1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members

From: Nathan Lavery, Fiscal Analyst

Date: September 9, 2013

Subject: Grant Requests

Enclosed please find two (2) items that the Joint Fiscal Office has received from the administration, including the establishment of two (2) limited service positions.

JFO #2638 – $5,060,380 grant from the U.S. Department of Health and Human Services to the Vermont Department of Health. These funds will be used to increase identification, early intervention and treatment for young adults at risk for substance abuse. This request includes establishment of **one (1) limited service position.**
[*JFO received 09/05/13*]

JFO #2639 – $2,512,866 grant from the U.S. Department of Health and Human Services to the Vermont Department of Health. These funds will be used to strengthen and enhance adolescent and transitional-aged youth treatment services. This request includes establishment of **one (1) limited service position.**
[*JFO received 09/06/13*]

These items will be placed on the agenda for action at the Joint Fiscal Committee's September 11, 2013 meeting.

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

JFO 2638

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	To increase identification and early intervention/treatment for young adults at risk for substance abuse.
Date:	8/27/2013
Department:	Department of Health
Legal Title of Grant:	Screening, Brief Intervention, and Referral to Treatment
Federal Catalog #:	93.243
Grant/Donor Name and Address:	Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Rockville, MD
Grant Period:	**From:** 8/1/2013 **To:** 7/31/2018
Grant/Donation	$9,983,102

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$1,060,380	$2,000,000	$2,000,000	$5,060,380	An additional $4,922,722 will be available for the final two grant years

	# Positions	Explanation/Comments
Position Information:	1 LSP	The position will end when the grant expires. The work for this grant cannot be completed with current VDH staff.

Additional Comments: See attached summary for additional grant information. The summary includes the specific contracts the department will execute using these funds because the terms of the grant required the department to name the vendors and specify the work that would be contracted.

Has Vantage budget detail been reviewed and reconciled? ☒ Yes ☐ No EB (Analyst Initial)

Department of Finance & Management		(Initial)
Secretary of Administration	8/28/13	(Initial)
Sent To Joint Fiscal Office	9/5/13	**Date**

RECEIVED
SEP 05 2013
JOINT FISCAL OFFICE

VERMONT

State of Vermont
Department of Health
Office of the Commissioner
108 Cherry Street - PO Box 70
Burlington, VT 05402-0070
healthvermont.gov

[phone] 802-863-7280
[fax] 802-951-1275
[tdd] 800-464-4343

Agency of Human Services

MEMORANDUM

TO: Legislative Joint Fiscal Committee

FROM: Harry Chen, MD, Commissioner

RE: Request for Grant Acceptance - Screening, Brief Intervention, and Referral to Treatment (SBIRT)

DATE: August 26, 2013

The Department of Health has received a grant from the Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, providing $1,983,102 each year for five years to enable the Department to increase identification and early intervention/treatment of adults at risk for substance abuse.

The project is focused on young adults between the ages of 18-25, who have lower incomes, less formal education, are less likely to access behavioral health services, and have a high rate of misuse of alcohol and other drugs. Efforts will be directed towards increasing regular access for at risk identification, reducing the impact of health disparities often present in rural state populations, actively coordinating primary care providers to community mental health and substance abuse providers, as well as effectively delivering and sharing integrated electronic health records in an effort to decrease provider burden through the development of new policies and procedures.

The funds will be used to support four sole source personal service contracts:

1. Evidence Based Solutions, LLC – will provide development of training, technical assistance and infrastructure changes.
2. VT Child Health Improvement Program (VCHIP) – will provide quality improvement and evaluation.
3. VT Information Technology Leaders (VITL) is the Health Information Exchange vendor for Vermont -- will provide health information technology consultation.
4. Covisint – is the Health Information Technology vendor for the Vermont Blueprint for Health -- will develop & implement an SBIRT suite within DocSite, a web-based EHR platform.

Additionally, four grants will be developed: to support a medical provider and her efforts to establish three free clinics; to support two medical facilities as participating practice sites; and, to develop and provide training, technical assistance, and quality assurance. Funds will also be used to establish a Substance Abuse Programs Manager position, to coordinate the project, as well as to support some travel activities. The Health Department is hereby seeking approval to receive $1,060,380 in new Federal funds in State Fiscal Year 2014 and the establishment of one limited service position. The remainder of the Federal funding will be included in the Department's future budget requests. We have attached the grant award document and a copy of the grant application as well as the Position Request Form.

STATE OF VERMONT REQUEST FOR GRANT (*) ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION				
1. Agency:	Agency of Human Services			
2. Department:	Health			
3. Program:	Alcohol & Drug Abuse Programs (ADAP)			
4. Legal Title of Grant:	Screening, Brief Intervention, and Referral to Treatment			
5. Federal Catalog #:	93.243			
6. Grant/Donor Name and Address: Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Rockville, MD				
7. Grant Period: **From:**	8/1/2013	**To:**	7/31/2018	
8. Purpose of Grant: See Attached Summary				
9. Impact on existing program if grant is not Accepted: None				

10. BUDGET INFORMATION				
	SFY 1	**SFY 2**	**SFY 3**	**Comments**
Expenditures:	**FY** 14	**FY** 15	**FY** 16	
Personal Services	$427,702	$726,560	$728,758	
Operating Expenses	$1,344	$1,344	$1,344	
Grants	$631,334	$1,272,096	$1,269,898	
Total	$1,060,380	$2,000,000	$2,000,000	
Revenues:				
State Funds:	$0	$0	$0	
Cash	$0	$0	$0	
In-Kind	$0	$0	$0	
Federal Funds:	$1,060,380	$2,000,000	$2,000,000	
(Direct Costs)	$1,038,877	$1,962,031	$1,960,892	
(Statewide Indirect)	$1,290	$2,278	$2,346	
(Departmental Indirect)	$20,213	$35,691	$36,762	
Other Funds:	$0	$0	$0	
Grant (source)	$0	$0	$0	
Total	$1,060,380	$2,000,000	$2,000,000	

Appropriation No:	3420010000	**Amount:**	$10,107
	3420060000		$1,050,273
			$
			$
			$
			$
			$
		Total	$1,060,380

AUG 22 2013

STATE OF VERMONT REQUEST FOR GRANT (*) ACCEPTANCE (Form AA-1)

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Harry Chen, M.D., Commissioner of Health Agreed by: HC (initial)

12. Limited Service Position Information:	# Positions	Title
	1	Substance Abuse Programs Manager
Total Positions	1	

12a. Equipment and space for these positions: ☐ Is presently available. ☒ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: [signature] Date: 8/8/13

Title: Commissioner of Health

Signature: [signature] Date: 8/15/13

Title: Acting AHS Secretary

14. SECRETARY OF ADMINISTRATION

☒ Approved: (Secretary or designee signature) [signature] Date: 08/20/13

15. ACTION BY GOVERNOR

☒ Check One Box: Accepted [signature] Date: 7/3/13

(Governor's signature)

☐ Rejected Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

(*) The term "grant" refers to any grant, gift, loan, or any sum of money or thing of value to be accepted by any agency, department, commission, board, or other part of state government (see 32 V.S.A. §5).

VERMONT

hand delivered ?

State of Vermont
Department of Health
108 Cherry Street, PO Box 70
Burlington, VT 05402

[phone] 802-863-7200
[fax] 802-865-7754

HOP received
8.20.13

MEMORANDUM

To: Jim Giffin, AHS CFO

From: Paul Daley, VDH Financial Director

Re: Grant Acceptance of the Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Date: 8/7/13

The Department of Health has received a grant from the United States Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, providing $1,983,102 each year for five years to enable the Department to increase identification and early intervention/treatment of adults at risk for substance abuse.

We are requesting approval to receive these funds and are enclosing: the Grant Acceptance Request (AA1) and attached summary, a copy of the grant award document, a copy of the grant application, a Position Request Form for one Substance Abuse Program Manager, and the RFR for the limited service position.

After review by your office, and approval by the Secretary of Human Services, this package should be forwarded in its entirety to Molly Paulger at DHR.

We appreciate your support in moving this request forward. Please let me know if you have questions or need additional information. Thank you.

RECEIVED
AUG 20 2013
State of Vermont
Dept. of Human Resources
Classification & Compensation Division

VERMONT DEPARTMENT OF HEALTH

SFY14 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

VISION Account	Admin & Support	ADAP	VDH Total
	(3420010000)	(3420060000)	
Employee Salaries	$0	$28,671	$28,671
Fringe Benefits	$0	$11,468	$11,468
3rd Party Contracts	$0	$366,060	$366,060
Total Personal Services	$0	$406,199	$406,199
Equipment	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Travel	$0	$1,344	$1,344
Total Operating Expenses	$0	$1,344	$1,344
Subgrants	$0	$631,334	$631,334
Total Direct Costs	$0	$1,038,877	$1,038,877
Total Indirect Costs	$10,107	$11,396	$21,502
Total SFY14 Grant Costs	$10,107	$1,050,273	$1,060,380

Appropriation Summary

Total Personal Services	$10,107	$417,595	$427,702
Total Operating Expenses	$0	$1,344	$1,344
Total Subgrants	$0	$631,334	$631,334
	$10,107	$1,050,273	$1,060,380

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS / Health Date: 8/7/2013

Name and Phone (of the person completing this request): Jackie Corbally 802 863-7208

Request is for:
- ☑ Positions funded and attached to a new grant.
- ☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

   Substance Abuse & Mental Health Services Administration; Screening, Brief Intervention, & Referral to Treatment (SBIRT), grant # 1U79TI025105-01.

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Substance Abuse Program Manager	1	ADAP	8/13 thru 7/18

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

   This position will provide and be responsible for administration and oversight of the SBIRT grant as described in the budget justification submitted as part of the federal application and approved by the granting Agency.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

MD 8/8/13
Signature of Agency or Department Head — Date

Molly Pumlaye 8.20.13
Approved/Denied by Department of Human Resources — Date

8-28-13
Approved/Denied by Finance and Management — Date

09/29/13
Approved/Denied by Secretary of Administration — Date

Comments:

Appendix F –Budget and Justification (no match required)

A. Personnel: Provide employee(s) (including names for each identified position) of the applicant/recipient organization, including in-kind costs for those positions whose work is tied to the grant project.

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Project Director	Barbara Cimaglio	$89,939	.05 FTE	$4,497
			TOTAL IN - KIND	**$4,497**

JUSTIFICATION: Describe the role and responsibilities of each position.
Project Director and Deputy Commissioner of Alcohol and Drug Abuse Programs, Ms. Cimaglio will provide administrative leadership for the grant and ensure that ADAP complies with all SAMHSA requirements and reporting needs. Deputy Commissioner Cimaglio has more than 30 years of experience in the ATOD field and represents the SSA for VT and was the Project Director for Vermont's SPF SIG. Her contribution will be in-kind.

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Substance Abuse Programs Manager	To be selected	$49,150	1 FTE	$49,150
			TOTAL	**$49,150**

JUSTIFICATION: Describe the role and responsibilities of each position.
The SBIRT Substance Abuse Programs Manager will be responsible for administration and oversight of the SBIRT grant both externally and internally. This position will work closely with sub-contractors and sub-grantees to insure that all partners are in compliance and meeting the identified expectations as outlined in the grant submission. This position will report directly to the Chief of Treatment, who in turn reports, to the Vermont Department of Health's Deputy Commissioner.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form S-424A) **$49,150**

B. Fringe Benefits: List all components that make up the fringe benefits rate

FEDERAL REQUEST

Component	Rate	Wage	Cost
FICA	7.65%	$49,150	$3,760
Retirement	9.00%	$49,150	$4,424

Component	Rate	Wage	Cost
Medical	80.00%	Of actual cost	See narrative below
Life Insurance	75.00%	Of actual cost	See narrative below
Dental	100.00%	Of actual cost	See narrative below
		TOTAL	**$19,660**

JUSTIFICATION: Fringe reflects current rate for agency.
The actual cost of fringe benefits (not a fringe benefit rate) will be reported as a direct cost of the program. The actual cost of fringe benefits varies from employee to employee based on salary, employee choice of health care plan, and employee election of certain other benefits. The usual major components of this cost are FICA at 7.65% of salary, retirement at 9% of salary and a portion - 80% for medical, 75% for life and 100% for dental – of the actual costs of the medical, dental and life insurance coverage selected by the employee. The cost of each employee's fringe benefits will be allocated to the program based on hours worked in the program relative to all hours worked by the employee. Based on the current cost of fringe benefits for employees in similar programs, we are estimating the cost of these fringe benefits at 40% of salary.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF-424A) $19,660

C. Travel: Explain need for all travel other than that required by this application. Local travel policies prevail.

FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
Required Grantee Conference Substance Abuse Programs Manager Note: 2 sub-contractors will attend. These expenses are described in section F)	Washington DC/Maryland	Airfare	$700	$700
		Baggage	$50	$50
		Hotel	$200 X 2 nights	$400
		Meals	$32/day X 2 days	$64
		Ground Transportation	$80	$80
		Airport Parking	$50	$50
			TOTAL	**$1,344**

JUSTIFICATION: Describe the purpose of travel and how costs were determined.
Costs associated with the SBIRT Substance Abuse Programs Manager traveling to the annual SBIRT Grantee Conference. Travel costs associated with two sub-contractors attending the Annual SBIRT Grantee Conference are described in Section F.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF-424A) **$1,344.00**

D. Equipment: an article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit (federal definition).

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF-424A) **$ 0.00**

E. Supplies: materials costing less than $5,000 per unit and often having one-time use

FEDERAL REQUEST

Item(s)	Rate	Cost
N/A	N/A	N/A
	TOTAL	**$0.00**

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.
N/A
FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF-424A) **$ 0.00**

F. Contract: A contractual arrangement to carry out a portion of the programmatic effort or for the acquisition of routine goods or services under the grant. Such arrangements may be in the form of consortium agreements or contracts. A consultant is an individual retained to provide professional advice or services for a fee. The applicant/grantee must establish written procurement policies and procedures that are consistently applied. All procurement transactions shall be conducted in a manner to provide to the maximum extent practical, open and free competition.

COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.

FEDERAL REQUEST

Name	Service	Rate	Other	Cost
(1) Evidence Based Solutions, LLC	Project Director	1 FTE	$85/hour X 48 weeks per year X 40 hours per week	$163,200
	Travel to federal grantee meeting (Project Director and Physician)	Airfare: $700 Baggage: $50 Lodging: 2 nights x $200 per night = $400 Meals: $32 per day x 2 days = $64 Transportation: $87		$1,301

Name	Service	Rate	Other	Cost
	Mileage	4000 miles x .565 per mile		$2,260
	Supplies	$200 per year		$200
	IT Contract: VT SBIRT Training Institute Website (Vendor to be determined)	1 sub-contract at $20,000		$20,000
(2) VCHIP	Staffing	Patricia Berry, Principle Investigator: .1 FTE		$15,230
		Quality Improvement (QI) Practice Facilitator (TBD): 1 FTE		$57,750
		Maria Avila, PhD(c), Cultural & Linguistic Competence/Health Literacy Trainer: .2 FTE		$14,700
		Evaluation Data Coordinator (TBD): .75 FTE (Y1 only, 1 FTE starting Y2)		$29,138
		Christine Dornbierer, Financial Specialist: .05 FTE		$2,259
		Fringe		$49,774
	Program Evaluation	Jody Kamon, PhD, Program Evaluator: .2 FTE		$14,560
		Fringe		$1,398
	Equipment/ Supplies	Computer, training materials, webinar annual fee, poster printing, manuscript costs		$7,400
	Phone	Monthly line for QI coach and conference calls for training/coaching		$1,728
	Participant Incentives	$20 gift cards for completing 6 month follow-up interview		$7,840
	Training	Regional meetings		$14,400

Name	Service	Rate	Other	Cost
	Postage and Shipping			$500
	Travel	Grantee national conference, Washington DC/Maryland	Meals: 2 days x $71 per day Lodging: 2 days x $224 per day Airfare: $500 Parking: $36 Transportation: $100	$1,226
		Instate coaching/training, evaluation meetings	Mileage, meals, parking, etc.	$8,767
	Indirect	33.5% Indirect Rate		$76,037
(3) Bi-State Primary Care Association (Bi-State)	Staffing	QI Practice Facilitator (TBD): .5 FTE QI/QA Project Manager (TBD): .25 FTE Program Director (TBD): .025 FTE Fringe @ 25%		$22500 $17,500 $1,875 $10,469
	Supplies	Computer, desk, chair		$2,000
	Mileage	$200 per month		$2,400
	Legal services	20 hrs X $400/hr		$8,000
	Fiscal Indirect	5% of direct costs		$3,237
	Administrative Indirect	25% of direct costs		$16,186
	Services for secondary screenings, brief interventions and brief treatment across 3 practice sites.	1 sub-grant @ $588,100 3000 Screenings 2000 Brief interventions 321 Brief Treatments		$588,100
	IT services for upgrading EHR	3 sub-grants @16,000 to 3 practice sites		$48,000
	GPRA data collection	3 sub-grants @ $1,500 to 3 practice sites		$7,500

Name	Service	Rate	Other	Cost
(4) Vermont Coalition of Clinics for the Uninsured (VCCU)	Staffing	Lynn Raymond-Empey, Technical Assistance, QI/QA for free clinics: .1 FTE		$12,000
	IT services for upgrading EHR(1 EHR system for 3 practice sites)	1 sub-grant @ $16,000		$16,000
	GPRA data collection (1 GPRA data collection system for 3 practice sites)	1 sub-grant@ $2,500		$2,500
	Services for secondary screenings, brief interventions and brief treatment across 3 practice sites.	1 sub-grant @ $50,000 across 3 practice sites. 260 screenings 172 Brief interventions 27 Brief Treatments		$50,000
(5) Vermont Information Technology Leaders (VITL)	Staffing	Jennifer Merand, VT Health Information Exchange Integrations: .06 FTE	125 hours at $150/hour	$18,750
(6) Vermont National Guard	Services for secondary screenings, brief interventions and brief treatment.	1 sub-grant at $50,000 248 screenings 166 Brief interventions 27 Brief Treatments		$50,000
	IT services for upgrading EHR	1 sub-grant @ $16,000		$16,000
	GPRA data collection	1 sub-grant @ $2,500		$2,500
(7) Central Vermont Medical Center (CVMC)	Services for secondary screenings, brief interventions and brief treatment.	1 sub-grant at $367,400 1888 screenings 1268 Brief interventions 199 Brief Treatments		$367,400
	IT services for upgrading EHR	1 sub-grant @ $16,000		$16,000
	GPRA data collection	1 sub-grant @ $2,500		$2,500

Name	Service	Rate	Other	Cost
(8) Covisint	Develop SBIRT suite within web-based EHR compatible platform (DocSite)	Development of DocSite SBIRT Suite Annual Recurring Fees for maintaining DocSite SBIRT Suite and managing related data		$88,500 $16,500
			TOTAL	**$1,876,085**

JUSTIFICATION: Explain the need for each contractual agreement and how it relates to the overall project.

(1) EBS Contractual: Cost of a full time Project Director (PD) with .5 of his FTE focused on managing the grant in collaboration with the Substance Abuse Program Manager and a second .5 of his FTE leading the development of training, technical assistance and infrastructure changes. Dr. Turner's hourly rate is based on his longstanding national expertise (i.e. serving as a consultant for CSAT, American Institutes of Research, JBS International, and the National Drug Court Institute) including expertise in developing and supporting training and technical assistance in other funded SBIRT communities. His rate is a consultant rate and therefore estimated withholding, employee taxes, and other benefit costs are factored into the final hourly rate. Cost of the PD attending 1 SAMHSA meeting each year of the project and cost of developing STI website, including initial development plus production of two to three instructional VT-SBIRT videos.

(2) VCHIP Contractual: VCHIP serves two distinct roles: 1) collaborate with the PD and Bi-State to develop and implement training, technical assistance, and continuous quality improvement and quality assurance to practice sites; and 2) conduct the VT-SBIRT evaluation. Costs include the following personnel at the effort and salary listed above: a) role of Principal Investigator which is a requirement of the College of Medicine at UVM; b) role of QI Practice Facilitator; c) role of Cultural and Linguistic Competence (CLC)/Health Literacy trainer, Maria Avila, PhD(c), d) role of Evaluator, Dr. Jody Kamon, e) role of Data Coordinator; and f) role of Financial Specialist, Christine Dornbierer, which is needed and required to process all budgetary items. Cost of supplies includes purchase of 2 computers for QI Practice Facilitator and Data Coordinator, STI training materials for regional and practice trainings & QI coaching meetings, annual webinar fee, and related costs. Cost of phone for monthly QI coaching calls is $144/month at $1728 annually. Cost of participant incentives for 6 month follow up pro-rated for 10% of 4900 patients who receive some level of intervention @ $20 per gift care incentive. In factoring cost of incentives, assumed 80% follow up rate. Cost of hosting training meetings across 8 regions and in practice settings projected at $14,400 includes cost of space, any A/V needs or other training site costs, and food/beverages for trainees. Cost of postage and shipping projected at $500 for mailings of toolbox resources to practice sites and other medical practices interested in VT-SBIRT.

(3) Bi-State Contractual: Bi-State will collaborate with the PD and VCHIP to implement SBIRT training, technical assistance, CQI and quality assurance to FQHC practice sites through the

QI Practice Facilitator. The role of QI Project Manager includes supporting HIT/HIE upgrades, providing quality assurance and time serving on the PSC and CCT workgroup. The Program Director is a requirement of B-State. Bi-State will also fund the FQHCs to deliver VT-SBIRT services. Cost of supplies includes purchase of 1 computer, desk and chair for QI Practice Facilitator/Project Manager. Cost of mileage is estimated at 350 miles per month @ $0.565 per mile. Cost of legal services for establishing contracts with the FQHCs and ensuring HIT/HIE upgrades meet their federal requirements is $8,000. Services costs include provision of 3000 secondary screenings @ $35 per screen, 2000 brief interventions @ $65 per intervention, and 321 brief treatments @ $1100 per brief treatment episode across 3 FQHCs. Bi-State will award each of the three FQHCs in Y1a one-time initial amount of $16,000 to support upgrades to their EHR/data reporting system to integrate VT-SBIRT process and data elements, including capturing GPRA data, electronically. An annual amount of $2,500 will also be awarded to each of the three FQHCs to support uploading of GPRA data to DocSite.

(4) VCCU Contractual: Lynn Raymond-Empey is the Executive Director and a medical provider for VCCU. Cost of Dr. Raymond-Empey's time includes her efforts to support the 3 free clinics in implementing VT-SBIRT including supporting HIT/HIE upgrades, providing quality assurance and her time serving on the PSC. Services costs include provision of 260 secondary screenings @ $35 per screen, 172 brief interventions @ $65 per intervention, and 27 brief treatments @ $1100 per brief treatment episode. VCCU utilizes one data reporting system for all of its clinics. The VCCU will receive a one-time initial amount of $16,000 to support upgrades to their EHR/data reporting system to integrate VT-SBIRT process and data elements, including capturing GPRA data, electronically. An annual amount of $2,500 will also be awarded to support uploading of GPRA data to DocSite.

(5) VITL Contractual: VITL, Vermont's vendor for the state's Health Information Exchange, is providing expertise and collaboration through regular consultation provided by one of its key health information technology officers, Jennifer Merand. Ms. Merand will be responsible for participating on the Policy Systems Committee and Care Coordination Technology Committee, as well as to help design and implement electronic, HIPPA and 42 CFR compliant linkages between medical practice sites and community service providers. Her cost is $18,750 (125 hours @ $150 per hour).

(6) Vermont National Guard Contractual: The National Guard's medical facility at Camp Johnson in Chittenden County is one of the participating practice sites. It is a smaller site serving 2400 guardsmen and guardswomen per year. It is anticipated that in Y1, the Guard will complete 248 secondary screenings @ $35 per screen, 166 brief interventions @ $65 per intervention, and 27 brief treatments @ $1100 per brief treatment episode. The Vermont National Guard will also receive a one-time initial amount of $16,000 to support upgrades to their EHR system to integrate VT-SBIRT process and data elements, including capturing GPRA data, electronically within their HER system. An annual amount of $2,500 will also be awarded to support uploading of GPRA data to DocSite.

(7) CVMC Contractual: Central Vermont Medical Center's (CVMC) Emergency Department in Washington County is one of the participating practice sites. It is the only ED site in the VT-

SBIRT initiative but a critical one as it will help us develop an effective model for delivering VT-SBIRT in such settings. It is anticipated that in Y1, CVMC will complete 1888 secondary screenings @ $35 per screen, 1268 brief interventions @ $65 per intervention, and 199 brief treatments @ $1100 per brief treatment episode. CVMC will also receive a one-time initial amount of $16,000 to support upgrades to their EHR system to integrate VT-SBIRT process and data elements, including capturing GPRA data, electronically within their HER system. An annual amount of $2,500 will also be awarded to support uploading of GPRA data to DocSite.

(8) Covisint Contractual: Covisint is the HIT vendor for the Vermont Blueprint for Health, managing its web-based EHR platform, DocSite. Covisint will be paid a one-time amount of $92,000 ($3,500 to be paid in Y2), to develop and implement an SBIRT suite within DocSite. All VT-SBIRT practices will utilize DocSite to administer the VT-SBIRT protocol and obtain GPRA data. Cost of Covisint to maintain Docsite's SBIRT suite and provide data uploading to SAIS, data extraction to VCHIP and high level utilization reports is $16,500 annually.

***Represents separate/distinct requested funds by cost category**

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF-424A) **$1,876,085**

G. Construction: NOT ALLOWED – Leave Section B columns 1& 2 line 6g on SF-424A blank.

H. Other: expenses not covered in any of the previous budget categories

FEDERAL REQUEST

Item	Rate	Cost
N/A	N/A	N/A
	TOTAL	**$0.00**

JUSTIFICATION: Break down costs into cost/unit (e.g. cost/square foot). Explain the use of each item requested.
N/A

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF-424A) **$0.00**

Indirect Cost Rate: Indirect costs can be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. For information on applying for the indirect rate go to: http://www.samhsa.gov then click on Grants – Grants Management – Contact Information – Important Offices at SAMHSA and DHHS - HHS Division of Cost Allocation – Regional Offices.

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF-424A)
75% of personnel (.75 x $49,150) **$36,863**

The Vermont Department of Health uses a Cost Allocation Plan, not an indirect rate. The Vermont Department of Health is a department of the Vermont Agency of Human Services, a public assistance agency, which uses a Cost Allocation Plan in lieu of an indirect rate agreement as authorized by OMB Circular A-87, Attachment D. This Cost Allocation Plan was approved by the US Department of Health and Human Services effective October 1, 1987. A copy of the original approval and a copy of the most recent approval letter are attached. The Cost Allocation Plan summarizes actual, allowable costs incurred in the operation of the program. These costs include items which are often shown as direct costs, such as telephone and general office supply expenses, as well as items which are often included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the salaries and wages paid in the program. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a rate. Based on costs allocated to similar programs during recent quarters, we would currently estimate these allocated costs at 75% of the direct salary line item.

TOTAL DIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF-424A) **$1,946,239**

INDIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6j of form SF-424A) **$36,863**

TOTALS: (sum of 6i and 6j)

FEDERAL REQUEST – (enter in Section B column 1 line 6k of form SF-424A) **$1,983,102**

Cost Allocation Breakdown:

	Administration	**Infrastructure**	**Evaluation**	**Services**	**Total**
ADAP	$107,017				$107,017
EBS	$83,290	$103,597			$186,887
VCHIP		$196,054	$106,728		$302,782
BiState		$132,167	$7,500	$588,100	$727,767
VCCU		$28,000	$2,500	$50,000	$80,500
VITL		$18,750			$18,750
VT Nat'l Guard		$16,000	$2,500	$50,000	$68,500
CVMC		$16,000	$2,500	$367,400	$385,900
Covisint		$70,000	$35,000		$105,000
Total	**$190,307**	**$580,568**	**$156,728**	**$1,055,500**	**$1,983,102**

Percent Allocation	**10%**	**29%**	**8%**	**53%**	**100%**

The cost allocation breakdown remains nearly the same across the life of the grant. In Y2 through Y5, the allocation for services increases slightly to approximately 60% while the allocation for the other cost categories decreases (i.e. Administration = 10%, Infrastructure = 22%, and Evaluation = 8%).

UNDER THIS SECTION REFLECT OTHER FEDERAL AND NON-FEDERAL SOURCES OF FUNDING BY DOLLAR AMOUNT AND NAME OF FUNDER e.g., Applicant, State, Local, Other, Program Income, etc.
Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions or non-federal means. [Note: Please see Appendix D, Funding Restrictions, regarding allowable costs.]Provide the total proposed project period and federal funding as follows:

Proposed Project Period

a. Start Date:	**10/1/2013**	b. End Date:	**09/30/2018**

BUDGET SUMMARY (should include future years and projected total)

Category	Year 1	Year 2*	Year 3*	Year 4*	Year 5*	Total Project Costs
Personnel	$49,150	$50,625	$52,144	$53,708	$55,319	$260,946
Fringe	$19,660	$20,250	$20,858	$21,483	$22,128	$104,379
Travel	$1,344	$1,344	$1,344	$1,344	$1,344	$6,720
Equipment	$0	$0	$0	$0	$0	$0
Supplies	$0	$0	$0	$0	$0	$0
Contractual	$1,876,085	$1,889,041	$1,885,775	$1,882,413	$1,878,949	$9,412,263
Other	$0	$0	$0	$0	$0	$0
Total Direct Charges	$1,946,239	$1,962,031	$1,960,892	$1,959,719	$1,958,511	$9,784,308
Indirect Charges	$36,863	$37,969	$39,108	$40,281	$41,489	$195,710
Total Project Costs	**$1,983,102**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$9,983,102**

TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF-424A) **$9,983,102**

SECTION A: POPULATION OF FOCUS AND STATEMENT OF NEED

Need for treatment. The proposed VT-SBIRT will be a statewide initiative serving eight of Vermont's 14 counties. Thus, data provided are mostly state-level data. Although a small state, Vermont's concerns around alcohol and other drug use are significant. Vermont has been successful reducing adolescent alcohol and other drug use, but the state continues to struggle with achieving the same outcomes among older populations. While consumption across the country has decreased over time, the relative ranking of Vermont has remained high. ***Among young adults 18 to 25,*** national data place Vermont as having the highest or one of the five highest past month prevalence of the following: alcohol use (74%), binge drinking (51%), marijuana use (33%), and illicit drug use other than marijuana (11%) (SAMHSA, 2010). This may not be surprising considering Vermont has the lowest national percentage (23%) of young adults 18 to 25 who perceive great risk of having five or more alcoholic beverages once or twice a week and third lowest percentage (11%) who perceive greater risk of smoking marijuana once a month. ***Among persons 26 and older,*** Vermont ranks among the top 20 states in past month prevalence of alcohol use (63%) and binge drinking (23%). In this same age group, Vermont ranks 20th for perceiving great risk of drinking five or more alcoholic beverages once or twice a week. For marijuana and other illicit drug use, Vermonters aged 26 and older rank first nationally for prevalence of past month marijuana use (9%) and third for past month illicit drug use other than marijuana (3%). Again, such rates are supported by the fact this age group is 6th in the nation for having the lowest perception of risk regarding past month marijuana use (26%).

Vermont ranks number 1 and 2 in the country for prevalence of cocaine among these age groups respectively (SAMHSA, 2010). Regarding nonmedical use of prescription drugs (in particular opiate pain relievers), Vermont ranks 7th among 18 to 25 year olds (13%) and 19th among adults 26 and older (4%). While current data suggest trends in prevalence rates of nonmedical use of prescription drugs are flat or decreasing in Vermont across time and surveys, past year prevalence rate of prescription drug misuse is higher than for all other illicit substances with the exception of marijuana. Tobacco use is more modest with only 15.4% of adult Vermonters reporting use of cigarettes or other tobacco products (national rank = 37th).

Given Vermont's high prevalence estimates for alcohol and other drug use, it is not surprising that the estimated need for but not receiving treatment is high as well. Compared to national estimates, over time, Vermont has consistently had a greater proportion of individuals age 12 and older needing and not receiving drug and alcohol treatment (Office of Applied Studies (OAS), 2008). Among persons aged 18 to 25, Vermont ranks among the top 10 states with the highest estimated need for but not receiving treatment for alcohol use and illicit drug use. Nationally, an estimated 19.3 million or 8% of persons aged 12 or older needed treatment for an alcohol problem in the past year. Tragically, only 8% of these 19.3 million individuals received specialty substance abuse treatment (OAS, 2009). Of those who did NOT receive treatment, the over 87%, did not perceive a need for treatment. **Thus, one of the great challenges is developing awareness of risky or problematic use within individuals and internal motivation to change. As indicated by previous literature, SBIRT is a critical step in reaching this 87% and initiating a course of change.** Among the 4.5% who felt a need for but did not receive treatment, the following were cited as barriers: readiness to stop using alcohol, cost/insurance barriers, social stigma at seeking out specialty treatment, access issues, belief can handle on own, and not knowing where to go for treatment. Because SBIRT is housed

within the primary care and other medical settings and because it is built on a foundation of motivational interviewing, it is well poised to address many if not all of these barriers.

Greater progress has been shown in reducing tobacco use. The Behavioral Risk Factor Survey System shows a trend of a 39% decline in smoking rates among adults ages 18 and older (Vermont Department of Health (VDH), 2012). Cigarette sales per capita (ages 18+) have also declined from 101 packs per capita in 1990 to 64 packs per capita in 2007. The VDH has a comprehensive resource program focused on prevention and offering free and easy access to trained tobacco cessation counselors via a toll-free quit line. This and other face-to-face counseling efforts are paired with tobacco cessation aids such as nicotine replacement aids.

Personal communication with previous SBIRT grantees indicates of those who receive an initial screening using the single-screener questions, 22% are recommended for secondary alcohol screening and 11% for secondary drug screening (Bruce Horowitz, University of Missouri, 4/8/2013; Jim Winkle, Project Director OHSU Family Medicine, 4/8/2013). Given these estimates, coupled with the fact that Vermont tends to have higher prevalence estimates, we anticipate 30% of individuals initially screened will be indicated for secondary screening using the AUDIT or Drug Abuse Screening Test (DAST). National SBIRT data suggest that of individuals screened for alcohol and other drug use using validated screening tools such as the AUDIT and DAST, 22.7% screen positive for a spectrum of use (risky/problematic, abuse/addiction) with the majority of individuals being recommended for a brief intervention (BI; 15.9%) and smaller percentages recommended for brief treatment or referral to specialty treatment (BT, RT; 3% and 4% respectively) (Madras et al., 2009). We anticipate across all sites combined, approximately 20% of individuals will be recommended for BI, 3% for BT and 4% for RT. For tobacco use, current Vermont prevalence estimates as described above would indicate that 15% of individuals will screen positive for a tobacco cessation intervention.

SAMHSA's National Survey on Drug Use and Health continually illustrates that co-occurring substance and mental health disorders are common. Over 8.9 million persons have co-occurring disorders yet only 7% of these individuals access integrated treatment and 56% receive no treatment at all (SAMHSA, 2012). Further, adults with any type of mental illness in the past year report increased rates of tobacco use, binge drinking, and heavy drinking. Data from a Department of Mental Health (DMH) found that the prevalence of co-occurring disorders ranged from 30-40% for individuals presenting at mental health facilities, and 50-80% among individuals presenting for substance use treatment (DMH, 2011). VT-SBIRT will intentionally increase identification, treatment and referrals for co-occurring disorders.

Continuum of care including funding. The Division of Alcohol and Drug Abuse Programs (ADAP) is well-poised for this much needed and timely SBIRT funding opportunity. ADAP, housed within the VDH, maintains a strong public health approach to preventing substance related problems, focusing on population level change to reduce community- and/or state-level indicators of substance use and related consequences. ADAP has developed a strong working relationship with the Department of Vermont Health Access (DVHA), the entity responsible for managing Vermont's publicly funded health insurance programs.

From prevention to recovery services, there are areas along the continuum of care providing sufficient funding and resources and significant gaps in others. When considering prevention, in addition to its' annual funding from the SAPT Block Grant and state legislature, ADAP was recently awarded a three-year grant from SAMHSA's CSAP, the Partnership for Success II Grant, which is focused on underage and binge drinking prevention and prescription drug misuse and abuse. Vermont's Prevention efforts focus on reducing underage drinking, high-

risk drinking among persons under age 25, and marijuana use among persons under age 25. ADAP's prevention programming tries to achieve these goals through a comprehensive approach emphasizing public information, education, substance free social and recreational opportunities, early intervention in school settings and among pregnant and low-income women, community organization, and environmental approaches. Much of the primary and secondary prevention focuses on youth under 25, especially youth under 18 and early intervention is focused primarily on adolescents through school based programming. **VT-SBIRT will increase targeted secondary prevention efforts by providing brief intervention to adults thereby reducing risky use and altering individuals' trajectories towards more problematic use. This service does not currently exist in Vermont.**

All programs described here are part of ADAP's Preferred Provider network, with the exception of independent licensed alcohol and drug counselors. ADAP offers outpatient specialty substance abuse and co-occurring mental health treatment in every county by providing grants to licensed substance abuse treatment organizations. ADAP's providers are more likely to see individuals on Medicaid/Medicare or uninsured individuals compared to independent counselors who predominantly see individuals with third party insurance or who can pay out of pocket. There are 10 adult intensive outpatient programs (IOP), with at least one IOP program in 5 of the 8 proposed site regions. There are three in-state residential treatment facilities – one in the northern tier, one in the central tier, and one in the southern tier of the state. Two of the five medication assisted treatment (MAT) programs (e.g. methadone) are in proposed site regions with additional physicians offering Buprenorphine treatment. Eleven recovery centers offer recovery coaching, with one center in each of the 8 site regions. Additional programs offer specific services such as public inebriate (e.g. emergency services for those under the influence), the CRASH program (e.g. offers education, screening, and referral for those with a driving under the influence charge), and adult drug court. In 2012, Vermont also launched its' "Hub and Spoke" treatment model in three communities, two of which are in the proposed site regions. "Hubs" are comprised of an interdisciplinary team, including a physician and a nurse, whose role it is to assess, develop a treatment plan, and begin serving opiate dependent individuals or substance dependent individuals with more complex needs. The "Hubs" coordinate with local medical homes and social service entities to better engage and meet these clients' needs.

As part of its treatment standards, ADAP requires Preferred Providers to use the ASAM Patient Placement Criteria (PPC) as the determining tool for level of care and treatment planning. As VT-SBIRT rolls out into our medical community, it will be critical that these medical practices understand the use of ASAM-PPC when making clinical determinations for referrals to treatment. The misnomer still exists in which community partners, including medical providers, mistakenly refer to residential care believing it to be the preferable treatment option. In actuality, ASAM-PPC may indicate a different level of care. Within the medical setting, if a screening result indicates a referral to treatment, it will be expected that the medical provider consider ASAM-PPC in their referral. In addition, as a client moves further on the intervention continuum through brief treatment, it will be important for the brief treatment therapist to utilize ASAM criteria to determine level of care to refer to if further treatment is indicated.

Our population of focus in the current proposal, VT-SBIRT, is adults 18 and older. Across the eight proposed site regions, VT-SBIRT medical practice sites include Federally Qualified Health Centers (FQHC) and the Vermont Coalition of Clinics for the Uninsured (VCCU) or free clinics. Additional sites include the Vermont National Guard medical facility, the University of Vermont's (UVM) Student Health Center, and the Central Vermont Medical

Center. The FQHCs and free clinics serve the majority of Medicaid/Medicare and uninsured populations. Among individuals served by the FQHCs and free clinics, approximately one-half to two-thirds receive Medicaid/Medicare and the percentage of uninsured ranges from 6% to 26% with the majority of sites reporting greater than 18% of their patients as uninsured. Between 55% and 100% of their patients are living below the national poverty level. One of our largest participating FQHCs, Burlington's Community Health Center (BCHC) reports among their patients, 11% are homeless; 28% identify as being of a culturally diverse race; and 11% are best served in a language other than English.

Vermont has no military installations and only 125 active duty military personnel. The state has 5,125 persons in the National Guard and reserves, with a significant number who have been deployed to Iraq and Afghanistan. It's medical facility, located in Chittenden County, provides primary care to its service members. UVM, the largest post-secondary education institution, is located in Burlington, and has a student population of approximately 10,000. UVM's Student Health Center serves two-thirds of its student population, an age range which, as described earlier, consistently ranks top in the nation for problematic alcohol and other drug use. Lastly, CVMC has one of top three largest Emergency Departments in the state and a network of primary care practices within Washington County. The last two sites were selected to serve as the first sites of their type to engage in the SBIRT process, thereby offering a model from which to ease long-term SBIRT expansion to other similar site types across the state.

While there are a wide range of specialty treatment services for adults, BI services are limited, focused mostly on adolescents. Adults seeking services in the Preferred Provider specialty treatment system often find themselves in a siloed service lacking a "system-ness" to it that can be found in the medical community. This provider system, in part due to its fee-for-service nature, struggles to promote a seamless service for clients seeking addiction services. Research has demonstrated the longer period of time between a request to be seen and the first appointment, the higher the rate of no shows (Galluci et al., 2005). Further, when a medical provider refers their patients to a specialized service, the likelihood of patients attending that service decreases when it is provided in a second location from the medical setting (Guck et al., 2007). VT-SBIRT will fill a gap in Vermont's continuum of care by initiating BI services in primary care settings and it will reduce described barriers, consequently increasing much needed access as indicated by Vermont's estimated need for services described above.

Funding streams for specialty treatment for Medicaid and uninsured patients are provided by federal block grant dollars to ADAP's Preferred Providers based on their anticipated number of clients to be served. Interestingly, while the estimated need for treatment has remained constant over time, the proportion of individuals accessing substance abuse treatment in Vermont has declined. DVHA also provides Medicaid/Medicare reimbursement for substance abuse services provided in medical settings. However, SBIRT codes are an exception and there appears to be a general lack of understanding on how best to integrate SBIRT codes into the current funding system. There have been periods of time in which the SBIRT codes have been active with very few SBIRT claims submitted (n=195) and only a small portion of those reimbursed at partial rates (3%). Most recently, the codes were turned off, possibly because of low utilization rates. Further, physicians were the only providers able to bill under the codes when they were on. VT-SBIRT provides a timely opportunity to resolve the system-related funding barriers which could increase provider SBIRT utilization.

For many of the individuals served by our proposed sites, access to services is limited by a number of factors. Because of financial and rural geography, transportation can be challenging

and/or limited. In a recent survey conducted by specialty providers across the state on behalf of ADAP, 24% indicated that the primary barrier for missing appointments is transportation (ADAP, 2013). Thus, an individual might be able to attend medical appointments but not pursue specialty substance abuse treatment in another setting. For many regions, there may be one primary substance abuse treatment provider that serves Medicaid/Medicare and those uninsured limiting patient choice. Within BCHC, because of the diverse patient population, they have developed culturally competent methods for working with their patients such as the regular use of translation services with appointments. Within both the National Guard and Student Health Services communities, these specific populations have been found to demonstrate higher levels of alcohol and other drug misuse. VT-SBIRT would eliminate such barriers to early and brief intervention and brief treatment. Further, by offering these sites, who understand their patient population, resources and support to help them screen and intervene on alcohol and substance use, we are maximizing on a patient centered approach.

Potential for policy and systems change. Potential policy change includes the development of policies that support secondary preventative intervention for adults and integration of co-occurring screening and intervention practices within primary care and other medical settings. Specific policy/systems change will include re-instituting SBIRT reimbursement codes in a sustainable manner. Strategies for rapidly initiating SBIRT include the development of an SBIRT suite for the primary web-based EHR platform used by all FQHCs, supported by the Blueprint for Health, and readily accessible by all Vermont medical practices. This development alone will benefit all Vermont medical settings beyond the grant-funded practice sites. Other improvements described later in the Narrative include enrolling VT-SBIRT patients into the Vermont Health Information Exchange's (HIE) consent repository to facilitate linkages between medical and specialty treatment providers. The development of policies that support the use of Vermont's HIE to facilitate such linkages is yet another way to improve VT-SBIRT's efficacy and sustainability.

Demographic profile. Vermont ranks 49th in population, encompassing a total state population of 625,741 with the largest county being Chittenden County (population: 156,545). Reflecting its rural tradition, Vermont has a large number of small towns, significant open land, dense forests, and many small dairy farms. Out of 246 towns and cities in Vermont, only 9 are cities, and even these are quite small by national standards. The city of Burlington, located in Chittenden County, with a population of 42,417 is the State's most populous city. Among all the States, Vermont has the lowest proportion of residents who live in urban areas (38.2 percent). Vermont has the second highest median age in the nation at 41.2 years. The State has a relatively homogeneous racial make-up with 96.5% of the population listing their race as white; 1.3% Hispanic; 1.2% Asian; 0.8% African American; 0.4% American Indian; and 1.1% list two or more races. Within Burlington, Vermont's most populous city and the area of one of the proposed VT-SBIRT implementation sites, 11.1% of individuals identify as being people of color (U.S. Census Bureau, 2012). Further, Burlington is a Federal Refugee Resettlement District, settling over 320 new refugees in Vermont annually, from places such as the former Yugoslavia, central Asia, Southeast Asia and Africa. From 2000 to 2010, the rate of Asian residents increased seven-fold to 8%, the black population nearly tripled to 9.9% and overall, the white population dropped from 84 to 77% (Burlington Free Press, April 10, 2011). Within the Burlington School District, over 47 languages other than English are spoken (Burlington Free Press, 2011). Further, nearly half of the state's racial and ethnic minority populations and one-third of the Hispanic population live in Chittenden County, where Burlington is located. The

BCHC, one of VT-SBIRT's sites, serves over 15,000 adults annually and of these, 28% identify as being black, American Indian, Asian, or belonging to more than one race, and 11% report they are best served in a language other than English. The remaining proposed practice sites demographic make-up is much similar to statewide census data described above.

Population of focus in relation to overall population. As stated earlier, proposed sites serve a significant number of adults on Medicaid/Medicare, or who are uninsured, with 55% to 100% living in poverty. One of the more prominent types of disparities in Vermont is socio-economic status. Living in Vermont can be expensive compared to elsewhere in the U.S., and federal poverty guidelines may not take into account cost-of-living differences across states. In Vermont, a family of four would have to earn over $10,000 more than the same size family elsewhere in the U.S. to have equal purchasing power. Due to the higher cost of living here, many Vermonters may not qualify for the help they need. Vermont's median income, $26, 223, falls below its estimated livable wage ($27,188). Low income Vermonters are more likely to be: young (18 to 34 years); less educated; unemployed/unable to work; female; and a member of a racial/ethnic minority group (VDH, 2010). Studies have shown many income-related disparities in health care. Compared to individuals whose income is above the federal poverty level (FPL), individuals whose income is 2.5 times less than the FPL are more likely to report having no health insurance (above: 6% vs. below: 22%) and needing a doctor but not going due to cost (above: 9% vs. below: 42%) (VDH, 2010). Lower income Vermonters report higher rates of depression and chronic conditions such as obesity, asthma, and heart disease, and are more likely to smoke (below FPL: 37% vs. above FPL: 9%) (VDH, 2010).

The challenges low income individuals face are compounded by lower levels of educational attainment. Vermonters with less than a high school education are two to four times as likely to experience depression and suffer from other chronic health problems compared to those who have a college degree. These discrepancies hold true for unemployed vs. employed adults as well (VDH, 2010). National data indicate that those living in poverty have a significant unmet need for addiction treatment and addressing this need may result in increases in economic sufficiency and employment, while decreasing health care costs and other adverse factors associated with substance use disorders (SAMHSA, 2010).

Due to the small numbers of racial and ethnic minorities in Vermont, race reporting errors and statistical analysis limitations sometimes make it difficult to determine if there are differences in health status across racial and ethnic groups. (Agency for Healthcare, Research, & Quality, 2004). Regarding anticipated access and outcomes, based on data related to physical health care described above, we anticipate that Vermonters who have lower income, have received less formal education, and are of diverse racial/ethnic background are less likely to access addiction and mental health services and when they do access such services, retention rates may be poorer due to low health literacy and other barriers. Further, these population groups tend to be overrepresented in FQHCs, free clinics, and emergency departments. VT-SBIRT will increase intervention access and reduce substance use among these groups.

SECTION B: PROPOSED EVIDENCE-BASED SERVICE/PRACTICE

Purpose: ADAP and committed partners propose implementation of VT-SBIRT to increase identification and early intervention/treatment of adults, ages 18 and older, at risk for substance misuse or abuse/dependence. VT-SBIRT will accomplish this by adopting, implementing and sustaining evidence based initial screening (AUDIT-C & NIDA), secondary screening (AUDIT & DAST), the brief negotiated intervention (BNI) , brief treatment (BT; MET/CBT) and active referral to specialty treatment (ART). During the 5 years of the grant,

these motivational interventions will be delivered statewide to 95,000 unduplicated adults in settings described earlier. This initiative will join Vermont's Blueprint for Health, a dramatic healthcare reform project, through development of an SBIRT "suite" in the web-based clinical registry (DocSite), linkage to Vermont's HIE and use of a new Vermont state consent repository. VT-SBIRT's comprehensive management structure, Policy Systems Committee (PSC), Care Coordination Technology (CCT) workgroup, and primary care settings create the optimal framework for achieving primary goals and objectives to a) increase regular access for identification, BI, BT, and RT; b) dramatically reduce the impact of health disparities often present in rural state populations; c) actively link primary care to community MH/SA providers; d) effectively deliver and share integrated electronic health records decreasing provider burden through development of new HIT/HIE policies and procedures; and e) utilize VT-SBIRT billing codes and advocate for changes in restrictions (as needed) to ensure sustainability.

ADAP, the Single State Authority, will lead this initiative through a partnership with Evidence Based Solutions, LLC, the University Of Vermont College Of Medicine's Vermont Child Health Improvement Program (VCHIP), and Bi-State Primary Care Association. Additional key stakeholders in Vermont's healthcare system include: practice sites listed in Section A, the VCCU, the Department of Vermont Health Access (DVHA), the Vermont National Guard, Vermont Information Technology Leaders (VITL), Vermont Association of Hospitals and Health Systems, the Office of Minority Health and Health Disparities, the Governor's Advisory Council, Vermont's Substance Abuse Treatment Provider Association (MH/SA), and the Vermont Recovery Network.

Goals and Objectives: The following list of goals and objectives provides the scope of the initiative and the integration of client-focused outcomes with sustainable system enhancements.

Goal 1: Increase access to universal screening, secondary prevention, early intervention and treatment for people engaging in substance misuse or abuse by implementing SBIRT in primary care and other health settings.

Objective 1.1: In month 4, Y1, begin systematic SBIRT process in patients 18+ (NIAA/NIDA Initial screening, AUDIT/DAST, BNI, BT & ART) resulting in the initial screening of the following numbers of unduplicated individuals: 18,000 in Y1, 25,000 in Year 2 (Y2), 18,000 in Year 3 (Y3), 19,000 in Year 4 (Y4), 15,000 in Year 5 (Y5).

Objective 1.2: Adults initially screened as positive receive secondary screening with AUDIT/DAST at the following rates: 50% in Y1, 75% in Y2 and Y3, 90% in Y4 and Y5.

Objective 1.3: In Y1 a minimum 75% and in Y2 through Y5, a minimum 90% of adults screened at risky levels (AUDIT: 8-15; DAST: 1-2) are offered BI; and adults screened at Harmful level (Audit: 16-19 DAST: 3-5) are offered BT. In Y1 through Y5 a minimum of 90% of adults screened at Dependent level (Audit: 20+ DAST: 6+) receive RT.

Objective 1.4: In Q1 of Y1, develop SBIRT readiness assessment tool which combines essential factors derived from previous successful SBIRT cohorts (OHSU SMART-SET www.sbirtoregon.org/aboutUs.php) and includes: organizational readiness, existing universal screening tools/protocols in place, EMR status and integration capability, clinic champion, existing use of patient data to measure and evaluate care outcomes, existing behavioral healthcare integration, (e.g. staff embedded, LCSW,NP etc.), EBPs for BI and BT and linkages with community based specialty treatment providers.

Objective1.5: Beginning no later than Q2 of Y1, Y1 practices complete baseline readiness assessment. Y3 practices no later than Q1 of Y3. All participating sites complete again

one year post-baseline. "Readiness reviews" utilized as primary CQI strategy to initiate rapid technical assistance to enhance adoption and sustained implementation of essential VT-SBIRT protocols.

Objective 1.6: Beginning in Q2, Y1, QI Practice Facilitators will work with practices sites to develop CQI projects, completing projects on an ongoing basis and selecting new projects designed to enhance VT-SBIRT implementation.

Goal 2: Develop a systematic training model that efficiently and effectively promotes needed clinical skill learning, practice competency and fidelity in SBIRT EBPs to a wide scope of healthcare providers through webinars, courses, onsite coaching/feedback and clinical toolbox resources.

Objective 2.1: In first quarter (Q1) of Y1, VT-SBIRT Training Institute (STI) develop initial curriculum and training/coaching schedule.

Objective 2.2: In Q1 of Y1, STI adopt and organize coursework resources, marketing approach, toolbox cards (www.sbirtoregon.org/tools.php).

Objective 2.3: In Q1 of Y1, develop cultural and linguistic competency (CLC) and health literacy training module with multiple methods of training and clinical toolbox resources.

Objective 2.4: In Q2 of Y1, initiate a train-the-trainers approach to teaching the CQI practice facilitators to train, coach and provide feedback to providers on the topics of health literacy and CLC.

Objective 2.5: Begin scheduling easy enrollment webinar, regular off site training & on site coaching sessions.

Objective 2.6: By end of Q1, Y1, designated healthcare providers from Y1 practice sites complete VT-SBIRT trainings in Foundation of SBIRT, Core MI, BNI and BT. By end of Q1, Y3 for practices starting in Y3.

Objective 2.7: Collect post-SBIRT training data from designated healthcare providers to determine utility and satisfaction with training methods and content, as well as to receive feedback for improvement for subsequent rounds of training.

Objective 2.8 Each practice site designates at least one VT-SBIRT "change champion" (MD, Nurse, clinical supervisor, practice manager) to motivate implementation and oversee adherence protocols (SBIRT workflow integration, sessions checklists & peer review)

Objective 2.9: Designated healthcare providers in Y2-Y5 systematically trained in all SBIRT protocols through STI.

Objective 2.10: In Y2-Y3, develop mechanism for trainees to receive CMEs and other incentives such as possible Maintenance of Certification, further incentivizing training process to ensure sustainability.

Goal 3: Ensure a sustainable VT-SBIRT model within Vermont's healthcare system

Objective 3.1: In Q1 of Y1, gather and schedule PSC, CCT and Health Disparity workgroups.

Objective 3.2: In Q2, Y1 – Y5, core project team, PSC, CCT, and Health Disparities workgroups fully functioning to provide stakeholder & consumer oriented VT-SBIRT oversight for training, TA, CQI plans, and implementation including development of HIT/HIE plans.

Objective3.3: In Y2, conduct systematic review of other SBIRT grant funded projects to date and "lessons learned" concerning topics, barriers and key solutions – special focus on reimbursement models leading to sustainability

Objective 3.4: In Q4 of Y2, PSC and CCT workgroup review Objective 3.3 and draft initial set of sustainability recommendations (funding source, billing, training, workforce, HIT) as a working guide for CQI in adoption/implementation phases Y3-Y5.

Objective 3.5: VT-SBIRT core team with DHVA beginning Q4 of Y1 develop strategies to educate providers on the existing billing code requirements and solicit feedback on potential changes needed to enhance sustainable reimbursement for SBIRT services.

Objective 3.6: "Get out the SBIRT message" and public service announcement campaign begins in Y1 with the notification from the Governor – to publically announce VT-SBIRT project initiation as an essential next step in Vermont's healthcare reform filling critical gaps in the continuum of integrated care.

Objective 3.7: PSC to host key health finance stakeholders to a "SBIRT billing forum" in Q4 of Y2 to review recommendations and propose next steps needed for code reform.

Goal 4: Develop the health information technology infrastructure to facilitate the use of SBIRT and communication among physical healthcare and behavioral health care providers.

Objective 4.1: In Q1 of Y1, CCT discusses and finalizes "scope of work" already in place to contract HIT design analysis with existing vendors of clinical registry and Vermont HIE to determine the best approach for integrating SBIRT within practice settings.

Objective 4.2: CCT workgroup and SAMHSA CCT review new HIT web portal, pilot test outcomes and other "best" options and drafts initial recommendations to discuss with all involved practice sights. Discussion leads to action steps including any new legal ramifications for the expedited refinement of VT-SBIRT HIT platforms capable of sharing information through HIE.

Objective 4.3: Vermont's HIE (VITL) reviews existing legal agreements under the direction of VDH's healthcare attorney and agreements shared with SAMHSA CCT workgroup for approval.

Objective 4.4: In Y3-Y5, VITL to conduct outreach, education and sign-up campaign with all new VT –SBIRT providers and specialty treatment agencies for the Vermont State Consent Repository.

Objective 4.5: Under guidance of CCT workgroup best option HIT plan in place, development of necessary adaptations through unique EHR integration and VT-SBIRT (DocSite).

Proposed evidenced based practices (EBP), screening tools, and modifications.

Motivational Interviewing (MI) will provide the foundation for the clinical interactions of all VT-SBIRT EBPs. MI is an evidence-based method for helping clients with a variety of health and behavioral concerns. Motivational approaches, as developed by Drs. Miller and Rollnick, seek to foster the intrinsic drive people have for healing, positive change, and self-development. Since 1983, more than 25,000 articles citing MI and 200 randomized clinical trials of MI have appeared in print repeatedly demonstrating that practiced use of basic MI strategies leads to greater rapport, desire and commitment to change across a number of medical and behavioral health conditions, and most importantly, actual behavior change (Miller & Rollnick, 2013). **Of note, MI will also serve as one of the foundations for engaging providers in the adoption and implementation of SBIRT, addressing attitudinal barriers and obstacles and will be integrated throughout the training and CQI approach.**

Single item initial screening questions and secondary screening tools selected were recommended in many of the publicly available resources from the National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and previous SAMHSA funded SBIRT initiatives (Oregon, Colorado, Texas, etc.). These specific screening tools help enhance health literacy as they are already translated into 7 languages and written in

common and easy to understand terms. The tools help to decrease implementation barriers in medical settings due to their brevity, ease of administration, scoring and existing templates for feedback to patients; factors critical in forming the bridge to motivational brief interventions and treatment (Babor et al., 2007).

Initial screening for drugs will be done with a commonly used single question screener validated in a primary care adult population study. This drug use question has good demonstrated sensitivity and specificity for detecting drug use regardless of education levels and primary language differences (Smith, 2010). Initial screening for alcohol misuse will be done with the three item AUDIT-C, a validated and regularly used screener in SBIRT projects. The chosen tobacco screening question is also regularly used in SBIRT projects and is NIDA recommended (NIDA, 2010). Secondary screening will occur with two valid and reliable SBIRT recommended tools: the AUDIT and the DAST (World Health Organization, 1982; Skinner, 1982). Many VT-SBIRT provider primary care sites already routinely screen for co-occurring disorders due to involvement in the Blueprint for Health and COSIG initiatives where the integration of behavioral health through mental health specialists is underway. While the tools vary across settings many use the Patient Health Questionnaire (PHQ). VT-SBIRT will adopt the PHQ-2 for initial and the PHQ-9 for secondary screening (if indicated). Both the shorter and longer versions of the PHQ tools have been validated in multiple studies demonstrating good sensitivity and specificity in diverse primary care populations (Gilbody, 2007).

For its brief intervention (BI), VT-SBIRT will utilize the Brief Negotiated Interview (BNI), a specialized "brief intervention" for medical settings. This technique was originally created for use in emergency departments by Drs. D'Onofrio, Bernstein, and Rollnick, one of the founders of MI. The BNI, a proven EBP, is a semi-structured interview process based on MI that can be completed in 5–15 minutes. The BNI has been demonstrated in multiple peer reviewed studies to be effective at facilitating a variety of positive health behavior changes including reductions in tobacco, alcohol, and drug use. One model of the BNI tailored specifically for emergency departments, Project ASSERT, is listed on the National Registry of Evidence-based Programs and Practices as a proven approach. The four steps in the BNI are clear, teachable and researched to lead to sustainable clinical practice 12 months after training (D'Onofrio et al. 1996; Bernstein, & Rollnick, 1996; D'Onofrio et al., 2005).

For its brief treatment (BT) VT-SBIRT will utilize an integrated Motivational Enhancement Therapy-Cognitive Behavior Therapy (MET/CBT) manualized approach. MET/CBT is based upon two EBPs: MI and cognitive behavior therapy (CBT; Miller & Rollnick, 2013; Beck & Beck, 2011). While the BI focuses on preparing and motivating clients to change their use, the BT builds on the BI by teaching clients with greater risk or problematic use effective skills to change. BTs can range from two sessions to 16, but the focus of BTs, unlike longer methods, is primarily on current situations and rapid implementation of specific behavioral change (Babor et al. 2007). Motivational Enhancement Treatment (MET) and Cognitive Behavior Therapy (CBT) alone and combined have been demonstrated as effective and efficient approaches to treating alcohol use disorders (e.g., Project Match Research Group, 1997; Anton et al. 2006), cannabis use disorders (e.g., Budney et al 2007; Copeland et al 2001; Dennis et al 2004; French et al 2003; Kadden et al 2006, 2007; Marijuana Treatment Project, 2004; Stephens et al 1994; 2000), cocaine use disorders (Carroll et al 2004; Crits-Christoph et al 2001), opioid use disorders (Carroll et al 2001), and tobacco use disorders (Baker et al 2002). This has repeatedly led to their routine inclusions in lists of EBPs to be adopted and used more

widely (e.g., Miller, et al 2002; Ingersoll & Cohen, 2005; IOM, 1990; NQF, 2007; Lamb et al 1998; Miller & Wilbourne, 2002; Weisner et al 2004).

Specifically, the VT-SBIRT approach will be adapted from a number of different sources, primarily Connecticut's LETS PLAY Brief Treatment intervention (Steinberg et al., 2012). This manual is formatted in an easy read style, provides excellent background on MI and CBT and has flexibility built into the design to individualize the delivery of content dependent on the patient's needs. This structured yet flexible approach is critical in VT-SBIRT as it allows for tailoring the intervention for the range of co-occurring problems typical to primary care settings involved (such as trauma, mood and anxiety disorders). LETS PLAY has been adapted by staff at the University of Connecticut Health Center from manuals prepared by the SBIRT grantee states of Illinois (Great Lakes Addiction Technology Transfer Center, 2004; Peer Assistance Services, Inc., 2009), Colorado (OMNI Institute, 2009), and Missouri (Dugan et al., 2009), as well as the manuals prepared by the Marijuana Treatment Project (MTP), describing Brief Marijuana Dependence Counseling. Another key strength to the VT-SBIRT's chosen BT are the session agendas, client handouts and checklists - proven resources needed for ease in transporting the model into a variety of settings while maintaining sustained fidelity.

VT-SBIRT's referral to specialty treatment approach, Active Referral to Treatment (ART), is recommended in literature and SBIRT resources to emphasize the need for positive, assertive linking of the patient referred from one healthcare setting to another (D'Onofrio et al. 1985, 2002; McKay et al., 2009). The ART method attempts to address barriers discussed in Section A by training providers to use their MI skills, compassion, clear advice and knowledge of specialty local resources and costs to recommend and warmly connect their patients to appropriate and accessible specialty care (www.bu.edu/bniart/sbirt-in-health-care/sbirt-active-referral-treatment-art/). All involved SBIRT providers will utilize a referral resource guide listing specialty treatment providers and other community resources as part of VT-SBIRTs ART networking strategy to increase provider and patient understanding of available treatment resources, access and funding requirements.

How chosen EBPs address disparities. VT-SBIRT providers will be trained to embody the "spirit" of MI: autonomy, collaboration, evocation and compassion. Delivery of all EBPs – whether it is for screening, BI, BT, or RT will be influenced by this intentionally respectful approach researched to empower personal choice regardless of race, ethnicity, gender, sexual orientation, poverty level, and education. Primary reasons for disparity in Vermont include four main factors: income level, education, language spoken and rural geographic location. When these factors interact with race/ethnicity, the conditions are worse. VT-SBIRT screening and interventions delivered in FQHCs and free clinics are offered regardless of ability to pay. The screening tools are translated into six languages and estimated to be written at a 6th grade level. For clients who speak an unwritten language (e.g. Mai Mai, the language of the Somali Bantu), use of interpreters is expected and required within the settings in which they seek care and will be utilized for this effort as well. VT-SBIRT primary care practice sites are located in both population centers like Burlington and Rutland and many rural health centers across the state.

How EHR/HIE will support EBP delivery. Vermont's evolving and "reformed" health information environment creates a strong foundation and synergy for VT-SBIRT's proposed EHR/HIE upgrades and the delivery of VT-SBIRTs protocols. Vermont's statewide Healthcare Reform Program, the Blueprint for Health, located in the Department of Vermont Health Access (DHVA) was enabled through legislation in 2003. The Blueprint is leading the transformation to provide a highly coordinated statewide approach to health, wellness, and disease prevention with

an Advanced Model of Primary Care statewide. This program includes nationally recognized Patient Centered Medical Homes supported by Community Heath Teams and a HIT infrastructure that supports guideline based care, population reporting, and health information exchange. The Blueprint received national recognition again in 2012, with a professional production (funded by the Agency for Healthcare Research and Quality Innovations Exchange) of several short documentary films and a webcast panel. "Vermont Blueprint for Health: Working Together for Better Care" can be seen at http://www.innovations.ahrq.gov/webevents/index.aspx?id=44. The 2013 edition of *U.S. News & World Report - Changes Ahead, Healthcare, Transformed,* featured the Blueprint as an example of an important and prominent state-led innovative program.

The Blueprint HIT/HIE capabilities and focus are centered on the Blueprint Sprint and the Central Clinical Registry (i.e. DocSite). The goal of the Blueprint Sprint is to establish accurate, timely and reliable end-to-end data extraction, transmission, and registry reporting to support the delivery of high quality health services. DocSite, Vermont's Central Clinical Registry, is a web-based system which enhances individualized patient care with guideline based decision support. It also supports management of populations with flexible reporting that moves easily between groups of patients selected by specific criteria and their individual patient records. Flexible comparative effectiveness reporting is increasingly available across providers, practices, organizations, and Health Service Areas. DocSite has the potential to serve as an integrated health record across independent practices and organizations, now in active development.

For VT-SBIRT, planned upgrades to existing EHR/HIT include a design analysis to ensure seamless integration of an SBIRT "suite" into both DocSite for rapid start-up and to allow non-EMR agencies to log in as users through tablets/laptops for online entry or uploads. Additionally FQHCs, Medical Centers and agencies with existing EMRs and DocSite links in place will integrate the SBIRT "suite" into their systems. DocSite's SBIRT "suite" will increase both Vermont's capacity to provide needed interventions and provide centralized place for SBIRT data to exist, so evaluators can be provided limited identifiable data they need to meet evaluation requirements (GPRA). This "choice based" integrated health information model reduces provider burden and allows for a more seamless adoption of the prescribed SBIRT protocols, techniques, tools, and data collection. By integrating VT-SBIRT into existing EHR/HIT platforms, providers will be able to focus their attention on the patient and the effective delivery of SBIRT EBPs instead of administrative tasks and IT characteristics. The SBIRT suite envisioned will be based on familiar "step by step" models where the response in the previous item determines the next item in the screening or intervention process. For example, the patient's score on the AUDIT and/or DAST will automatically generate an individualized feedback report allowing the provider and patient to focus the discussion on endorsed risk level and associated areas. Of importance, VT-SBIRT will be a collaborator in the new Vermont consent repository and VITL, the operator of the VT-HIE, will oversee outreach to providers and patients to sign on. Enrolling VT-SBIRT patients into the consent repository will facilitate linkages between medical providers and specialty treatment.

SECTION C: PROPOSED IMPLEMENTATION APPROACH

How achievement of goals will produce results. The current system is severely lacking in its capacity to systematically identify risk, intervene early, and effectively treat substance misuse and disorders. This reality is experienced in Vermont communities and translates into negative sequelae such as increased traumas, family discord and disruptions, medical and emotional illness, and associated demands on healthcare services (e.g. cost offsets). VT-SBIRT's

statewide implementation will reach over 90,000 adults, markedly increasing access to proactive screening, identification and needed interventions. VT-SBIRT's chosen practice locations serve as the "safety nets" of our system of care. By delivering SBIRT protocols in these locations; we will be able to diminish existing health disparity barriers for a significant percentage of low income Vermonters, refugees, migrant farmers, and other subpopulations relying on physical health resources; but often not entering SA/MH treatment points. Increased access to immediate interventions will largely impact rural communities where two-thirds of our populations live. State census statistics demonstrate that within rural communities, incomes/education levels are typically lower and treatment options are limited by transportation barriers and a lack of affordable childcare for parents. For the first time, our Veterans and National Guard Service Members will routinely receive standardized proactive screening and immediately accessible EBP interventions during annual physical health check-ups. The establishment of VT-SBIRT's Training Institute will allow providers across the state ready, free, convenient access to SBIRT EBPs, protocols, and tools, increasing sustainability and promoting widespread adoption. The funding, TA and infrastructure upgrades in HIT and HIE policies and procedures will allow for a new communication bridge between medical patient records and their specialty treatment providers- an essential connection for comprehensive patient care.

Overcoming barriers using VT-SBIRT. Currently, no system or intervention mechanisms exist in Vermont to support routine, annual substance use screening for adults. Rather, adults may be identified as having a substance use problem by self-identification, trouble with the legal or child welfare system, or some other mandated source. If a medical provider expresses concern about a patient's substance use, s/he does not have screening or any form of intervention protocol in place to assist them in intervening most efficiently and effectively. They are not typically trained in behavioral health screening, nor in optimal engagement strategies for activating behavioral change. The one exception to this is the Blueprint-ADAP collaboration of the "Hub and Spoke" model used to target opiate addiction – a very specific need representing a small proportion of Vermont's entire population. Thus, our current system is set up for primary prevention or to be reactive vs. proactive in addressing adult substance misuse and abuse. Implementing VT-SBIRT will likely be impeded by barriers previously identified in the literature including: 1) provider attitudes and competence – lack of motivation/training, culturally responsive strategies ; 2) workflow and resources – lack of time for overburdened healthcare workers; 3) SBIRT adaptability – each provider is unique in capability; and 4) organizational support – competing priorities, time for training, HIT infrastructure and EMR upgrades (Babor et al., 2007; National Center on Addiction and Substance Abuse at Columbia University, 2012). Primary barriers to linking patients to treatment include: patient readiness, cultural and language barriers, network dynamics, transportation, stigma, funding, and communication – including patient confidentiality regulations (42CFR/HIPPA). A related, important barrier may be the need for philosophical shifts on the part of providers and organizations to meaningfully allow for integration of SBIRT strategies. For example, traditional substance abuse programs may utilize protocols that will be off-putting and fundamentally antithetical to the VT-SBIRT mission.

VT-SBIRT will address many of these readiness and attitudinal barriers by its MI approach to providing training and coaching to all providers, including supervisors and administrators. MI is an effective approach for motivating providers to understand SBIRT's benefits for improving healthcare and effectively helping to move providers and their patients along the change continuum (from pre-contemplative or contemplative into preparation or action) to attend to needed wellness and treatment actions. We will offer providers a clear rationale to adopt SBIRT, developing their knowledge and competency in the basic foundations

of SBIRT protocols including: positive outcomes for the system of care, patient health benefits, easy to use clinical tools, HIT infrastructures to allow easier care coordination, referral resources and billing options. As written in a review of SBIRT initiatives, "Successful implementation of SBIRT tends to occur at those sites where clinicians are reimbursed for their services and well trained for their task." (Babor et al., 2007 p. 140) Aside from primary prevention efforts, Vermont is set up as a reactive system in part because of what services are reimbursed. How VT-SBIRT will remove this barrier is discussed below.

To address barriers linking patients between levels of needed treatment, in addition to their regular meeting schedule, the PSC, CCT, and Health Disparity workgroups will convene in special work meetings to focus on the topic "linking patient's to specialty care - barriers to treatment" with the goal of producing a recommendations report for ADAP to act on between Y2 and Y5. The key stakeholders involved allow for perspectives from all components of healthcare. Research on comprehensive strategies for disease management emphasizes "continued care" vs. episodic care and so VT-SBIRT's RT plan is to incorporate this researched understanding of how best to manage addictive and co-occurring disorders to extend the benefits of SBIRT interventions and treatment (McKay, 2009). VT-SBIRT will train primary care providers to utilize the ART method, which emphasizes protocols to overcome barriers in linking patients to specialty treatment services while still maintaining a therapeutic connection for follow-up.

Proposed use of project and other available funding. VT-SBIRT will begin by funding eight practices in Y1 and Y2 with SBIRT grant funds. Four of the eight Y1 practice sites are reimbursed for services by DVHA and commercial insurers. Because the VT National Guard, free clinics, and UVM Student Health fund their programs with contracts, grants, donations, and student fees, we will need to explore reimbursement models beyond billing codes. In Y3, three additional practice sites will begin to implement SBIRT with grant funding. In order to support expanding SBIRT to all 11 practice sites starting in Y3, we intend to implement a blended funding model in Y3 for sites funded in Y1. The blended funding model will combine SBIRT grant funds with billing reimbursements and ADAP grants. The three primary funding streams in addition to SBIRT grant funds include State General Fund, Medicaid/Medicare, and Substance Abuse Prevention and Treatment Block Grant. A priority for VT-SBIRT is developing a funding model that supports sustainability in as short a timeframe as possible; without sacrificing clinical effectiveness and adherence to the goals of SBIRT.

Any sustainable VT-SBIRT reimbursement model must focus on building the organizational and IT infrastructure needed to support SBIRT reimbursement, as well as initiating policy changes that enable and allow for consistent and comprehensive appropriate SBIRT reimbursement. As part of this pursuit, the PSC will help guide the needed changes in Vermont's SBIRT billing codes by first reviewing the billing models across previous SBIRT grantees that have had success in "funding for sustainability". We will incorporate key findings and "lessons learned" from a special PSC, providers and key stakeholders focus group to examine various billing perspectives. In addition, the Program Manager, with guidance from the PSC will conduct a financial mapping of different available funding sources. Information from these steps will be used by the Project Director, in collaboration with ADAP, DVHA, and commercial insurers via the Department of Financial Regulation, to develop a VT-SBIRT financial model to be adopted by the state. It is anticipated that an emphasis within these recommendations will be on synchronizing the code regulations to more accurately reflect how SBIRT services are delivered in our community settings. As soon as these systems are in place and practices demonstrate consistent competency in implementing SBIRT, we will collaborate

with practices to gradually decrease their grant funds while facilitating their billing practices and increasing revenue generation. If opportunity and time are available, we have the possibility of recruiting additional, new primary care practice sites to adopt SBIRT with grant funds.

See next two pages for VT-SBIRT Project Timeline.

Plan to make training and TA available. Upon notice of award, ADAP, EBS, and VCHIP will collaborate in the development of the Vermont SBIRT Training Institute (STI). The STI will provide regularly scheduled regional trainings on core SBIRT content (listed below), webinars, online courses and on-site coaching sessions throughout the grant. Providing regular coaching with feedback is essential to improving clinical skill development, and sustaining competency in SBIRT techniques (CASA, 2012; Babor et al., 2007). This aspect of ongoing learning will be emphasized through a "train-the-trainer" model and practice opportunities during regular staffings to reduce time burdens using three approaches: the Project Director and QI Practice Facilitators via training and coaching, the QI Practice Facilitators via CQI efforts, and on-site clinical champions (MDs, Nurses, Health Coaches). Practices will also have contact information for each site's clinical champion and are able to contact each other as resources.

An STI web learning portal with all SBIRT courses, clinical tools, video vignettes, as well as links to other valuable online resources will be made publically available in Y3-Y5 of the grant. The VT Agency of Human Services eLearning website http://mentalhealth.vermont.gov/training/online and http://www.sbirtoregon.org/tools.php provide clear examples of our intentions. Core STI courses will include the following topics: a) Foundations of SBIRT; b) Core MI; c) Conducting the BNI; d) BT and ART (MET/CBT); e) CLC/health literacy; and f) Understanding ASAM PPC-2R. Initial training/coaching on DocSite and HIE/Consent Repository enhancements will be contracted through Covisint and VITL and for sustainability include a similar "train-the-trainer" coaching plan as illustrated above to: a) enhance learning and competency at each practice site; b) support ongoing workforce development (i.e. training of new staff); and c) provide opportunities for regional community partner agency inclusion. Additional courses will be added to enhance the SBIRT provider knowledge base when specifically relevant including: a) From the War Zone to the Home Front: Supporting the Mental Health of Veterans and Families; and b) Agency of Human Services E-Learning Course on Co-Occurring Mental Health & Substance Use Conditions. Each of the training topics above have existing training curricula from SBIRT sites and which the Project Director helped develop in some cases. We plan to utilize resources from SBIRT sites (with permission) to not only develop trainings but also an SBIRT clinical toolbox and resources. In addition, VCHIP has experience in incentivizing training and the CQI process within primary care settings by awarding CMEs and developing Maintenance of Certification projects. Such efforts will be applied to incentivize funded sites in the SBIRT adoption process.

All regional trainings will be made available to all medical providers and all medical providers will be able to access STI's website and view online courses and training videos, webinars, and examples of CQI projects, as well as download SBIRT informational resources