A Southern State achieved a high GPRA reporting percentage by using its VMS/MIS to alert users that reports were due. If the user ignored the alerts and a GPRA report became overdue, the VMS/MIS blocked user access to the homepage until the user clicked through to view the missing reports.



A Western grantee found that members of the State government who were initially opposed to ATR quickly became advocates for the program when they were presented with up-to-date reports, on demand, showing how ATR money was helping their constituents recover from substance use disorders.

## Section 2. Assessment of your current capabilities

### Goals

- Understanding the capabilities of your current information systems.
- Understanding how your current system differs from what you'll need in your ATR project's VMS/MIS.

### Themes

- The **modules** of your VMS/MIS should be interconnected—they should work together and talk to each other just as the people do who make up your ATR network.
- Information technology (IT) specialists need to understand your ATR project and participate in management aspects of the project.
- Broad perspective, adaptability, and strategic thinking are important traits in IT specialists and data managers.

### Considerations for success

- Know your current system's strengths and weaknesses.
- Train IT staff to collaborate with finance staff, providers, and project managers throughout the design and implementation stages of your VMS/MIS.
- Follow the lead of some grantees who have organized groups of stakeholders as advisors on MIS design.



Some ATR projects have created advisory stakeholder teams to meet regularly with the IT coordinator and staff to provide their perspective on system design and implementation. As their systems were launched and used, the groups also helped determine their effectiveness in providing all users the specific type of information needed.



### How do we currently manage program information?

Consider the following questions.

1. Describe the capabilities of our current information system that can be used to support the ATR project. Does it support:

a. A provider network?

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b. Client choice?

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c. Preauthorized service plans (vouchers)?

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2. What is the current capacity of our information system to manage client and services data in a fee-for-service system?

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3. How can a provider enter service details into the current system from a remote location? What do we need to do to structure the data to support detailed tracking and invoicing for services?

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4. How does the current system record client outcome information?

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5. What are the current system's Web capabilities? (For example, is the system Web-based? Does it support links to other informational or technical assistance Web sites?)

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6. Is the current system modular? If so, list the modules it runs and their use in the ATR project.

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7. How can we use the current information system's capacity to plan for the ATR VMS/MIS system?

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## What are our skills?

Consider the following questions.

1. What are the technological capabilities of our current staff (consider an administrative services organization as well as in-house staff)? Can we build our own VMS/MIS? Can we maintain the system during operations?

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2. What is the role of our IT staff in our current operations? Describe their role on the ATR project team. How do they support staff needs? How are we helping them to improve their knowledge of program needs?

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3. To what extent do our IT staff collaborate as members of the ATR project team and with providers and other agencies? If current collaboration is limited, what are the barriers to collaboration?

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4. How can our IT staff use their interactions with program and other staff to improve the information system and make it more responsive to staff needs?

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5. Describe the role of IT staff in program planning. Identify strategies they have applied that support an evolving program.

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6. What support and training do our IT staff need in order to meet the requirements of a dynamic program model such as ATR?

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7. Describe the capabilities of our IT staff to “speak the language” of providers and others without technical experience. What can we do to overcome any communication barriers between IT staff and providers and other partners?

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# Section 3. Developing your VMS/MIS

## Goals

- Understanding the costs and benefits of using an existing system, a new system, or a commercial system.
- Understanding the costs and benefits of using an ASO to help develop or run your VMS/MIS.

## Themes

- Situations unique to States and tribes will drive how they choose to build and run their VMS/MIS.
- Budget, time, and resources are important considerations while planning your VMS/MIS.

## Considerations for success

- When you are developing your VMS/MIS, determine if you have clearly documented your organization’s business practices and be sure your new system will support them.
- Remember: you may not have to start from scratch.
- Be aware that your VMS/MIS design and development costs may continue throughout the duration of the ATR project due to unforeseen problems, programmatic changes, and ongoing maintenance and development.



Developing an in-house IT advisory group can be a critical factor to your success. The group should

meet regularly to plan VMS/MIS functionality, continue to evaluate VMS/MIS performance in response to need, and recommend changes throughout the duration of the ATR program.

This team should include:

- Representatives from all VMS/MIS users within your organization—especially those who will work with the system every day, such as data entry clerks, administrative assistants, and provider staff.
- At least a few members with less technology experience who can provide valuable user insights.
- Representatives from technologically savvy organizations to provide tips for VMS/MIS development.
- At least one member with professional clinical expertise, especially if you include vouchers for treatment services in your ATR program.



Within 4 months, your system must support the functions that are required to meet SAMHSA project implementation guide-

lines. Like some of the earlier grantees, you may find that you want to add other features later on to give you greater capabilities.



Two grantees—a State and a tribal authority based in the State—developed their system together. By jointly commissioning the system, these two grantees avoided “reinventing the wheel” and spent their administrative money frugally.

WORKSHEET  
**5**

## Where will our system and our expertise come from?

*Before answering the following questions, follow the decision tree in Exhibit 4 to consider how you might acquire your integrated VMS/MIS.*

1. What parameters will affect the cost of modifying, building, or buying our system?

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2. What can we afford to pay for our VMS/MIS?

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3. What help might we need in this process, either from SAMHSA technical assistance, previous grantees, consultants, or an ASO?

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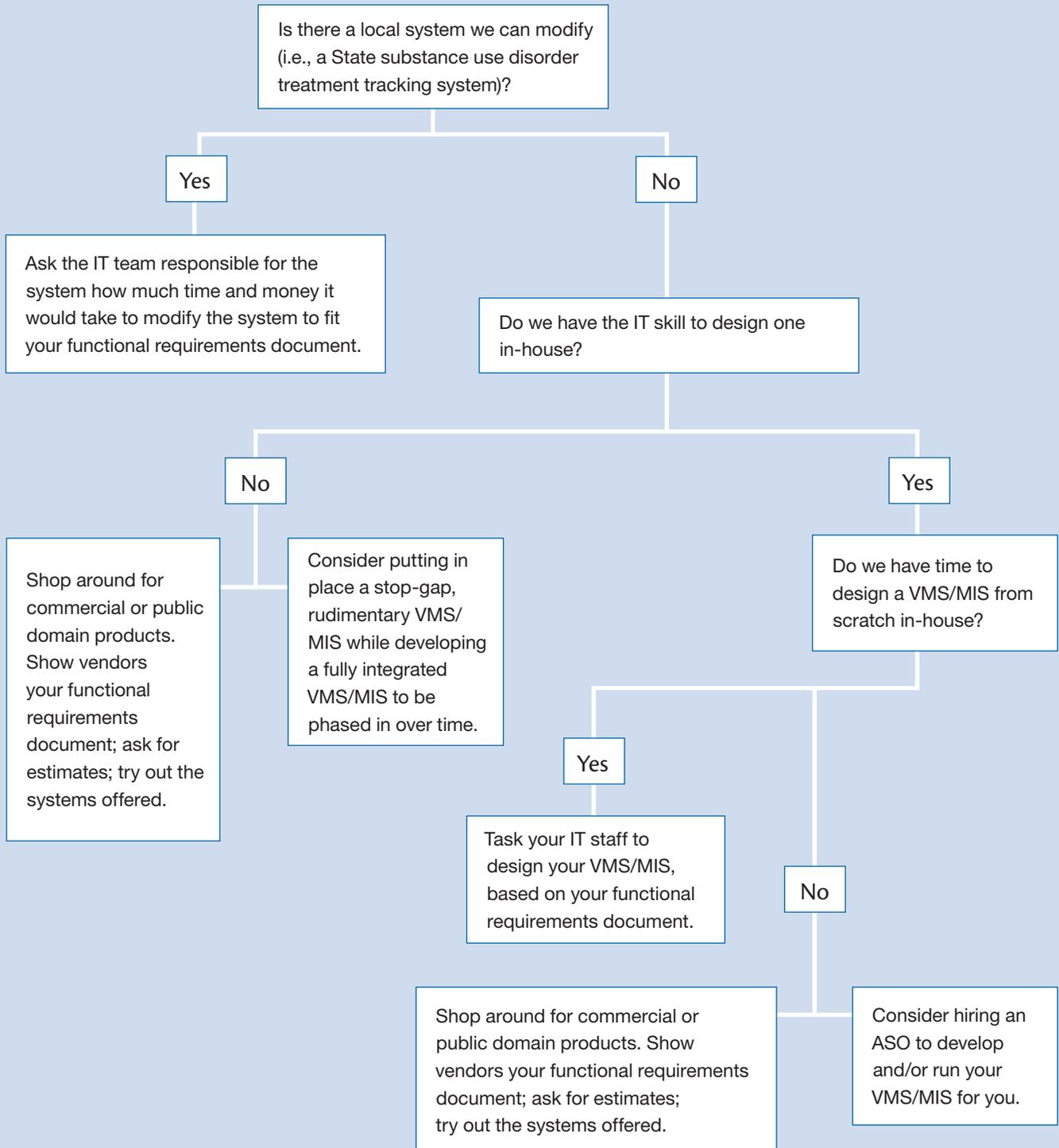


Be aware that public domain software and commercial systems are available to meet ATR needs and requirements. Each has cost associated with it, even those that are open source. Costs must be factored in, for example, for developing ATR modules, maintaining the system, and technical support.

## Exhibit 4. Decision Tree

### Sourcing your VMS/MIS

Follow this decision tree, beginning with the question at the top of the tree. With each “yes” or “no” answer, proceed to the next set of tree “branches.” Use the recommendations of the tree to help guide your decision about how to acquire your ATR program’s VMS/MIS. The suggestions given by this decision tree are meant to guide you, not to give a definitive answer.



## Section 4. ATR vouchers and your VMS/MIS

### Goals

- Understanding why your system needs to be client-focused.
- Knowing why vouchers facilitate client choice.
- Understanding the types of information you'll need to collect in your VMS/MIS to support your ATR project.
- Recognizing the need for flexibility in your ATR project's VMS/MIS.

### Themes

- Your information system needs to reflect ATR's client focus.
- Keeping track of ATR vouchers might be more than your current system can handle.
- Vouchers—and the complications they bring—are necessary to maintain client choice and promote recovery.

### Considerations for success

- Detail your “business practices or processes”—or the way your voucher-based ATR program will need to run to be successful—*before* you begin developing your VMS/MIS.
- Maintain as much data on clients as possible because ultimately those data will help your project answer the many questions that will be asked about client profiles and outcomes, services received, and the cost of services.



## What do we need to handle a voucher system of recovery?

Consider the following questions.

1. How will our VMS/MIS handle these situations:

a. Every client in our program accesses completely different services with their vouchers?

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b. Some of our clients go months without accessing services, while others receive recovery services nearly every day?

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c. ATR project managers want to know what clients' service usage rates are by various demographic criteria?

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d. Some of our clients change their minds about services, or their needs change?

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## Section 5. Constructing an automated, integrated VMS/MIS

### Goals

- Understanding the concept of an integrated VMS/MIS and why this is necessary for ATR.
- Understanding the importance of a Web-based VMS/MIS.

### Themes

- A VMS/MIS is more than a database—it is an interactive tool to aid you in making management decisions.
- Information access for all parts of the ATR project is imperative for success.

### Consideration for success

- Design your VMS/MIS to do as much of your work for you as possible.



A Web environment allows both grantee and provider staff to gain real-time access to client data collected by multiple organizations. This allows monitoring of all aspects of voucher usage.



A VMS/MIS should be able to:

- Handle client information (e.g., GPRA data, assessments, demographics, voucher use information).
- Allow providers to enter clients' service records and download client information.
- Track clients' service records for grantee program staff.
- Serve as a tracking and communications system between the grantee project staff and the rest of the ATR network.

WORKSHEET  
**7**

## How will we manage our data electronically?

Consider the following questions.

1. How can an automated data system help all parts of our ATR network keep track of:
  - a. Clients?

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- b. Services?

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- c. Finances?

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The term “burn rate” is best thought of as the rate at which funds are actually expended on services by the holders of vouchers, expressed as a percentage of the funds allocated to outstanding vouchers. Converting the actual spending on each voucher into a percentage of the funds allocated for that voucher, and averaging that for all your vouchers or types of services provided, give the management team the ability to forecast expenditures. You will know, for example, that on average, 80 percent of the funds you allocate will actually be used to pay for services. This also allows your project to re-allocate unspent encumbered funds to other clients without endangering the project’s fiscal stability. Most grantees have found that if they allocate a certain amount for a certain type of voucher, the average expenditure by holders of those vouchers is consistently less.

2. How can an automated data system integrate different data domains into a unified information tool?

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3. What view of our information system will each group of people working for ATR need to support their activities?

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4. How can our VMS/MIS help us make provider data accessible to our ATR project staff and to SAMHSA?

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5. How will a Web-based, integrated VMS/MIS help us with the reporting obligations of our ATR grant?

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6. How might a Web-based VMS/MIS make it easier for providers to participate in our ATR program?

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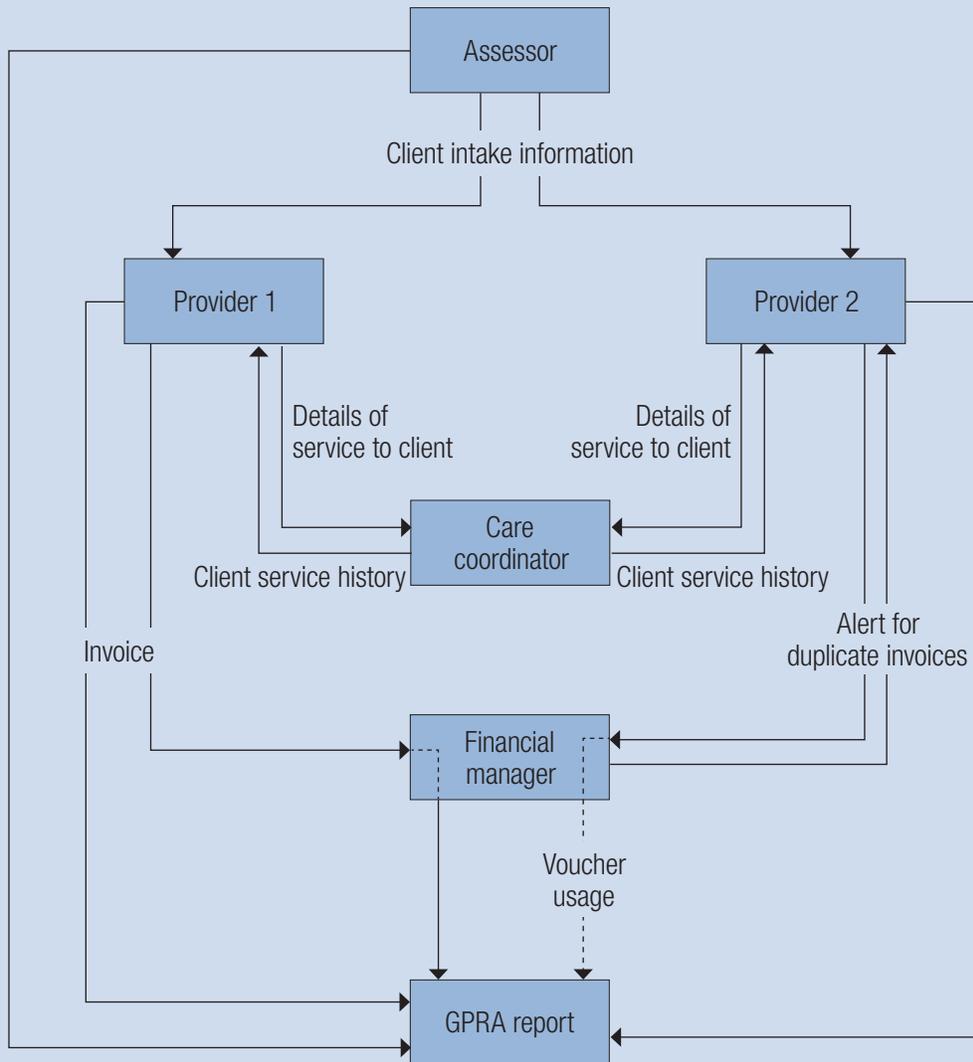
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A care coordinator logs into the ATR project's VMS/MIS to check client progress. She uses the system to generate a report showing the dates on which her clients accessed services. She notices one client has not received RSS for quite a while. She moves down to the last service report available and reads a note from the provider saying that this client mentioned he had recently lost his car. After calling the client and discussing his situation, she logs back into the system and authorizes transportation assistance to update his service plan.

### Exhibit 5. Data Links Between the Modules of an Integrated, Automated VMS/MIS

This diagram of a VMS/MIS demonstrates how some of the different parts of an ATR network share information generated by one client's visit to two RSS providers. Information regarding this client's service history and voucher usage is shared automatically between linked modules within the VMS/MIS.



# Section 6. Implementing and testing your VMS/MIS

## Final steps before launch

### Goals

- Determining how a “dry run” of your new VMS/MIS will be done.
- Deciding who needs what training, when, and by whom.

### Themes

- Expect that you will make mistakes and learn from them.
- Everyone in your ATR network has different skill sets and different training needs.
- Training is for everyone involved, not just for beginners.

### Considerations for success

- Don't make assumptions about technical know-how.
- Assess the training needs of the members of your team.
- Plan to train early and often.



“When we started, we created the big typical IT manual. We used up reams and reams of paper, and everybody hated it. What people liked were brief fact sheets.”

—Previous ATR grantee staff member



#### PAST ATR GRANTEE ADVICE FOR IT TRAINING

- Consider using writers to create user manuals, rather than IT staff.
- Require that provider staff receive training as a condition for being part of the ATR project.
- Keep the training fun and simple, using personable trainers, simple terminology, and experiential learning.
- Provide ongoing education through media such as newsletters, Web alerts, and fact sheets.



## How will we prepare our network to use the ATR VMS/MIS?

Consider the following questions.

1. Who will provide the necessary training on use of the VMS/MIS? What role can our current IT staff take in training people who are not IT specialists?

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2. Who will design training modules, manuals, or other materials? What outside help will we need?

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3. What training needs can we anticipate as our VMS/MIS is developed and the grant cycle matures?

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4. How can we coordinate our VMS/MIS training with other training efforts? What other areas that require training overlap with VMS/MIS usage (e.g., GPRA collection)?

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5. How will we conduct a “dry run” of our VMS/MIS? Who will be in charge of the testing? What aspects, functions, or modules of the system will be ready to test first and when?

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6. Which users must be represented in the dry run?

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7. How will we plan for and implement changes that result from the test?

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8. How will we design our training and trials so that all participants understand how recovery and choice underlie our VMS/MIS?

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According to past grantees, the most critical parts of VMS/MIS implementation are:

- Training.
- Clear definitions of services.
- More training.
- Provision of a help desk and technical assistance.
- Ongoing training and education.



You can avoid the sudden realization that you have too large an amount of unspent money from the beginning: Build into your information system the capacity to monitor actual expenditures by voucher, by type, and by client. Over the course of your grant, as you gain many examples of each type of client, defined by the intensity of their disorders, this capability will enable you to arrive at a better understanding of your clients' actual needs and help you serve them more efficiently. Being able to accurately estimate actual expenditures by type of client disorder and need will help you decide which clients you can serve with which services, how long you can issue vouchers, and which services you can limit offering.

# 5

Building Financial  
Management and Forecasting  
into your ATR System



# Building Financial Management and Forecasting Into your ATR System

## Key Concepts

- All ATR project systems have a common focus. In fact, successful financial control depends on remaining focused on the client. Measuring financial management success by tracking average cost per client is the route to ensuring program stability and predictability.
- ATR's financial system reflects and supports its underlying vision for substance use recovery.
- Pre-planning and frequent monitoring of voucher use is vital to program success.
- A comprehensive, electronic financial management system will keep your finances (and your clients and providers) on track.

### Your challenge: To make the money follow the client, not the provider

Unlike money in a contracting system, which follows the providers, ATR grant money follows the client. This client-directed movement of funds is facilitated by the use of vouchers. The vouchers issued to your clients provide them a choice of services, and offer you a way to keep costs down by ensuring that money is spent only when clients access services. Vouchers also can help you better monitor your finances and your clients' use of services. However, a voucher system may be more complicated than what you are used to.

Some challenges you may face while creating your ATR financial system include:

- Getting used to the absence of a set payment schedule—you don't know when clients will access services or how much your invoices will total in any given month. Financial forecasting and modeling are keys to controlling the spending rate of your grant.
- Designing and implementing the comprehensive, Web-based management information system needed to track invoices, payments, voucher use, and client progress.
- Achieving the integration and coordination needed among your State's or tribal agency's billing department, program officers, and recovery support services provider network.
- Establishing comprehensive policies and procedures detailing time frames for voucher issuance, redemption, and expiration, which are the foundation for successful financial management.

This chapter will help you overcome these challenges. Throughout the chapter, you will be presented with information and questions to lead you through the planning process for a sound financial system to support your ATR project.



# Section 1. Assessment of your current capabilities

## Are you ready for change?

### Goals

- Recognizing the need for change in your financial system.
- Identifying the strengths in your current organization that will help you build ATR's voucher-based system: openness to new ideas, ability to collaborate with different departments and organizations, motivation to participate in ATR.
- Identifying the weak points in your organization that might inhibit successful implementation of ATR, such as infrequent or retrospective analysis of program finances or opposition to new ways of doing business.
- Understanding how you can structure your ATR financial organization in relation to your State's needs and capabilities.
- Understanding some of the costs and benefits to using contractors or administrative services organizations (ASOs).

### Themes

- ATR's finance personnel need to work closely with project managers and service providers as an integral part of the ATR management team.
- Broad perspective, adaptability, and strategic thinking are important traits in financial officers, too.
- For the program to be successful, finance personnel must provide frequent and timely support for both retrospective analysis and forecasting.

### Considerations for success

- Train finance and IT staff to work together with providers and program managers to design and implement a management information system and to use that system to manage the program.
- Determine the appropriateness of outsourcing ATR management and finances to private companies and your willingness to do so.
- Review financial operations daily, a few times each week, or at least weekly. This contrasts sharply with the usual practice of reviewing finance operations retrospectively at quarterly and/or annual intervals.

## 1

## What is our current financial management capacity?

Consider the following questions.

1. Does our finance department currently handle preauthorized (prior authorized) service reimbursement? If so, does it have a tracking system sufficient to determine—by client and by provider—what services have been authorized, which have been provided, and which reimbursed?

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2. What does our finance staff need in order to be able to support a preauthorized fee-for-service system?

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- a. What steps need to be taken by the project director or others in our system of care to assist the finance department?

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- b. Do we need to seek outside help? If so, in what specific areas?

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3. To operate an effective voucher system, financial staff need to work closely with other administrators and with service providers who have the information needed to set up a financial system. To what extent are finance personnel currently involved in project management activities?

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a. Do they participate with other administrative and program managers in making decisions?

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b. What changes can we make to help our financial staff become more involved?

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4. Which staff members are experienced in preauthorized payment systems (vouchers)? Use information on their experience and qualifications to help determine who else we need to talk to about such systems.

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5. To what extent do our financial and IT staff collaborate with program staff, providers, and other State agencies?

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6. What barriers to collaboration do we need to overcome?

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A Southern State implements its ATR program on a county level, though all funding comes from a single statewide pool. Formerly, funding was allocated by the counties, but this became unwieldy because county referral and usage rates differed, so State-level funding is now available to all clients throughout the State on a first-come, first-served basis.

7. List in detail the changes necessary to meet the financial management requirements of ATR.

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Identify changes needed in the following areas:

a. Policies

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b. Procedures

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c. Structural systems design (including chart of accounts, organization of accounting records, and frequency of reporting and analysis)

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d. Communications

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e. Reporting

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f. Analysis

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g. Staffing

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## Are we ready to make the financial management changes needed in ATR?

*Consider the following questions.*

1. What steps do we need to take to implement staffing changes that will improve our financial management capacity?

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2. Do our staff understand the changes required to create new processes and how to implement those changes? If not, what steps are needed?

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3. What skills do our staff need to educate providers, many with little administrative experience, and to help them understand our new financial and information management systems?

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4. What support will our financial staff need to interact with grassroots faith-based and secular community providers to help them understand the voucher processes and successfully participate in the ATR system of care? Do we have processes for assessing their capabilities and needs in handling vouchers?

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5. How can we foster a spirit of collaboration between financial staff, ATR project personnel, and providers?

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6. How will our new voucher-based payment system increase recovering clients' access to recovery support? How will we impart this idea to our financial/technical staff?

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7. Do our staff have the ability to “speak the language” of providers with no technical experience in order to help them understand and troubleshoot our new financial management system? If not, how can we help them learn to do so?

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8. How can we foster a spirit of collaboration between financial/technical staff and other ATR stakeholders in and outside our agency?

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## How will we plan an ATR financial system to fit our needs?

Consider the following questions.

1. In which specific areas of our financial and/or technical capabilities might we need outside assistance before undertaking our ATR program?
  - a. IT design to support financial requirements?

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- b. Technical training for providers?

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- c. Issuing vouchers?

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- d. Analyzing voucher issuance and usage to manage financial resources effectively?

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- e. Issuing regular financial reports?

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f. Receiving and cross-checking invoices?

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g. Issuing payments to providers?

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h. Setting rates and establishing service agreements with providers?

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2. What are some potential sources of outside assistance?

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3. If we can't identify needed resources, who can help us?

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A Northern State has formed a statewide ASO to help in the management of its ATR program. The ASO is responsible for recruiting recovery support services (RSS) providers, negotiating agreements with assessment and RSS providers, and issuing reports on voucher usage. The State, however, issues all vouchers to clients and adjusts program parameters if the ASO's fiscal reports indicate the need to do so in order to control burn rate.

## Section 2. Setting rates for services

### Considering costs of recovery support services

#### Goals

- Understanding a variety of proven methods to establish rates for RSS.
- Knowing how to control rates throughout the duration of your grant.

#### Themes

- Setting a price for RSS might be a new concept for both you and your providers.
- Rates for services are in place in other States; they can serve as one helpful source of information.
- Rate consistency—also known as comparability—is key.
- You will be reimbursing providers on a fee-for-service basis.
- View rate setting as an opportunity to provide incentives to providers for offering and delivering quality services.

#### Considerations for success

- Analyze voucher issuance and usage rates to manage financial resources effectively.
- Look at how other agencies or grantees have set their rates for RSS before you set yours.
- Determine if your rates undercut those for similar services provided by other government agencies—you're not competitors!
- Include a mechanism to control costs when setting rates.



To make the process of setting rates for RSS a little easier, look for precedent. (Also be sure to see Exhibit 1, *Rate Ranges for Recovery Support Services*.)

- **Providers.** Some of your providers may have already been receiving reimbursement for services from public funds. The rates you set should be consistent with current or recent rates from other public sources.
- **ATR programs in other States or tribal areas.** You don't necessarily have to reinvent the wheel. Look at other State programs with economic environments and service parameters similar to yours.
- **Tribal, State, or local welfare programs.** Some services may already be funded by other programs in your area. Your rates should be consistent with theirs.

## Exhibit 1. Rate Ranges for Selected Recovery Support Services

Note that these rates are only a guide. The rates you set will depend on the particular service parameters of your RSS and your local costs of living and doing business.

Recovery support service	Unit of service	Range
Transportation	Round trip	\$10–\$14 bus pass
Employment services or job training	Hour	\$10–\$46.79
Case management	Hour	\$10–\$56.90
Housing assistance or services	Daily transitional	\$25–\$33
Housing assistance or services	Recovery house (monthly)	\$1,359–\$2,000
Child care	Hour	\$3.85–\$12
Family, marriage counseling, and education	Hour (individual)	\$5–\$81.98
Peer-to-peer services, mentoring, coaching	Hour (individual)	\$10–\$56.89
Peer-to-peer services, mentoring, coaching	Hour (group)	\$15–\$20.50
Other types of service		
Life skills	Hour	\$25–\$30
Spiritual and faith-based support	Hour	\$5–\$10
Education	Hour (individual)	\$20–\$25

SAMHSA ATR 2010 Request for Applications No. TI-10-008, Appendix I, page 70.



## How will we accommodate ATR’s reimbursement system?

Consider the following questions.

1. How does fee-for-service reimbursement differ from our current payment system?

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2. What changes in our system and our thinking will we need, if any, to embrace fee-for-service payments?

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3. Which government agencies in our State have been providing RSS? What are their rates?

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4. Of the RSS providers in our network, have any of them ever received reimbursement from a government agency for RSS? Which providers, which services, and at what rates?

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5. How will we ensure that our rates are defensible under public examination? How will we ensure that our rates compare favorably to those of other payors in the market, while fully considering the incentives that ATR is offering to providers?

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## What will we pay providers for RSS?

Consider the following questions.

1. Do we have any treatment and recovery support services in our network that carry a risk for potential abuse or excessive costs?

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2. Would reimbursement caps be appropriate for particular services or subsidized client purchases? Which services? At what level will we set the caps?

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3. Do rates include incentives for providers? In setting rates, what incentives do we want to offer our providers? How will we determine if the incentives are effective?

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4. How will we monitor the effectiveness of our rate-setting methodology and its impact on services?

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5. Have finance and program staff worked together to formulate a typical cost profile for clients with low, moderate, and intense needs?

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## Section 3. Designing a financial information management system

### Keeping track of a complex system

#### Goal

- Understanding the types of financial information that should be included and integrated in an electronic management information system—voucher usage data, client recovery progress data, RSS usage data, invoice and payment data, etc.

#### Themes

- The more information you have on your clients, your services, and your spending, the better you will be able to manage your money.
- Your voucher and management information system (VMS/MIS) can be your most effective tool for tracking how much of the money obligated (or encumbered) for vouchers is actually spent on services—often called your “burn rate.”

#### Considerations for success

- Design your electronic management information system to provide you with a detailed breakdown of spending by different types of clients and different types of services and by any other variables relevant to your project (see Exhibit 2, *Considerations for Building Financial Management Tools*).
- Your VMS/MIS should be designed first and foremost to help you run an effective, solvent ATR project.



One State already had an online system in place for substance use disorder treatment data. Their in-house information technology staff added on and integrated a module for ATR after collaboration with finance managers, providers, and assessment staff. The new module contained all recovery and financial information accessible to authorized users through a highly versatile interface. However, the State did not properly plan for training in the use of the new module, and had a difficult startup because many of their providers lacked computer literacy and did not understand how to use the VMS/MIS. Corrections were made and training is now routinely offered.

## Exhibit 2. Considerations for Building Financial Management Tools

### General considerations

Your management information system must allow for standard financial management operations (like the ability to monitor provider services and pay for them) and specially designed financial forecasting tools related to ATR's voucher system.

ATR clients have choice. To facilitate choice, a voucher authorizing payment for the services chosen is issued to each client. Because they direct their own recoveries, clients not only choose their services and providers, they also may choose when to stop receiving services or never use services. These two factors directly cause the major financial management challenge faced by nearly all ATR projects: knowing how much of their funds they have spent.

Very important tools for managing your finances are your policies and procedures that govern voucher issuance and redemption. The most important are the following.

- 1. Voucher duration/life**—how long a voucher may be active or available for use by the client. Based on ATR grantee experience, shorter duration is better because it will allow you to know in a reasonable period of time which services are accessed and how much money can be reallocated for other clients.
- 2. Voucher initial use**—the maximum time a voucher may remain active before its first use. This policy helps to support timely accounting of usage/spending for a newly issued voucher, but also provides very important information to the care coordinator about a client's engagement in services. A voucher that closes automatically because a client does not use it can trigger a contact with the client to find out if help with concerns about or problems related to services would be appropriate and welcomed.
- 3. Voucher inactivity**—similar to the policy for initial use, this policy governs how long you allow vouchers to remain open without being used again after a client has started services. This policy ensures that ATR program management knows in real time which vouchers have been used and supports care coordination by identifying clients who are not continuing to receive services.
- 4. Billing/reporting of services provided**—the maximum time allowed for a provider to bill or, at minimum, report a client service provided. The less time allowed, the sooner you will know what funds have actually been spent. Some grantees have required 5 days and have achieved compliance, helping them manage their voucher pool better (see ATR Tip).

*continued*



An important factor in how quickly you can monitor expenditures is how soon providers in your network enter their service records into the voucher management system. Ideally, they should enter a service as soon as it has been delivered to the client so that you can monitor spending almost in real time. As you train your providers to use the system, the value of this should be emphasized and your system should make it simple to do. For example, some grantees have made the default date in the service record entry module “today.” Require and expect your providers to enter service records within a few days at most, and develop incentives to encourage this. Everyone will benefit; your providers will be paid for services they render in a more timely fashion and your ATR project will be able to monitor spending more rapidly (see policy 4).

*Exhibit 2. Considerations for Building Financial Management Tools, cont.*

These policies and procedures make possible the collection of critical data about use of services and funds in the shortest reasonable time, allowing ATR managers timely oversight of finances. They also support effective management of clients to help them achieve their desired outcomes.

You might also wish to consider building into your management information system two general financial management tools to provide:

1. The ability for your accounting system to immediately and automatically deduct the value of a newly issued voucher from the amount of funds available to pay for services.
2. The ability to monitor individual voucher expenditures by date of voucher issuance.

The first of these tools sets aside, or encumbers, the amount of money that would be spent if the client used every service authorized on the voucher. Many clients do not use all authorized services, but this step keeps your ATR project from spending money it would not have if all services were used.

That gap between what has been authorized and what is spent is where the potential problem lies. Your real “burn rate” is found using the second of these general financial management tools to monitor actual spending on each voucher. The sum of all voucher expenditures each month compared to the sum of vouchers issued is your burn rate.

Most grantees find it useful to express this as the percentage of funds encumbered rather than as a dollar amount. For example, if you have obligated \$100,000 this month to pay for outstanding vouchers, but deliver only \$80,000 in services, your burn rate is 80 percent. That is the rate at which you can reasonably forecast usage of the funds committed on a voucher. ATR projects, over the course of time, typically find a consistent pattern in the percentage of funds expended each month of the vouchers’ life. You can use this pattern, identified by analyzing your voucher expenditure rates, to help you forecast how much of your funds will actually be used and when. This will enable you to adjust your voucher issuance limits to account for it, making possible vouchers for more clients.

Your system must be able to monitor actual expenditures in a timely manner so that your project will not suddenly find—perhaps too late to adjust spending within the grant period—that it has a large pool of unspent money or is spending at an unsustainable rate. Avoid this from the beginning: Build into your system a financial management tool that can track actual voucher expenditures, preferably every day, and weekly at a minimum. That way, as soon as a voucher has been closed, your financial manager will know exactly how much the client expended. The difference between that and what was encumbered will be available again to pay for another client’s services.

*continued*

### **Specific consideration**

In the long run, you will find another financial management tool to be very useful. It builds on the second one, described above, but goes a step further.

Instead of stopping at the ability to monitor individual voucher expenditure, build into your financial management system the ability to sort voucher expenditures by substance use disorder intensity level.

The value of this extra step might not be apparent at first. Perhaps you have allotted \$1,000 per voucher for those who present with a low-intensity disorder and need only recovery support services; \$1,500 for vouchers issued at a medium level of intensity, for clients who need not only recovery support services but also some clinical help; and \$2,500 for high-level intensity vouchers to cover the costs of more treatment.

As your project serves its first clients, you might notice that Jim, who was assessed at a medium level of intensity, expended only \$1,200 of his voucher, but his 6-month follow-up GPRA indicated a successful care episode. Similarly, Mary, who received a low-intensity level voucher, used only \$750 of recovery support services, also with good outcomes.

Expenditure data on one client tells you little, but as your client numbers grow, and you have data on 100, then 200, then 1,000 clients in each disorder intensity level, meaningful averages can be calculated. This will translate into a better awareness of client needs upon assessment and consequently, more efficient delivery of services. It might even lead to adjusting the amount on the voucher as it is issued, based on the likely “real” expenditure as “predicted” by the assessment.

Further down the road, you will find another reason why this financial tool will be of great benefit. Right now, grant closeout in 4 years probably seems an eternity away. It’s not. As your grant period nears its end, ensuring that expenditures occur so that all the money is gone at the end of the grant without leaving any clients stranded can be very tricky. Starting now with the ability to look at your data in this fine-grained way will be invaluable when that time comes. You will be accustomed to monitoring your financial data closely. You will know what funds you have available and will be able to calculate how many clients of each intensity level you can serve in the time remaining. You can determine when you must stop issuing each type of voucher and what services you can no longer afford. Most important, you will not find yourself with clients you can no longer provide care for.

These tools will benefit your clients and your ATR project throughout your entire grant period.

## Building financial management tools into our VMS/MIS

Consider the following questions.

1. What financial management functions do we want our VMS/MIS to perform? Of those selected, describe briefly how the system will provide this information.

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- a. Encumbered vs. spent funds (calculating burn rate)?

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- b. Single-voucher spending vs. systemwide spending?

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- c. Spending by client type?

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- d. Spending by service type?

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- e. Spending as a function of time?

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f. Fraud, waste, and abuse?

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g. Reports for ATR staff and for SAMHSA?

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h. Payment requests and receipts?

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2. What financial management needs will our provider network, our intake and assessment teams, and our care coordinators have, and which of these can the VMS/MIS help them with?

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3. What are our specific business practices and how might these affect our electronic management information system?

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4. How might our financial managers to be able to use the VMS/MIS to analyze spending in detail and how will this help our program?

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5. How will financial management staff work with information technology staff to ensure that the system will meet all the requirements for effective financial management?

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6. Who will monitor the effectiveness of the financial aspects of the VMS/MIS and suggest improvements?

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See Exhibit 2 in chapter 4 entitled *VMS Functional Requirements Development Plan* for more indepth discussions of the functional requirements of your VMS/MIS.

## Section 4. Forecasting Basics

### Learning how to anticipate future expenditures

#### Goals

- Understanding why forecasting is vital to an effective ATR project.
- Being able to construct a model for your ATR project, similar to the one in Exhibit 3.
- Understanding how you will monitor and track your expenditures.

#### Themes

- Plan now to avoid cash-flow and budget problems later.
- Accrual accounting is the way to go.
- Constant monitoring of expenditures is a core function.

#### Considerations for success

- Consider the similarities and differences between the kind of forecasting needed for ATR and any financial forecasting you currently do.
- Understand the forecasting capabilities of your current staff and where you will need assistance or training.
- Be prepared to monitor your expenditures frequently against all baselines—budgeted, cumulative year-to-date, and cumulative project-to-date. Monitoring at least weekly is highly recommended by ATR I and II grantees.



Forecasting possible spending scenarios will help you keep up with or ahead of any changes in conditions or assumptions, and realistically project what can happen under different scenarios.

## Preparing to be financial forecasters

Consider the following questions.

1. What will be the total cost of client services in the first grant year based on our grant amount?

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- a. What will be the breakdown between recovery support and treatment services?

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- b. Will there be a budget allocation for faith-based and secular organizations?

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2. What will be our voucher management policies in the following areas?

- a. Multiple services on one voucher?

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- b. Multiple providers on one voucher?

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- c. Duration of voucher?

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d. Service unit limitations?

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e. Required voucher usage frequency?

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3. What systems must we have in place to issue our first vouchers?

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4. How quickly do we expect our clients to spend their vouchers? How much time will we allow them to access their first service, and how much time will we allow them to use up their vouchers?

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5. What is the impact of accrual accounting on voucher management and how will we use it for ATR?

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6. How will providers report electronically on services delivered?

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### Exhibit 3. Sample Projected Expenditures, First 6 Months of 36-Month Grant

This sample projection is based on a system in which 3,000 available vouchers are worth \$2,500 each and are valid for 3 months. Note that there is a 3-month startup period in which no vouchers are issued. Also note that this initial model assumes that each client spends exactly one-third of his or her voucher every month, and that exactly 100 vouchers are issued each month.

Month	1	2	3	4	5	6
New vouchers issued				100	100	100
Open vouchers (total)				100	200	300
Monthly cost per client				\$833	\$833	\$833
Total monthly expenditure				\$83,333	\$166,667	\$250,000

Source: Chapter 3: Pre-planning and developing a model. *Expenditures Forecasting and Management Handbook*. Altarum ATR Technical Assistance Handbook 1. Access to Recovery Grant Program.

Fill in the chart below based on the planning you've done for your State's ATR program.

Month	1	2	3	4	5	6
New vouchers issued						
Open vouchers (total)						
Monthly cost per client						
Total monthly expenditure						



Time limits can help you build a better forecasting and monitoring system.

- Shorter voucher expiration periods and tight termination policies make managing program expenditures easier.
- Requiring (and offering incentives for) quick reporting of services and invoicing maintains spending control and easier monitoring of voucher usage.



## Monitoring our spending

Consider the following questions.

1. What factors might have an impact on the simple model we've constructed on the previous page?

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2. Which variables should we plan on tracking to catch any deviations from our original model?

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3. What are the key indicators of financial system performance? How can we compare our data against baselines to track program performance? Which baselines will we use? Why?

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4. How will we collect data? What measures or thresholds will we set to determine system effectiveness? How often will we review the effectiveness of our indicators and data collection?

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5. What type of financial forecasting do we currently have? How does our current financial forecasting system differ from the type of forecasting we will have to employ for ATR?

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6. How will prior authorization of services affect our financial forecasting and monitoring?

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7. How will a VMS/MIS help us pay providers as soon as possible after a voucher-authorized service is performed, irrespective of the date or time the service was rendered, the type of service, or the number of clients who receive the service?

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## Section 5. Adjusting your financial model and facing challenges

### Dealing with the trials of the real world

#### Goals

- Understanding why your financial model will need constant revision.
- Understanding how preplanning and forecasting will help you maintain steady grant usage and solvency.
- Becoming aware of the different financial challenges past grantees have faced and how to avoid them through preplanning, forecasting, and model revision.

#### Themes

- Keep your eye on the ball by watching the money.
- Be prepared for the challenges that preauthorized fee-for-service systems can bring that you may not be used to facing.

#### Considerations for success

- Develop your model to help you meet your client goal numbers while spending all your grant—this is why your model must be refined and updated often, using your actual numbers.
- Assign a financial manager to the task of monitoring expenditures and making suggestions for project revisions in order to control spending.
- If you need to make changes to control spending, don't make too many at one time. Too many changes can be disruptive and their effects difficult to monitor. Instead, make one or two well-considered changes in your project only after consultation with—and advance notice to—providers and project staff.
- Collect sufficient data prior to making changes. Trends based on substantive data sets are a reliable source of intelligence about your system; dips and spikes may represent only temporary conditions.
- One key trend is found by comparing the amount of services and costs associated with the vouchers written to the number of services actually used and the actual expenditures (payments made) on each voucher. This ratio/trend analysis will be critical in forecasting.

WORKSHEET  
**9**

## How will we revise our model based on monitoring data?

*Consider the following questions.*

1. Why might we need to make changes or adjustments to both our voucher system and our project after it starts?

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2. How often will we need to check our actual data?

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The ATR financial manager in one State tracks voucher use and expenditure data for the first several months and enters the new numbers into her forecasting tool.

She sees that the real numbers she is entering are much lower than her team's original projections, and is worried that the project will undershoot its goals. After meeting with program managers and consulting with several providers and clients, she and her colleagues decide to engage more transitional housing providers and to lengthen the period of voucher validity by 30 days. She adjusts her tool accordingly and is pleased to see after another several months of monitoring that spending seems to be back on track.

## Implementing our changes

Consider the following questions.

- 1. In the Lesson Learned on the previous page about one State’s ATR project, what might have led the financial management team to increase the number of housing providers? Why did they take the approach they did?

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- 2. How will we prepare our system, staff, and stakeholders for any changes or adjustments we need to make after launch?

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## Section 6. Fraud, waste, and abuse

### Preventing and detecting misuse of funds

#### Goals

- Planning to include fraud, waste and abuse (FWA) monitoring and detection tools into your VMS/MIS.
- Being able to take corrective action when FWA is detected.
- Understanding the roles of project managers and staff in the FWA monitoring effort.

#### Themes

- Prevention of FWA must be built into your system; it cannot be ad hoc or episodic.
- A well-designed VMS/MIS will give you the tools you need to detect and counter FWA.
- Supplement existing substance treatment and recovery services, don't supplant them.
- FWA is the enemy of true client choice.

#### Considerations for success

- Plan your system to catch FWA for you.
- Make sure all providers know about FWA monitoring procedures, and what constitutes FWA.
- Be vigilant.
- Stay in communication with clients—they'll be able to tell you if providers are doing their jobs.
- Plan on conducting site visits and audits.

## How will we build fraud, waste, and abuse monitoring into our financial system?

*Consider the following questions.*

1. How do we currently monitor for FWA?

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2. How will the use of vouchers affect our FWA procedures and policies?

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3. Will our FWA policies need any modification to be useful for ATR? If so, how?

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4. If we are using contractors, ASOs, or behavioral health managed care, how will they handle FWA? What will be our responsibilities?

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5. What is the financial manager's role in FWA detection? What about financial staff? Nonfinancial staff and managers?

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*Consider the following questions.*

1. What are indicators of FWA in our project?

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2. What data in our VMS/MIS will be used to identify indicators of FWA?

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3. Will all FWA instances be related to finance? If not, what are the other instances, and do we have a plan for monitoring them?

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4. Will clients be able to commit FWA? In what instances?

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5. Will we identify specific staff to be FWA monitors? If so, what other responsibilities might they have?

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6. How will our VMS/MIS assist us in detecting FWA?

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7. Is our team clear about the differences between supplanting and supplementing? Have we explained this to all staff and all providers?

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8. How will we ensure that our ATR funds supplement existing substance use treatment services, rather than supplanting them? Why is this an important distinction?

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9. Why was the following action taken?

Two sister agencies were both part of an ATR provider network, one as an assessment provider and the other providing recovery support services. After a year of tracking system data, the FWA manager noticed a trend—clients who were assessed by one sister agency and authorized to get job counseling tended to go to the other sister agency to receive it, rather than to another job counseling provider. Client surveys revealed that assessment specialists would recommend the sister agency to clients if asked for a recommendation. The State terminated its relationship with the assessing agency and replaced it with an organization that was unaffiliated with any existing providers.

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## Section 7. Testing your financial system and training your staff and providers

### Last steps to ensure effective change

#### Goals

- Determining the duration of a “dry run,” or test, of your new financial system and how it would work.
- Deciding who needs what training, when, and by whom.

#### Themes

- All of your recovery support services providers have different skill sets and different training needs.
- Training is not just for beginners; it should include all project staff and be repeated when changes are made.

#### Considerations for success

- Don't make assumptions about technical know-how.
- Design your training to fit specific trainees' needs rather than basing it on general assumptions about possible training requirements.
- Be transparent with all financial operations; everyone needs to know what is going on.

## How do we make sure we're prepared to start ATR?

Consider the following questions.

1. The chart below can help you determine which stakeholders will need training in each general area of the ATR financial and information system. Complete the chart with notes on the types of training different program participants will require.

Training	Finance staff	Program staff	Intake/assessment staff	RSS provider staff	Others
Finance system					
FWA monitoring					
Use of data					
Other					

2. Who will provide the necessary training? Are our current financial/information technology staff capable of training nonspecialists? What training will staff need?

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3. Will different trainers teach each topic area? Or will we have fewer trainers, each responsible for several topics?

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4. Who will design training modules, manuals, or other materials?

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5. What training needs will we have throughout our grant period? How will those needs be different from the needs before implementation? How will training be affected by staff and provider turnover?

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6. Will financial training be coordinated with other training efforts? If so, how?

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Consider the following questions.

1. How will we test our finance system? Who will be included in a dry run?

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2. When will this dry run take place, and who will be in charge of it and of monitoring its outcomes?

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3. How will we design our training and trials so that all participants understand how recovery and choice underlie the financial and information system we have created for our ATR project?

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4. How can we involve key personnel from each component of the ATR program in designing the test scenarios to be used?

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# 6

Sustaining ATR Advances



# Sustaining ATR Advances

## Key Concepts

- Sustainability has two meanings in ATR: 1) obtaining funds for continued operation after the grant ends and 2) implementing elements of ATR more broadly throughout your jurisdiction's system of care.
- To achieve either type of sustained operation, you will need to demonstrate that the project, or elements of it, warrant continuation. The evidence you need will come from the ATR data you collect throughout the implementation phase.
- Stakeholders' embrace of the project or portions of it will also be important; their input can help guide your decisions.
- If you wait until the closeout phase of your grant to start your sustainability initiative, it will be too late. As with any system change, continuing ATR or incorporating program elements into the broader system of care will take time and careful planning to prepare everyone involved for the change.
- To continue ATR or elements of it without interruption, planners in your jurisdiction will need time to ensure compliance with regulations and gain all necessary approvals, as well as to prepare system components that will be affected by the implementation of new policies and program features. Your planning should be near completion by the time you begin phase 3.
- Some ATR grants have relied on project data and stakeholder contributions to justify the continuation of their projects after Federal funding ended or to implement elements of ATR throughout their jurisdictions.

After their grants ended, a number of jurisdictions have funded the continuation of ATR or implemented ATR-like elements within their systems of care. These jurisdictions have seen evidence that such changes improve system performance, save money, and—most importantly—lead to improved outcomes for clients and communities. You may see this yourself as you start to get results from your project.



Your ATR grant provides the opportunity to test client-centered, recovery-oriented treatment and recovery support services (RSS) and keep internal and external

stakeholders informed about your progress and accomplishments.

The suggestions throughout the toolkit for sustainability activities are based on experiences in current and former ATR projects and jurisdictions. For previous grant cohorts, the continuation of ATR after Federal funding ended or the spread of ATR elements and approaches beyond ATR has been facilitated by two major factors:

1. The ATR projects regularly shared information on their activities, progress, and data with jurisdictional officials and programs, and with community and institutional stakeholders.
2. They designed and emphasized the use of processes not only for informing community and institutional stakeholders about ATR but also for gathering feedback and guidance from them.

As a result of these two factors, the system of care and community stakeholders had time to learn about and develop support for ATR's client-centered approach to helping clients achieve long-term recovery. As positive findings about ATR success began to accumulate toward the end of year 2 of the project, a climate of acceptance grew.

Introducing change, such as new elements of care, into long-standing systems takes time. You can help pave the way for change by getting information about ATR success to system personnel and the community early and often. Reporting these findings as early as possible and following up with regular reports, while working with community stakeholders to incorporate their useful ideas, prepares the way for sustaining the best parts of ATR after the project ends.

In fact, many stakeholders will be eager to work with you and provide ideas, feedback, and advice. A diverse group of selected stakeholders can be a vital part of your sustainability initiative. The reality is that your project management team members are busy enough planning and managing your ATR project—they do not have time to lead sustainability planning. A properly prepared stakeholder group can assume responsibility for observing project operations, reviewing data as they are generated, and making suggestions to the State or tribal authority and the project about elements to sustain. Such a group might be coordinated by a staff member in the SSA or a tribal official.

## Stakeholders' Contributions to Sustainability

ATR projects have used numerous approaches to getting support from stakeholders in the community, existing institutions, and throughout the system. Successful approaches include:

- Gaining the vocal support of influential members of the Single State Authority or tribal authorities for ATR and ROSC.
- Consistent presentation and dissemination of information about ATR to officials and personnel in jurisdictional programs, other institutions in the community, and consumers' and other stakeholder groups.
- Establishing a method for obtaining stakeholder support for sustainability through activities such as:
  - Meeting regularly with diverse stakeholders to ascertain how well the ATR project is meeting their needs.
  - Creating stakeholder groups to regularly provide ideas and feedback on project operations and service delivery.
  - Holding focus groups with representative stakeholders to identify ATR successes and their assessment of client-centered care introduced by ATR.
  - Holding public town hall meetings throughout the community.
  - Conducting focus groups with long-term clients or those who have completed the course of ATR services.
  - Selecting representatives of diverse stakeholder groups to constitute a strategic advisory group that helps plan for sustaining appropriate elements of ATR within the jurisdictional system. Members could represent the State or tribal authority, clients, consumer advocates, family members, other institutions such as public health or corrections, and treatment and recovery support services providers.
  - Creating regional, district, or county stakeholder groups; communicating with them regularly about ATR progress; and obtaining their input on the value and potential continuation of ATR elements after the project ends.
  - Other approaches your ATR project will identify and creatively develop.

These groups might be coordinated by an ATR project staff member from the State or tribal authority who does not have direct project responsibility.

## Sustainability Means Preparing for More Change

By preparing throughout your grant to sustain successful elements of ATR in other portions of your jurisdictional system, you will make it possible for system officials to take the needed steps to make such a change. For example, regulatory changes and State or tribal requirements must be considered and system staff must be prepared. You can't assume that others will simply adopt something that you have had 4 years to learn about.

Think of your ATR grant as a means to move toward long-term change in your jurisdictional system. The grant allows you to incorporate new program and system elements, while collecting data that demonstrate the benefits of new services in a client-directed system. By preparing for sustainability throughout your project, your team and your community partners will help ensure longevity for proven ATR advances.

This chapter is intended to help you begin the sustainability process in phase 1, by planning how to:

- Gain buy-in for ATR concepts among all stakeholders, from top officials to consumer advocates.
- Work with community stakeholders who can assist in the sustainability effort.
- Use your project data to verify the rationale for continuing the project or implementing ATR elements more widely.
- Conduct fundamental sustainability activities appropriate to this phase of the grant.



Sustainability planning also includes taking measures to ensure that providers' services are still needed after the ATR grant ends and helping providers to be prepared to continue their operations.



Continuing ATR or adding elements such as care coordination and recovery support services to other parts of your system of care can help your State or tribe build a recovery-oriented system of care (ROSC). The White House Office of National Drug Control Policy has endorsed ROSC, especially as implemented by ATR.

# Section 1. Building sustainability by keeping stakeholders informed and involved

## Goals

- Understanding the need to begin sustainability planning at the outset of your ATR project.
- Recognizing the importance of data in validating the need to sustain the project or elements of it within your jurisdictional system.
- Recognizing the importance of stakeholders in sustainability planning.
- Developing transparency as a means for gaining stakeholder support and ensuring success in sustainability planning.
- Understanding the role stakeholders can play in planning for the future.

## Themes

- Making sustainability a priority from day 1 is essential to the long-term success of your ATR project.
- There is a clear link between sustainability and data pertaining to performance and client outcomes. These data can reveal improved delivery of client-centered care that supports long-term recovery.
- Communicating the findings from data analysis throughout your jurisdictional system of care and among stakeholder groups builds their support for the ATR project and for its most successful elements.
- You can also build stakeholder support for ATR just by keeping them informed about your successful performance and outcomes.

## Considerations for success

- Start creating a sustainability plan as soon as you receive your ATR grant.
- Make it a priority to respond quickly and openly to community and stakeholder concerns. This will earn respect for and trust in ATR.
- A stakeholder advisory group that is not part of the project team can be created to assess ATR's successes and the project itself and make recommendations for sustaining successful elements in the future.
- As data begin to accumulate, provide stakeholders with all the help they need to help you “sell” client choice and recovery support services to the community and the State or tribal system.

## 1

## How will we communicate with stakeholders to build their support for ATR?

Consider the following questions.

1. What sustainability considerations are important during our start-up phase?

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2. What benefits can our system of care and the community gain from ATR?

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3. In our system of care and in the community, is there general understanding and acceptance of ATR's client focus and our goal of expanding capacity to include recovery support services? Who are the key internal and external supporters of ATR in the following stakeholder groups?

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### Internal

- SSA or tribal authority staff?

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- Program directors and staff?

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- ATR project staff (finance, IT, and service coordinators; referral, intake, and assessment staff)?

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- ATR treatment and RSS providers?

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- Referral organizations?
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External

- Clients and alumni?
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- Advocacy groups?
- 
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- Families?
- 
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- Institutions (e.g., courts and corrections, public health, community health programs, housing and employment services, family services)?
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- Recovery community organizations?
- 
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- Faith-based organizations?
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- Businesses?
- 
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- Others?
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4. How will we share data or information on ATR performance and outcomes with these stakeholder groups throughout the grant?

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5. Who will develop plans for stakeholder communications and start the process?

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The ATR III application request encouraged you to “include a broad range of stakeholders in planning and designing” your proposal. That group can evolve to provide ideas and feedback on sustainability.

## Tapping into stakeholder resources

Consider the following questions.

1. How can we obtain a broad representation of stakeholders to help us plan for sustainability? Can we recruit representatives of the stakeholder groups identified in Worksheet 1? From other important segments of the community?

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2. How will we ensure that diverse stakeholder representatives understand the three main goals of ATR—client choice among treatment and recovery support services, expansion of services to include a wide array of both types of services, and increased SUD system capacity?

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3. What types of responsibilities do we want to give to stakeholders that will help us pave the way for sustainability?

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4. Who will be responsible for recruiting stakeholders and coordinating their sustainability activities?

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Consider asking community and stakeholder groups—such as the community advisory committee to the State or tribal jurisdiction or another group of stakeholders formed to assist with your ATR proposal—to continue to serve in the capacity of sustainability advisors.

5. How will we achieve transparency in our sustainability effort?

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The SSA director, tribal officials, governor, and State legislators can work with stakeholders to help ensure that ATR advances are made permanent.



“We built support for sustainability by identifying one person in each of the counties we served and giving that person responsibility for keeping everyone informed about ATR progress. If people in your system aren’t kept in the loop, they won’t support continuation of ATR or implementation of ATR features within the State system. You have to give someone responsibility for sharing the information.

“As a result of keeping every county informed, we were able to easily incorporate ATR features into our State system before the grant ended.”

—An ATR Project Director

WORKSHEET  
**3**

## Who should be involved and how will they help us plan for sustainability?

*Consider the following questions.*

1. Considering the list of potential stakeholders in Worksheet 1, can we actually recruit stakeholders to assist us in planning for sustainability? What particular role could each play as sustainability advisors?

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2. What role can be played by State or tribal system directors or members of their staff to ensure top-level leaders are involved in sustainability activities with the stakeholders?

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3. What roles and responsibilities will we ask the stakeholders to assume? (Possibilities: Assuming responsibility for observing project operations, reviewing data as they are generated, and making suggestions to the State or tribal authority and the project about elements to sustain. Don't limit yourself to these.)

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4. What influential individuals in our State or tribe do we need to include in the stakeholder group?

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The involvement of community residents and advocates on a committee, along with influential community leaders from the business or professional communities, can create a rich dynamic and build community support for sustaining the best portions of ATR after the grant ends.

5. What kinds of data will we routinely provide to stakeholders?

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6. What do we need to do to recruit an appropriate number of stakeholders by the end of phase 1?

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7. What activities can we conduct to fully engage them from the start?

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Appendix:  
ATR Grant Contributors



# ATR Grant Contributors

This Toolkit could not have been produced without the many contributions of the ATR grant project staff in the second cohort of grants who reported on their experiences over 3 years of project implementation. In addition, a number of grant project directors and key staff provided information in a series of interviews conducted at the time of the final Grantee Meeting in 2010:

- Rex Alexander, MS, Illinois Pathways to Recovery
- Rebecca Boss, MA, Accessing Recovery in Rhode Island
- Alicia Clark, Ohio Choice for Recovery
- Vincent Collins, MSW, Washington Access to Recovery Program
- Angela Cornelius Dawson, LPC, MRC, MS, Ohio Choice for Recovery
- Marie DiBianco, MSW, New Mexico Access to Recovery
- Kevin Gabbart, Access to Recovery—Iowa
- John Gastorf, PhD, Cherokee Nation Many Paths
- Charlene Gradney, MSW, Louisiana ATR
- Robert Gurule, New Mexico Access to Recovery
- Mindy Hale, New Mexico Access to Recovery
- Sheri Jackson, Texas ATR II
- William Halsey, MSW, MBA, Connecticut Access to Recovery II
- Sue Heavens, California Access to Recovery Effort (CARE) Program
- Aneska Schwenter, Circle of Recovery, Alaska Southcentral Foundation
- Eric Scott, Indiana Access to Recovery
- Chuck Sigurdgson, Milwaukee Wiser Choice, Wisconsin
- April Stewart, Tennessee ATR II
- Bernie Strand, MSW, Hawaii Access to Recovery Project
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