ACCESS TO RECOVERY (ATR) PROGRAM

SUPPORTING STATEMENT

A. JUSTIFICATION

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is requesting a revision from the Office of Management and Budget for the three Access to Recovery (ATR) Program data collection tools:

1. Voucher Information Form – no change (OMB 0930-0266, Expiration Date 5/31/08);

2. Voucher Transaction Form –additional question which will allow CSAT to report on faith-based providers, an important component of the ATR program (OMB 0930-0266, Expiration Date 5/31/08).

3. Replace the current ATR data collection instrument (OMB 0930-0266, Expiration Date 5/31/08) with the CSAT Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs instrument (OMB 0930-0208 (Expiration Date 06/30/2010)).

The authorizing legislation for the ATR program can be found in sections 501 (d)(5) and 509 of the Public Health Service Act (42 U.S.C. sections 290aa(d)(5) and 290bb-2).

The convergence of numerous forces that demand increased cost-effectiveness and accountability has created an opportune time to work toward transforming the behavioral health delivery systems for adults and children with substance use and mental disorders. On March 4, 2004, SAMHSA announced the first Access to Recovery (ATR) Presidential initiative: $100 million in grants to 14 States and 1 Tribal Organization supporting the design and implementation of community-based service delivery systems in which a voucher is the method of payment. The initiative continued in 2007 with the awarding of 24 grants which included 1 Tribal Organization. A copy of the Access to Recovery Request for Applications (RFA) Announcement can be found in Attachment A.

The essence of the ATR program is the use of a voucher system. This approach represents a significant change from the way substance abuse services are typically delivered. For ATR, vouchers assure client choice from an expanded array of service providers, thereby fostering healthy competition that is expected to result in more efficient use of public resources and improved results. Further, ATR requires the integration of evidence-based practices, a systematic federal scrutiny of outcomes through the Government Performance and Results Act (GPRA) of 1993 (OMB No. 0930–0208), and the provision of incentives for high-performing providers. GPRA mandates accountability and performance-based management by Federal agencies. The

GPRA focuses on results or outcomes in evaluating the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives. All SAMHSA grantees must comply with GPRA data collection and reporting requirements.

ATR is also based on the knowledge that there are many pathways to recovery from addiction. ATR ensures the availability of a full range of treatment options and other recovery support services, including the transforming power of faith. Through the ATR grants, grantees have flexibility in designing and implementing a voucher program to meet the needs of clients in the State. The key to successful implementation of the voucher programs supported by the ATR grants will be the relationship between the grantees and clients receiving services. This will ensure that clients have a genuine, free, and independent choice among eligible providers. Grantees were encouraged to support any mixture of clinical treatment and recovery support services to accomplish the program's goal of achieving cost-effectiveness and successful outcomes for the largest number of people. The grantees proposed a broad range of innovative services, approaches, and target populations.

According to the RFA, grantees are expected to:

- Conduct significant outreach to a wide range of new service providers
- Develop an eligibility system for new providers and maintain up-to-date lists of all eligible providers
- Develop assessment, level of care determination, and referral processes
- Be accountable for service outcomes

Under ATR, clients will be assessed and will be given a voucher for identified services along with a list of appropriate service providers from which to choose. The RFA specified that to be eligible for voucher reimbursement, clinical treatment and recovery support programs should meet standards that are required by the State for other providers that render the same type of services, (e.g., residential, outpatient, family support services, etc.)

2. Purpose and Use of Information

SAMHSA will assess outcomes for the ATR program through the National Outcome Measures (NOMs) for substance abuse treatment that SAMHSA has developed. Grantees will be required to report performance in several areas relating to the client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice status. Grantees must collect and report data using the CSAT GPRA Client Outcome Measures for Discretionary Programs tool (Attachment B). There are two other tools grantees are responsible for reporting to CSAT: the voucher information tool and a voucher transaction tool that are in Attachment D. Grantees use the voucher information tool to report the amount for which the voucher was issued, and the voucher transaction tool is used to report the amount for which a specific provider redeemed the voucher. These two tools are used primarily for tracking the status of each voucher that is issued to an ATR client. It is important to note that

these two tools are not asked of the client. It is the responsibility of program staff to report this programmatic information.

The purpose of the ATR outcomes data is for program monitoring. ATR grantees must report financial and outcome data to SAMHSA on a routine basis. Financial data will be used to monitor costs and to ensure funds are appropriately used. Outcome data will be used to measure the success of clinical treatment and recovery support services. These data will ultimately measure the success of the voucher program.

Outcome data reflect the Agency's desire for consistency in data collected within the Agency. SAMHSA has implemented specific performance domains called National Outcome Measures (NOMs) to assess the accountability and performance of its discretionary and formula grant programs. These domains represent SAMHSA CSAT's focus on the factors that contribute to the success of substance abuse treatment. The CSAT domains include clients who are adults and children/adolescents under age 18 years. The CSAT GPRA Client Outcome Measures for Discretionary Programs will address the following performance domains:

- Abstinence from Drug / Alcohol Use
- Employment / Education
- Crime and Criminal Justice
- Family and Living Conditions
- Social Connectedness
- Access / Capacity
- Retention
- Cost effectiveness information is taken from the grant application.

SAMHSA uses the performance measures to report on the performance of its discretionary services grant programs. The performance measures information is used by individuals at three different levels: the SAMHSA administrator and staff, the Center administrators and government project officers, and grantees:

SAMHSA Level—The information is used to inform the administration of the performance of the programs funded through the Agency. The performance is based on the goals of the grant program and includes the NOMs. This information serves as the basis of the annual GPRA report to Congress contained in the Justifications of Budget Estimates.

Center Level—In addition to exploring the performance of the various programs, the information is used to monitor and manage individual grant projects within each program. The information informs the government project officers of the projects staff's abilities to meet their individual goals. The information has been used by government project officers to make funding continuation decisions.

Grantee Level—In addition to monitoring performance outcomes, the grantee staff uses the information to improve the quality of treatment and prevention services that are provided to clients within their projects.

SAMHSA and each of its Centers will use the data for annual reporting required by GPRA and for NOMs comparing baseline with discharge and follow-up data. GPRA requires that SAMHSA's report for each fiscal year include actual results of performance monitoring for the three preceding fiscal years. The additional information collected through this process will allow SAMHSA to report on the results of these performance outcomes as well as be consistent with the specific performance domains that SAMHSA is implementing as the NOMs, to assess the accountability and performance of its discretionary and formula grant programs. The CSAT client-level data items were initially identified from widely used data collection instruments (i.e., the Addiction Severity Index [ASI]; the 2000 National Household Survey on Drug Abuse; the McKinney Homeless Program reporting system; and the Risk Assessment Behavior Battery.)

Attachment B is a matrix showing the interrelationships among the SAMHSA goals and data items, and identifies the source of the items. There are no changes requested.

Among the measures delineated in SAMHSA's annual, fiscal year GPRA Plan are a core set of client/participant outcome measures to be applied, as appropriate, to all of SAMHSA's discretionary grant programs providing client services, including ATR. SAMHSA has established these standardized client outcome measures in order to capture this essential client level information. The data set collected under this approval comprises items typically collected by substance abuse prevention and substance abuse treatment providers at the client level. The measures for the agency that are the subject of this information collection, CSAT, are presented here.-

CSAT: Substance Abuse Treatment Measures

1. Over the past year, the percentage of adults:

a) Who were currently employed or engaged in productive activities increased for those receiving services compared to the national average or project baselines.
b) Who had a permanent place to live in the community increased for those receiving services compared to the national average or project baselines.
c) Who had reduced involvement with the criminal justice system increased for those receiving services compared to the national average or project baselines.
d) Who had no past month use of illegal drugs or misuse of prescription drugs increased for those receiving services compared to the national average or project baselines.
e) Who increased retention in the program/services compared to the national average or project baselines.
f) Who increased social connectedness to family and friends compared to the national average or project baselines.
g) Who increased access to services compared to the national average or project baselines.

An additional measure is for those adults:

Who experienced reduced alcohol or illegal drug related health, behavior, or social consequences (including the misuse of prescription drugs), increased for those receiving services compared to the national average or project baselines.

2) Over the past year, the percentage of children/adolescents under age 18:

a) Who were attending school increased for those receiving services compared to the national average or project baselines.
b) Who were residing in a stable living environment increased for those receiving services compared to the national average or project baselines.
c) Who had no involvement in the juvenile justice system increased for those receiving services compared to the national average or project baselines.
d) Who had no past month use of alcohol or illegal drugs (population data limited to 12 through 17 year olds) increased for those receiving services compared to the national average or project baselines.
e) Who increased retention in the program/services compared to the national average or project baselines.
f) Who increased social connectedness to family and friends compared to the national average or project baselines.
g) Who increased access to services compared to the national average or project baselines.

An additional measure is for those children/adolescents under age 18:

The percentage of youth (population data limited to 12 through17 year olds) who experienced no substance abuse related health, behavior, or social consequences increased for those receiving services compared to the national average or project baselines.

3) Retention in the program—determines the percentage of clients who completed the program or who left the program before completion and their status (discharge status).

4) Types of services received while in the program—which will show the percentage of clients in the different types of treatment modalities.

5) Did clients seek help from self-help groups to support their recovery?

By design, ATR outcome data are consistent with the performance outcome domains that SAMHSA is implementing to assess the accountability and performance of its discretionary and formula grant programs. In addition, these same domains will be used by SAMHSA to meet the reporting requirements of the GPRA.

Data expectations for each domain were provided in the ATR RFA. The grantee's ability to demonstrate improvement in the domains listed above will be a factor in determining grantee-funding levels in years occurring after year one of each grant.

Data emerging from this program will be supportive of many of the new initiatives that are being implemented by CSAT. This is to encourage the substance abuse treatment system to become more responsive and bridge the gap between what is needed by individuals, States, localities, and/or Tribal Organizations and what is known about effective treatment services to meet those needs. Information will be made available regarding the process of establishing and maintaining linkages among State, local, and private agencies with whom the grantees coordinate in order to provide services. The findings from this data collection effort will be useful as grantees seek support from other sources once their CSAT funding expires. It is expected that the information collected will have particular value to the ATR grantees, Federal, State, Tribal Organizations, local governments, and the private sector as well.

SAMHSA has established these standardized client outcome treatment measures for its ATR grant program in order to capture this essential client level information. The data set for which approval is sought comprises items at the client level at intake, 6 months post-intake, and at discharge. Grantees also are required to report information on the vouchers that are distributed to the clients. The data obtained will be used to assess changes in client outcomes as a measure of performance by programs. The CSAT Client Outcome Measures for Discretionary Programs can be found in Attachment C (The aforementioned Attachment B contains a matrix that identifies the source of each item.)

There are ten sections that comprise the CSAT Client Outcome Measures for Discretionary Programs:

A. Record Management and Demographics
B. Drug and Alcohol Use
C. Family and Living Condition
D. Education, Employment, and Income
E. Crime and Criminal Justice Status
F. Mental and Physical Health Problems and Treatment/Recovery
G Social Connectedness
H. (No Section H)
I. Follow-up Status
J. Discharge Status
K. Services Received

Section A: Record Management and Demographics – pertains to both grantee and client identification information. (This section is completed by ATR providers at the intake/baseline interview.) In addition to collecting identification information, this section gathers information about treatment modality, treatment services, case management services, medical services, after care services, education services and peer-to-peer support services. Demographics are collected only at intake/baseline and records gender, ethnicity (if Latino or Hispanic), race, and month and year of birth.

Sections B through G are reported at every data collection point (intake, 6 months post-intake, and discharge).

Section B: Drug and Alcohol Use – asks the client questions regarding his/her use of alcohol and drugs (cocaine, opiates, non-prescription methadone, hallucinogens/psychedelics, or methamphetamines, etc.) during the past 30 days, and the route of administration.

Section C: Family and Living Condition – aims to ascertain where the client has been living for the past 30 days, and whether the client has lost his/her parental rights to any of his/her children. In addition, questions in this section ask about the impact of alcohol or other drugs on stress levels, impact on participation in important activities, or if alcohol or drugs caused emotional problems.

Section D: Education, Employment, and Income – gathers information regarding the client's education and employment status. An additional question asks how much money the client received in the past 30 days from sources such as wages, public assistance, retirement and disability.

Section E: Crime and Criminal Justice – asks the client to describe his/her criminal justice status during the past 30 days. Other questions also ask whether client is awaiting charges, trial or sentencing, and whether the client is currently on parole or probation.

Section F: Mental and Physical Health Problems and Treatment/Recovery –asks whether the client has received, in the past 30 days, inpatient treatment, outpatient treatment or emergency room treatment for physical complaints, mental or emotional difficulties, or alcohol or substance abuse. There are questions about sexual contacts, and whether the client experienced serious depression, anxiety or tension, and hallucinations.

Section G: Social Connectedness – asks the client about his/her attendance at voluntary self-help groups during the past 30 days, and who the client turns to for support.

[Section H: There is no Section H.]

Section I: Follow-up Status – reported by program staff about the client only at follow-up. It is the last section in a follow-up interview, consisting of two questions about completion status, ability to locate, or follow-up refusal, and whether the client is still receiving services from the program.

Section J: Discharge Status – is reported by program staff about the client only at discharge. Two questions indicate the date of discharge and completion or termination status.

Section K: Services Received – completed by the providers at the discharge data point; records information about the services the client received since the client's latest interview including modality, treatment services, case management services, medical services, after care services, education services, and peer-to-peer recovery support services.

There are two other ATR tools that grantees use to report to CSAT: the Voucher Information (VI) tool and a Voucher Transaction (VT) tool, both are contained in Attachment D. These two tools are used primarily for tracking the status of each voucher that is issued to an ATR client

and the services planned for that client. The information collected on these two tools is not asked of the client; it is the responsibility of program staff to report this programmatic information.

Changes in Data Collection Tools

The Voucher Information Tool is unchanged.

One question has been added to the previously approved Voucher Transaction tool which asks if the provider is a faith-based provider. A major part of the ATR program requires that grantees recruit, train and utilize faith-based providers to serve clients, and grantees are required to report if an organization is faith-based. The faith-based identification is part of the provider ID. Adding a question on the Voucher Transaction tool will eliminate the burden of remembering to add the indicator to the first two characters of the ID.

CSAT requests replacement of the current ATR data collection instrument (OMB 0930-0266 Expiration Date 5/31/08) with the CSAT Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs instrument (OMB 0930-0208 (Expiration Date 06/30/2010)).

3. Use of Information Technology

Information will be obtained by providers using paper-and-pencil, as is the generally accepted assessment technique within treatment/service settings. Providers will then enter the client-level information into their State/Tribal Organization data management system directly or into CSAT's GPRA web system.

A web-based data collection and entry system has been developed through CSAT and is available to all programs for data collection. This web-based system allows for easy data entry, submission, and reporting to all those who have access to the system. Copies of the CSAT screens that data entry staff see when entering data are in Attachment E. Levels of access have been defined for users based on their authority and responsibilities regarding the data and reports. Access to the data and reports is limited to those individuals with a username and password.

If the grantees enter the data into their own system, the data will have to be electronically transmitted to CSAT. These programs submit their data electronically through an upload process. This facilitates the submission of data while avoiding duplication of the data entry process. Programs that collect these data for other purposes are spared the additional collection burden.

Electronic submission of the data promotes enhanced data quality. It is expected that grantees will have data quality checks incorporated in their data systems. CSAT's own system reviews each data set submitted electronically and returns all data sets that contain errors to the grantee, along with a report that identifies the nature and location of specific errors. With built-in data quality checks, easy access to data outputs and reports, users of the data can feel confident about the quality of the output. The electronic submission also promotes immediate access to the

dataset. Once the data are put into the web-based system, it is available for access, review, and reporting by all those with access to the system from Center staff to the grantee staff.

4. Effort to Identify Duplication

The items collected on the ATR tools are a necessary component of the ATR Program in order to assess grantee performance and are not available elsewhere. Many of the questions can be transferred from a State/Tribal Organization's data management system as long as they are the exact same question and the data collection time points are the same.

5. Involvement of Small Entities

Individual grantees are States and an Indian/Tribal Organization. Each of the grantees will utilize some small entity providers to provide treatment/services to the clients, however, there is no significant impact involving the small entities.

6. Consequences if Information Collected Less Frequently

The ATR grantees are required to collect information at intake, 6 months post-intake and at discharge. The intake and discharge data collection points are part of every grantee's regular program activity. However, to help determine change in behavior grantees will be required to collect the information 6 months post-intake. If ATR grantees do not collect the data at the aforementioned data points, this may decrease the response rates for the initiative and lower the value of the data for GPRA use, in particular, by losing measurement of intermediate and long-term effects.

7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

This information collection fully complies with 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required by 5 CFR 1520.8(d) was published in the *Federal Register* on November 2, 2007 (72 FR 62248). No comments were received.

9. Payment to Respondents

Grantees will be expected to achieve a minimum response rate of 80 percent for all follow-up interview efforts and are asked to budget for data collection in their grant applications. Individual grantees are not prohibited from providing payments to their respondents for follow-up, which is customary practice in the field. Substance abusers are typically a harder-to-reach population for whom out-of-pocket costs of participation (e.g., transportation, child care) are significant barriers. If the grantees do provide payment for the follow-up, the maximum incentive is $20.00 or the equivalent in coupons, transportation tokens, or other items per follow-up.

Survey research literature suggests that monetary incentives have a strong positive effect on follow-up response rates in this population and no known adverse effect on reliability.

10. Assurance of Confidentiality

SAMHSA has statutory authority to collect data under the Government Performance and Results Act (Public Law 1103(a), Title 31) and is subject to the Privacy Act for the protection of data. Substance abuse treatment providers are subject to the federal regulations for the confidentiality of alcohol and substance abuse patient records (42 CFR Part 2), (OMB No. 0930-0092) which govern the protection of patient-identifying data. In some cases, these same providers meet the definition of a HIPAA-covered entity and are additionally subject to the Privacy Rule (45 CFR Parts 160 and 164) for the protection of individually identifiable data.

SAMHSA and its contractors will not receive identifiable client records. Provider-level information will be aggregated to, at the least, the level of the grant/cooperative agreement-funding announcement.

Grantees and all other potential respondents will be assured that protection of individually identifiable data is maintained throughout data collection (to the extent permitted by law). All data will be closely safeguarded, and no institutional or individual identifiers will be used in reports. Only aggregated data will be reported.

SAMHSA/CSAT or its contractors will maintain no records containing personal identifiers. Before submitting these data to CSAT, grantees will be instructed to delete all personal identifiers (such as names, addresses, phone numbers, Social Security numbers, medical record numbers, etc.) from the data files. The grantees also will be directed to assign a unique identifier to each client that does not overtly identify the client. This identifier will enable the contractor to keep track of individual client records in the absence of personal identifiers, and to link client records over the course of the repeated submissions per client that will take place as part of the data collection process. Participation in all of the studies is voluntary and a client identifier will identify all information provided by participants only. The participant's name will not appear with any of the data collected and no names or other identifiers will be linked to the data. ATR has been determined by the CSAT Director to fall under the SAMHSA Participant Protection Procedures. These procedures require each applicant to the RFA to provide information which will be used to determine whether the level of protection of human subjects appears adequate or whether further provisions are needed according to standards set forth in 45 CFR 46.

Adequate protection of human subjects is an essential part of an application and was carefully reviewed by the grant review panel. Applicants must have reported any foreseeable participant protection risks and the procedures developed to protect participants from those risks. Applicants must describe the selection of participants, consent procedures, privacy and confidentiality procedures, and data collection including from whom the data will be collected, the form of specimens, records, or data. In addition, applicants must include a discussion of why the risks to subjects are reasonable in relation to the anticipated benefits to subjects and in relation to the importance of the knowledge that may reasonably be expected to result. The applications were

also examined by a Federal Project Officer to determine whether these procedures are being met. The Project Officer works with applicants when the review panel has concerns or comments in order to enable award.

The ATR program will comply with applicable Federal and State laws and with ethical principles in the collection of information from and about persons enrolled in, or related to persons enrolled in, treatment. Among the rights commonly held for these types of programs are:

1. The right of informed consent, which requires the clinical staff to provide sufficient information about the study's objectives, level of burden, and uses of participants' information so that individuals may make an informed decision on participation;

2. The right to refuse to participate, which applies to the individual's right to decline to participate at all in the study or to decline to answer specific questions without penalty or loss of benefits; and

3. The right to privacy, which guarantees against invasions of privacy as well as the specific protections provided by the Privacy Act of 1974.

11. Questions of a Sensitive Nature

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society. In carrying out this mission it is necessary for service providers to collect sensitive items such as criminal justice involvement, use of alcohol or other drugs, as well as issues of child custody, sexual contacts and mental health. The data that will be submitted by each grantee will be based in large part on data that most of the programs are already routinely collecting. This primarily includes data on client demographics, substance abuse and treatment history, services received, and client outcomes. These issues are essential to the service/treatment context. Grant projects use informed consent forms as required and as viewed appropriate by their individual organizations (see Attachment F for a Sample Consent Form); they use the appropriate forms for minor/adolescent participants requiring parental approval. Client data are routinely collected and subject to the Federal Regulations on Human Subject Protection (45 CFR Part 46; OMB No. 0925-0404). Alcohol and drug abuse client records in federally supported programs are also protected by 42 CFR Part 2.

12. Estimates of Annualized Hour Burden

The total amount of time that is estimated for completion of the client interview, record management by provider staff and extract and upload by the grantees is 46,251 hours. The annualized hourly costs to respondents are estimated to be $977,717. The burden estimates, summarized in the following table, are based on the reported experience of CSAT grantees and contractors in compiling, completing, and reporting similar data to CSAT. As estimated for SAMHSA's Treatment Episode Data Set (TEDS) (OMB No. 0930-0106), more senior staff

(average salary of $25/hour) are expected to handle the data extraction and upload submission. The wage rate is estimated at $15.90 for provider staff who will conduct the ATR data interviews and the staff who will provide the voucher record management.

Annual Reporting Burden[1]

Center/Form/ Respondent Type	Number of Respondents	Responses Per Respondent	Total Responses	Hours Per Response	Total Hour Burden	Added Burden Proportion[2]	Total Annual Burden Hours	Total An Hour C Respond
CSAT GPRA Client Outcome Measures for Access to Recovery Programs								
Clients								
Adults	53,333	3	160,000	.33	52,800	.33	17,424	$277,
Client Subtotal	**53,333**		**160,000**				**17,424**	**$277,**
Data Extract[4]								
Adult Records	53,333	3	160,000	.16	25,600	--	25,600	$640,
Data Extract Subtotal	**53,333**		**160,000**				**25,600**	**$640,**
Upload[5]	24 grants	3	160,000	1 hr. per 6,000 records	27	--	27	$
Upload Subtotal	**24 grants**		**160,000**				**27**	**$**
ATR Voucher Information and Voucher Transaction								
Voucher Information and Transaction[6]	53,333	2	106,666	.03	3,200	--	3,200	$80,
Voucher Information and Transaction Subtotal	**53,333**		**106,666**				**3,200**	**$80,**
TOTAL	**160,000**		**586,666**		**81,627**		**46,251**	**$997,**

NOTES:

[1] This table represents the maximum burden if adult/adolescent respondents provide three sets of responses/data.

[2] Added burden proportion is an adjustment reflecting customary and usual business practices programs engage in (e.g., they already collect the data items).

[3] Estimates based on $15.90 for program staff (interviews and record management) and $25.00 for IT (extraction and upload).

[4] Data Extract: Grant burden for capturing customary and usual data for GPRA and vouchers.

[5] Upload: This represents the maximum burden if all ATR grants upload GPRA and voucher data.

[6] It is estimated that 1 voucher information and 1 voucher transaction form per client will be completed annually.

The estimates in this table reflect the maximum annual burden for currently funded ATR programs. The number of participants served in following years is estimated to be the same assuming level funding of the ATR programs, resulting in the same annual burden estimate for those years.

Client Data Collection

There are 63 items (including record management) in the CSAT Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs instrument, which will take approximately 20 minutes per client to administer at each of there data collection points. However, 42 of the items are taken from the Addiction Severity Index (ASI), which is used in the substance abuse treatment field by researchers and providers as a baseline and follow-up instrument, or are considered standard items in the file. The resulting Added Burden Proportion is then (63 – 42) / 63, or .33.

Record Management by Provider Staff

The Voucher Information and Voucher Transaction forms describe the voucher received by the client (voucher ID, voucher amount, voucher amount redeemed, voucher service type, etc.) are completed by project staff. Reporting this information should take approximately 2 minutes. Although one item has been added to the Voucher Transaction tool, the time to check the faith-based indicator box will not increase the form completion time.

Grantee (State/Tribal Organization) Extracts and Uploads

Grantees are responsible for extracting GPRA data from their voucher management system and electronically uploading both the GPRA and Voucher data to CSAT. It is estimated that extracting and uploading of these data to CSAT should take 2 minutes per upload.

13. Estimates of Annualized Cost Burden to Respondents

There are neither capital or startup costs nor are there any operation and maintenance costs to respondents.

14. Estimates of Annualized Cost to Government

The principal additional cost to the government for this project is the cost of a contract to collect the data from the various programs and to conduct analyses which generate routine reports from the data collected. The reports examine baseline characteristics as well as the changes between baseline, discharge and each of the follow-up periods. It is the responsibility of the contractor to work with the Government Project Officer (GPO) when preparing reports that combine the client data with the annual reports of the project.

The estimated annualized cost to CSAT for a contract for the ATR GPRA mandate is $1.2 million and the cost of 1 FTE staff (25 percent for the midpoint of one GS-14 $25,899 and 75 percent for one GS-12 $48,786) responsible for the ATR data collection effort is approximately $74, 685 per year.

15. Changes in Burden

Currently, there are 81,318 total burden hours for this data collection. The Program is requesting 81,627 burden hours, an increase of 309 hours. This increase is due to a program change that is the result of the GPRA tool that takes about 5 minutes longer to complete than the former ATR data collection instrument.

16. Time Schedule, Publication and Analysis Plans

16. a. Time Schedule

The ATR program is funded for 3 years. Data for the annual GPRA plan/report are needed by SAMHSA by no later than September each year. The ATR programs will provide their data to CSAT within 7 business days from receiving the data. ATR will be included in the annual SAMHSA Budget Justification report that must be submitted to the Department and to OMB by September and is released to the public February 1st.

The annualized schedule below shows when activities will occur for the ATR program.

Conduct site visits to grantees	Month 1-2
Conduct training of trainers for providers on data collection	Month 1-2, ongoing
Receive and process data from grantees	Month 3 and then daily
Verification of findings with grantees	Month 3 and then daily
Data analysis	Month 3, ongoing

16. b. Publication Plans

Client outcome data and voucher data will be collected through the States/Tribal Organizations from each ATR provider. Data will be used to report to Congress regarding the program performance as specified in the SAMHSA Budget Justification report. In addition, presentations will be made at grantee meetings at which time aggregate data will be provided about the performance of the entire grantee portfolio.

16. c. Analysis Plans

The data from this activity will be used to provide monitoring and oversight on the performance of the grantees. (Note: there will be an Evaluation of ATR under a separate procurement. A separate OMB package will be submitted for approval for the required data collection necessary for that evaluation.) For program monitoring, the ATR data will primarily be analyzed for two purposes: descriptive information and outcomes.

The descriptive analysis primarily will utilize frequency distributions and counts from intake data collected as part of the admission process in order to address such questions as:

1) How many clients were seen in this program?
2) What were the demographic characteristics of the clients seen in this program?
3) Dollar amount of vouchers issued to individuals and for what services?
4) What were the characteristics of the clients in terms of the following areas:
    a. Employment Status
    b. Housing Status
    c. Criminal Justice Involvement
    d. Social Support
    e. Substance Use

SAMHSA/CSAT reports on the characteristics of the clients/participants seen in its grant portfolios to the US Department of Health and Human Services and the Office of Management and Budget, as required.

The outcome analysis will utilize a pre and post measurement methodology. Clients will be followed and interviewed again at 6 months post intake and at discharge. Change measures will be generated comparing the intake to follow-up interviews and intake to discharge using the corresponding variables. The 6-month follow-up data also will be described using frequency distributions and measures of central tendency in order to determine the distribution. For example, the percent of clients showing changes will be calculated on each of the ATR client categorical outcome measures. For continuous items, mean differences will be used. Tables will be constructed to describe the change across projects on client outcomes.

This limited data collection will not produce any nationally representative estimates. CSAT only will produce basic descriptive statistics for program monitoring reports that SAMHSA can utilize for performance review, improvement and oversight. For the principal outcome items, (e.g., drug use, criminal involvement, employment), the proportion of individuals showing improvement from baseline to follow-up/discharge will be calculated and aggregated. The results will be examined occasionally for subpopulations of interest within individual activities (e.g., by age or by gender). See Attachment G for sample analyses table examples.

17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments.

18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions. The certifications are included in this submission.

B. STATISTICAL METHODS

1. Respondent Universe and Sampling Methods

The estimated number of individual respondents is 53,333 per year for the ATR grant program. The starting point for use of the measures is a census of all clients at intake. Beyond the initial census, there will be variation in the number of respondents receiving a 6-month post-intake interview. Grantees will be directed to achieve a minimum response rate of 80 percent for all follow-up interview efforts. This guidance will apply to the response rate as defined against the intake or baseline census.

Based on the amount of funds received, each grantee will be given a target to reach for the number of clients served. Based on similar programs that report to GPRA, most clients will not refuse to participate in the program, thus grantees should not have a problem reaching their targets because of client refusal.

All clients are administered the GPRA instrument during or at the beginning of an episode of care. An episode of care begins when the client receives a voucher to enter ATR-funded treatment or services and ends when the voucher is no longer valid or active and the client is no longer receiving ATR-funded treatment or services, regardless of whether the client is receiving services funded through another source. The GPRA measures are to be collected from each client at the established data points for each episode of care. Grantees are required to track each voucher that is issued to a client. Program staff will complete a Voucher Information form whenever a voucher is issued and a Voucher Transaction form whenever funds for a voucher are redeemed (see Attachment D for an example of the aforementioned forms). A designated provider or case manager is responsible for follow-up interviews although the client may have received, or are receiving, services from other providers.

2. Information Collection Procedures

Intake workers and/or counselors will obtain GPRA intake/baseline information in a face-to-face interview**.** The information will also be obtained at 6-month follow-up and discharge. In instances where clients are no longer in direct contact with a provider, but the client has not been discharged from the program, staff from the designated provider will contact the client and conduct the follow-up interviews. It will be stressed to grantees and providers that all information used for tracking clients should be kept in a locked facility, (e.g., file cabinet).

Most provider programs collect their client information using a paper and pencil method. This project will not interfere with ongoing program operations. Providers will submit the data to the State/Tribal organization by entering the data into the State/Tribal organization's data system. Clinical staff will administer the GPRA interview, and are responsible for submitting the data to the State/Tribal organization. The providers will be instructed to review the data and check the data for errors before sending to the State/Tribal Organization and then to CSAT. For clients with baseline, follow-up and discharge interview data, their records are matched using a unique encrypted client identifier, which is developed by each program.

Attachment H contains an example (taken from the ATR RFA) of how a State could use vouchers for assessment and level of care determination as well as for substance use clinical treatment and recovery support services.

As discussed earlier, there are ten sections that comprise the ATR client tool:

A. Record Management - Demographics
B. Drug and Alcohol Use
C. Family and Living Condition
D. Education, Employment, and Income
E. Crime and Criminal Justice Status
F. Mental and Physical Health Problems and Treatment/Recovery
G Social Connectedness
H. (No Section H)
I. Follow-up Status
J. Discharge Status
K. Services Received

Sections A, B, C, D, E, F and G are to be reported during intake. Sections A, B, C, D, E, F, G and I are to be reported at the 6-month follow-up interview. Sections A, B, C, D, E, F, G, I, J, and K are to be reported at discharge.

3. Methods to Maximize Response Rates

During the intake process for a client, the providers explain to the client the importance of the tool and why the information is being collected. Based on data collection for the GPRA Services (OMB No. 0930-0208), it is rare that clients refuse to be administered this type of interview. Each grantee will have established its own client follow-up procedures as part of the original protocol. At the time of intake, information is typically obtained from clients to assist with locating them later, if for instance, they drop out of the program. This includes information on current residence plus contact information for one or two other individuals who are likely to know where the client is if s/he relocates. In addition, some programs are adept at using other community resources to assist with locating clients. Clients are typically quite cooperative with program staff because of the relationship established during treatment. Since all participating grant programs propose a census at initial intake, considerable options also exist for non-respondent analysis and associated adjustments to the data such as weighting.

However, it is important to recognize there may sometimes be missing data, because the client opted not to provide a particular data element or the program failed to record the data element, or for a variety of other reasons. Steps can be taken to minimize the amount of missing data.

Several methods will be used to retain participants and maximize response rates, including the optimal completeness of data:

a) Clients will be asked to sign a consent form during their orientation to the program. The intrinsic value of their participation in the data collection for their own treatment, and for the future treatment of other substance abusers will be stressed.

b) Information, (i.e., name, address, and/or phone number) will be gathered from next of kin, close friends, or other emergency contacts. This information will be used when necessary to follow up on clients who drop out of the program or who otherwise become difficult to reach.

c) Steps will be taken to ease the reporting burden on programs by allowing programs to use client responses to other commonly used tools.

Follow-up has been a challenge to some grantees given the remote locations that they serve and the challenge of locating clients as far out as 6 months. For grantees that have not been aware of the strategies they can employ to begin the follow-up process at intake, how to maintain contact with clients, and the importance of good locator forms, several strategies have been implemented to assist the grantees with followup. First, follow-up training is offered which assists grantees in learning about and conducting follow-up at their sites. This program is offered to all grantees and after the grantees are trained through the grantee orientation process, monthly follow-up trainings are offered for those that need additional training or for new project staff. Individual grantee technical assistance is also available for sites that need additional follow-up instruction. These group and individual trainings are conducted by follow-up experts. Each grantee receives a follow-up tracking manual at these trainings that may be used as a future reference. A second strategy provides the grantees with data status reports on how close they are to meeting their follow-up goals. These reports are available from the web-based system to the grantees and Government Project Officers for the grants they are responsible. A third strategy is the automatic, system generated notice of when follow-up interviews are due for each client. A fourth strategy provides technical assistance at national meetings. Experts, including grantees, have been identified and asked to make presentations at national grantee meetings on how to conduct follow-up. These sessions are well attended by grantees. It is anticipated that these strategies will continue to improve the follow-up rates and it is continually stressed to the grantees that a minimum 80 percent follow-up rate is expected.

4. Tests of Procedures

The procedures for this data collection were tested in the initial cycle that expires May 31, 2008. Based on that experience CSAT have found that they do not need to change the procedures for this activity. The GPRA instrument is the standard tool that CSAT will be implementing with all of it's discretionary programs in the future.

5. Statistical Consultants

The names and phone numbers of the contractors and project officers are as follows:

CONTRACTORS/STATISTICAL CONSULTANTS		
Name	**Address**	**Contact Information**
Scott Cross, Ph.D. Senior Analyst	Westat, 1650 Research Boulevard, Rockville, MD 20850	Phone: (301) 294-3979 ScottCrosse@Westat.com
CSAT PROJECT OFFICER AND STAFF/STATISTICAL CONSULTANTS		
Name	**Address**	**Contact Information**
Deepa Avula Lead Social Science Analyst	Center for Substance Abuse Treatment, Division of Services Improvement, 1 Choke Cherry Rd., Room 5-1148, Rockville, MD 20857	Phone: 240-276-2961 Deepa.Avula@samhsaa.hhs.gov
Hal Krause Public Health Advisor	Center for Substance Abuse Treatment, Division of State and Community Assistance, 1 Choke Cherry Rd., Room 8-185, Rockville, MD 20857	Phone: 240-276-2897 Hal.Krause@samhsa.hhs.gov
Andrea Kopstein, Ph.D. Branch Chief, Practice Improvement Branch	Center for Substance Abuse Treatment, Division of Services Improvement, 1 Choke Cherry Rd., Room 5-1095, Rockville, MD 20857	Phone: 240-276-1575 Andrea.Kopstein@samhsa.hhs.gov
STATE/TRIBAL ORGANIZATION PROJECT OFFICERS		
Dawn Levinson Public Health Advisor	Center for Substance Abuse Treatment, Division of State and Community Assistance, 1 Choke Cherry Rd., Room 4-1082, Rockville, MD 20857	Phone: 240-276-2015 Dawn.Levinson@samhsa.hhs.gov
Natalie Lu Public Health Advisor	Center for Substance Abuse Treatment, Division of State and Community Assistance, 1 Choke Cherry Rd., Room 5-1089, Rockville, MD 20857	Phone: 240-276-1582 Natalie.Lu@samhsa.hhs.gov
Linda Fulton Public Health Advisor	Center for Substance Abuse Treatment, Division of Services Improvement, 1 Choke Cherry Rd., Room 5-1136, Rockville, MD 20857	Phone: 240-276-1573 Linda.Fulton@samhsa.hhs.gov

Roula Sweis Public Health Advisor	Center for Substance Abuse Treatment, Division of Services Improvement, 1 Choke Cherry Rd., Room 5-1116, Rockville, MD 20857	Phone: 240-276-1574 Roula.Sweis@samhsa.hhs.gov

ATTACHMENTS

A. Access to Recovery Request For Applications (RFA) Announcement

B. Item Source Matrix

C. CSAT GPRA Client Outcome Measures for Discretionary Programs

D. Voucher Information and Voucher Transaction Tools

E. Data Entry Screens

F. Sample Consent Form

G. Sample Analyses

H. Example of How a State Could Implement a Voucher Program