ACCESS TO RECOVERY (ATR) PROGRAM

SUPPORTING STATEMENT

A1. Circumstances Making the Collection of Information Necessary

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 extension of previous OMB approval for two Access to Recovery (ATR) Program data collection tools:

1. Voucher Information Form – no change (OMB No. 0930-0266 Expiration Date 05/31/11)

2. Voucher Transaction Form –no change (OMB No. 0930-0266 Expiration Date 05/31/2011)

The client-level tool that was previous part of the previous data collection effort was dropped because of a program change to ATR. The client level tool was submitted to OMB under request for approval (No. 0930-0208).

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 States and Tribal Organizations supporting the design and implementation of community-based service delivery systems in which a voucher is the method of payment. 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 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.

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.)

A2. Purposes and Use of the Information Collection

SAMHSA will use the voucher information tool and a voucher transaction tool that are in Attachment A. 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.

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

> **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. 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.

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 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.

The data set for which approval is sought comprises information on the vouchers that are distributed to the clients. The data obtained will be used to assess changes in client outcomes and cost efficiency per client as a measure of performance by programs. The Voucher Information (VI) tool and a Voucher Transaction (VT) tool, both are contained in Attachment A. 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

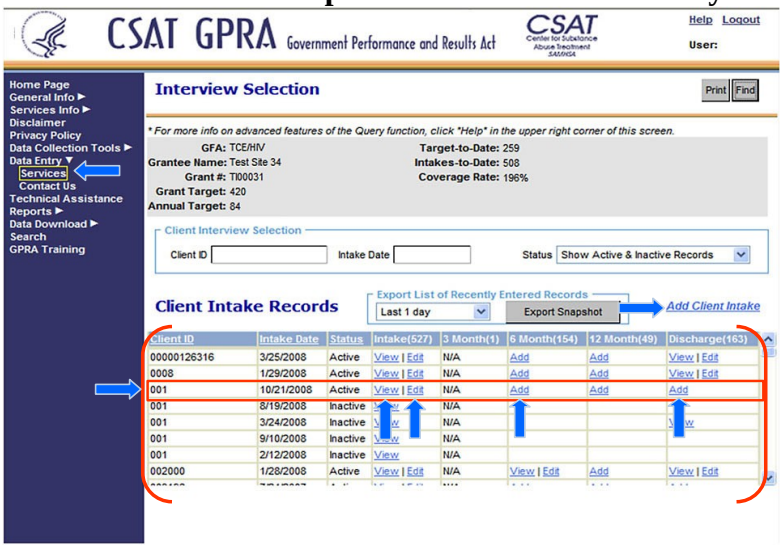
There are no changes to the Voucher Information or Voucher Transaction Tools. SAMHSA has established standardized client outcome treatment measures for its ATR grant program in order to capture client level information on treatment outcomes. Due to a change in the ATR program, changes to the client tool are dropped from this package. The client tool is now to be submitted with the OMB 0930-0208 package.

A3. Use of Improved Information Technology and Burden Reduction

Most programs collect their Voucher Information and Voucher Transactions using a variety of methods from paper and pencil to electronic methods. This project will not interfere with ongoing program collection operations that facilitate information collection at each site.

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 (see **Exhibit 1**) allows for easy data entry, submission, and reporting to all those who have access to the system. 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. A sample data entry screen is below:

Exhibit 1. Screen capture of electronic data entry field



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SAIS: CSAT GPRA Web-Based Data Entry System Training

A few 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 an additional collection burden.

Electronic submission of the data promotes enhanced data quality. 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.

A4. Efforts to Identify Duplication and Use of Similar Information

The items collected are necessary in order to assess grantee performance. They are collected for the purposes of this project and where available may be used for this data collection activity.

A5. Involvement of Small Entities

Individual grantees vary from small entities through large provider organizations. Every effort has been made to minimize the number of data items collected from programs to the least number required to accomplish the objectives of the effort and to meet GPRA reporting requirements and therefore, there is no significant impact involving small entities.

A6. Consequences of Collecting the Information Less Frequently

If ATR grantees do not collect the data at the aforementioned Voucher Information and Voucher Transaction, this may decrease their ability to monitor costs and client outcomes for the initiative and lower the value of the data for GPRA use.

A7. Consistency with the Guidelines in 5 CFR1320.5(d)(2)

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

A8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the *Federal Register* on March 9, 2011 (76 FR 12980). No comments were received in response to this notice.

A9. Payment to Respondents

There is no payment for completion of the Voucher Information and Voucher Transaction Tools

A10. Assurance of Confidentiality Respondents

Grantees and all other potential respondents will be informed of the processes used to protect client level data. Efforts will be made to ensure privacy at all points in the data collection and

reporting processes. All data will be closely safeguarded, and no institutional or individual identifiers will be used in reports. Only aggregated data will be reported. 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.

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. Federally assisted substance abuse treatment providers are subject to the federal regulations for 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/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.

A11. 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. The Voucher Information and Voucher Transaction forms contain client-level information on the services that were delivered at the time of treatment. These issues are essential to the service/treatment context and are linked to client level outcome data for analysis.

A12. Estimates of Annualized Hour Burden

As data collection will be completed within 1.5 times per year, the following estimates represent the total cost burden for the client survey (see **Exhibit 2**). There are no direct costs to respondents other than their time to participate in the study. The estimated total cost of the time respondents spend completing these surveys is $44,160 (number of total client respondent hours × $18.40, the estimated average hourly wages for adults as published by the Bureau of Labor Statistics, 2010).

Exhibit 2. Estimates of Annualized Hour Burden [1]

Center/Form/ Respondent Type	Number of Respondent	Responses Per Respondent	Total Responses	Hours Per Response	Total Hour Burden	Total Wage Cost	Total Hour Cost / Respondent[1]
Voucher information and transaction	53,333	1.5	80,000	.03	2,400	$18.40	$44,160

1. This table represents the maximum additional burden if adult respondents for ART provide responses/data at an estimated hourly wage (from 2010 Bureau of Labor Statistics).

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.

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.

A13. Estimates of Cost Burden to Respondents

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

A14. Estimates of Annualized Cost to the Federal 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 services data with the annual reports of the project.

The estimated annualized cost for a contract for the GPRA mandate is $7.2 million and the cost of 1 FTE staff (25% for the midpoint of one GS-14 $25,899 and 75% for one GS-12 $48,786) responsible for the CSAT data collection effort is approximately $74,685/year.

A15. Changes in Burden

Currently there are 81,627 burden hours in the OMB inventory. The Program is requesting 2,400 burden hours. The decrease of 79,227 is due to a program change with the removal of the client tool. The client tool is now to be submitted with the OMB 0930-0208 package. There are no changes to the Voucher Information or Voucher Transaction Tools.

A16. Time Schedule, Publication and Analysis Plans

Data for the annual GPRA plan/report are needed by SAMHSA by September of each year. The discretionary services program data are readily available through the web-based system. Data are provided for the most recently completed calendar year to SAMHSA in May in order to assure analysis in time for the annual GPRA report. The annual GPRA report must be submitted to the U.S. Department of Health and Human Services (the Department) and to OMB by September and is included in the President's annual budget request which is released to the public February 1st. Data may be refined and added to the final Presidential budget request after the Department submits its initial GPRA report.

Analysis/Publication Plans

Client outcome data will be collected through the web site. Data will be used to report to Congress regarding the GPRA as specified in the SAMHSA Annual Justifications of Budget Estimates. The data might also be used for specific comparisons relative to ONDCP National Drug Control Strategic Goals, especially for some of the secondary treatment outcomes (e.g., homelessness).

In the future, the indicators for clients served under these programs might be compared to similar indicators for clients served under block grant programs as a general indicator of whether the programs are doing better than "typical" services. This could be done for discretionary services programs as a group or for specific programs.

SAMHSA and each of its Centers specifically will use the data for annual reporting required by GPRA on the previously stated items, comparing baseline with discharge and follow-up data. The GPRA dataset will consist of each element coded into the reporting categories as seen in Attachment 1. These data are at the client record level. The SAMHSA GPRA client outcome data will be aggregated at the following levels: Project/Grantee, Program/Division, and Activity. The analysis will be organized around SAMHSA's GPRA measures and the measures relating to the Family Drug Courts and the NOMs.

Baseline level analysis involves using frequency distributions and measures of central tendency to describe the populations across the GPRA client outcomes and by various demographic groups (e.g., gender, race, ethnicity, age, and level of education). The client will be followed longitudinally and the GPRA client outcome items will be re-administered again at discharge, 6 and 12 months after baseline. The follow-up data also will be described using frequency distributions and measures of central tendency. Change will be addressed by comparing the discharge and follow-up measurements with baseline data for each client. The percent of clients showing the target changes will be calculated on each of the GPRA client outcome measures that are categorical. For continuous items, mean differences will be calculated. Tables will be constructed to describe the change across projects on client outcomes.

It is important to note that each Center is responsible for its own analyses of the data. Common analyses will be used as appropriate for GPRA purposes, but control of the data rests with the Center funding the grant. The Centers submit a GPRA report to SAMHSA Office of the Administrator and SAMHSA then synthesizes results from the Centers in a descriptive manner for the GPRA report.

There also will be Center unique analysis of these data because each Center has a distinct set of programs. The data items collected will be analyzed and presented in GPRA reports using basic descriptive statistics. On the principal outcome items (e.g., drug use, criminal involvement, and employment), the proportion of individuals showing improvement from baseline to discharge and follow-up (baseline to discharge, baseline to 6 months, baseline to 12 months) will be calculated and aggregated at the program level (e.g., discretionary services). If deemed necessary for CSAT specific issues, the data will be examined at the individual activity level. Occasionally, the results will be examined for subpopulations of interest within individual activities (e.g., by age or by gender).

A17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments for which approval is being sought.

A18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.