ABSTRACT

The Division of Behavioral Health Prevention Program plans to implement a comprehensive system of Screening, Brief Intervention, Brief Treatment and Referral to Structured Treatment services including Medicated Assisted Treatment for those individuals addicted to Opioids. The project will be a State wide initiative and will be involving three Cohorts of programming implementation and will be implemented in phases throughout the five years of the grant. Cohort I, Phase I will include the Avera Medical Health System – one of the largest Health Care Systems in the State – which primarily includes the Eastern part of South Dakota. At the Cohort I site we will partnering with community based programs prevention and behavioral health treatment programs that have been operating in their local communities for decades. All providers selected have licensed behavioral health professionals and licensed or certified substance abuse counselors on staff. During the first six months of the project the required screening tools, will be incorporated into the Avera Medical Health System, the Evidenced Based Programming will be approved by a workgroup consisting of behavioral health professionals from the local community provider system, and all involved staff will be trained to conduct the Evidence Based Programs selected for the project. By the 7th month of the project, the screening process within the clinics will begin, and community based services will also begin during the 7th month of the grant award.

Cohort II, Phase II of the project will replicate the screening tools, screening process and programming in the Central part of the State, and will focus on rural health care clinics and clinics operated by Indian Health Services. During Cohort III, Phase III, the project will replicate the screening tools; screening process and programming in the Western part of the State with clinics operate by the Regional Healthcare System

The proposed goals of the grant are as follows: Goal 1: To develop the organizational relationships and infrastructure for integration of SBIRT services into primary care clinics and community behavioral health systems in South Dakota; Goal 2: To develop and Implement SBIRT Training for primary care, community health, substance abuse prevention and treatment providers; Goal 3: Implement SBIRT services in primary care and community behavioral health settings in South Dakota; and Goal 4: Monitor quality and evaluate SBIRT implementation and programming.

The State of South Dakota, the Medical Community, and the Behavioral Health providers are very excited about the prospect of obtaining and implementing the South Dakota SBIRT project.

Table of Contents

ABSTRACT **1**

TABLE OF CONTENTS **2**

PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION **3**

SECTION A 3
SECTION B 9
SECTION C 13
SECTION D 22
SECTION E 27
SECTION F 33
SECTION G 44

BUDGET INFORMATION FORM (SF-424A) 49

ATTACHMENT 1 .... **.54**

ATTACHMENT 2 .... **61**

ATTACHMENT 3 .... **66**

ATTACHMENT 4 .... **70**

Section A: Population of Focus and Statement of Need (15 points)

"**A-1**", South Dakota's geography consists of a mix of urban, sub-urban, small towns, rural, and frontier landscape spread across over 75,000 square miles and home to approximately 833,354 residents. A large number of counties in the state have a population base of five persons or less per square mile. The enormous challenge is providing statewide services to ensure all citizens have access to needed services, including prevention and intervention services for substance abuse and mental health services. Sioux Falls (159,908) and Rapid City (69,854) are the largest cities. Nine towns have 10,000 to 30,000 residents and five communities have 5,000 to 10,000 residents. The remainder of the citizens are spread out across wide stretches of agricultural and prairie lands dotted by farms and small communities.

The population of South Dakota is 86.2% Caucasian. American Indians make up 8.9% of the population within the state that includes nine tribal reservations. Other racial groups comprise 4.9% of the population and are a mix of Black, Hispanic, Asian, and minority immigrants from Africa, Eastern Europe and Southeast Asia.

Table 1: Racial and Ethnic Composition of South Dakota

Ethnicity	% of total population	Median Age	Under 5	12 to 20	21 to 25	26 and Over
White persons	86.2%	39	6.3%	11.6%	6.5%	67.0%
Native American and Alaska Native persons	8.9%	24	11.4%	17.5%	8.7%	47.1%
All Others	4.9%	23	13.1%	16.9%	10.0%	44.7%

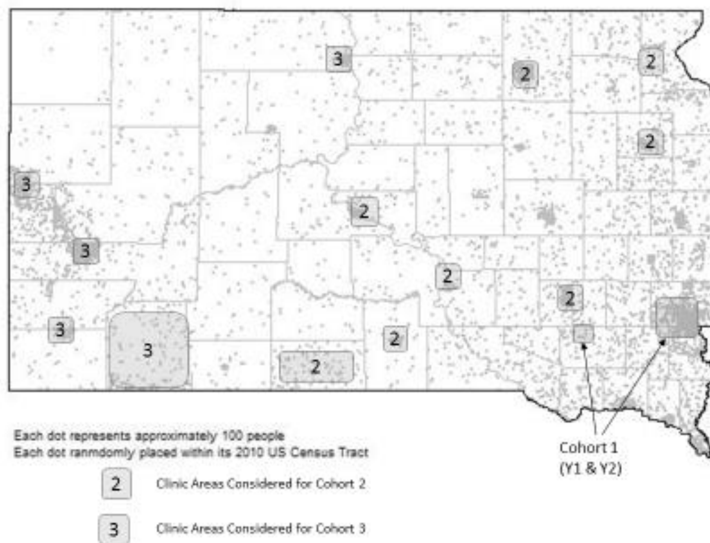
Source: U.S. Census Bureau: Census 2012 Population Estimates

South Dakota's per capita 12 month income was $25,740 which was less than the national figure of $28,155. The median house hold income for South Dakota residents of $49,495 is over $3,000 lower than the national average. Based on the most recent U.S. Census Bureau data, 26.2% of South Dakota residents age 25 and older hold a Bachelor's degree (or higher) compared to 28.8% nationally.

There is limited data available on gender identity and sexual orientation for South Dakota. An analysis of Gallup's "State of the States" series by the Williams Institute, UCLA School of Law reports that 4.4% of South Dakota citizens responding to a Gallup poll question of "Do you, personally, identify as lesbian, gay, bisexual, or transgender?" respond a "Yes, do". [Source: http://www.gallup.com/poll/160517/lgbt-percentage-highest-lowest-north-dakota.aspx]

"**A-2**", The states proposes to develop the skills and knowledge base for integrating effective screening, brief intervention, and referral to treatment services (SBIRT) into primary care and community health settings within an initial set of clinics (Cohort 1) in years one and two of the grant period. The project will utilize the experience and knowledge gained to expand SBIRT to clinics across the state in Cohort 2 and Cohort 3 during the last three years of the grant period. Figure 1 illustrates the states implementation plan. The demographic and other characteristics of patents served through the proposed approach is anticipated to mirror the population demographics of the South Dakota.

Figure 1: Proposed Primary Care Clinical Areas to be Served During Years 1 and 2 (Cohort 1) and Clinical Areas under Consideration for Years 3 through 5 (Cohort 2 & 3)



Overall South Dakota has low death rates due to heart disease and other chronic diseases, but relatively high rates of unintentional injuries and suicide. Disparities are well noted and documented for sub-populations across the state, particularly Native Americans. The death rates for unintentional injuries are four times higher for Native Americans as compared to the states white population. Therefore, South Dakota proposes to focus on Native American's as one population of focus as part of the grant.

South Dakota has also identified women of childbearing age as a second population of focus for the project. South Dakota supports this rationale since the binge drinking rates for females is 13.5%, and17.2% of pregnant women report smoking during pregnancy. An SBIRT approach, integrated into primary care settings is an ideal opportunity to identify and provide brief intervention for alcohol use risk and smoking risks in women of child bearing age prior to pregnancy.

Table 2: Comparison of Health Indicators for Populations of Focus compared to Non-Hispanic White Population

Major causes of death (rate per 100,000)	Non-Hispanic White	Native American (Population of Focus)	Females of Childbearing Age (Population of Focus)
All Cause	678.7	1,317.2	596.0
Heart disease	151.7	205.9	123.0
Lung Cancer	44.5	63.5	33.3
Diabetes-related	72.3	266.4	67.9
Unintentional injuries	37.3	126.8	26.6
Suicide	15.5	31.0	9.9
Source: Health Disparities Profiles: 2014 Edition. Washington, DC: DHHS Office on Women's Health. 2014.			
	Non-Hispanic White	Other Races	Females
Binge Drinking	18.3%	26.8%	13.5%
Smoking Currently	17.2%	38.1%	19.4%

Smoking during pregnancy	-	-	17.2%
Source: national Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System			

"**A-3**", Excessive alcohol use is one of the largest, if not the largest, social and health affecting behavior within South Dakota:

- The state has historically ranked within the top few states in the nation for binge drinking (NSDUH);
- South Dakota ranked 21st among all state with a rate of 30 deaths per 100,000 for Alcohol-Attributable Deaths due to excessive alcohol use (CDC);
- 52% of South Dakota young adults age 18 -25 years of age report binge drinking in the last 30 days (NSDUH);
- In 2012, 35% of arrests in South Dakota were alcohol related (Sourcebook of Criminal Justice Statistics, 2014); and
- In 2012, South Dakotan's consumed an average of 3.1 gallons of ethanol per person compared to the national rate of 2.6 per person (NIAAA surveillance report #98, April 2014)

The results of the comparison using the most recent state and national data from the National Survey of Drug Use and Health (NSDUH) are presented in Table 3 below. On each of the alcohol indicators, South Dakota's rates were above the national averages while the rate of perception of harm was lower than the national average.

Table 3. Comparison of South Dakota and National Indicators

Relevant Indicators from NSDUH		18-25 yrs.	26 + yrs.
Alcohol use in the past month reported by persons aged 12 and older	South Dakota	64.39%	59.3%
	National	59.60%	56.18%
Binge drinking in the past month reported by persons 12 and over	South Dakota	44.74%	24.62%
	National	37.82%	22.44%
A perception of great risk from binge drinking reported by persons 12 and older	South Dakota	28.45%	35.75%
	National	33.36%	42.27%
Nonmedical use of pain relievers in the past year reported by persons aged 12 or older	South Dakota	7.46%	2.71%
	National	8.32%	3.26%
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Abuse and Health, 2013-2014			

Comparison of the indicator for nonmedical use of pain relievers found South Dakota's rate to be lower than the national averages in all age groups with no increase in usage rates from 2014 to 2015. In SFY 2014 according to the data from the Division of Behavioral Health, there were 256 (4%) out of 6,444 clients who received treatment within the public funded treatment system in the State who were identified as abusing Opioids. Also in SFY 2014, according to the Department of Health there were 787 visits to emergency rooms in the State that were related to Opioid misuse/abuse of the 193,685 emergency room visits reported by participating Emergency Rooms. In SFY 2015, according to the data from the Division of Behavioral Health, there were 208 (3%) individuals out of 6,110 clients who received treatment within the public funded treatment system in the State who were identified as abusing Opioids. Although the rates of opiate abuse are low, the misuse and abuse of opiates will be monitored to detect any increase in the rate of use through the clinic screening process.

On a State wide basis, the service gaps include a lack of community based brief intervention and brief treatment services. Evidence Based Programs for adults related to early intervention and brief treatment do not exist across the State. Another gap is the availability of Medicated Assisted Treatment options which is very limited in the State, which is in part due to the low number of opiate addicted clients presenting themselves for treatment.

Within the clinic based setting, gaps include a lack of screenings for multiple areas of risk in all primary care clinics in the Avera Health Care System and other clinics operated by other Health Care Organizations in the State. The patients themselves are not engaging in prevention, early intervention or treatment services until issues reach a crisis stage. In addition, the Helmsley Trust Survey "Focus on South Dakota: A Picture of Health" also notes the number one barrier to mental health and chemical dependency care is cost.

"**A-4**",We do plan to use grant funding to expand the HIT and the EMR information systems within the Avera Health Care System and the other Health Care systems clinic based services as we move the project across the State in years 2, 3 and 4 of the grant. Currently the Avera Health Care System does enter screenings results on PHQ-9, PHQ-A, and GAD-7 into their Electronic Medical Record (EMR) system. The information entered includes the score, date administered, checklist of symptoms, and overall positive/negative result options. These screenings are entered into the system by nurses, providers, or behavioral health specialists. There are options to enter additional screenings using canned or quick text (to provide efficiency in documentation) options in the system, which could be shared by others once developed and entered into the Health Information Exchange (HIE). The goal would be to explore the enhancements needed to the HIE system, and add the addition of the new screening, prevention, early intervention and treatment related data is entered into EMR system.

The EMR system will need to be modified to add information on the following screening tools: pre-screenings for alcohol using the NIAAA single question screen + binge question, the AUDIT-C + binge screening and the AUDIT full screen if there is an indication of an alcohol use disorder; pre-screening for drugs using the NIDA single question drug screen and conduct a full screening using the DAST-10 question tool; the screening for Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) 2 for tobacco use; and the PHQ-2 to identify those individuals for co-occurring disorders. Other information to be entered into the EMR includes the results of any substance abuse or mental health referral and treatment a patient might receive, the patient's involvement and outcome of their involvement in Brief Intervention or Brief Treatment, and their referral to treatment and the outcome of that treatment experience. For those individuals that are opiate dependent, the EMR should also include specific information on the quantity of opiates used, the duration of use, the types of medication they were administered during treatment, and the types of medication they are continuing on during their continued treatment within a community setting.

The addition of the screening and the patient's involvement in structured programming will alert the medical personnel to the seriousness of the behavioral health condition and which patients

complied with the recommendations and completed the recommended level of care. This information also establishes a baseline for the patient that can be monitored annually by medical personnel on each annual visit the patient makes to the clinic to determine whether the screenings and/or behavioral health assessments show deterioration in the patient's symptoms, and there is a need for further interventions by the physician and behavioral health staff. For those patients who have a major mental illness, co-occurring disorder or are suicidal, and have refused involvement in treatment, the behavioral health staff in Avera, or staff from the behavioral health organizations in the community will conduct outreach services to engage the patient in active treatment.

The above process will ensure that the medical personnel at the clinic have timely information on the patient's behavioral health conditions, and be proactively seeking out patients that are non-compliant, and help motivate the patient to seek services before the behavioral health condition results in a crisis situation. Taking these steps will improve the behavioral health outcomes for these patients.

After the grant is awarded, the following timeline is projected for the modifications in the EMR record keeping system:

- October 1 to November 1 – meet with key staff within the Avera Health Care System to review the additional screening, assessment, prevention, early intervention and treatment data that needs to be entered into the EMR system. This would include the following personnel: Patient Service Representatives (PSRs)who distribute the screening instruments; In-house Outpatient Therapists (LPC-MH) and Coordinated Care (Social Worker (MSW-PIP) and RN (Case Worker) who administer, score, and assess symptoms; Licensed and Certified Addictions Counselors (LAC) who would be qualified to provide further assessment when referring out to treatment; and a physician. Discuss the required additional data that will need to be entered into the EMR system and respond to questions or concerns. Also begin discussions on the process to integrate the additional information into Avera's HIE system. The issues to be discussed include: current information available in the HIE system; processes in place to ensure compliance with HIPPA, and CFR 42 requirements for those clients with alcohol or drug issues.
- November 1 to December 1 – meet with the personnel within the Avera system in charge with modifying the EMR system. Include representatives from the meeting held in the first month of the grant award. Discuss the modifications that need to be made and the projected time line to complete these modifications. Also explore the modifications that need to be made to the HIE system to allow the sharing of information with community providers.
- December 1 to February – the added information and modifications will be programed into the EMR and HIE systems.
- February 1 to March 1 – the additional screening data will be loaded into a Tablet to be utilized in the clinics for screening purposes by March 1. The required releases will be developed to allow referral agencies to access HIE information on the clients served. Begin utilizing all screening instruments by March 1 and have the HIE information in place to share

with community based prevention and treatment agencies, and the process for sharing this information.

"**A-5**", By expanding the capabilities of the HIT system within the Avera Health Care Clinics, when a patient is referred to community based programming for prevention, early intervention, or treatment services, the information available through the HIT system, will allow the local provider to gather valuable information from the screening processes. This information will allow them to complete a more comprehensive treatment needs assessment and treatment plan for those patients in need of treatment for substance abuse, mental health, tobacco or co-occurring disorders. This additional information will expedite the completion of the comprehensive assessment and treatment plan. This will result in an improvement in the provider workforce by being able to target patients for services in a more timely manner, and help reduce the time it would take the provider agency to secure all the client information available in the HIT system.

Through the five years of the grant project the screening and related BI, BT and referral to structured treatment will be promoted to other Avera clinics in the South Dakota, the Regional Health Care System in the Western part of the State, and the Indian Health clinics in the Reservation areas. As the project moves to other Avera clinics and additional Health Care systems, the screening tools and the established evidence based programs and referral programs will be included in these systems with the information flowing into the EMR system at these locations. By the end of the five year project, the evidence based programs will be available across the State.

The benefit of incorporating the screening, prevention, early intervention and treatment information into the EMR system is that this information can be in loaded into the HIT system, after the appropriate releases are signed, and the local provider will have real time information on the clients they serve. Once the patient completes the needed services, this information will then be incorporated into the EMR record. This will allow medical staff in the clinic to monitor the patient's behavioral health issues over time

The substance abuse screening tools will also allow the clinics to monitor the extent of opiate use and abuse at the community level, which in turn will provide information on whether the expansion of Medicated Assisted Treatment approaches are needed in local communities.

The State does maintain a billing process for those individuals who qualify for public funding including Medicaid for targeted populations. Private insurance carriers also cover some, but not all, of the services for clients experiencing behavioral health issues. Although the grant will allow the State to utilize a percentage of grant funds to pay for evidence based services not covered by exiting funding sources, it is anticipated that this will be on a limited basis since maintains an extensive public sector funding source for those individuals that need assistance with the cost of treatment. The current billing and reimbursement processes would be utilized for this limited population needing assistance under the grant.

Section B: Proposed Evidence-Based Service/Practice (25 points)

"**B-1**", The purpose of the project is as follows: establish a comprehensive screening process in medical clinics operated by Avera Medical services, Indian Health Services and the Regional Health Care System; utilize evidence based programs for individuals screened to be in need of brief intervention or brief treatment services for their substance abuse and mental health issues; establish a referral and treatment protocol for individuals in need of addiction treatment for opiate abuse or other substance dependency issues; and establish a referral protocol for those individuals identified as having a co-occurring disorder or a severe mental illness.

GOAL and OUTCOME OBJECTIVES
Goal 1: To develop the organizational relationships and infrastructure for integration of SBIRT services into primary care and community behavioral health settings in South Dakota.
Objective 1.1: Enhance organizational readiness and commitment for implementation of SBIRT into community behavioral health systems.
Objective 1.2: Develop SBIRT patient flow process for primary care and community behavioral health settings.
Objective 1.3: Develop patent flow and referral protocols for referral of patients from primary care settings to behavioral prevention services, treatment services, and/or Medication-Assisted Treatment.
Objective 1.4: Facilitate the establishment of formal referral agreements between SBIRT and partner organizations.
Goal 2: To develop and Implement SBIRT Training for primary care, community behavioral health including substance abuse prevention and treatment providers.
Objective 2.1: Assemble an SBIRT training curriculum for primary care clinics, community behavioral health including substance abuse prevention and treatment providers.
Objective 2.2: Train all staff involved in SBIRT services in primary care clinicians, community behavioral health including substance abuse prevention and treatment provider in each partnering community.
Objective 2.3: Provide annual refresher training in SBIRT to Behavioral Health prevention and treatment provider agencies participating in each community.
Goal 3: Implement SBIRT services in primary care and community Behavioral Health settings in South Dakota.
Objective 3.1: Integrate screening tools into clinical processes and EHRs.
Objective 3.2: Integrate brief Intervention and prevention services into the clinical process.
Objective 3.3: Integrate referral to treatment and or MAT.
Objective 3.4: Implement the SBIRT in primary care and community health settings.
Goal 4: Monitor quality and evaluate SBIRT implementation and programming.
Objective 4.1: Develop data collection protocol.
Objective 4.2: Monitor program implementation.
Objective 4.3: Conduct ongoing formative evaluation of SBIRT screening, brief intervention, and referral to treatment and/or MAT.
Objective 4.4: Conduct an impact evaluation of patient outcomes.
Objective 4.5: Participate in national evaluation through collection and reporting of required data elements.

"**B-2**", The following information describes the process to be utilized to select the Evidence Based Programs that will be utilized during the project and the Steps to implement the various components of the model:

Step 1: prior to the implementation of the SBIRT component of the project, the following screening tools will be loaded into a Tablet: the NIAAA single question screen + binge question; the AUDIT-C + binge screening and the AUDIT full screen if there is an indication of an alcohol

use disorder; pre-screening for drugs using the NIDA single question drug screen; the full screening using the DAST-10 question tool; the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) 2 for tobacco use; and the PHQ-2 to identify those individuals with co-occurring disorders.

Step 2: when the individual arrives for their appointment at the clinic, they will be given a tablet and asked to complete the following screens: the NIAAA singe question screen + binge question; pre-screening for drugs suing the NIDA single question drug screen; the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) 2 for tobacco use; and the PHQ-2 for co-occurring disorders.

Step 3: the information from the screening instruments will be available for the physician to review with the patient during their visit. During this Step the number of individuals that would not have a positive test for an alcohol or drug problem is estimated to be between 75-85%. This estimate is based on a publication Titled Clinicians Toolkit - SBIRT: A Step-By Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use developed by the Massachusetts Bureau of Substance Abuse Services. For the remaining 15 to 25% of the patients it is also estimated that 5% of this population would need to be referred out for treatment services.

For the 15 to 25% that would need some level of prevention or treatment intervention, the Physician would review the information with the patient and utilize a brief 5 to 10 minute motivational interviewing approach to attempt to motivate the patient to recognize the problem and agree to additional services. If the initial screenings demonstrate that a patient's use of substances is elevated and there appears to be additional mental health problem, the patient would be referred to the in-house behavioral health specialist for the following additional screenings: AUDIT-C +binge and the AUDIT full screen; the full screening using the DAST-10 question tool; and a further mental health assessment.

Step 4: After the in-house behavioral health specialists completes their additional screening and assessment, the information will be reviewed with the patient and a brief session of motivational interviewing will be completed to assist the individual in accepting the need for ongoing services. The patient would then be referred by the behavioral health specialist to the in-house case manager for referral to the appropriate intervention.

Step 5: The in-house case manager would review screening and/or assessment information and the recommendations of the behavioral health specialists for additional services. At this stage, based on a publication Titled Clinicians Toolkit - SBIRT: A Step-By Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use developed by the Massachusetts Bureau of Substance Abuse Services it is estimated that 15 to 25% that had screened positive, around 5% would need a referral for additional addiction assessment or referral to treatment. Of the remaining 10 to 20% that would need a Brief Intervention (BI) or a Brief Treatment (BT), the case manager would base the level of intervention on the results of the screening tool and the recommendation of the behavioral health professional who conducted the advanced screening and assessment processes.

Step 6: For those individuals screened as needing a BI educational program, the evidence based program being considered is the Prime for Life (PFL) which is a motivational intervention used in group settings to prevent alcohol and drug problems. The curriculum is available in a 4.5 hour

module. The PFL is based on a Lifestyle Risk Reduction Model and focuses on increasing the perceived risk of alcoholism and drug use, and decreasing the intention to drink or use drugs. The population that it is assessed as being appropriate for include young adults ages 18 – 25 and adults 26 to 55, both male and female, African American, Hispanic or Latino and White. The program has also been utilized by the U.S. Army worldwide. This is the curriculum we are considering at this time, but we will continue to explore other evidence based programs as we engage in the six month planning process for implementation.
Step 7: For those individuals screened as needing a BT approach the program we are considering is a Cognitive-Behavioral-Coping Skills Therapy approach. This program is based on the principles of social learning theory and views drinking behavior as functionally related to major problems in the patient's life. Emphasis is placed on overcoming skill deficits and increasing the patient's ability to cope with high-risk situations that commonly precipitate relapse. The program consists of 12 sessions aimed at training the patient to use active behavioral or cognitive coping methods to deal with problems rather than relying on alcohol/drugs as a maladaptive coping strategy. We will continue to explore additional curriculums as we engage in the six month planning process before implementation.
Step 8: For those individuals assessed as needing treatment for alcohol and drug, mental health and co-occurring disorders, the case manager will facilitate their entrance into the appropriate level of care for the patient's behavioral health issues. Placement in either the in-house behavioral health programming or community based services will be determined by the Avera case manager.
Step 9: If a patient needs to wait for a placement in the required level of care, the behavioral health staff within Avera will provide interim services until the individual can begin the recommended outpatient, or inpatient treatment services.
Step 10: Upon completion of the required screening, BI, BT, outpatient or inpatient treatment programming, the case manager will work with the Avera personnel on assuring that information is loaded into the patients EMR.
Step 11: For those patients assessed as having a tobacco abuse or dependency problem, these patients will be referred to the State Department of Health Quitline for medicated assisted treatment for their tobacco abuse/dependency issue and for ongoing counseling support.

"**B-3**", The advantage of the identified approaches and curriculums is that the Avera Medical Clinics have started to implement a Screening and Brief Intervention model in some of their clinics for substance abuse and mental issues utilizing a brief 5 to 10 minute motivational therapeutic intervention by the physician. In addition, we currently have a prevention workforce who has been trained in several of the Prime for Life evidenced based programs so they are familiar with the concepts and approach utilized for brief interventions.   We also have a workforce in the State who has been trained in Cognitive Behavioral therapy approaches. During the 6 month start-up phase of the grant, we propose to work with the medical community and the prevention and treatment system providers, review other evidenced based programming listed on the SAMHSA website, and identify other potential models that look promising for use within a clinic based and community based setting. The goal is to gain consensus from our

partner organizations on which approach and evidence based programming would best fit the needs of the population targeted under this grant project.

"**B-4**", During the first 6 month start up period of the grant we will pull together a workgroup made up of medical personnel, prevention specialists and behavioral health treatment professionals from the community provider system, and prevention and behavioral health specialists from the Division of Behavioral Health, to review the Evidence based approaches proposed to be utilized in the project to determine what limitations there are with the proposed programs, how the proposed programs will be perceived by the individuals who present themselves at the clinics for medical care, which populations served within the clinics would be resistant to the screening process, and what factors would create a negative experience for an individual seeking services with a resulting negative outcome related to their behavioral health issues.

After the above process is completed, the final selection of the evidence based programs will be completed with implementation to occur in month 7 of the grant award.

"**B-5**", Sioux Falls, SD is the largest metropolitan city in the State with a population of 159,908. Although Sioux Fall's population is primarily Caucasian, there is a significant minority population consisting of African Americans, Hispanic, Asian, Native Americans, and minority immigrants from Africa, Eastern Europe and Southeast Asia. Since Sioux Falls also has a vibrant support system for individuals with physical and intellectual abilities, including a deaf and hard of hearing contingent, there will need to be modifications made to any EBP selected to meet the needs of this diverse population. Work will begin during the 6 month start up period with the developer of the EBP's to work on modifications of the EBP's to meet the special needs of the identified special populations. If the selected populations cannot be modified, the search for additional EBP's to address the cultural, intellectual and language barriers that might occur during the screening, BI, BT and treatment phases will be completed during the 6 month planning phase.

"**B-6**", Once the grant is awarded, the Division of Behavioral Health will hire a Community Coordinator who will be responsible to manage the activities of the grant. This individual will not only assist in the planning, but also the processes for monitoring for and implementation of identified services and be responsible for ensuring that the selected Evidence Based Programs (EBP's) are implemented with Fidelity. During the first six months of the grant, the selection of the EBP's to be utilized in the different components of the grant will be finalized, training will be secured for both the Community Coordinator and the community based providers in the prevention and treatment area. The Community Coordinator will subsequently work with the developer of the EBP on a Fidelity Checklist for each EBP, and will monitor the local programs compliance with program fidelity on a quarterly basis.

Section C: Proposed Implementation Approach (30 points)

"C-1", Time line of the project is listed below:

Project Timeline	Activities	Key Staff
Year 1 Months 1-6	Convene partners and formalize operational relationships (M)	Project Director Project Evaluator
	Conduct Analysis and Develop and Submit Health Disparities Impact Statement (M2)	Project Evaluator
	Meet with Avera staff and review the screening tools to be utilized for the project	Project Director
	Work with Avera's programming staff to enter screening tools into their EMR system	Project Director Project Evaluator
	Meet with Avera and community workgroup to review the selected EBP's, discuss modifications to meet the needs of the target population – gain consensus on selected EBP's	Project Director Project Evaluator Workgroup
	If modifications are recommended, contact the EBP developer and discuss needed changes without impacting fidelity	Project Director
	After the EBP's are selected, identify a trainer and train Avera and community based providers on the selected EBP	Project Director Trainer
	Review the components of the grants with all partner organizations.	Project Director Project Evaluator
	Obtain tablets for the clinics and enter screening tools into the tablets	Avera Clinical Director
	Hire a Community Coordinator	Project Director
Year 1 Months 7-12	Implement SBIRT in Clinical Cohort 1 at the selected Avera Clinics	Avera Clinical Director Project Director Grant Coordinator
	Establish contracts with community based providers and Avera for screening, prevention, early intervention and treatment services	Project Director Program Assistant
	Monitor the implementation of the of the screening protocols in the Avera Clinics	Avera Clinical Director Community Coordinator
	Monitor the implementation and fidelity of the EBP's within the community and Avera	Community Coordinator
	Collect and submit the required data for each reporting period according to the federal requirements	Program Director Project Evaluator
Year 2 Months 1-6	Continue to implement SBIRT in the Clinics in Cohort 1 (cont.) and the EBP's within the clinic and community based setting	Avera Clinical Director
	Identify additional Regional Health Care System for Cohort 2	Project Director
	Identify community based partners in substance abuse and mental health for Cohort 2	Project Director
	Develop MOU's detailing the referral process for patients needing prevention, treatment or MAT Services	Project Director
	Modify the clinic's EMR system to include screening tools	Clinic Staff Project Director Project Evaluator
	Modify the clinics HIE system	Clinic Staff Project Director Project Evaluator
Year 2	Conduct SBIRT Training for Clinical Cohort 2 (cont.) and	Community Coordinator

Months 7-12	community based providers.	Clinic Staff
	Establish contracts with community based providers and conics for screening, prevention, early intervention and treatment services	Project Director
	Implement Screening in the Clinics and community based programming	Clinic staff
	Monitor the implementation of the of the screening protocols in the Avera Clinics	Clinic Director Community Coordinator
	Monitor the implementation and fidelity of the EBP's within the community and Clinic systems	Community Coordinator
	Collect and submit the required data for each reporting period according to the federal requirements	Program Director Project Evaluator Project Director
Year 3 Months 1-6	Implement SBIRT in Clinical Cohort 2 and community based prevention and treatment programming Continue to implement SBIRT and community based prevention and treatment programming in in Clinical Cohort 1 with other then grant funds	Clinic Director Project Director Project Evaluator
Year 3 Months 7-12	Identify additional Regional Health Care System in Western South Dakota for Cohort 3	Project Director
	Identify community based partners in substance abuse and mental health for Cohort 2	Project Director
	Develop MOU's detailing the referral process for patients needing prevention, treatment or MAT Services	Project Director
	Provide training to Avera and community based providers on the selected EBP	Community Coordinator
	Implement SBIRT in Clinical Cohort 3	Clinic Staff Project Evaluator
	Monitor the implementation of the of the screening protocols in the Western Clinics	Project Director Project Evaluator
	Monitor the implementation and fidelity of the EBP's within the community and Avera	Community Coordinator
	Collect and submit the required data for each reporting period according to the federal requirements	Project Director Project Evaluator
Year 4 Months 1-6	Continue to Implement SBIRT and community based prevention and treatment programming in Clinical Cohort 2 and 3	Clinic staff Project Director Project evaluator
	Provide updated training if needed	Community Coordinator
Year 4 Months 7-12	Monitor the implementation of the screening protocols and EBP's in the Western Clinics	Program Director Community Coordinator Project Evaluator
	Collect and submit the required data for each reporting period according to the federal requirements	Project Director Project Evaluator
Year 5 Months 1-9	Continue to Implement SBIRT and community based programming in Clinical Cohort 3 (cont.) with grant funds	Clinic Staff
	Continue to monitor the EBP's to ensure fidelity	Community Coordinator
	Collect and submit the required data for each reporting period according to the federal requirements	Project Evaluator Project Director
Year 1 to Year 5	All target sites will be exploring alternate funding sources to maintain services after the grant ends	Clinics Community based providers
Year 5	Project Wrap up	Project Evaluator

Months 10-12	Final Evaluation Report	Project Director

"**C-2**", The key activities of the grant will include the addition of the Screening tools during a patients annual visit at the medical clinics in Cohort I, II, and III of the project. The Division of Behavioral Health Prevention Program currently has a letter of commitment form the CEO of the Avera McKennan Health Care System to partner with the State on the project which would include the inclusion of the Screening Tools within the Avera clinics in Cohort I of the project. For the Brief Intervention and Brief Treatment components of the project, we have letters of support and commitment from partner agencies to be available to provide the needed level of programming in Cohort I of the project. For the specialized MAT treatment services, we have a MOU with Avera and Keystone Treatment Center that details the referral process and a commitment from the Avera system and Keystone Treatment Center to utilized MAT for those individuals addicted to Opiates.

The behavioral health treatment system in the State have licensed and certified substance abuse counselors trained in motivational interviewing and cognitive behavioral treatment approaches. The screening tools and the EBP's that have been proposed for Brief Intervention and Brief Treatment do integrate a motivational/cognitive behavioral approach to their curriculums. The plan is to have the proposed EBP's reviewed by a workgroup of behavioral health specialists to determine their cultural appropriateness before a decision is made to finalize their selection for use in the State. After the EBP's are finalized, training will be provided to the behavioral health professionals conducting the programming.

For Cohort II and Cohort III in years 2 to 5 of the project, we will work on selecting additional clinics to partner with across the State, identify local behavioral health partner agencies to partner with, assess the need for additional MAT services in the Central and Western part of the State, and expand these services if the data demonstrates a need. After the partners have been identified, the screening tools and protocols will be replicated in the Cohort II and Cohort III clinics, the brief intervention and brief treatment evidence based programs will be made available to the community based partners, and training on the referral process and the EBP's will be conducted.

"**C-3**", Similar to the United States population, the population of South Dakota is becoming more and more diverse. An individual's culture and language play a significant role in how substance abuse prevention services are viewed and received by the individual. Effective screening, prevention and treatment services require that all programming be delivered with sensitivity to culture and language. South Dakota has worked to enhance the capacity of the Behavioral Health system to address and meet the needs of the target population. The state will integrate the national Standards for culturally and Linguistic Appropriate Services (CLAS) into a continuous quality improvement plan, and a Behavioral Health Disparities Impact Statement for the screening, prevention and treatment programming will be completed once the application is approved for funding. This is consistent with page eight of the application guidance.

"**C- 4**", The current grant proposal will focus on adults 18 years of age or older. There is no plan to include adolescents below the age of 18 in the project.

"**C-5**", During the patients screening process at the clinic level, if a patient screens positive for a mental health disorder, they would be referred to the in-house behavioral health program for a comprehensive clinical assessment. For those individuals assessed as needing treatment for a co-occurring disorder, the case manager working in the clinic will facilitate their entrance into an outpatient behavioral health program within the Avera health care system, or refer the patient to one of our community base partner agencies for continued services.

The Avera Health Care System and our community based partner agencies have licensed or certified addiction counselors and licensed mental health counselors on staff so they have the capacity to provide appropriate co-occurring treatment to the targeted population.

The project is also partnering with the Community Mental Health Center in Sioux Falls who provides comprehensive services to individuals with severe mental illness including medication management. This program also has both licensed mental health counselors and licensed and/or certified addiction counselors on staff to effectively treat the patient's with a major mental illness and substance abuse issues.

"**C-6**", The first step in increasing patient retention process is to identify the demographic information on the patients served within the Avera Health Care System. Utilizing State wide population data an estimate will be made on the age, race, and cultural make-up of the patients seen by Avera medical clinics in Sioux Falls and the rural clinic operated by the Avera Service System. The second step would be then to assess what training staff need related to the populations served. This training would help staff better understand the patient's cultural background, beliefs and value system, and life experiences so that the contact with medical or other personnel within the clinic can be better tailored to each patient. This approach will help reduce patient anxiety and fear that patients may experience as a component of the clinic visit and the screening process. Once a patient feels welcome and understood, they are more likely to follow through on the recommended services.

Training would focus on the front line staff that interacts with the patient. These staff include Patient Service Representatives (PSRs) who distribute the screening tools, Nurses and Providers who may also administer and score the screenings tools, In-house Outpatient Therapists (LPC-MH) and Coordinated Care (Social Worker (MSW-PIP) and RN Case Worker) who administer, score, and assess symptoms, and the Licensed/or Certified Addictions Counselors (LAC) who would provide further assessment when referring out to treatment.

If a patient is screened to need continued brief intervention, brief treatment or referral to a structured treatment program, the care coordinator would meet with the patient to explain the need for the additional service, answer any questions the patient may have about the recommended service and do a warm handoff to the case manager who would work with the patient on setting up an appointment or facilitate the patients entrance into a higher level of care,

if the determination is made that the patient has a major mental health or a substance abuse dependency issue.

"**C-7**", The Division of Behavioral Health Prevention Program's major partner is the Avera Health Care System. The Avera Health Care System is a health ministry rooted in the Gospel. Their mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values. The Avera system owns/leases or manages a total of 33 hospitals, 23 long term care facilities, 29 apartments & assisted living centers, 194 clinics and 3 community mental health centers. The above facilities are located in North Dakota, South Dakota, Minnesota, Iowa and Nebraska. For the first 18 months of the grant, our focus will be on establishing clinic based Screening, Brief Intervention and Referral to Treatment Services in 2 to 3 Avera Medical clinics operating in Sioux Falls the, largest city in the South Dakota, and in one of the rural Avera Medical clinics. The Roles and Responsibilities of the Avera system in the targeted community include the following:

- Provide pre-screenings for alcohol using the NIAAA single question screen + binge question, the AUDIT-C + binge screening and the AUDIT full screen if there is an indication of an alcohol use disorder;
- Provide a pre-screening for drugs using the NIDA single question drug screen and conduct a full screening using the DAST-10 question tool;
- Provide the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) 2 for tobacco use;
- Utilize the PHQ-2 to identify those individuals for co-occurring disorders;
- Case manage those individuals who are screened to have an alcohol and drug disorder and refer to community based provider for a Brief Intervention or Brief Treatment, with yhe level of services based on the results of the screening tool;
- Case manage those individuals who are screened to have an tobacco use disorder and refer to the South Dakota Department of Health QUITLINE for medicated assisted treatment related to Tobacco Cessation and ongoing counseling support;
- Case manage those individuals who are screened to be experiencing a mental health disorder and set up an appointment with a community based behavioral health agency for ongoing therapy;
- Complete a full Behavioral Health Assessment on those individuals screened as having a potential substance use dependency issue related to their substance of use or experiencing a major mental health disorder;
- When an individual is assessed as having a substance use dependency or experiencing a major mental health disorder after the completion of a comprehensive Behavioral Health assessment, the case manage will refer these individuals to the Avera Behavior Health program or a community based provider for placement in programming based on the ASAM placement criteria;
- Case manage those individuals assessed as having a co-occurring disorder and refer them to the Avera Behavioral Health program or to the local Community Mental Health Center for ongoing care related to their mental health and substance abuse disorders;

- Case manage those individuals assessed as having an opiate disorder into a medically managed detoxification program and link the individual to ongoing medicated assisted treatment with Avera Behavioral Health Services for ongoing outpatient treatment services; and
- Monitor the inclusion of the clinical information in the patient's clinical file.
  Other partners in the grant include the following:
- Keystone Treatment Center – will provide inpatient medicated assisted detoxification for opiate addicted individuals and Medically Monitored inpatient treatment for those individuals identified as being in need of these services;
- Carroll Institute – will be available to provide screenings, brief intervention services, outpatient substance abuse treatment and prevention services;
- Volunteers of America- Dakotas – will be available to provide training related to the selected Evidence Based Programs, screenings, and brief intervention services;
- Southeastern Behavioral Healthcare – is the Community Mental Health Center in the Sioux Falls area and will provide needed outpatient services for those individuals identified as having serious mental illness or co-occurring disorder mental illness and substance use disorders;
- Helpline Center – is currently partnering with the Division of Behavioral Health Prevention Program and Avera Behavioral Health Care Services under a federal grant to provide follow-up services for adolescents and young adults who were admitted to the Avera Behavioral Health Inpatient Psychiatric program for a suicide attempt or suicide ideation. This follow up program will also be available to one of the target populations of the grant – 18 to 24 year olds.

"**C-8**", When a substance abuse screening is completed in the clinic by medical personnel, and an individual's screening indicates a misuse or abuse of a specific substance, a case manager will assist the individual in securing a Brief Intervention or Brief Treatment provider in the community for continued services. If an individual is screened for Opiate abuse, the individual will be referred to Avera Behavioral Health Services program for a comprehensive assessment of their use/abuse of opiates. Based on the results of the assessment, a case manager will follow one of these options if the assessment demonstrates a misuse or abuse and not dependency: refer to the Avera Behavioral Health Service unit or a community based provider for a Brief Intervention. If the assessment shows a dependency on opiates, and there is a minimal risk of withdrawal, the case manager will refer the individual to Avera Behavioral Health Services for outpatient treatment. If an individual is assessed as being opiate dependent with an elevated risk of withdrawal, the individual will be referred to Keystone for medically monitored detoxification services, utilizing a medicated treatment approach, and then link the individual to ongoing medicated assisted treatment with Avera Behavioral Health Services for ongoing outpatient treatment services upon discharge from the Keystone facility.

For the Avera Behavioral Health Services program, Dr. Xiaofan Li, an addiction board-certified psychiatrist is in charge of the addiction clinic that utilizes a MAT approach to the treatment of opioid addicted clients. For patients with opioid use disorder, the addiction clinic can help

patients with outpatient detoxification and sobriety maintenance using medications. However, the ideal candidates for outpatient treatment for an opioid use disorder are patients with oral opioid addiction primarily. The approached utilized is as follows:

A. Outpatient detoxification from opioid dependence can be managed with symptomatic treatment using various medications other than opioids, for example, clonidine for autonomic system hyperactivity, or tylenol and ibuprofen for pain, or zofran/promethazine for nausea and loperamide for diarrhea. Or it can also be managed with suboxone detoxification.
B. For patients referred for sobriety maintenance, they will be evaluated to see if they are appropriate candidates for office-based suboxone treatment. If not, they will be recommended with other treatment options.
C. If they are appropriate candidates for outpatient suboxone therapy and they are willing to follow the policy and regulations of the clinic, they will proceed with the induction of suboxone and receive 7 days of supply of suboxone.
D. Patients need to come on a weekly basis in the beginning until they have four consecutive clean urine tests and seem to be doing well, then the visit interval can be extended to bi-weekly until another two consecutive clean urine tests, then the interval can be extended to every 4 weeks. The cycle restarts with each relapse. Patients need to come at least every 4 weeks to get their prescription of suboxone.
E. If patients have positive urine drug screen, they need to go back to once a week visit. Depending on what substance is positive in the urine drug screen, they may be asked to engage in other treatment modality, including starting outpatient chemical dependency counseling, attendance at an intensive outpatient treatment program for chemical dependence, or residential treatment. If their urine tests are positive for benzodiazepines, they will not receive their prescription on suboxone until their UDS is negative for Benzodiazepines.
F. In any circumstance, there won't be early refill or make up prescription for lost medications.
G. If patients violate the clinic policy and regulations repeatedly, they may be terminated from the clinic, especially with concern of diversions.
H. If patients could not stay abstinent for extended period of time, despite the maximum management with suboxone and other conjunctive psychosocial interventions, patients may be terminated from the clinic with recommendations for other treatment modalities.

The other treatment modality that a patient would be referred to is the MAT inpatient treatment program at Keystone Treatment Center. Keystone does medical monitored detox for opioid addicted patients. The detox is under the direction of a Medical physician. The program also has 4 physicians on staff with 2 of them being addictionologists. The program utilizes a 7 – 10 day withdrawal regimen using buphrenorphine. At the end of the buprenorphine schedule, they may be placed on a maintenance regiment of either Naltrexone or Vivitrol injections. After they complete the detox and the inpatient treatment program, they will be referred back to Dr. Xiofan for continued maintain in the community and for ongoing outpatient substance abuse treatment programming.

During years 2, 3 and 4 of the project, the plan is to expand programming to Avera clinics outside of the Sioux Falls area, develop partnerships with Medical Clinics operated by Indian Health Services located on the Reservations in the State, and with the Regional Health Care System that operates medical clinics in Western, South Dakota. Once the project becomes operational in Sioux Falls, the State will begin engaging other Medical organizations and clinics during the first year of the grant award and obtain community based partners in the other targeted regions of the State. If it is determined that there exists a need for MAT services, the Division of behavioral Health will call upon the expertise of Avera Medical Services and Keystone on the development of needed programming.
Attachment 4 contains a Signed MOU between the Division of Behavioral Health Prevention Program, Avera Behavioral Health Care Services and Keystone Treatment Center to provide Medicated Assisted Treatment for those clients who re assessed as having an opiate addiction. The MOU also contains information on the Referral process that will be followed for the placement in Medically Monitored Detoxification and ongoing community based support during ongoing outpatient treatment programming.

"**C-9**", The following table summarizes the projected number of unduplicated individuals estimated to be served through the project. The estimates for race/ethnicity and gender where drawn from the U.S. Census Bureau for the state since the projects proposes to serve a sample of the state population across the entire state over the three years of the project. LGBT and transgender estimates are based on analysis of Gallup's "State of the States" data services by the Williams Institute, UCLA School of Law which reports the number of individuals identifying themselves as lesbian, gay, bisexual or transgender at 4.4% for South Dakota.

	White @ 86.2%	**American Indian @ 8.9%**	**Other Races @ 4.9%**	**Total Pre/ Screen.**	**BI @ 7.5%**	**BT @ 5%**	**RT @ 5%**
Year 1 - Clinical Cohort 1 for Months 7-12							
Male @ 50.1%	4,788	494	272	5,554	417	278	278
Females @ 49.25%	4,670	482	265	5,417	407	271	271
Transgender @ 0.25%*	24	2	1	27	3	2	2
Pre/Screened Year 1	9,482	978	538	10,998	825	550	550
LGBT @ 4.4%*	209	22	12	243	19	13	13
Year 2 - Clinical Cohort 1							
Male @ 50.1%	9,576	988	544	11,108	834	556	556
Females @ 49.25%	9,339	964	530	10,833	813	542	542
Transgender @ 0.25%*	47	4	2	53	4	3	3
Pre/Screened Year 2	18,962	1,956	1,076	21,994	1,650	1,100	1100
LGBT @ 4.4%*	834	86	47	967	73	49	49
Year 3 - Clinical Cohort 1 for Months 1-6 and Clinical Cohort 2							
Male @ 50.1%	13,408	1,384	762	15,554	1,167	778	778

Females @ 49.25%	13,290	1,372	755	15,417	1,157	771	771
Transgender @ 0.25%*	45	5	3	53	4	3	3
Pre/Screened Year 3	26,743	2,761	1,520	31,024	2,327	1,552	1,552
LGBT @ 4.4%*	1,177	121	67	1,365	103	69	69
Year 4 - Clinical Cohort 2 and 3							
Male @ 50.1%	10,883	1,124	619	12,626	947	632	632
Females @ 49.25%	10,613	1,096	603	12,312	924	616	616
Transgender @ 0.25%*	54	6	3	63	5	4	4
Pre/Screened Year 4	21,550	2,226	1,225	25,001	1,876	1,251	1,251
LGBT @ 4.4%*	948	98	54	1,100	83	55	55
Year 5 - Clinical Cohort 3 for Months 1-9							
Male @ 50.1%	4,897	506	278	5,681	427	285	285
Females @ 49.25%	4,776	493	271	5,540	416	277	277
Transgender @ 0.25%*	24	3	1	28	3	2	2
Pre/Screened Year 5	9,697	1,002	550	11,249	844	563	563
LGBT @ 4.4%*	427	44	24	495	38	25	25
Total Across All Grant Years							
Male @ 50.1%	43,552	4,496	2,475	50,523	3,790	2,527	2,527
Females @ 49.25%	42,688	4,407	2,424	49,519	3,714	2,476	2,476
Transgender @ 0.25%*	194	20	10	224	17	12	12
Pre/Screened Years 1-5	86,434	8,923	4,909	100,266	7,520	5,014	5,014
LGBT @ 4.4%*	3,595	371	204	4,170	313	209	209

*Source: Gallup's "State of the States" data and analysis by the Williams Institute, UCLA School of Law. Since individuals that identify as lesbian, gay, or bisexual may identify their gender as being male and female, the estimate is reported separately. It is estimated that some individuals will identify their gender as "transgender" and thus it is included as a distinct category under gender.

"**C-10**", A per-person cost for the program was calculated based on the total number of individuals projected to be served. Over the five years of the project, it is anticipated that the clinics will prescreen and screen 100,266. Using the budgeted amount of money identified for direct services over the life of the project of $6,289,580 an average per-person cost of $62.73 is attained. This amount is an average amount for all participants screened. It should be noted that some will only screen and consume very few resources, while others that require treatment and MAT services will consume a considerably large portion of the project resources. The project team believes it is premature at this point to estimate the expenditures for the higher level of services since the proposed model has not been implemented within South Dakota previously. Calculation of the per-person cost for each level of services will be examined as the project is implemented.

Section D: Staff and Organizational Experience (10 points)
"**D-1**", Under the direction of Governor Daugaard, behavioral health services in South Dakota transitioned from the Department of Human Services (DHS) to the Department of Social Services (DSS), effective April 14, 2011. The purpose of the behavioral health reorganization was to create a more integrated approach to behavioral health services in South Dakota. Secretary Valenti has designated the Division of Behavioral Health Prevention Program as the lead within the Department to manage and implement the SBIRT Cooperative Agreement. Amy Iversen-Pollreisz is the Deputy Secretary for the Department and is responsible for the operations of the Division of Behavioral Health and the State's Inpatient Psychiatric Hospital. Tiffany Wolfgang is the Division Director of Behavioral Health and is the Single State Authority in South Dakota for mental health and alcohol and drug services. Gib Sudbeck, the Program Manager for Prevention Services in the Behavioral Health Division and is the NPN for South Dakota and will be the Project Director.

Since the reorganization in 2011, Division of Behavioral Health Prevention Program has successfully managed the Strategic Prevention Framework State Incentive Grant (SPF-SIG), the Strategic Prevention Enhancement Grant (SPE) through the Center for Substance Abuse Prevention, and the Garrett Lee Smith grant through the Center for Mental Health Services. All of these federal grant programs are under the Substance Abuse and Mental Health Services Administration (SAMHSA). In September of 2014, the Prevention Program also received a Partnership for Success Grant through the Center for Substance Abuse Prevention Services, a Suicide Prevention Grant through the Center for Mental Health Services, and in September 2015, the Prevention Program also received a "Now is the Time" Project Aware Grant through the Center for Mental Health Services funded by SAMHSA. With the aforementioned grants, the Prevention Program has met the goals, objectives and activities of past and current grants, and has never missed a target date for the submission of required data, or information related to quarterly reports or continuation applications.

The Partner Agencies for the SBIRT grant are currently accredited by the Division of Behavioral Health or have national accreditation or recognition in the prevention, early intervention, and substance abuse treatment areas. The Division of Behavioral Health also contracts with the partner agencies to provide mental health and/or substance abuse services. These agencies have provided behavioral health services to the target populations in their communities for decades.

"**D-2**", The Avera Medical Group that operates 11 medical clinics in the greater Sioux Empire area which includes Sioux Falls, SD, the largest city in the State and in smaller towns in Eastern, SD. A letter of support is included in the application.

The Keystone Treatment Center provides an array of treatment services in the substance abuse and gambling treatment areas. Services provided include early intervention services, gambling treatment, intensive outpatient treatment, outpatient services, detox, Level III.7 Medically Monitored Intensive Treatment for Adults, and Medicated Assisted Treatment (MAT). A letter of support from Carol Regier, the Program Director, is included in the application.

Carroll Institute is located in Sioux Falls, SD and provides a comprehensive array of substance abuse services. This program would be available to provide screenings, Brief Intervention, Brief Treatment and outpatient treatment services upon request. A letter of support from Gary Tuschen, the Executive Director, is attached to this application.

The Helpline Center, located in Sioux Falls currently operates the NSPL Help Line in the State and provides training to behavioral health professionals on suicide prevention curriculums. A letter of support from Janet Kittams-Lalley, the President of the Helpline Center, agreeing to partner with the state on this project is attached to this application.

Southeastern Behavioral HealthCare, located in Sioux Falls, is a Community Mental Health Center, and would be available to provide integrated services for those individuals with chronic mental health and other related medical conditions. A support letter from Kris Graham, the CEO of Southeastern Behavioral Health is attached to this application.

Volunteers of America - Dakotas, located in Sioux Falls can assist the project in the areas of screening, brief interventions and training of agency staff in the new Evidence Based Programs proposed for the project. A letter of support from Dennis Hoffman, the CEO of the agency is attached to this application.

Each of the substance abuse and mental health partner agencies in the Sioux Falls area are accredited by the Division of Behavioral Health, and have had decades of experience partnering with community organizations on the needs of individuals with substance abuse and/or mental illness. These organizations include NAMI, a Recovery Support organization, the court system, and the department of corrections, the department of social services, tribal organizations, the City of Sioux Falls, the Minnehaha County Commission, local AA, NA and GA organizations.

For those programs accredited in the prevention area, they are required to complete a needs assessment, develop a community strategic plan with input from the local community. They are then required to complete yearly work-plans identifying areas of need and focus, and establish yearly outcome measures for the programming that is implemented.

"**D-3**", The document below outlines the key staff and their roles and responsibilities under the project.

Project Director Gib Sudbeck	▪ Leads the Project Management Team; ▪ Final responsibility for implementation of the SBIRT Grant; ▪ Corresponds with the Substance Abuse and Mental Health Services Administration on all activities related to the grant; ▪ Works with community partners and oversees relevant operations, evaluation and outcomes tasks for the grant; ▪ Completes all federal reports related to the Grant Project; ▪ Ensures project funds are obligated and expended within the required guidelines; ▪ Budgeted for 50% effort in all years of the project.

Community Coordinator	▪ Assist in the planning, development of processes for monitoring and managing the planning and implementation of identified services; ▪ Acts as a liaison between the medical clinics and the community based partners; ▪ Participates as part of the project team for data collection, performance measurement and performance assessment and data collection; ▪ Provides technical assistance to providers to resolve barriers associated with the ongoing operation of the project; ▪ Assists the Project Director in compiling information for the required federal reports; ▪ Budgeted for 100% effort in all years of the project.
Katie Tostenson Project Coordinator	▪ Assist in identifying trainers for the selected EBP's.; ▪ Assist the local prevention providers in implementing EBP's; ▪ Conduct onsite reviews; ▪ Assist in monitoring compliance with federal grant requirements; ▪ Budgeted 10% effort in all years of the project.
Tina Miller	▪ Support staff or the project; ▪ Assist with the coordination and documentation of the activities of the grant; ▪ Provide clerical and computer support services. ▪ Budgeted 25% effort in all years of the project.
George Summerside Program Assistant	▪ Assists Project Director and Community Coordinator in the oversight of the expenditures by local projects; ▪ Participates in the Project Management Team; ▪ Develops needed contracts with partner agencies; ▪ Tracks monthly expenditures for the grant project and helps prepare any required fiscal reports for the Grant; ▪ Budgeted for 10% effort in all years of the project.
Lead Evaluator Gary Leonardson	▪ Provides technical support for the SBIRT project; ▪ Manages, analyzes and synthesizes data related to the SBIRT program activities; ▪ Establish and maintain data collection system and prepare evaluation reports on the project; ▪ Assists the Project Director and Community Coordinator in entering data into the federal reporting systems; ▪ Participates in the Management Team; ▪ Budgeted for 30% effort in all years of the project.
Contracted Evaluator Roland Loudenburg	▪ Assist the Lead Evaluator in providing technical support for the SBIRT project; ▪ Helps manages, analyze and synthesize data related to the SBIRT program activities; ▪ Under the direction of the Lead Evaluator establishes and maintains data collection system and prepare draft evaluation reports on the project; ▪ Assists the Lead Evaluator, Project Director and Community Coordinator in entering data into the federal reporting systems; ▪ Participates in the Management Team; ▪ Budgeted for 20% effort in all years of the project.

Project Director - Gilbert "Gib" Sudbeck, the DSS Prevention Program Manager, National Prevention Networker (NPN), Licensed Addiction Counselor, will serve as the Project Director. In this capacity, he will have the responsibility for implementation of the SBIRT Grant Project. He had served as the Director of Division of Alcohol and Drug Abuse in the State from 1990 to 2011. Mr. Sudbeck has had over 30 years of high-level administrative experience in administering behavioral health services in South Dakota.

Program Assistant George Summerside will serve as program assistant for the project. He has worked in the behavioral health area since January of 2010. His current responsibilities include

the following: Assistant Coordinator for the SD Youth Prevention Project Grant and the Partnership for Success Grant, review and management of the projects budget; contract and billing processes.
Project Coordinator Katie Tostenson, Human Services Program Specialists I, will serve as SBIRT Program Coordinator. Katie has worked for the DSS Prevention Program since April of 2012. She currently is the State level trainer for Mental Health First Aid. Her responsibilities with the SBIRT grant will be to assist in onsite reviews to monitor services to assure compliance with federal and state rules and regulations.
Support Staff Tina Miller, Senior Secretary, and will serve as support staff for the project. She has been working with the Division of Behavioral Health for 14 years and has provided support services to multiple federal grants.
Community Coordinator - to be determined. The individual hired, once the grant is received, will have a professional background in behavioral health and experience in working in community based prevention and treatment systems both in the alcohol and drug and mental health area. This position would also be the liaison between the Division of Behavioral Health prevention program, the Avera Health Care System and the community based behavioral Health Providers to ensure that the processes identified in the grant are followed and fidelity checks will be completed to ensure that the programming is implemented with fidelity.
Lead Evaluator – Gary Leonardson – Ph.D. will serve as the Lead Evaluator for the project. He has 30 years of experience and his Field of Study includes: Research and Statistical Methodology, Education Psychology and Sociology. Dr. Leonardson's professional experience include the following: Private Consulting (Mountain Plains Research) consisting of data analysis and applied research grant and contracts; main contractors for Cook Inlet Tribal Council, University of South Dakota, Centers for Disease Control, State of Montana, and State of South Dakota; research and evaluation activities are in substance abuse treatment programs, educational programs, criminal justice projects, medical related programs, and general human service and educational programs.
Contracted Evaluator – contracted position- Roland Loudenburg, M.P.H., Ed.S. will serve as the contracted evaluator for the project. He has nearly 30 years of experience in research and evaluation of human service programs at the local, state, and national level. Mr. Loudenburg's past professional positions include Interim Vice-President for Research at the USD, Director of Population Studies at the USD Center for Disabilities, and Chief Administrative Officer of the American Association of University Affiliated Programs. Roland currently is the lead evaluator for the SD Youth Suicide Prevention Grant and the Now is the Time Youth Mental Health Training Grant, provides support to local coalitions on data collection and evaluation and is the epidemiologist for the State prevention program.

Given the level of expertise of the State staff, consultants and community partner organizations, we are confident the State can successfully plan and implement the grant once an award is made to the State.

"**D-4**", The State of South Dakota has nine Indian Reservations in the State and a large Native American population in the metropolitan areas like Sioux Falls. The Avera Health Care System does provide clinic based services to this population in Sioux Falls and other areas of the State.

The Project Director, Gilbert "Gib" Sudbeck, is a licensed addition counselor. Mr. Sudbeck has extensive experience working in the substance abuse field and has developed a positive working relationship with Tribal providers.

George Summerside, Program Assistant, has over twenty five years of experience working with or been involved in programs and services relating to veterans, the selected reserves and their families. Before leaving the Division of Veterans Affairs in December 2009 he served as the Division Director, Education Program Manager and in other key roles within the division. His participation in the project provides a link to the military community which is also a critical population to receive services under the grant.

Katie Tostenson is the State level trainer for Mental Health First Aid and in February 2016 will be trained in Youth Mental Health First Aid. She currently provides technical assistance to the 22 local substance abuse prevention coalitions and 8 suicide prevention coalitions on the implementation of evidence based or promising practices prevention programs, on the collection and submission of local data and billing information. Her participation helps link the project to both the substance abuse and mental health populations who are one of the targets for services.

Gary Leonardson – Ph.D. will serve as the Lead Evaluator for the project. He has 30 years of experience and his Field of Study includes: Research and Statistical Methodology, Education Psychology and Sociology.

Roland Loudenburg is a contracted evaluator for the project. Roland is currently serving as the contracted epidemiologist for the SEOW project. He has nearly 30 years of experience in research and evaluation of human service programs as the local, state, and national levels. His participation in the grant project will ensure a robust data collection and evaluation plan.

The Community Coordinator will be an individual with professional credentials in the behavioral health area, and have experience in providing behavioral health services in a community based setting. This experience will be critical as we plan to serve individuals from a variety of cultural and racial background under this grant.

"**D-5**", A Policy Steering Committee (PSE) will developed to advise the Project Director (PD) on the planning phase of the project, and to provide ongoing input into the implementation of the SBIRT project plan within Health Care Organizations clinics and the community based provider system. The roles of the PSE include advising the Division of Behavioral Health on policy policies that may impact the success of the project, problem-resolution between partner organizations, oversight of the local programs to ensure performance standards are being met; assist the Division of Behavioral Health with modifying polices made by policy-making bodies; promote reimbursement code adoption/use; social marketing and dissemination; assist the PD in developing, executing, assist the

reporting annually on sustainability plans and achievements; ensuring the feasibility and successful implementation of the state/tribal HIT plan; reviewing, recommending action on, and approving the required semi-annual reports, and ensuring SBIRT training is disseminated to non-grant service organizations.

The membership of the PSE will include: representatives from the health care systems who are partners with the state on the project, medical staff from health care systems, a representative from the information technology division of the health care organization, a nurse, a representative from an insurance carrier; substance abuse provider, mental health provider, a representative of the military/national guard; a representative for Indian Health Services; a representative from a Community Health Center; representatives of past or current consumers of substance abuse or mental health services; and representatives from various ethnic and cultural backgrounds. All members of the PSE group will share the responsibility of providing input and oversight to the implementation of the SBIRT project.

Section E: Data Collection and Performance Measurement (20 points)

"**E-1**", Collection and Reporting of Performance Measures - The South Dakota SBIRT program will incorporate and document the effectiveness of the program activities through the collection of performance measures and implementation of local evaluations. Mountain Plains Evaluation, LLC (MPE) is an independent research and Evaluation Company based in South Dakota and will serve as the lead for the South Dakota SBIRT performance measurement and local evaluation activities. MPE's staff has expertise in research and program evaluation design and implementation, data and statistical analysis, and support for data collection, management, and tracking. Dr. Gary Leonardson, Ph.D. (40% FTE) and Roland Loudenburg, M.P.H., Ed.S. (10% FTE), have over 65 combined years of research and evaluation experience at the state and national level in health care, mental health, and substance abuse programs and will serve as leaders of the evaluation efforts. In particular Dr. Leonardson and Mr. Loudenburg have collaborated and independently participated in numerous SAMHSA grant evaluation programs over the past 30 plus years.

The performance measure and evaluation design will provide a comprehensive procedure for answering important questions regarding the effectiveness of the program, to increase access to effective alcohol and drug and mental focused mental healt treatment and service systems in communities for adults. Process, qualitative, and outcome evaluation procedures will be utilized to assess the effectiveness and efficiency of the SBIRT activities.

The South Dakota SBIRT and MPE, LLC team has extensive experience in the collection of the required performance measures data. As part of previous grant projects the team has collected the required National Outcome Measures (NOMs) Client-Level Measures and submitted the data via SAMHSA's data-entry and reporting systems. It should also be noted that the evaluation team has worked closely with multiple federally required cross site evaluations on previous grants.

It should also be noted that the project is budgeting resources for health care systems to adapt and modify EHRs and health information systems. An expectation of the modification is the

ability for the EHRs and health information systems to collect and report performance measures to assist in the required data collection and support the overall evaluation activities.

"E-2", Plan for Data Collection, Management, Analysis, and Reporting

Data Collection: South Dakota SBIRT evaluation team will work closely with the primary health care providers to utilize and adapt existing EHRs and health information systems to collect and document the data required for the SBIRT program. For the CSAT-GPRA data collection tools, a face-to-face data collection process must be employed. The South Dakota SBIRT evaluation team will work closely with the primary care clinical staff to integrate the data collection into the clinic process in a manner the maintains the reliability and validity of the data.

The evaluation team will work with Avera staff to integrate the screening tools into the EHRs as allowable under the grant. An advantage to using an integrated screening tool is the enhancement and standardization of the screening and assessment into the clinical process for clinicians to utilize with their patients. Screening tools and assessments integrated into EHR environments also increases the data reliability and validity of the information collected with the added benefit of the information in the system being available for review and use by the clinician. This reduces the potential for data entry errors, and when an error is noted a correction can be made quickly. The following table provides a summary of which assessments that are being used and at what time the data is being collected.

Summary of Data Collection Instruments and Assessments and Time of Administration

Instrument	Client Screened (only)	Screen +	Screen + and Ref. Treat.	Discharge	6-Months Post Baseline
CSAT-GPRA (Sections to be completed by type of Client)	✓	✓	✓	✓	✓
AUDIT-C	✓	✓	✓	✓	
AUDIT	✓	✓	✓	✓	
DAST	✓	✓	✓	✓	
PHQ-2 or PHQ-9	✓	✓	✓	✓	
Tracking Information Sheet		✓		✓	
Exit Interview/Satisfaction Survey				✓	✓

An additional advantage of using EHRs is protection of patient information and the security built into the system. Processes for extracting data from the EHRs will be developed that de-identify the data to the degree possible. Exported data will be maintained on secure password protected computer networks to further enhance confidentiality. To the degree possible, the EHRs will be adapted to aid in the identification and tracking of patients that require the administration of the CSAT-GPRA follow-up data components. This will avoid the necessity to maintain patient identifiers in a system external to the EHR.

While the EHR system form the foundation for collection of client related data. Project records, training logs, staff activity logs will be used to collect data to track progress in regards to the non-clinical project objectives. The following table summarizes data collection and measurement by project objectives and the person responsible.

GOAL, PROCESS and OUTCOME OBJECTIVES, and Measurement/Responsible Person
Goal 1: To develop the organizational relationships and infrastructure for integration of SBIRT services into primary care and community behavioral health settings in South Dakota.
Objective 1.1: Enhance organizational readiness and commitment for implementation of SBIRT into community behavioral health systems.
Measurement: Documentation and observation of organizational meetings for the SBIRT project. Conduct a qualitative readiness assessment interview with key project stakeholders from primary care, prevention and treatment organizations. Person Responsible: Lead Evaluator and evaluation team.
Objective 1.2: Develop SBIRT patient flow process for primary care and community behavioral health settings.
Measurement: Documentation of patient flow process and evidence of adherence to identified patient flow process in SBIRT implementation. Person Responsible: Lead Evaluator and evaluation team.
Objective 1.3: Develop patent flow and referral protocols for referral of patients from primary care settings to behavioral prevention services, treatment services, and/or Medication-Assisted Treatment.
Measurement: Documentation of referral protocols and evidence of adherence to identified protocols in SBIRT implementation. Person Responsible: Lead Evaluator and evaluation team
Objective 1.4: Facilitate the establishment of formal referral agreements between SBIRT and partner organizations.
Measurement: Documentation of referral agreements and evidence of adherence to agreements in SBIRT implementation. Person Responsible: Lead Evaluator and evaluation team.
Goal 2: To develop and Implement SBIRT Training for primary care, community behavioral health including substance abuse prevention and treatment providers.
Objective 2.1: Assemble an SBIRT training curriculum for primary care clinics, community behavioral health including substance abuse prevention and treatment providers.
Measurement: Documentation of training curriculum in the form of manuals and other materials. Evidence that the training is consistent and inclusive of national recognized constructs associated with SBIRT training. Person Responsible: Lead Evaluator and evaluation team.
Objective 2.2: Train all staff involved in SBIRT services in primary care clinicians, community behavioral health including substance abuse prevention and treatment provider in each partnering community.
Measurement: Documentation of the number of individuals participating in training, ratings of training by participants, and follow-up questionnaires and interviews of clinicians regarding the adequacy of training. Person Responsible: Lead Evaluator and evaluation team.
Objective 2.3: Provide annual refresher training in SBIRT to Behavioral Health prevention and treatment provider agencies participating in each community.
Measurement: Documentation of number of individuals participating in refresher training, ratings of training by participants, and follow-up questionnaires and interviews of Behavioral Health participants regarding the adequacy of training. Person Responsible: Lead Evaluator and evaluation team.
Goal 3: Implement SBIRT services in primary care and community Behavioral Health settings in South Dakota.
Objective 3.1: Integrate screening tools into clinical processes and EHRs.
Measurement: Documentation of screening protocols in EHRs and confirmation of patient screening data within the system that appears consistent with screening rates reported within the research literature. Person Responsible: Lead Evaluator and evaluation team in coordination with health systems IT Departments.
Objective 3.2: Integrate brief Intervention into clinical processes and prevention services.

GOAL, PROCESS and OUTCOME OBJECTIVES, and Measurement/Responsible Person
Measurement: Documentation of brief intervention processes integrated into the clinical process and confirmed within patient's EHR. Person Responsible: Lead Evaluator and evaluation team in coordination with health systems IT Departments.
Objective 3.3: Integrate referral to treatment and or MAT.
Measurement: Documentation of MAT processes integrated into clinical process and confirmation within patient EHR data. Person Responsible: Lead Evaluator and evaluation team in coordination with health systems IT Departments.
Objective 3.4: Implement the SBIRT in primary care and community health settings.
Measurement: Number of clients participating in screening, assessments, and evaluations. Number of clients receiving brief intervention or referral to treatment and/or MAT. Person Responsible: Project Director and Lead Evaluator.
Goal 4: Monitor quality and evaluate SBIRT implementation and programming.
Objective 4.1: Develop data collection protocol.
Measurement: Documented by a written data collection protocol that is disseminated to clinical and project staff. Person Responsible: Lead Evaluator and evaluation team.
Objective 4.2: Monitor program implementation.
Measurement: Documented by the number of clinics implementing SBIRT and number of patients screened and referred. Qualitative observations within clinics and confirmed by peer-observation. Person Responsible: Project Director and Lead Evaluator.
Objective 4.3: Conduct ongoing formative evaluation of SBIRT screening, brief intervention, and referral to treatment and/or MAT.
Measurement: Documented by evidence of data summations shared with project and clinical staff. Qualitative observations of evaluation data discussions included in team meeting minutes. Person Responsible: Lead Evaluator and evaluation team.
Objective 4.4: Conduct an impact evaluation of patient outcomes.
Measurement: Documented by evidence of patient outcome data at follow up points and summation in formal evaluation reports and grant reports. Person Responsible: Lead Evaluator and evaluation team.
Objective 4.5: Participate in national evaluation through collection and reporting of required data elements.
Measurement: Documented by evidence of data submitted to national reporting system. Qualitative evidence of participation in evaluation national meetings. Person Responsible: Lead Evaluator and evaluation team.

Analysis: The quantitative data collected will provide descriptive analysis of the clients and describe client demographics, characteristics and screening results. Frequency tables will be generated to describe the number of clients served and provide a description of various cohorts developed in the evaluation process. Scores obtained from the various screening and assessments will be used to monitor changes in various constructs identified for the clients: behavior, stress, knowledge, etc. A covariance of analysis will be performed to determine if various SBIRT intervention or treatment strategies are effective. Independent factors will include age, gender, type of intervention (screening only, BI, BT and Treatment or MAT), dosage, data collection period (pre, post, or follow-up), and ethnicity. Through analysis, it will be determined whether the SBIRT interventions contributed to significant changes in the substance use behaviors, depression, and social connectedness. Qualitative data, interviews, and case studies will be used to triangulate the quantitative data and aid in explaining and illustrating the needs of the patients and the impact of SBIRT treatment and services. This information will be used to support or

provide a linkage to measurable changes measured in patient behaviors through the SBIRT process and collected through the EHR and required CSAT-GPRA data.

The goal of the data analysis procedures is to obtain a *Power* of at least .80, while maintaining an *Alpha* value of .05 with the *Beta* level at or below .20. To illustrate that sufficient statistical *Power* is expected based on the proposed sample, a *Power* analysis using Multiple and Logistic regression analysis will be conducted and determine whether the proposed number of clients each year provides sufficient power (e.g., > .79) to conduct multiple and logistic regression procedures.

Reporting and Dissemination: Once the data is collected and analyzed, preliminary findings and results of the project evaluation and project activities will be reported and disseminated to three primary audiences as follows:
SBIRT Program Staff: Formative information is helpful in refining and enhancing the program and will be shared with program staff and partnering organization staff and other program partners through meetings, presentations, and short data reports. This will aid in continuing to enhance the program effectiveness and will embody a data driven approach to the program to maximize program outcomes. A quarterly evaluation summary report completed at the end of each quarter will be submitted to project staff as part of the quarterly reporting requirements. The evaluation findings and recommendations will be used for continuous program improvement and for documenting the effectiveness of each of the components identified for the South Dakota SBIRT project. A final evaluation report at the end of the project period will document the program outcomes as well as progress of the South Dakota SBIRT project in meeting the proposed goals and objectives.
SAMHSA, Policy Makers, and Stakeholders: Formal results of the program evaluation data will be shared with SAMHSA as part of the required reporting process. In addition, summary reports will be shared with state policy makers, and other stakeholders to document the effectiveness of the program and to aid in fostering the expansion of SBIRT prevention and treatment services across the state.
The results of the program and lessons learned during the implementation of the program will be shared with the other grantees and similar programs through participation and presentation at regional and national meetings, conferences and webinars. The South Dakota SBIRT team has participated in presenting at regional and national conferences in the past sharing program results.
General Public and Communities: The project will work to share stories about the purpose of the program and the impact of the programming on reducing substance use and enhancing patient outcomes. The project will also target community stakeholders and potential partners with the information to enhance the awareness, adoption and integration of SBIRT services within the service delivery system.

"**E-3**" Local Performance Assessment Plan – The local performance assessment plan employs a biopsychosocial model to measure the effectiveness of the implementation of the South Dakota SBIRT program and the achievement of the stated patient outcomes. Substance use/misuse,

mental health and associated illnesses are conceptualized as products of a variety of factors, including biological variables (genetic predisposition, exposure to pathogens), psychological factors (behaviors, beliefs, attitudes, emotions), and social conditions (social support, cultural influences). Effective SBIRT services must account for the wide range of potential causes and provide a tool for clinicians to utilize to meet the needs of individual clients. Documenting epidemiological information, relevant demographics, assessment and screening data, and clinical intervention and treatment approaches to manage substance use and associated symptoms is a critical component of the evaluation process. Through a series of assessments and feedback from the patients and clinical staff, the SBIRT project staff lead, guided by the evaluation team, will be able to ascertain if specific SBIRT strategies are effective and which areas require modification. The following evaluation questions will be addressed using the data described above as part of the local performance assessment plan.

Evaluation Questions:

Evaluation Questions
Question 1: As a result of the South Dakota SBIRT project, was there an increase in the number of patients identified through the screening processes as at-risk for substance abuse problems?
Question 2: As a result of the South Dakota SBIRT project, what are the number and type of training opportunities made available to clinicians and service providers in order to improve SBIRT services and interventions?
Question 3: As a result of the South Dakota SBIRT project, what is the number/percentage of service provider staff who report increased expertise in SBIRT services?
Question 4: As a result of the South Dakota SBIRT project, was there an increase in the number and quality of community partnerships inclusive of formal SBIRT referral processes and agreements?
Question 5: After participating in the South Dakota SBIRT project, what is the number/percentage of patients experiencing a reduction in substance use symptoms, depression, and other health indicators?
Question 6: After participating in the South Dakota SBIRT project, what is the number/percentage of participating patients who demonstrated an improvement in relationships with clinicians?
Question 7: As a result of the South Dakota SBIRT project, is there increased in access to effective treatment for individuals referred for substance abuse treatment services?

"**E-4**", Quality Improvement Process - The South Dakota SBIRT project will convene regular staff meetings in which the program staff review their activities and reflect upon the challenges faced by the program. This process forms the foundation for an ongoing quality improvement process. For clinical services data from the EHR system and the CSAT-GPRA forms will be used to examine the effectiveness of services and identify areas for improvements in services. The staff meetings will also serve as a forum to review training and outreach activities and evaluation forms providing feedback for training events. As part of the quarterly reporting process, progress towards meeting the project Goals and Objectives will be reviewed by the South Dakota SBIRT project team. Adaptations to project activities can then be addressed and implemented in the following quarter.

Section F: Biographical Sketches and Job Descriptions

"F-1", Biographical Sketch – State Staff

Name: Gilbert "Gib" Sudbeck
Position Title: Prevention Program Manager

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
University of South Dakota, Vermillion, SD	MA	1980	Counseling, Guidance, & Personnel Services
University of South Dakota, Vermillion, SD	BS	1978	Social Work; Psychology (double major)

PROFESSIONAL EXPERIENCE

2014 – Present Project Director – "Now is the Time" Project Aware Grant
2014 –present Project Director – South Dakota Youth Prevention Project
2014 – Present Project Director – South Dakota Partnership for Success Grant
2012 – 2013 Project Director – Garrett Lee Smith Grant
2011 – 2013 Project Director – State Prevention Enhancement Grant
2012 – Present Project Director – State Prevention Framework State Incentive Grant
2011 – Present Program Manager – Prevention Services/Behavioral Health Dept. of Social Services
1990 -2011 Director, Division of Alcohol & Drug Abuse, South Dakota Dept. of Human Services, Pierre, SD.
1988-1990 Director, Corrections Substance Abuse Programs, Dept. of Corrections, Pierre, SD.
1986-1988 Alcohol and Drug Supervisor & Counselor, Chemical Dependency Program, Lewis and Clark Mental Health Center, Yankton, SD.
1981-1986 Alcohol and Drug Supervisor & Counselor, Human Services Center, Yankton, SD.
1980-1981 Social Worker II, Youth Drug & Alcohol Treatment Program, Human Services Center, Yankton, SD.
1978-1979 Social Worker I, Center for the Developmentally Disabled, University of South Dakota, Vermillion, and SD.

RELATED PROFESSIONAL EXPERIENCE

April 2012 NPN (National Prevention Network) for South Dakota
2008- 2012 Appointed by Secretary Leavitt to serve as a member of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment National Advisory Council
2004-2011 Appointed by the Governor to serve on the Juvenile Justice Task Force for the State
2004 - 2008 Project Director for the FASD Prevention Project through the Center for Excellence

2003-present named as the Fetal Alcohol Syndrome Coordinator for the State of South Dakota
2003-2007 Regional VIII representative for the National Association of Alcohol and Drug Abuse Directors
1996-2001 Project Director, State of South Dakota Needs Assessment.

Gilbert Sudbeck – Job Description

Position Title: Prevention Program Manager – Behavioral Health Services

Duties: Provide programmatic and fiscal oversight for the 22 substance abuse prevention programs, the 3 prevention resource centers and the 8 suicide prevention coalitions in the State. Prepare yearly budgets for the prevention providers, and oversee the expenditure of federal dollars. Develop federal grant applications, plan and implement approved projects and complete the required federal reports.

Supervisory: the position supervises two positions; one position is a Program Specialists I and the other position is a Program Specialists II.

Skills and knowledge required: Experience in managing budgets, personnel, grant writing, data collection, knowledge of evaluation and the ability to communicate with a variety of community based organizations and federal partners.

Personal qualities: honesty, integrity and willingness to be a part if a team approache.

Amount of Travel: both in-state and out-of-state travel on a frequent basis

Salary: $84,000

Hours per week: Salaried position – minimum of 40 hours per week.

Name: Katie Tostenson

Position Title: Program Specialists

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
Ashford University, Clinton IA	BA	2011	Psychology

PROFESSIONAL EXPERIENCE

2014 – Present Program Coordinator "Now is the Time" Project Aware Grant

2014 –present Program Coordinator – South Dakota Youth Prevention Project

2014 - Present Program Coordinator - South Dakota Partnership for Success Grant

2012 – Present Program Specialist I, Prevention Program/Behavioral Health Dept. of Social Services, Pierre, SD
2007 – 2012 Team Lead, Habilitative Services Inc., Worthington, MN
2007 Team Lead Assist, Habilitative Services Inc., Worthington, MN
2006 – 2007 Direct Support Professional, Habilitative Services Inc., Worthington, MN
2004 – 2007 Direct Support Professional, Independent School District 518, Worthington, MN

RELATED PROFESSIONAL EXPERIENCE
2014 – Present Trained Strengthening Families Facilitator
2013 Participated in the Department of Health Tobacco Strategic Plan writing
2013 – Present Trained Project Success Facilitator
2013 – Present Trained Mental Health First Aid Instructor
2012 – 2014 Trained Safe Dates Instructor
2007 – 2012 Trained Medication Administration Instructor
2008 – 2012 CPR Instructor

Katie Tostenson – Job Description
Position Title: Program Specialists I –Division of Behavioral Health

Duties: Provide technical assistance to the 22 substance abuse prevention programs, the 3 prevention resource centers and the 8 suicide prevention coalitions in the State on the planning and implementation of evidence based programming. Verify the billing information for the prevention provider's reimbursement for prevention services provided. Assist in developing federal grant applications, collect needed information for the required federal reports and enter the data into the federal reporting systems. Conduct onsite accreditation reviews of the community based prevention providers. Provide mental health first aid training to local communities.

Supervisory: No supervisory responsibilities.

Skills and knowledge required; knowledge of the Evidence Based Programs being implemented in the State, knowledge of the prevention programs administrative prevention rules, knowledge of multiple state supported computer programs, and knowledge of federal reporting data collection systems.

Personal qualities: ability to work with others, good communication skills and the ability to handle multiple tasks in a condensed time period.

Amount of Travel: both in-state and out-of-state travel on a frequent basis

Salary: $45,000

Hours per week: Salaried position – minimum of 40 hours per week.

Biographical Sketch – Contracted Staff

Name: Leonardson, Gary R., Ph.D.

Education

Institution and Location	Degree	Year Conferred	Field of Study
University of Northern Colorado Greeley, CO	Ph.D.	1976	Research and Statistical Methodology
Brigham Young University Provo, UT	M.A.	1973	Education Psychology
Brigham Young University Provo, UT	B.S.	1971	Sociology

Professional Experience

- Private Consulting (Mountain Plains Research) consisting of data analysis and applied research grant and contracts. Main contractors: Cook Inlet Tribal Council, University of South Dakota, Centers for Disease Control, State of Montana, and State of South Dakota. Research and evaluation activities: substance abuse treatment programs, educational programs, criminal justice projects, medical related programs, and general human service and educational programs. 1991-present
- Research Coordinator, Office of Educational Research, School of Medicine, University of South Dakota, Vermillion, SD, 1982-1991
- Social Scientist, U.S. Forest Service. Work entailed survey research, ethnographic research, computer modeling of job and income production, report writing, and analysis of primary and secondary data. Part-time teacher at Western Montana College. 1977-1982
- Research Specialist, College of Education, Bowling Green State University, Bowling Green, OH, 1976-1977

Honors Received

Honor Society – Clark County High School
Meritorious Service Award: US Forest Service
Award for Significant Contribution to Strong Heart Study
Alpha Kappa Delta (National Sociology Honor Society)
Graduated magna cum laude at BYU and UNC
Awarded two graduate student assistantships at UNC

Relevant Publications (8 of 50 publications)

- Leonardson, G.R., Loudenburg, R. (2003) Risk Factors for High-Risk Women Drinking in a Multi-State Area, Neurotoxicology Teratology, 25 (2003) 651-658.
- Loudenburg, R. Leonardson, G.R., (2003) A Multifaceted Intervention Strategy for Reducing Substance Use in High-Risk Women, Neurotoxicology Teratology 25 (2003) 737-744.
- Leonardson, G.R. Montana-based program shows reductions in domestic violence re-arrests after treatment, Cognitive-Behavioral Treatment Review: 9(1): 1-3, 2000.

- Leonardson, G.R. Evaluation of substance abuse treatment program at Flowering Tree, Pine Ridge, South Dakota. Report summated to Center for Substance Abuse Treatment, 2002.
- Leonardson, G.R. Evaluation of substance abuse treatment program at Thunder Child Treatment Center, Sheridan, Wyoming. Report submitted to Center for Substance Abuse Treatment, 2003.
- Kvigne, V.K., Bad Heart Bull, L., Welty, T.K., Leonardson, G.L., Lacina, L. Relationship of prenatal alcohol use with maternal and prenatal factors in Americn Indian woman, Social Biology, 45(3-4): 215-222, 1999.
- Bad Heart Bull, L., Kvigne, V.K., Leonardson, G.L., Lacina, L., Welty, T.K. Validation of self-administered questionnaire to screen for prenatal alcohol use in Northern Plains Indian women. American Journal of Preventive Medicine, 16(3): 240-242, 1999.
- Han, L., Hagel, J., Welty, T., Ross, R., Leonardson, G., Keckler, A. Cultural factors associated with health-risk behavior among Cheyenne River Sioux, Journal of American Indian Mental Health, 5(3): 15-29, 1994.

Relevant Evaluation Contracts (last 8 years)

Co-Evaluator for Salish and Kootenai Environmental Supports for Prevention of Diabetes with the Salish Kootenai College in Pablo Montana, Grant from Center for Disease Control, 2005-2008.

Co-Evaluator for Circles of Care (mental health services for adolescent Native Alaskans) with the Cook Inlet Tribal Council (Anchorage, Alaska) Grant from US Department of Education, 2004-2008.

Co-Evaluator for Mentoring Project (for Alaska Native youth) with the Cook Inlet Tribal Council (Anchorage, Alaska) Grant from US Department of Education, 2004-2007.

Contract with the Division of Alcohol and Drug Abuse-State of South Dakota to provide outcome studies research. Clients (community-based and penitentiary) receiving services are followed tracked one-year post-treatment. Outcome factors are correlated with information collected during treatment, 1999-2008.

Contract to assess student achievement and related factors in school district with a significant minority population. Developed profiles of students who achieve, determined risk and protective factors related to achievement, and developed projected level of achievement of school district and all other school district in the state. Wahluke School District, Mattawa, Washington, 2000-2005.

Project Evaluator for the 4-State FAS Consortium. A six-year CSAP funded project administered by the University of South Dakota. This is a research project that examines the utility of community based intervention programs for high risk pregnant women. Also, the

project will establish the prevalence of FAS/FAE in the four-state area of Montana, South Dakota, North Dakota, and Minnesota, 2000-2007.

Co-Project Evaluator for CSAT funded Targeted Capacity Expansion grant administered by the Thunder Child Treatment Center in Sheridan, WY. This is a treatment program for substance abusing HIV and Hepatitis positive persons of Native American heritage. 1999-2004.
Contract to assess disproportionate minority confinement of juveniles in Montana (2001) and South Dakota (2004).

Co-Project Evaluator for CSAP funded mentoring project with high-risk middle school students in Native American community in South Dakota, 1999-2002.

Biographical Sketch
Name Loudenburg, Roland B., M.P.H., Ed.S.
Education

Institution and Location	Degree	Year Conferred	Major Field of Study
University of South Dakota, Vermillion, SD	Ed.S.	2014	Research and Statistics Educational Psychology
University of Michigan School of Public Health Ann Arbor, MI	M.P.H.	1997	Public Health Policy and Administration
University of Maryland, College Park, MD	B.S.	1994	Biology

Professional Experience

- Mountain Plains Evaluation, LLC, Senior Research/Evaluation Scientist, Primary Clients: South Dakota Department of Public Safety, South Dakota Department of Human Services, and private substance abuse service providers in South Dakota. July 2005 – Present
- Interim Vice President for Research, University of South Dakota, January 2005 – June 2005
- Assistant Professor, Department of Family Medicine, University of South Dakota, December 2003- July 2005
- Associate Director/Director of Program Evaluation and Population Studies, Center for Disabilities (formerly SDUAP), Department of Pediatrics, University of South Dakota School of Medicine, Sioux Falls, SD, 1999-2003
- Chief Administrative Officer, American Association of University Affiliated Programs, (AAUAP), Silver Spring, MD, 1998
- Director of Data, Information, and Reporting, American Association of University Affiliated Programs (AAUAP), Silver Spring, MD, 1994-1998
- Research Associate, COSMOS Corporation, Washington, D.C., 1992-1993

Current Appointments/Membership

- Adjunct Professor, University of South Dakota
- Former Chair and Alternate Member, University of South Dakota, Institutional Review Board
- Clerk, Benton Township, McCook County South Dakota
- Adjunct Faculty, Montana State University, Billings, College of Allied Health Professions
- Member American Evaluation Association

Relevant Publications

- Eckrich, J., Loudenburg R. (2012) "Answering the Call: Drug Courts in South Dakota." *South Dakota Law Review* 57.2 (2012): 171-87. Print.
- “South Dakota 24/7 Sobriety Program Evaluation Findings Report”, South Dakota Office of the Attorney General and South Dakota Department of Public Safety, 2010.

- Leonardson, GR., Loudenburg, R., and Struck, J. (in publication) Factors Predictive of Alcohol Use During Pregnancy in Three Rural States, Behavioral and Brain Functions
- "South Dakota Substance Abuse Epidemiological Profile," Division of Alcohol and Drug Abuse, South Dakota Department of Human Services, Spring 2008 (primary author)
- "South Dakota Regional Profile of Substance Abuse Consequences and Consumption," Division of Alcohol and Drug Abuse, South Dakota Department of Human Services, January 2008 (primary author)
- Bhatara, V, Loudenburg, R., and Ellis, R. Association of Attention Defict Hyperactivity Disorder and Gestational Alcohol Exposure, Journal of Attention Disorders, 9, 515-522, 2006.
- Leonardson, G.R., Loudenburg, R. (2003) Risk Factors for High-Risk Women Drinking in a Multi-State Area, Neurotoxicology and Teratology, 25, 651-658, 2003.
- Loudenburg, R., Leonardson, G.R. (2003) A Multifaceted Intervention Strategy for Reducing Substance Use in High-Risk Women, Neurotoxicology and Teratology, 25, , 2003.
- "Outcome Measures: A Conceptual Model," American Association of University Affiliated Programs, October 1996 (primary author)
- "High Risk Youth (HRY) and Pregnant and Postpartum Women Grant Classification Database Manual," Center for Substance Abuse Prevention (CSAP), COSMOS Corporation, January 1993 (co-author)

Name: George Summerside
Position Title: Program Specialists
II

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
Huron University, Huron, SD	BA	1985	Human Services

PROFESSIONAL EXPERIENCE

2014 – Present Program Assistant "Now is the Time" Project Aware Grant

2014 - Present Program Specialists – South Dakota Youth Prevention Project
2010 – 2014 State Coordinator – State Prevention Framework State Incentive Grant
2012 - Present SEOW Coordinator – State Prevention Framework State Incentive
Grant 2012– 2013 State Coordinator – State Prevention Enhancement Grant
2011 – 2012 Program Staff – State Prevention Enhancement Grant
2010 – Present Program Specialist II, Prevention Program/Behavioral Health Dept. of Social
Services, Pierre, SD
2007 – 2009 Acting Director, SD Division of Veterans Affairs, Pierre, SD
1996 – 2007 Education Program Manager, SD Division of Veterans Affairs, Pierre,
SD 1994 – 1996 Education Program Specialist, SD Division of Veterans Affairs,
Pierre, SD 1988 – 1994 Veterans Services Specialist, SD Division of Veterans
Affairs, Pierre, SD 1985 – 1988 Job Service Representative, Job Service of South
Dakota, Huron, SD

RELATED PROFESSIONAL EXPERIENCE
2008 – 2009 Chairman for SD Veterans Affairs Leadership Team
2007 – 2008 Chairman for SD Veterans Preference Work Study Committee
2007 Member of County/Veterans Service Officer Compensation Task Force
2007 – 2008 Testified before Congress at two field hearings and at one committee hearing
in Washington, DC on veterans' education issues and program funding
2004 Project Coordinator for "Welcome Home Outreach"
1998 – 2000 Vice Chairman, Other On-The-Job Training & Apprenticeship Committee for
National Association of State Approving Agencies (NASAA)
1997 – 2007 Chairman, Automation & Technology Committee for National Association of
State Approving Agencies (NASAA)
1998, 2001 Instructor at National Training Institute for National Association of State
Approving Agencies (NASAA)
1997 – 1998 State Chairman, Department of South Dakota American Legion Rehabilitation
Committee 1990 – 1994 Project Coordinator for "Hall of Honor Project"
1990 Member of Veterans Transportation Task Force
1989 – 1992 Editor of South Division of Veterans Affairs "Bi-Monthly Vet Letter"

George Summerside – Job Description

Position Title: Program Specialists II – Division of Behavioral Health

Duties: provide technical assistance to the 22 substance abuse prevention programs, the 3 prevention resource centers and the 8 suicide prevention coalitions in the State on the planning and implementation of evidence based programming. Generate vouchers for the payment of local providers. Prepare yearly contracts with prevention providers once approved by the prevention program manager. Monitor grants fund expenditures on a monthly basis. Assist in developing federal grant applications. Collect needed fiscal information for the required federal reports. Conduct onsite accreditation reviews of the community based prevention providers, and act as the prevention programs liaison with the SEOW workgroup in the State.

Supervisory: No supervisory responsibilities.

Skills and knowledge required: knowledge of the Evidence Based Programs being implemented in the State, knowledge of the prevention programs administrative prevention rules, knowledge of multiple state supported computer programs, knowledge of the state's fiscal operations, and the state's budging process.

Personal qualities: ability to work with others, good communication skills, detailed orientated, and the ability to work with a variety of state and community based organizations.

Amount of Travel: both in-state and out-of-state travel on a frequent basis

Salary: $56,000

Hours per week: Salaried position – minimum of 40 hours per week.

Section G: Confidentiality and SAMHSA Participant Protection/Human Subjects

"**G -1**", Data collection Instruments/Interview Protocols - The South Dakota Screening, Brief Intervention and Treatment and Referral to Treatment project is designed to increase access to effective Screening, Early Intervention and Treatment Services for adults identified as having substance abuse, tobacco and/or mental health issues at the time of their annual visit to Medical Clinics in communities across South Dakota. The project will utilize evidence based screening protocols and tools, and evidence based prevention, early intervention and treatment services, including medicated assisted treatment for those individuals addicted to opiates. The Division of Behavioral Health Prevention Program, the Medical Clinics involved with the project, and the community based prevention and treatment providers are committed to protect the confidentiality of participants and the project present minimum to no risk to participants.

1. Protection from Potential Risks:

- **Identify and describe any foreseeable physical, medical, psychological, social, legal or other risks or potential adverse effects.** Participants will not be subject to any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects through participating in this grant project. The planned screenings and therapeutic services are designed to help to address substance abuse and mental health symptoms. Participation in this project will not increase risk of self-harm or increase substance abuse or mental health symptoms, but is intended to offer additional resources and support to adults who have experienced problems with mental illness, the use of substances including tobacco, and this use is adversely affecting their lives. An identified risk to the participant would be the protection of the information that he/she is participating in the project. Thus, it would be important to maintain the identity of the participants in this project in a confidential manner. Current services and follow-up protocols contain safeguards in maintaining confidentiality in all contacts with participants. The only exception to this is when a person is deemed to be at imminent risk for suicide or harm to others and contact information is then released to emergency response personnel in those situations.

a. **Describe the procedures you will follow to minimize or protect participants against potential risks, including risks to confidentiality.** Any contact and personal information collected from project participants will be treated confidentially following established protocols. Information collected from the participants will be de-identified and entered into computer data systems for analysis. The information will be identified by numeric ID, and only project staff and evaluators will have access to computerized data. Names are not generally associated with the computerized information, since numeric ID's will be used. Any forms or hard copy data collection forms will be stored in locked cabinets.

b. **Identify plans to provide help if there are adverse effects to participants.** The likelihood of any adverse effects to participants is extremely rare. In the event a participant is assessed to be at imminent risk for self-harm or harm to others, an emergency response protocol will be activated. Clinical treatment programs and recovery support services providers that are accredited or certified are available to provide help if adverse events should occur with participants that do not involve imminent risk.

c. **Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reason for not using them.** If needed, any additional treatments and interventions will be provided to the participants. The advantages of various aftercare and treatment programs will be determined and appropriate referrals made as needed. Alternative programs, if utilized, will be culturally appropriate. The only rationale for nonuse is lack of cultural appropriateness with specific populations.

2. Fair selection of participants:

a. Describe the target population(s) for the proposed project. The South Dakota Screening, Brief Intervention and Referral to Treatment Project will target adults in the State. The projects has prioritized Native Americans and Pregnant women, but will also deliver services to military personnel including returning veterans, underserved racial/ethnic minorities and with individuals who fall in a low socioeconomic status . The Project will work to reduce disparities and increase access to evidence based, prevention and treatment services in communities across South Dakota. The project will provide training to health, mental health and substance abuse providers on the screening protocols, the evidence based prevention and treatment programs and the referral protocol for participants. All trainings provided will be culturally appropriate

b. Explain the reasons for including groups of pregnant women, children, people with mental disabilities, and people in institutions, prisoners or others who are likely to be vulnerable to HIV/AIDS. The rational for including the identified Native American target population is based upon the data that demonstrates they are at high risk for substance abuse and mental health issues. The selection of pregnant women as another target population is based on data that demonstrates that women of child bearing age have a high rate of drinking and binge drinking which could have a negative impact on the women, or future infants in the State. It is possible that these target groups may also be likely to be vulnerable to HIV/AIDS, but these characteristics would not be a reason for inclusion or exclusion from the project.

c. Explain the reasons for including or excluding participants. It is not anticipated that participants will be excluded except in instances where they exclude themselves by declining to participate in the project as offered to them or choose not to access the behavioral health or healthcare providers to which they are referred.

d. Explain how participants will be recruited and selected. Identify who will select participants. The Division of Behavioral Health Prevention Program has developed a working relationships with the Medical Community in the State, and has had decades of experience working with prevention and treatment providers across the State. The Medical Community, who will be identifying individuals through a screening process for inclusion in recommended programming, have a long and successful history of providing medical care in communities across the State. The prevention, substance abuse and mental health professionals involved with the project have extensive experience working with the populations of focus, and the agencies they work for have had decades of experience providing substance and mental health services in local communities. Their familiarity with the language, beliefs, norms, values, and

socioeconomic factors of the State's population, helps them establish trusting relationships with the target population for this project which is critical to motivate individuals to enter and complete the recommended community based services.

3. Absence of Coercion

a. **Explain if participation in the project is voluntary or required. Identify possible reasons why it is required, for example, court orders requiring people to participate in a program.** Participation will be voluntary, including the signing of releases and informed consent forms when necessary and depending on the nature of the services or referral provided.

b. **If you plan to pay participants, state how participants will be awarded money or gifts.** Participants will not be awarded money or gifts.

c. **State how volunteer participants will be told that they may receive services even if they do not participate in the project.** No behavioral health or health care services will be withheld from any eligible person needing those services, regardless of their decision to participate or not in any components of the proposed grant project.

4. Data Collection

a. Identify from whom you will collect data. Describe the data collection procedures and specify the sources for obtaining data. Describe the data collection setting. Data will be collected from all individuals that participate in the South Dakota Screening, Brief Intervention and Referral to Treatment project implemented through the Division of Behavioral Health Prevention Program. The required reporting data for the grant will be collected by Mountain Plains Evaluation, Inc. who will be under contract with the state to perform this function. The CIMI system will be utilized which includes safeguards and requires informed consent for participation. Trained staff will conduct face-to-face follow up with selected program participants.

The evaluation team will work closely with the project director and project staff to design a data collection, performance measurement and evaluation plan that will provide a comprehensive set of procedures for collecting the required data and performance measures. In addition, a local performance assessment and evaluation will be conducted to answer important questions regarding program effectiveness in improving services that are trauma-focused and informed and the results of those services for participants.

Process, qualitative, and outcome evaluation procedures will be utilized to assess the effectiveness and efficiency of the program. The evaluation design will focus on the following: assess the fidelity of the implementation of the evidence-based services, describe the program participants served by program activities, document the number of individuals screened and served in each component of the project, assess the perceived quality of the services received by the individual participants, and determine the impact of the program related to the number of individuals who enroll and complete behavioral health services through the community based partners.

b. Identify what types of specimens will be used if any. State if the material will be used just for evaluation or if other use(s) will be made. Self-report information will be used to collect information in this grant project. The evaluation team, data coordinators and project staff will be responsible for monitoring the data to ensure the safety of the subjects.

c. Instruments are provided in Appendix 2 as requested.

5. Privacy and Confidentiality:

Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected. Describe: How you will use data collection instruments. Where data will be stored. Who will or will not have access to information. How the identity of participants will be kept private. Data and assessments will be collected from persons participating in the South Dakota Screening, Early Intervention and Referral to Treatment Project. Data are stored on secure computers or, in the case of hard copies, locked in filing cabinets. Data will be collected by project staff, and reported to project evaluators. Information will be used to report results to project staff, stakeholders, community programs, SAMHSA, and the cross site evaluation team if applicable. Outcome studies information will be used to assess the effectiveness of the programs.

The CIMI system will services as the primary data collection system Evaluators and project staff will extract the data from CIMI via the CIMI reporting option or through export. All the data is de-identified within the CIMI system. Additional analysis will use specialized software for analytical computations such as SPSS and tests will be made for out-of-range and inconsistent responses. All information is initially entered and stored on secure computers, and the data will be backed-up through the secure backup procedures. Consent forms, program evaluations, and related hard copy data collection forms will be stored in locked cabinets. All computerized and hard copy information will be kept for the required period of time with access limited to project evaluators, and the project staff. Client permission (informed consent) will be obtained from all clients, allowing the project to collect data and conduct follow-up procedures. The data coordinator and evaluators will be responsible for data storage and access. This project intends to maintain the confidentiality of any participants with alcohol and drug abuse issues in accordance with the provisions of Title 42 of the Code of Federal Regulations.

6. Adequate Consent Procedures:

a. **List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.** It will be explained to the participants that their participation is voluntary, they may withdraw at any time without prejudice, and confidentiality will be maintained. In addition to standardized assessments and other required forms, a consumer satisfaction survey will be used to assess participants' perception of the programming and process. Data will be used to make progress reports, ascertain participant and provider performance, and conduct outcome studies.

b. **The client's right to a genuine, free, and independent choice among eligible providers that includes the client's right to an alternative provider to which the client has no religious objection. The client's right to leave the project at any time without problems. Possible risks from participation in the project. Plans to protect clients from these risks.** Participation in this project is strictly voluntary. Those who sign releases and consent forms can withdraw from the project at any time without penalty. The potential risks are very limited, but could include taking a small amount of time to complete required forms, or potential embarrassment of participant in disclosing their mental health or substance use information.

c. **Indicate if informed consent will be requested from participants or, in the case of minor children, from their parents or legal guardians. Describe how the consent will be documented. For example: Will consent forms be read? Will prospective participants be questioned to be sure they understand the forms? Will they be given copies of what they sign?** The informed consent forms will be used to obtain intake, programmatic, and follow-up information for participants in the program. Consent forms will be distributed in one-on-one settings. Participants with limited reading skills will be assisted by staff members in charge of the initial data collection, including signing of informed consent forms. If needed, the informed consent forms will be read to the clients.

d. **Sample consent form is included in Attachment 3, as requested**.

e. **Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data.** Consent forms will be utilized at intake for all participants interested in participating in this program.

f. **Additionally, if other consents will be used in the project (e.g., consents to release information to others or gather information from others), provide a description of these consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?** No other consent forms (other than the one mentioned above) will be used in this project.

7. Risk/Benefit Discussion.

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project. As stated earlier, the risks to participants are extremely minute and involve primarily confidentiality issue or embarrassment of disclosure of sensitive information. The potential benefits to participants in far outweigh any potential risks. This project is designed to help optimize services provided to adults with substance abuse, tobacco and mental health issues.