

I: State Information

State Information

Plan Year

Start Year:

2012

End Year:

2013

State DUNS Number

Number

609980255

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name

Maryland Department of Health and Mental Hygiene

Organizational Unit

Alcohol and Drug Abuse Administration

Mailing Address

55 Wade Avenue

City

Catonsville

Zip Code

21228

II. Contact Person for the Grantee of the Block Grant

First Name

Tom

Last Name

Cargiulo

Agency Name

Alcohol And Drug Abuse Administration

Mailing Address

55 Wade Avenue

City

Catonsville

Zip Code

21228

Telephone

410-402-8610

Fax

Email Address

tcargiulo@dhmh.state.md.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

7/1/2009

To

6/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

10/3/2011 11:47:02 PM

Revision Date

1/3/2012 7:28:31 AM

V. Contact Person Responsible for Application Submission

First Name

Fran

Last Name

Givens

Telephone

410-402-8576

Fax

Email Address

fgivens@dhhm.state.md.us

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="Thomas Cargiulo, Pharm.D."/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Maryland Alcohol and Drug Abuse Administration"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

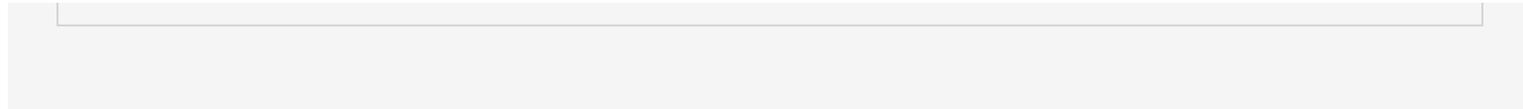
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Thomas Cargiulo, Pharm.D.
Title	Director
Organization	Alcohol and Drug Abuse Administration

Signature: _____ Date: _____

Footnotes:



I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Maryland will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	<input type="text" value="Thomas Cargiulo, Pharm.D."/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Alcohol and Drug Abuse Administration"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

STEP 1 – Assess the Strengths and Needs of the Service System to Address Specific Populations

EXECUTIVE SUMMARY: During FY 2011 and moving into FY 2012, the Alcohol and Drug Abuse Administration (ADAA), the division of the State of Maryland Department of Health and Mental Hygiene (DHMH) responsible for overseeing the delivery of publicly funded addictions prevention and treatment services in the state, was actively involved in numerous activities to refine, enhance, and improve management of the system. The Deputy Secretary for Behavioral Health and Disabilities, Renata Henry, oversees the Department's Administrations for Mental Health (MHA), Alcohol and Drug Abuse (ADAA) and Developmental Disabilities (DDA), as well as the DHMH Office of Forensic Services, under the leadership of the DHMH Secretary Joshua Sharfstein.

The ADAA preserves and strengthens the service system through various collaborative efforts. The ADAA places high priority on access to services and the development of a system in which services meet individual needs across the lifespan and efforts are coordinated that support recovery and resiliency. The ADAA continues efforts to support the Department's mission of fostering an integrated process for planning and collaboration, and of ensuring that a quality system of care is available for individuals with behavioral health conditions.

As Maryland continues to move toward the implementation of Health Care Reform, several planning activities are underway for integrating the care of individuals with behavioral health disorders. The Department is examining the regulatory changes required of both the mental health and the substance abuse systems into an integrated behavioral health system with a single set of behavioral health regulations. Additionally, the Department is reviewing available data and involving experts and stakeholders so as to develop an inclusive approach for recommending potential financing alternatives. Finally, the Department is exploring the incremental stages necessary for the development and coordination of an integrated Behavioral Health Administration. The Department intends to provide, via conference calls and a designated website, opportunities for soliciting input from, and informing the public about, each of the planning and development stages.

Maryland is providing separate applications for the FY 2012-2013 Mental Health Block Grant and Substance Abuse Block application; however, there are common areas in which the MHA and the ADAA are providing joint responses. The two administrations plan to explore procedures for the development of a joint behavioral health needs assessment process to further identify behavioral health needs in Maryland.

NEW UNIFIED ADAA AND MHA PLANNING PROCESSES:

In an effort to streamline the application and reporting procedures, SAMHSA has developed a uniform application and reporting process to promote consistent planning, application, assurance and reporting dates across both block grant programs (Mental Health Services and Substance Abuse Prevention and Treatment), to commence with the FY 2012 and FY 2013 block grant submissions. In previous block grant application submissions, the mental health block grant (MHBG), the assessment, current and new developments, and planning activities were addressed under five (5) criteria for adults with serious mental illness (SMI) and children and adolescents with serious emotional disorders (SED). Previous MHBG applications required submission of separate Adult and Child Plans. The SAPT-BG required that the State report on compliance with, progress toward, and intended use of, SAPT block grant funds designed to accomplish 17 national goals for individuals with or at risk of developing substance use disorders.

This year, States are required to develop the behavioral health assessment and plan consistent with the five (5) criteria for the MHBG and for the SAPT-BG, consistent with the 17 national goals. States must submit their Block Grant applications for 2012 and 2013 based on the new guidance.

Although SAMHSA is encouraging States to submit a “unified” application, Maryland is submitting separate block grant applications for mental health and substance abuse, however, throughout the document there are discussions of joint and collaborative efforts of the behavioral health administrations.

For this submission the current statutory deadline for the SAPT-BG application submission (October 1) is unchanged, however, the application time period is for the period 10/1/11 – 6/30/13 to align with most States’ fiscal year budget cycles. Subsequent Block Grant applications should be submitted on 4/1/2013 for a two year period (07/01/2013 – 06/30/2015).

In this section, Maryland first will identify the strengths, needs, and priorities of the State’s behavioral health system, taking into account the specific populations that are the current focus of SAPT-BG as well as the changing health care environment and SAMHSA’s strategic initiatives.

OVERVIEW OF MARYLAND’S PUBLIC BEHAVIORAL HEALTH SYSTEM:

Alcohol and Drug Abuse Administration (ADAA): The ADAA is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention treatment and recovery support services. As the Single State Authority (SSA) for Maryland, the ADAA is responsible for planning, developing and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. The ADAA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes public health and safety of patients, families and communities. The ADAA designates, approves, plans and coordinates programming within Maryland that offers prevention, intervention, treatment and recovery support services;

establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates “science to service” information relating to services for persons with SUDs, services for the prevention/diagnosis/treatment/rehabilitation of substance use, abuse and dependence, and support services to sustain recovery beyond the treatment/rehabilitation episode..

Mental Hygiene Administration (MHA): The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. Specialty mental health care is carved out from physical care and is administered by MHA. MHA operates five inpatient psychiatric facilities and two residential treatment centers for children and adolescents. From the time of admission, facilities work collaboratively with CSAs, community providers, consumers, and families toward patient discharge. The focus is on returning the individual to the lowest level of care necessary to meet the individual’s medical needs. The State psychiatric hospitals are participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland

Behavioral Health Integration within DHMH: The Secretary of Health and Mental Hygiene and the Deputy Secretary of Behavioral Health have appointed a Behavioral Health Integrated Regulations Committee (the "Committee") to develop regulations governing providers of Behavioral Health (mental health and substance abuse services). The Committee, which consists of staff from the ADAA, the ADAA, the Office of the Attorney General, and the Resident Grievance System, as well as service providers, is charged with developing a process, including identifying statutory barriers, to fully integrating mental health and substance abuse regulations. The group has met five times and has discussed the various avenues through which this goal can be attained.

In order to achieve the goal of effective integration of regulations, the Committee examined the current and prospective health-care climates and recognized that the health-care delivery system in Maryland will be undergoing significant change in the months and years ahead. The following conditions were considered:

- The current system of care, to a great extent, operates apart from a whole-person system, with services being delivered by different providers for different disorders.
- Individuals who provide mental health or substance abuse services are licensed or certified by the respective Health Occupations Boards established under the Health Occupations Article, Annotated Code of Maryland. Once licensed, physicians, psychologists, nurses, social workers, and professional counselors are authorized to provide both mental health and substance abuse services.
- At this time, individuals in need of BH services through the public system receive care through an entity's license or certification to deliver either alcohol and drug abuse or mental health services, and the State, through ADAA and MHA, regulates these services separately and differently. A growing number of entities provide both services.
- Services for substance abuse and mental health disorders are similar in that they consist

of outpatient treatment (talk and pharmacological therapies), rehabilitation services, inpatient care, and residential services.

- Entities are approved to provide respective services, such as mobile treatment and level 1 substance abuse services. It is recognized that current regulations are restrictive, due to their level of specificity.
- The State's system of regulated care focuses primarily on individuals who are uninsured or whose care is government-reimbursed.

Health care reform will change the profile of insured/uninsured, giving individuals expanded choice and allowing providers to deliver care to individuals with differing payment and reimbursement streams. Becoming a part of the new system will likely require compliance with universal standards with respect both to services and billing structure.

After lengthy and thoughtful discussion, the Committee concluded that, given the changing environment and the need to create a system that is accessible, streamlined, and durable, a new direction is indicated. The Committee concluded that the appropriate approach is to eliminate overly-detailed, program-specific Departmental regulations and, instead, begin to move providers into a system of approval by national accreditation bodies.

This new approach will accomplish several major goals:

- Addiction and mental health provider and treatment systems will use one set of standards to govern their programs, which will allow providers to concentrate on treatment goals rather than on compliance with an overabundance of redundant regulations.
- The accreditation of Behavioral Health services will promote the integration of clinical services to the individual and, thus, allow providers to better deliver the services to meet an individual's treatment goals.
- All Behavioral Health providers will be accredited by nationally-recognized accreditation bodies that have established standards, including utilization review and quality assurance, which will result in consistency in service delivery and constancy for providers in service expectation.
- Purchasing requirements will generate additional data that can be used to develop best practices, advance recovery models of practice, assure the efficient use of State and federal dollars, and develop incentive payment systems for specialized services.
- Departmental resources, instead of being spread over all providers, can be devoted to providing technical assistance and promoting best practices, investigating complaints, addressing problems, and bringing marginal programs into compliance, while working in concert with national accrediting bodies.
- Requiring accreditation by national accreditation bodies, which by the nature of their business and ability to respond rapidly to changing standards, permits the use of best practices by providers for the benefit of the individual served and the purchaser of the service.

DHMH will revise the current substance abuse (COMAR 10.47) and mental health (COMAR 10.21) regulations to develop a set of behavioral health regulations. This work will be guided by the following principles:

- **Regulations will reflect both system and service integration.** System integration focuses on the framework within which agencies and programs operate. Services integration focuses on the clinical services needed to meet the individual’s needs.
- **Regulations will promote administrative simplicity.** The modalities or levels of care are essentially the same for both conditions, so where possible, the regulations will use common language and definitions to describe clinical activities.
- **Regulations will facilitate and support the use of effective evidence-based interventions.**
- **Regulations will promote a person-centered approach.** Regulations will support intervening with “whole-person health” – social, emotional, and physical.

Throughout the regulations development process, DHMH will consult with stakeholders for feedback. This will provide DHMH with critical information that will help guide the process. Drafts will be posted on the DHMH behavioral health integration webpage. There will be at least three opportunities for public comment; comments will be accepted via email.

ORGANIZATION OF MARYLAND’S PUBLIC BEHAVIORAL HEALTH SYSTEM:

The ADAA and Maryland’s Public Substance Use Disorders System: Maryland is divided into twenty-four political subdivisions, including twenty-three counties and Baltimore City. The ADAA awards State and Federal funds to the 24 jurisdictions for substance abuse prevention, treatment and recovery support services through grants that support the services infrastructure for Maryland’s uninsured or under-insured patient population. Public funding through the ADAA is therefore the “safety net” for individuals in need of services who would otherwise lack the ability to pay, which is a particularly important consideration in view of the number of court commitments and other justice system referrals.

Conditions of award for these grants provide contractual parameters for the sub-recipient jurisdictions to ensure that SAPT-BG and other Federal and State requirements are met. Jurisdictions control the type and method of service delivery, including directly operated programs, subcontracts with private providers, a preferred provider network, or a combination model. Access to programs within a jurisdiction may be restricted to residents within that jurisdiction or a designated region. Other programs have statewide capacity and are funded with State, local and federal dollars.

Maryland strives to provide a statewide continuum of care with all levels of treatment, where individuals move among levels based on their individual needs. Within all 24 jurisdictions in MD there are State and locally funded systems for assessment, referral and treatment of persons with substance use, abuse and dependence problems. Individuals may self-refer, or be referred from a primary care provider, other health care professional, the courts or other sources. Local Health Departments are generally designated for initial contact with the un- or under-insured.

Programmatic functions in all State and privately funded treatment programs, from assessment through every level of care in the continuum, are governed by the Code of MD Regulations (COMAR). State laws and regulations require that all SUD treatment programs in MD be certified by the Dept of Health and Mental Hygiene (DHMH) Office of Health Care Quality

(OHCQ). The continuum of certified treatment programs in MD consists of 467 certified treatment providers; 219 receive funding from the ADAA and 248 are privately funded.

The Maryland Addictions Directors Council (MADC) is a nonprofit organization that supports the prevention, intervention, treatment and recovery programs throughout the State. MADC members include public, private, nonprofit and for-profit programs. MADC initiates, facilitates and supports advocacy, outreach, research, publication and educational activities that improve access to quality substance use disorder services. MADC's mission is to advocate for quality addictions services that promote healthy individuals, strong families and thriving communities.

Each jurisdiction has a prevention coordinator. The ADAA requires that prevention providers utilize evidence-based programs (EBPs) from SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).

The ADAA's Regional Managers in its Recovery Oriented Systems of Care (ROSC) Division are liaisons to local prevention and treatment service providers working with local jurisdictions to coordinate the provision of services. The ROSC Division provides on-site clinical development activities for programs, and leads Technical Assistance (TA) Teams that provide proactive (ADAA initiated) assistance as well as assistance requested by jurisdictions and programs. *RecoveryNet* Regional Coordinators, supported with CSAT Access to Recovery (ATR) funds, are an extended part of the TA teams and have the full resources of the teams to ensure communication and integration of *RecoveryNet* services into the overall service continuum.

The ADAA's Quality Assurance (QA) Division is responsible for developing, implementing and maintaining service improvement strategies to enhance the quality of services provided in Maryland. Compliance Unit Staff within the QA Division conduct compliance reviews on a random basis to assure the provision of quality services, and conduct complaint investigations as needed in response to complaints by patients, families or the public. The QA Division reviews various aspects of program operations to determine compliance with substance abuse treatment program regulations and ADAA Conditions of Award, and identifies relationships between program practices and the quality of care. Code of Maryland Regulations (COMAR), Code of Federal Regulations (CFR) and ADAA Conditions of Award determine the basis for the reviews.

Compliance Staff within the QA division work with programs to implement a number of possible solutions to non-compliance with COMAR, CFR, or ADAA Conditions of Award. If there is a risk to the health and safety of the patient or the community, administrative action may be taken, including possible program closure. For less serious deficiencies, Corrective Action Plans (CAPs) are submitted with appropriate timelines for implementation, and follow-up reviews are conducted to ensure that the CAP has been completed.

All Maryland Department of Health and Mental Hygiene (DHMH) certified or Joint Committee on Accreditation of Healthcare Organization (JCAHO) accredited alcohol and drug abuse treatment programs are required to report data in the ADAA's State of Maryland Automated Record System (SMART). These data reflect the status of substance treatment, intervention, and prevention programs in Maryland, services delivered and populations served. At the time of this

writing, the ADAA was in the process of performing quality checks of FY 2011 data, therefore the following analyses reflect only patient and service utilization data for FY 2010, the latest year for which a complete set of data are available.

Patients must be comprehensively assessed within ten days of initial contact (except for pregnant women, and women with dependent children, who must receive priority admission within 24 hours). Assessment instruments include the Treatment Assignment Protocol (TAP) for adults and the Adolescent Drug and Alcohol Diagnosis (ADAD) for adolescents; these are available in the ADAA funded system's electronic record. All assessments must measure along several domains, including physical health, employment status, drug and alcohol use, treatment history and mental health status.

Referrals and admissions are based on the American Society of Addiction Medicine Patient Placement Criteria- 2 Revised (ASAM PPC-2R) and correspond with various levels of care (LOC) available throughout the State. Services include intervention and the levels of treatment illustrated in Table 1. COMAR mandates the use of ASAM PPC-2R criteria for placement in the most appropriate LOC; assessed individuals are referred to programs with the corresponding LOC, based on bed or slot availability. Programs incorporate EBPs in the delivery of funded services, and are evaluated on performance measurement standards which have been developed by the ADAA and written into grant award conditions.

The MHA and Maryland's Public Mental Health System (PMHS): The PMHS is managed in collaboration with Core Service Agencies (CSAs) and an Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services within a defined service area.

The MHA and CSAs share responsibilities within the PMHS. There are nineteen (19) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that meets the needs of eligible individuals of all ages. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluating appropriateness and effectiveness of service.

Additionally, CSAs are important points of contact for both consumers and providers in the PMHS and develop partnerships with other local, state and federal agencies. CSAs provide numerous public education events and trainings. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA. Additionally, local mental health advisory committees and CSA Boards have the opportunity and responsibility to advise CSAs regarding the PMHS and to participate in the development of local mental health plans and budgets.

The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its

local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and State priorities. Additionally, CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various MHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues. Also, the CSAs work closely with the MHA Management Information System (MIS) staff on the Data Committee to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve. CSAs also serve as authorization agents for some specialized services and play point leadership roles in a number of federally funded local demonstration projects.

ROLES OF THE SSA, SMHA AND OTHER STATE AGENCIES:

The Maryland Department of Health and Mental Hygiene (DHMH) manages Maryland's behavioral health, public health and Medicaid service systems. The Alcohol and Drug Abuse Administration (ADAA) within DHMH is the designated SSA, and the Mental Hygiene Administration (MHA) is the designated SMHA. The ADAA and MHA Directors report to the DHMH Deputy Director for Behavioral Health and Disabilities, who in turn reports to the Secretary of DHMH. The Secretary reports to the Governor.

The placement of the ADAA and the MHA within the State structure enhances Maryland's ability to deliver integrated services. The DHMH Secretary and Maryland's Governor have a strong interest in and commitment to substance abuse issues. As a result, the substance abuse treatment system is prominently represented in Maryland's plans for health care reform.

The Governor designated "increasing access to substance abuse treatment by 25 percent by the year 2012" among 15 strategic policy goals within his Administration. The Governor's Office uses a comprehensive statewide performance measurement program called StateStat to track progress towards these goals, and StateStat has enhanced the ADAA's prominence among other (often much larger) stakeholder agencies such as Medicaid and the criminal justice community. The ADAA has developed collaborative performance plans and goals with these agencies.

State Drug and Alcohol Abuse Council (SDAAC):

In July 2008, Governor Martin O'Malley signed an Executive Order re-authorizing the Maryland State Drug and Alcohol Abuse Council (DAAC), which is composed of 27 members, including key state cabinet secretaries, judges, legislators, providers, consumers and citizens. The primary purpose of the DAAC is to develop a comprehensive, coordinated and strategic approach to the use of State and local resources for substance abuse prevention and treatment services. The DAAC promotes collaboration among State and local agencies for the allocation of adequate resources to address the substance abuse services needs of individuals with co-occurring problems, including mental health disorders, cognitive impairments, somatic health problems, homelessness, and/or criminal justice or child welfare system involvement.

House Bill 219, Acts of 2010 (Chapter 661) created the Maryland State Drug and Alcohol Abuse Council (DAAC) within the Office of the Governor. The voting members of the DAAC include

representatives from the State legislature, State agencies, and councils (including DHMH, criminal justice agencies, human resources, budget and management, housing and community development, transportation, State Superintendent of Schools, and the Governor's Office for Children), as well as eight appointed members representing geographic regions of the State, at-risk populations, knowledgeable professionals, consumers, family members, and service providers. The DAAC is directed by statute to meet at least four times per year; however, in practice the Council meets approximately six times per year.

The DAAC's chief duties are to develop a strategic plan for substance abuse services, to encourage collaboration between and among State agencies and local drug and alcohol abuse councils (LDAACs), and to ensure cost-effective and quality services that are consistent with the priorities in the State Plan. The ADAA provides staff support to the DAAC and its five work groups, which include:

- Collaboration and Coordination
- Criminal Justice Services
- Prevention of Underage Drinking (MSPF Advisory Committee)
- Technology
- Workforce Development

Other State Agencies:

- DHMH Infections Disease and Environmental Health Administration (IDEHA): The ADAA maintains a memorandum of understanding (MOU) with IDEHA (formerly the "AIDS Administration"), to provide HIV/AIDS counseling, testing and referral for individuals in areas of the State with the greatest need, at the locations in which they are receiving substance abuse treatment. A portion of the Set Aside (approximately \$405,000) is awarded annually via a memorandum of understanding (MOU) with IDEHA. The remaining portion of the Set Aside is provided to each of the 24 local jurisdictions to support HIV screening and referral services for each individual admitted to substance abuse treatment in Maryland.
- Maryland Department of Public Safety and Correctional Services (DPSCS): The ADAA collaborates with the DPSCS as follows:
 - HG 8-505 and HG 8-507: The ADAA maintains an MOU with the DPSCS to provide court-ordered HG 8-505 evaluations for inmates within the State correctional institutions and local detention centers. Inmates from each of the 24 jurisdictions who are identified as being in need of treatment are referred to community-based treatment programs throughout the State per HG 8-507. Per Maryland legislation, DPSCS staffs provide clearance status for court-ordered HG 8-505 and HG 8-507 inmates to permit their transfer to and enrollment in community-based treatment programs. The ADAA's Medical Director attends meetings of Maryland's Problem-Solving Courts Mental Health Oversight Committee, and the ADAA's Manager of Justice Services attends meetings of its Substance Abuse Oversight Committee. The ADAA's Medical Director and

Manager of Justice Services convene routine meetings, often attended by representatives from local jurisdictions, to perform Case Conference Reviews as a part of the ADAA's internal quality assurance process.

- Residential Substance Abuse Treatment (RSAT): The DPSCS operates five RSAT programs within the Maryland correctional system. These programs are managed by a contractor, Gaudenzia, Inc., and are Level III.5 modified therapeutic communities. One of the RSAT programs within the system is a *RecoveryNet* (Maryland Access to Recovery-ATR) referral portal program. Designated staff are trained to apply for *RecoveryNet* services for eligible individuals, and to arrange for client meetings with Care Coordinators prior to discharge from the correctional system.
- Maryland Department of Juvenile Services (DJS): The ADAA maintains a long-standing MOU to address the needs of substance-using youth who are under the control and supervision of the DJS. The MOU provides salary support for the DJS Addiction Services Office Administrator, Clinical Supervisor and eight clinicians who deliver screening, drug education, and individual and group counseling.
- Maryland Department of Human Resources (DHR): The ADAA maintains an MOU to provide addictions counseling in local Department of Social Services (DSS) offices throughout the State. There are approximately 61 counselor positions (at least one for each jurisdiction, and several for Baltimore City). These counselors provide SUDs screening for individuals applying for Temporary Cash Assistance (TCA) and refer individuals in need of treatment to local health departments for community-based services.
- Maryland Medical Assistance (MA) Program: The ADAA is involved in a collaborative partnership with the Maryland MA Program to expand access to community-based services for all Medicaid beneficiaries in need of treatment for SUDs. The ADAA has worked with MA to set up the conditions (rate structure, fee-for-service billing, authorization requirements, necessary forms, etc.) under which community-based providers can participate in Medicaid and Medicaid Primary Adult Care (PAC). Through this partnership, MA has added certain community-based services to its fee-for-service program, added certain SUDs treatment services to the PAC benefit package, and increased rates for other previously covered services such as methadone maintenance. Additionally, MA and the ADAA partnered to develop the Substance Abuse Improvement Initiative (SAII) which allows Health Choice and PAC enrollees to select their own provider for substance abuse treatment, even if the provider does not have a contract with a Managed Care Organization (MCO), if the enrollee meets American Society of Addiction Medicine (ASAM) Patient Placement Criteria to evaluate level of care and continued stay.
- Maryland Office of Health Care Quality (OHCQ): The OHCQ is the agency within the Maryland Department of Health and Mental Hygiene (DHMH) charged with monitoring the quality of care in Maryland's 9,900 health, mental health and SUDs programs and

agencies. The OHCQ licenses and certifies the state's health care facilities, and certifies all addiction treatment programs. The OHCQ uses state and federal regulations, which set forth minimum standards for provision of care and conducts surveys to determine compliance. When problems or deficiencies are noted, the OHCQ initiates administrative action against facilities that violate State rules and regulations. If a facility fails to correct problems and is unable or unwilling to do so, the OHCQ may impose sanctions such as license revocation, fines, bans on admission, or other restrictions on the operating license.

- Maryland Department of Veterans Affairs: The Perry Point VA Medical Center offers long- and short-term inpatient behavioral health care, domiciliary care, and a unique and innovative intensive outpatient addictions treatment program for veterans with drug/alcohol problems. The VA has designated a referral liaison to identify veterans in residential treatment who meet *RecoveryNet* program eligibility criteria, help eligible veterans apply for recovery support services, and arrange for meetings with their Care Coordinators prior to discharge from treatment.
- University of Maryland-College Park Institute for Governmental Service and Research (IGSR): The ADAA maintains an MOU with IGSR to support the Statewide Maryland Automated Record Tracking (SMART) system for the collection of statewide substance abuse client and services data. Treatment providers and drug courts use the SMART management information system to enable comprehensive substance abuse treatment data collection, to track patient and drug court client services, and analyze program data for monitoring and reporting on performance and progress of treatment providers and drug courts throughout the state. The agreement has been modified to enable IGSR to make enhancements to SMART which will assist the ADAA in the development of a certified "Electronic Health Record" (EHR), with a target date of January 1, 2012.
- University of Maryland-Baltimore (UMB):
 - UMB School of Nursing (SON): For the past three years, the ADAA has maintained an MOU with the UMB-SON to support 40-60% effort of an Assistant Professor who has extensive experience working within Single State Agencies (SSAs) for substance abuse services in Maryland and one other state. This person serves as a Special Projects Manager and lead grant writer within the ADAA's Grants Development and Evaluation unit. The MOU is funded through the SAPT-Block Grant.
 - UMB School of Pharmacy (SOP): The ADAA recently developed the following MOUs with the UMB-SOP.
 - Statewide Epidemiologic Outcomes Workgroup (SEOW): One MOU with the UMB-SOP supports a portion of the effort of several research faculty who manage and operate the Maryland SEOW. This MOU is funded through the SAPT-Block Grant 20% Prevention Set Aside.

- Maryland Strategic Prevention Framework (MSPF): A second MOU with the UMB-SOP supports a portion of the effort of a number of research faculty who are conducting the MSPF process and outcome evaluations. This MOU is funded through the Center for Substance Abuse Prevention (CSAP) SPF grant.
 - Pharmacotherapies: Another MOU with the UMB-SOP supports 20% effort of an Assistant Professor who is conducting a statewide analysis of Vivitrol (Naltrexone injection) utilization. Additionally, he is preparing an implementation plan for the expansion of Vivitrol and other pharmacotherapies used in the treatment of addiction. This MOU is supported with State General Funds.
- UMB School of Medicine (SOM): The ADAA maintains two MOUs with the UMB-SOM:
 - Problem/Pathological Gambling: One MOU with the UMB-SOM supports the operation of Maryland’s problem and pathological gambling Hotline. Individuals with gambling disorders and their families/friends call the Gambling Hotline for referral to gambling disorders treatment services. The UMB-SOM also provides clinical training in problem/pathological gambling for counselors within the State’s treatment programs.
 - Deaf and Hard of Hearing (DHH): For several years, the ADAA has maintained an MOU with the UMB-SOM to provide SUDs treatment services for individuals who are DHH. Community-based treatment providers throughout the State request the services on an as-needed basis for DHH patients. The SOM program provides necessary services through professional counseling staff that are proficient in American Sign Language and knowledgeable in the unique treatment and cultural needs of this population.

REGIONAL, COUNTY AND LOCAL BEHAVIORAL HEALTH ENTITIES:

County Health Departments: The ADAA contracts directly with accredited providers for the delivery of some residential treatment services. Other services are delivered through 24 jurisdictions that consist of the County Health Department (CHD) in 23 Maryland Counties and the City of Baltimore. County Health Departments are usually arms of DHMH and their employees are State employees, except in home-rule counties, where CHDs are arms of the county government and employees are county employees.

Programmatic functions in all State and privately funded treatment programs, from assessment through every level of care in the continuum, are governed by the Code of Maryland Regulations (COMAR). Within each jurisdiction, there are State and locally funded systems for assessment, referral and treatment of persons with substance use disorders. Individuals may self-refer, or be

referred from a primary care provider, other health professionals, the courts or other sources. The CHDs are generally the designated location for initial contact with the un- or under-insured. While CHDs provide most services directly, in some cases, CHDs also subcontract for services with accredited substance abuse treatment providers. When sub-contracting, the CHD assumes responsibility for program monitoring and, in this way, functions as a traditional intermediary to services.

Maryland utilizes a two-tiered level of monitoring compliance with conditions of award. First, the ADAA's Division of Quality Assurance regulatory compliance staff review and audit the jurisdictional health departments and the Baltimore Substance Abuse Services (BSAS) regarding the services that they directly provide. Local jurisdictions are responsible for monitoring programs from which they subcontract for additional services, and they submit program monitoring data to the ADAA on a quarterly basis. ADAA staff members perform second tier audit functions as they continually monitor jurisdictional-level data reports to ensure that services are provided in communities with highest need. Compliance review teams audit those reports during routine compliance or problem investigation review visits, with a focus on adherence to applicable regulations, policies and accepted standards of care. Addictions programs are certified by the Department of Health and Mental Hygiene (DHMH) Office of Health Care Quality (OHCQ) on a biannual basis. The certification process includes a thorough review of client records, clinical and medical policies and procedures, as well as fiscal and personnel practices based on COMAR.

Local Drug and Alcohol Abuse Councils (LDAACs): Maryland utilizes its local advisory councils to conduct State and Sub-state level planning. Legislation proposed by Governor Robert L. Ehrlich and signed into law on May 11, 2004 established a mandate that all twenty-four political subdivisions in Maryland (23 counties and Baltimore City) develop, and appoint certain agency representatives to **Local Drug and Alcohol Advisory Councils (LDAACs)**. Each LDAAC prepares a biennial plan and consistently reports every six months to the ADAA on progress toward implementation of the plan. The composition of each LDAAC must, per the Annotated Code of Maryland § 8-1001, consist of the following agency representatives or their designees:

- ~ Health officer of the local health department;
- ~ Director of the local department of social services;
- ~ Regional director of the Department of Juvenile Services;
- ~ Regional director of the Division of Parole and Probation;
- ~ State's Attorney for the county;
- ~ District public defender;
- ~ Chief of the county police department or sheriff;
- ~ President of the local board of education;
- ~ Representative of the county executive, the Mayor of Baltimore City, or the county commissioners;
- ~ County administrative judge of the circuit court; and
- ~ The following individuals appointed by the county executive, the Mayor of Baltimore City, or the county commissioner:

- At least one recipient of addictions treatment services;
- Two substance abuse providers, at least one with experience with services to individuals with co-occurring substance abuse and mental health disorders;
- At least one substance abuse prevention provider;
- At least one individual who is knowledgeable and active on substance abuse issues that affect the county;
- The superintendent, warden or director of the local correctional facility located in the county or in Baltimore City, the warden of the Baltimore City Detention Center; and
- At least one other individual who is knowledgeable about treatment of substance abuse in the county, including members of civic organizations, the chamber of commerce, health care professional organizations, or the clergy.

MARYLAND’S HEALTH CARE REFORM PLANNING EFFORTS:

Maryland’s Health Care Reform Coordinating Council: In response to the enactment of the Patient Protection and Affordable Care Act (PPACA), Maryland Governor Martin Governor O’Malley created the Maryland Health Care Reform Coordinating Council (HCRCC) through an Executive Order to advise the administration on policies and procedures to implement the recent and future federal health reform as efficiently and effectively as possible. The Council made policy recommendations and offered implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs.

The Council was co-chaired by Lt. Governor, Anthony Brown , former DHMH Secretary, John Colmers and was comprised of health leaders across the state. The Council first milestone was the submission of an interim report to the Governor that provides a comprehensive evaluation of the federal legislation and identifies critical decision points that must be considered by the State. The report includes a timeline of legislative and regulatory changes necessary for implementation. The HCRCC has established workgroups, which are open to the public, on six identified areas of focus to address the full scope and complexity of the fundamental aspects of reform. The workgroups focus areas were:

1. *Health Insurance Exchange and Insurance Markets;*
2. *Entry Into Coverage;*
3. *Outreach and Education;*
4. *Public Health, Safety Net and Special Populations;*
5. *Health Care Workforce; and*
6. *Health Care Delivery System*

Maryland’s implementation of the Patient Protection and Affordable Care Act (PPACA) offers a once-in-a-generation opportunity to make a profound impact on the health and well-being of every Marylander. If implemented well, we will have the good fortune of overseeing a transformation of our health care system, which will improve the lives of all Marylanders (Maryland Health Care Reform Coordinating Council *Interim Report*, July 2010). The Health

Care Reform Coordinating Council's Entry Into Coverage Workgroup was charged with identifying options for Maryland to consider in its approach of Entry into Coverage. These options, as presented in the Workgroup's White Paper (Maryland Health Care Reform Coordinating Council, Entry into Coverage Workgroup, October 2010) include:

- *Income based eligibility determination policy and process should be dramatically simplified relative to the current policy and process for Medicaid and MCHP;*
- *Eligibility determinations should be integrated and seamless (across both health and public assistance programs);*
- *Eligibility policy and process should reflect the culture of insurance (where all individuals have insurance coverage as required by the federal mandate) envisioned by ACA and called for in the Interim Report of the HCRCC;*
- *There should be a "No Wrong Door" approach to applying for coverage (across both health and public assistance programs);*
- *Eligibility and enrollment into health plans should be part of a continuous process rather than distinct systems.*

The HCRCC issued a final report on January 1, 2011. The report set forth a blueprint for well-planned and inclusive implementation of health care reform. The report contained 16 recommendations. These include:

- *Establishment of a Health Benefit Exchange*
- *Development of a centralized education and outreach strategy*
- *Improvement of coordination of behavioral health and somatic services*
- *Incorporation of strategies to promote access to high quality care for special populations*
- *Institution of comprehensive workforce development planning*
- *Achieve reduction and elimination of health disparities through the exploration of financial, performance based incentives and incorporation of other strategies*
- *Establishment of a Governor's Office of Health Reform*

Maryland has already made significant progress implementing these recommendations. In April 2011 Governor O'Malley signed a law that established the Health Benefit Exchange. On May 26, 2011 he appointed a nine member board to oversee the Exchange. DMHH's Secretary will serve as a board member for the Exchange. That same day the Governor signed an executive order to establish the Governor's Office of Health Care Reform. In addition, he extended the term of the HCRCC through 2015. The HCRCC will continue to meet quarterly to monitor progress on implementation of recommendations.

BI-DIRECTIONAL INTEGRATION: BEHAVIORAL HEALTH AND PRIMARY CARE

Under the direction of the Deputy Secretary for Behavioral Health and Disabilities (BHD), the three administrations (MHA, ADAA, and the Developmental Disabilities Administration—DDA) have improved collaboration and meet on a regular basis to discuss training, health disparities, and data. The Office of the Deputy Secretary is working toward the goal of

expanding the development of a system of integrated services including substance abuse, mental health, developmental disabilities, and somatic care.

The ADAA and MHA, in collaboration with Medicaid, Managed Care Organizations (MCOs) and Administrative Services Organizations (ASOs), have formed the Coordination of Care Committee to address information technology and service integration issues at the administrative, policy, and provider levels. This committee provides input to policy development with Medical Assistance (MA), addresses the role of the Federally Qualified Health Centers (FQHCs), and offers consultation as needed. The ADAA and the MHA each work with a consortium of directors who meet monthly to maintain ongoing communication and support between the state's leadership and the medical leadership of the substance abuse programs and community outpatient mental health centers. Discussions include efforts to coordinate and integrate behavioral health and primary health care services.

Research at the University of Maryland and at Johns Hopkins-Bayview has demonstrated that a high percentage of patients view their mental health provider as their primary source of health care, and some (approximately 1/3) do not access their MCO for primary health care at all. As a result, both institutions are exploring the integration of somatic health care into behavioral health services for individuals who do not choose to access services through a primary care provider.

Maryland is exploring a variety of integration options through the Coordination of Care Committee. A recent study by the Milbank Memorial Foundation has noted a number of models that can work, and the pros and cons of each. One model promotes the primary care sector as the patient's health home, with either full integration of behavioral health services, or referral out to specialty care for behavioral health care. Another model promotes behavioral health providers serving as the health home, with either full integration or referral out for primary care. There will be a need for a variety of options based on the needs and choices of each individual patient.

Maryland has used the four quadrant model in its work on co-occurring disorders and finds it to be a useful guide for discussions regarding the integration of behavioral health and primary care services:

- **Quadrant I: Low Behavioral and Physical Complexity/Risk** – served in primary care with behavioral health staff on site.
- **Quadrant II: High Behavioral Health, Low Physical Health Complexity/Risk** – served in a specialty behavioral health system that coordinates with the primary care provider, or in more advanced integrated systems, that provides primary care services within the behavioral health setting.
- **Quadrant III: Low Behavioral, High Physical Health Complexity/Risk** – served in the primary care/medical specialty system with behavioral staff on site in primary or medical specialty care, coordinating with all medical care providers including disease care managers.
- **Quadrant IV: High Behavioral, High Physical Health Complexity/Risk** – served in both the specialty behavioral health and primary care/medical specialty systems. (excerpted from Barbara Mauer, “Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities”, 2005).

Additionally, local efforts on integrated health have been implemented. Mosaic Community Services, a private, non-profit organization specializing in serving individuals and families with mental illness and substance use issues, recently received a grant from the Maryland Community Health Resources Commission to hire a somatic care nurse practitioner and a case manager to do assessments and triage individuals who have not seen a somatic primary care provider for 6 months or more. Integrating somatic care, mental health, and addiction services is a priority goal for Mosaic. Also, Mosaic was one of fifteen organizations selected to participate in SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) Learning Collaborative. The Collaborative provides a learning environment for the selected community mental health and addiction providers to assess, build, and share outcomes related to their organizations' efforts to integrate behavioral healthcare and primary care. CIHS is run by the National Council for Community Behavioral Healthcare

NEEDS OF DIVERSE RACIAL, ETHNIC AND SEXUAL GENDER MINORITIES & PROACTIVE EFFORTS TO REDUCE HEALTH DISPARITIES:

The ADA values the fundamental right of all individuals to high quality healthcare regardless of race/ethnicity, sexual orientation or disability status, and believes that elimination of minority disparities in health and healthcare provides personal, social and economic benefits for individuals, communities and the State (Maryland Office of Minority Health and Health Disparities-MHHS, 2006; Sullivan Commission, 2004). In 2006, the MHHS within the Maryland Department of Health and Mental Hygiene (DHMH) released the *Maryland Plan to Eliminate Health Disparities*, developed with the input of > 1,200 citizens, health professionals, academia, and public and private health groups (MHHS, 2006). The *Plan* promotes strategies to eliminate health disparities (the disproportionate distribution of the burden of illness, injury, disability or mortality of minorities in relation to a reference group) and healthcare disparities (differences in insurance coverage, access to or quality of healthcare services (Kaiser, 2005a).

Racial minorities, including African-Americans suffer disproportionately from homelessness, incarceration, child welfare involvement, trauma and poverty. Nearly 1 in 3 African-American males will serve time in prison during their lifetime (Iguchi et al, 2005); their incarceration rates are 5-7 times greater than for Whites (Williams and Jackson, 2005). Drug addiction and incarceration increase their risks for mental illness (anxiety, depression, PTSD) and infectious diseases (HIV, TB, hepatitis). They equal 13% of the population yet account for 49% of new AIDS cases (Kaiser, 2005b). Minorities and veterans with addiction disproportionately face unemployment, disenfranchisement, limited housing, and poor access (Iguchi, 2005).

African-Americans represent 63% of the population in Baltimore (some zip codes higher at 76%), compared to 29% for Maryland and 12% for the U.S. It is well-known that opioid and crack cocaine addiction has reached "epidemic" proportions in Baltimore City. Therefore, African-Americans living in Baltimore and around the State are disproportionately at higher risk of experiencing poverty, low educational attainment, high infant mortality rates, homicide, incarceration and drug-related health risks (HIV, hepatitis, and other infectious or acute diseases), certain cancers, and complications/poor outcomes from chronic diseases such as hypertension, diabetes, kidney disease, etc.).

Maryland's *RecoveryNet* (Access to Recovery-ATR) program enrolls individuals into *RecoveryNet* via its portal programs—residential treatment programs, the Department of Public Safety and Correctional Services (DPSCS) and the Maryland Department of Veterans Affairs (MDVA)—and provides these individuals with enhanced treatment and recovery supports. By increasing efforts in Baltimore and by designating approximately 35% of *RecoveryNet* ATR funds for clinical and recovery support services for substance-using individuals in the City, Maryland will improve treatment outcomes for African-Americans and other minorities, and significantly reduce health disparities in Maryland.

The DHMH Mental Hygiene Administration (MHA) Office of Consumer Affairs (OCA) works to gradually increase the sustainability and accountability of the 25 Wellness & Recovery Centers (formerly known as drop-in centers) currently established across the state. Many of these centers address issues of co-occurring disorders (mental illness and substance use disorders) within their programming. The LGBTQ Wellness & Recovery Center has offered several outreach sessions throughout the year on topics such as: “The Gay Community and Stereotypes”, “Mental Health First Aid” and a workshop on community resources for LGBTQ patients who are homeless with mental illness or co-occurring disorders. In FY 2012, the ADAA will collaborate more extensively with the MHA-OCA to increase the focus on SUDs within the Wellness and Recovery centers, and to ensure that Wellness Centers are inclusive of LGBTQ and other subpopulations of substance users.

To improve the health of Hispanic Marylanders, the DHMH Secretary recently formed an internal workgroup to develop a work plan to address specific areas needed to improve DHMH's engagement with the Hispanic community. The Secretary has recruited a behavioral health representative from the ADAA. The priorities identified by the Secretary and to be included in the work plan include: communications, forms/data collection, staff training, health care provider education /expectations, and outreach activities. The workgroup convened in late Summer 2011, and will present an internal work plan to the Secretary by the end of October 2011.

Culturally competent healthcare providers are major factors in reduction of disparities (Mitchell and Lassiter, 2006). Maryland continues to sustain a culturally competent infrastructure and promote the health of racially diverse populations (African-American, Hispanic/Latino, Asian/Pacific Islander and American Indian communities in MD) and other minorities (gay/lesbian, deaf, disabled) by supporting training and supervision for a culturally competent workforce; soliciting feedback about programming and policies from vulnerable populations via surveys and focus groups; providing for representation of minority populations on committees including State and Local Drug and Alcohol Abuse Councils (DAAC, LDAACs); ensuring that hiring practices include recruitment of minority professionals; and building expectations for cultural competence into contractual agreements with providers, evaluation instruments, consent forms and other written materials.

During FY 2012 and 2013, Maryland will adopt measures from the Cultural Competence Health Practitioner Assessment (CCHPA) and other tools developed by the National Center for Cultural Competence (NCCC) for the Health Resources and Services Administration (<http://www.hrsa.gov/culturalcompetence/>) to provide objective evidence of cultural and

linguistic competence at the provider agency level. These measures will be incorporated into client satisfaction surveys and monitoring forms.

This application addresses the needs and strengths of the following populations as appropriate for the SAPT-BG:

**SERVICES FOR PERSONS WITH OR AT RISK OF HAVING
SUBSTANCE USE AND/OR MENTAL HEALTH DISORDERS:**

⇒ **PERSONS WHO ARE INTRAVENOUS DRUG USERS (IDU)**

Maryland's HIV Prevention Goals and Priorities : The Maryland Community Planning Group (CPG) develops a set of statewide HIV prevention priorities. Representatives from the Maryland Department of Health and Mental Hygiene (DHMH) Alcohol and Drug Abuse and Mental Hygiene Administrations (ADAA and MHA) serve on the CPG. The CPG's priorities are based on evidence including as HIV and AIDS statistics, injection drug use trends, behavioral science, and input from affected communities. The CPG's Plan is used by the DHMH Infectious Disease and Environmental Health Administration (IDEHA) in writing the state's application to the CDC for funding to support HIV prevention programs across the state.

Injection drug use ranks among the top five priorities for the CPG. The CPG approved Maryland's 2010-2011 HIV prevention priorities were ranked as follows:

1. *HIV Positive Persons*
2. *Men who have Sex with Men (72% African American)**
3. *Heterosexual (83% African American)**
4. *Injection Drug Users (IDU) (86% African American)**
5. *Deaf and Transgender persons*

*These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized. Within each risk group, African Americans are emphasized, given the disproportionate impact of HIV in this group. When aggregated, the HIV prevention projects targeting each risk group serve mostly African Americans. Individual projects do not have to meet these racial goals (e.g., when client level data from all injection drug users (IDU) projects are added together, 86% of the IDU served should be African American IDU).

ADAA Treatment Data: From CY 2007 to 2010, heroin-related treatment admissions increased 6.5 percent, but even more significant is the trend in route of admission. Over the four years, heroin admissions primarily involving inhalation declined by 5.3 percent, while those primarily involving injection went up by 20 percent. CY 2007 was the first year since 2000 that primary injectors outnumbered primary inhalers among heroin-related admissions. In 2007, 49 percent of heroin admissions were injectors, increasing steadily to 55 percent in 2010.

For some years we have noted that heroin injectors are more likely than inhalers to be younger whites. The percentage of injectors who were white increased steadily from 55.5 percent in 2007 to 67.4 percent in 2010. The percentage of injectors aged 30 or younger went from 35.7 percent in 2007 to 45.8 percent in 2010. The proportion of African-American heroin-related admissions who reported injection has remained stable at about one third.

In a recent presentation by Colin Flynn, Chief of the Center for HIV Surveillance and Epidemiology, showed that the decade-long downward trend in HIV exposure through injecting drug use continued in 2009. However, ADAA data suggest that there was a significant shift from blacks to whites in the percentage of IDU exposure cases in 2009. Treatment admissions involving white primary injectors increased by 54 percent from 2007 to 2010, whereas admissions for African-American primary injectors increased by only 3 percent.

The numbers of IDUs continues to be overwhelming African-American, with disproportionate rates of testing positive for HIV infection, primarily due to Baltimore City's large percentage of African-Americans and high rates of opioid addiction and injection use. However, based on recent data showing the increases in white injection drug use in suburban and rural counties, it can be expected that there will be a corresponding rise in HIV infection among whites in those suburban and rural counties in the future. The pre-existing high rates of IDU-related HIV infection among African-Americans primarily in urban communities and the potential future increase among whites and other races in suburban and rural communities are a major concern for several of the administrations within the DHMH, including IDEHA, ADAA, MHA and others.

Some of DHMH's programmatic efforts to prevent drug- and sex-related HIV infection among Marylanders of all races include:

Real Men are Safe (REMAS): A Gender-Focused HIV & Sexual Risk Reduction Intervention for Men in Substance Abuse Treatment: <http://ctndisseminationlibrary.org/PDF/397.pdf>

The ADAA is encouraging all jurisdictions to utilize evidence-based Real Men are Safe interventions with their high risk populations. REMAS was developed by the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN) Gender Specific HIV Intervention Protocol Team. REMAS is a five-session group delivered intervention package designed to assist clients in substance abuse treatment reduce their HIV risk. Much of material is taken from the manual *Time Out for Men! A Sexuality and Communications Skills Workshop* (Bartholomew & Simpson, 1996, Texas Christian University Institute of Behavior Research) and *Project Light* (The National Institute of Mental Health Multisite HIV Prevention Group, 1998). In addition, material from Bartholomew and Simpson's (1992) *Approaches to HIV/AIDS Education in Drug Treatment (HIV-ED)* was utilized (Boatler et al., 1992). The development of this specialized treatment intervention for —men only followed the success of a similar workshops designed for women: *Project Worth: Women on the Road to Health* (Schilling et al., 1991; El-Bassel & Schilling, 1992; Columbia University School of Social Work Social Intervention Group) and *Time Out! For Me: A Sexuality and Assertiveness Module for Women* (Texas Christian University, Institute of Behavior Research; available at <http://www.ibr.tcu.edu>). The modules focus on basic information about HIV transmission, self risk assessment, exploration of safe sex

options, assertive communication skills, using I-Statements, negotiation skills, and exploration of ways to have enjoyable sex without drugs. Men are provided a forum to discuss and dispel sexual myths and stereotypes. There is also a focus on relapse prevention related to sexuality. In clinical trials, men randomized to the REMAS intervention or a single HIV Education session had significantly fewer unprotected sexual occasions at 3 and 6 months. Men in the REMAS condition who reported sex under the influence decreased from 36.8% at baseline to 25.7% at 3 months, whereas men in the HIV Education condition increased from 36.9% to 38.3%.

Needle Exchange Program: <http://www.baltimorehealth.org/nep.html>

The Baltimore City Needle Exchange (NEP) seeks to reduce HIV, hepatitis C, and other infections by reducing the circulation of unclean syringes. The program also helps drug users to overcome addiction by linking them to drug treatment services. In addition, the program provides testing for syphilis, HIV, and hepatitis C. These services are provided in 17 locations in the city of Baltimore.

Staying Alive Drug Overdose Prevention and Response Program
<http://www.baltimorehealth.org/stayingalive.html>

Since 2004, the Baltimore City Health Department's Staying Alive Drug Overdose Prevention and Response Program has taught more than 3,000 injection drug users, drug treatment clients and providers, prison inmates, and corrections officers about how to prevent drug overdoses. More than 220 reversals (lives saved) have been documented.

One survey of injection drug users found that approximately 50 percent personally experience at least one non-fatal overdose, and 70 percent witness at least one overdose during their injection career. Drug overdose is now the second-leading cause of accidental death in America, according to The Drug Policy Alliance. The Staying Alive training program teaches individuals how to recognize an opiate/heroin overdose and respond by calling 911 and administering rescue breathing and the drug Naloxone (also known as Narcan). Naloxone is an opioid antagonist that effectively reverses life-threatening symptoms of patients who have overdosed on heroin or other opioids. Naloxone is safe; patients experience few side effects and there are no negative effects on people who are free of opioids. Emergency medical technicians have long used Naloxone as an intramuscular or intravenous injection. Naloxone can also be administered intranasally, reducing the risk of disease transmission by accidental needle sticks.

The Staying Alive program also links drug users to substance abuse treatment and other services. Since launching the Staying Alive program, the number of Baltimore City residents who died of drug overdose associated with use of heroin and other opioids has decreased significantly. In 2006, the death rate from drug overdose in Baltimore City was more than three times higher than the national average and was among the top 10 leading causes of death in the city. In 2007, 213 Baltimore City residents died of drug overdose associated with use of heroin and other opioids.

Interim Methadone: During FY 2012-2013, the ADAA intends to continue its support of Interim Methadone services when indicated. When demand for services requires is such that patients cannot be admitted to treatment in a timely manner, patients can be admitted to Interim Methadone (IM) services instead of being placed on waiting lists. Under the IM standard

protocol, patients can receive daily doses of opioid maintenance medication for a period of time not to exceed 120 days, at which time they must be placed into a permanent treatment slot.

Baltimore Substance Abuse Services (BSAS) initiated Interim Methadone (IM) services in FY 2005. The IM pilot project was converted to a standard protocol for opioid-addicted individuals in Baltimore City, and the ADAA has supported the IM standard protocol in Baltimore City through Baltimore Substance Abuse Services (BSAS) since FY 2006 and in Anne Arundel County through the County Dept. of Health since FY 2007. BSAS expanded IM services to Johns Hopkins BPRU and the University of Maryland Methadone Program in FY 2010. In FY 2012, only Anne Arundel County continues to offer interim maintenance. As of July 1, 2011, BSAS will no longer be funding any IM as their utilization has been very low since there is capacity in standard OMTs.

Tracking Capacity: The ADAA will continue to use its online data collection system, SMART (State of Maryland Automated Record Tracking) to track slots and admissions data for capacity management during FY 2012-2013. The ADAA utilizes SMART data to identify patient census levels for all IVDU programs. All programs, including IVDU programs receiving state and/or federal funds, submit monthly Census and Waiting List data to the ADAA MIS Section. The ADAA MIS reconciles individual programs' active patient lists against the monthly census and waiting list reports and the ADAA centralized database. This allows an ongoing count of slot availability and, in concert with Compliance Services Section program visits, ensures that programs serving IV drug users (IVDU) provide notification to the State when they reach 90% capacity. The Community Services Division will continue to provide technical assistance to help local programs with their plans for addressing utilization issues.

Requirements for SAPT-BG Subrecipients: (Formerly Goal 4, from FFY 2012-2013 Intended Use Plan) During FY 2012-2013, the ADAA will continue to require that the Conditions of Award for sub-recipients will contain the following requirements:

“If the program treats individuals for intravenous substance abuse, the program must adhere to items (8.) through (15.).

8. Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State that 90 percent of the capacity has been reached.

9. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:

(a.) 14 days after making the request or

(b.) 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program

10. When applicable, the program offers interim services that include, at a minimum , the following:

(a.) Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission do not occur

(b.) Referral for HIV or TB treatment services, if necessary

(c.) Counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women

11. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

12. The program has a mechanism that enables it to:

(a.) Maintain contact with individuals awaiting admission

(b.) Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area

13. The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when one of the following conditions exists:

(a.) Such persons cannot be located for admission into treatment or

(b.) Such persons refuse treatment

14. The program carries out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:

*(a.) The standard intervention model as described in *The NIDA Standard**

Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)

*(b.) The health education model as described in Rhodes, F. Humfleet, G.L. et al., *AIDS Intervention Program for Injection Drug Users: Intervention Manual, (Feb. 1992)**

*(c.) The indigenous leader model as described in Wiebel, W., Levin, L.B., *The Indigenous Leader Model: Intervention Manual, (Feb. 1992)**

15. The program ensures that outreach efforts (have procedures for):

(a.) Selecting, training, and supervising outreach workers

(b.) Contacting, communicating, and following up with high-risk substance abusers, their associates and neighborhood residents within the constraints of Federal and State confidentiality requirements

(c.) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV

(d.) Recommending steps that can be taken to ensure that HIV transmission does not occur”.

⇒ **ADOLESCENTS WITH SUBSTANCE USE AND/OR MENTAL HEALTH DISORDERS**

The 2008 National Survey on Health (NSDUH) estimates for 2008 that about 21,000 Maryland adolescents needed and did not receive treatment for alcohol and about 16,000 for drugs. Adjusting for the overlap suggests about 30,000 Maryland adolescents needed but did not receive treatment for alcohol and/or drugs in 2008. The more conservative Poisson need-estimation method based on treatment data suggested about 22,000 Maryland adolescents needed but did not receive treatment in 2008. The Poisson estimate for FY 2010 was about 20,000. An additional 5,800 individual adolescents did receive treatment during FY 2010. Total adolescent admissions have been relatively stable for the past three fiscal years, although those reported as primary patients increased 9 percent during that period. (Maryland Adolescent Outlooks and Outcomes, 2010)

About two-thirds of adolescents admitted during FY 2010 were 16 or 17 years of age. Less than 4 percent were under 14. Only 18 percent of adolescent admissions involved females, whereas about one-third of adult admissions were females. About 94 percent of adolescents admitted were involved in school, a job and/or skills training. It is estimated about 9 percent of adolescents admitted were high-school drop-outs. About half of adolescents admitted reported Medicaid eligibility; nearly a third had private insurance (not necessarily supporting the current treatment).

From FY 2008 to FY 2010 admissions of adolescents residing in Allegany, Anne Arundel, Cecil, Harford, St. Mary's, Somerset, Talbot, Washington and Worcester counties declined sharply. Substantial increases occurred among residents of Baltimore, Howard and Wicomico counties; otherwise adolescent admissions were fairly stable. Whereas 30 percent of adults admitted resided in Baltimore City, only 20 percent of adolescents did.

Over 56 percent of FY 2010 adolescent admissions originated in the juvenile and criminal-justice system; the adult percentage coming from the criminal-justice system was 41. Seventeen percent of adolescent admissions were referred by schools and student-assistance programs. Over 90 percent of adolescent admissions at the start of episodes were to outpatient levels of care compared with about 66 percent for adults. Nearly three-fourths of adolescents entered Level I initially.

Adolescents were less likely than adults to be reported as having mental-health problems – 35 percent of adolescents and 41 percent of adults were in that category. In FY 2009 only 29 percent of adolescents had reported mental-health problems. Adolescents were also less likely than adults to be tobacco users, 45 versus 72 percent, having decreased from 52 percent the previous year.

Nine in every ten adolescent admissions involved marijuana; 45 percent involved alcohol. Admissions rarely had alcohol as the only reported substance problem (4.4 percent), but 44 percent had marijuana as the lone-problem substance. Over the past several years the fastest growing substance problems among adolescent admissions were the same as among adults – prescription opiates and other pharmaceuticals. From FY 2008 to 2010 Oxycodone-related

admissions increased 77 percent, other opiate painkillers 35 percent, and benzodiazepines 92 percent. Marijuana-related admissions increased 10 percent; admissions involving both marijuana and alcohol fell by 5 percent while those not involving alcohol increased 27 percent. Cocaine-related admissions decreased nearly 80 percent, heroin fell by 22 percent and alcohol by nearly a third.

The admission/discharge ratio for adolescents was about 1.00 for 2008; however, during FY 2009 it was .88 and during FY 2010 it was .87, suggesting a continuing downward trend in adolescents receiving treatment in Maryland. A substantial number of adolescent patients leave treatment with the end of the school year in the summer months, and the numbers of active adolescent patients increase in the Fall, peaking in the Spring. Just under half of adolescent discharges from treatment involved treatment-plan completion; the adult completion percentage was 52 percent. Referrals for further treatment were made in 30 percent of adolescent discharges, 35 percent of adult. Five percent of adolescents were discharged for noncompliance with program rules and 31 percent left before completing treatment. The respective percentages for adults were 9 and 29 percent.

The number of adolescent patients using substances in the preceding 30 days was reduced by 53 percent during treatment. There was little change in the percentage of adolescents involved in productive activities (employment/school/skills training) between admission and discharge. The number of patients arrested in the preceding 30 days was reduced by 65 percent during treatment. Treatment completers remained in their programs longer than non-completers in every level of care except Level 0.5 and Level II.5. Adolescents who completed treatment in Level I stayed 153 days on average; non-completers stayed 96 days. The mean length of stay for completers of Level III.7 was 42 days; non-completers stayed about two weeks. Adolescents were less likely than adults to enter another level of care within 30 days of completion/transfer/referral from Levels III.7, III.7.D and Level II.1. Twenty-three percent of Level III.7, 44 percent of Level III.7.D and 56 percent of Level II.1 adolescent completion/transfer/referral dis-enrollments, entered other levels of care within 30 days.

⇒ **CHILDREN AND YOUTH WHO ARE AT RISK FOR MENTAL, EMOTIONAL AND BEHAVIORAL DISORDERS**

Forty percent of the CY 2010 admissions and half of the female admissions reported having one or more dependent children. Based on the numbers reported, over 35,000 children were dependents of persons entering funded substance abuse treatment in 2010. Of the 14,030 females admitted, 407 (2.9 percent) were known to be pregnant at admission and another 414 were uncertain. Of the 43,843 total admissions 4,122 (9.4 percent) were under age 18 and 504 of them (12.2 percent) were early intervention patients.

Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical, emotional, and developmental problems. The harm caused to the child can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated as soon as possible. To address the needs of these infants and children, the ADAA contracts with qualified bidders to provide a 24 hour program of American Society of Addiction Medicine (ASAM) Level III.3 Medium Intensity Residential Treatment Services to adult

pregnant women and women with children who are diagnosed with substance abuse/dependence. These women may be involved with the criminal justice system and may be, as a result of Health General 8-507, committed to the ADAA for treatment. The ADAA purchases approximately 46 beds. The average length of stay for these women varies from five to seven months, depending on the patient's treatment needs.

The contractors must provide the following services in accordance with the patient treatment plan as described in COMAR 10.47.01.04.C:

- a.) *Individual, group and family counseling focusing on the problems of substance abuse and the development of an abstinent and productive lifestyle;*
- b.) *Education programs to include the bio-psycho-social aspects of substance abuse and mental illness including eating disorders;*
- c.) *Trauma informed services for the woman and her children that will provide the family with healthy coping strategies for present and past traumas;*
- d.) *Fetal Alcohol Spectrum Disorders education to all participants in program;*
- e.) *Life skills seminars that focus upon the activities of daily living and social skills necessary for age appropriate, gender appropriate, socially acceptable functioning in the community;*
- f.) *Parenting skills classes;*
- g.) *Health and nutritional education programs;*
- h.) *Appropriate leisure skills;*
- i.) *Monitoring of medication as necessary; and*
- j.) *Vocational skills development.*

The contractor(s) provide services for the patients' children that include, but are not limited to:

- a.) *A care plan for the child(ren) that will be developed based on an assessment of the needs of the child(ren);*
- b.) *Substance abuse prevention programming;*
- c.) *Child care;*
- d.) *Education;*
- e.) *Recreational activities that will support the developmental needs of the children;*
- f.) *Services that support children who have been exposed to sexual and physical abuse as well as any neglect issues.*

Priority Admission: During FY 2012-2013, as in FY 2010-2011, the Administration will continue to ensure priority admission within 24 hours for pregnant women and women with dependent children, by including the following requirements in its conditions of grant award to local health departments and sub-contractors:

“If the program receives Block Grant funds set aside for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must adhere to items (1.) through (7.).

- 1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate.*
- 2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.*
- 3. The program provides or arranges for child care while the women are receiving services.*
- 4. The program provides or arranges for primary pediatric care for the women’s children, including immunizations.*
- 5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.*
- 6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children’s developmental needs and their issues of sexual abuse, physical abuse, neglect and FASD*
- 7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above”.*

⇒ **WOMEN WHO ARE PREGNANT and WOMEN WITH DEPENDENT CHILDREN THAT HAVE A SUBSTANCE USE AND/OR MENTAL DISORDER**

Role of the Maryland Department of Social Services: The Keeping Children and Families Safe Act of 2003 reauthorized and amended the federal Child Abuse Prevention and Treatment Act (CAPTA) requiring states to establish policies and procedures to address the needs of newborn infants exposed to illegal drugs.

Maryland requires that local departments of social services (LDSS) identify a coordinator who implements the Drug-Exposed Newborn Care Plan within their agency. The coordinator forms a team of staff who have experience working with families with substance abuse problems and who have a working knowledge of child protective services including investigation, continuing services, and foster care services.

The coordinator also forms a team with partnering agencies, including other staff from the LDSS, hospital(s), the health department’s divisions of maternal and child health and of addictions/mental health, and other agencies who share these clients. This team meets on a regular basis to coordinate services for drug-exposed newborns, their mothers, and families, and to identify resources, barriers to care, and gaps in services.

The team determines how the mother's substance abuse problem and her treatment needs can be assessed in an expedited manner, either by hospital or local health department staff or other qualified professionals, so that an assessment can be completed, a treatment plan developed, and a referral to the appropriate level of care made.

Upon receiving a referral from a hospital of a drug-exposed newborn infant, screeners in local departments use structured decision making to determine what conditions exist that create a substantial likelihood that the infant will be harmed due to caregiver's neglect. It is not necessary for injury to have occurred.

In addition to conditions in the infant, conditions or behaviors in the mother that may indicate risk of harm include, but are not limited to:

- Special medical and/or physical problems in the newborn infant;
- Close medical monitoring and/or special equipment or medications needed by the newborn infant;
- Lack of or inconsistent prenatal care;
- Previous delivery of drug-exposed newborn infant;
- Prior protective services history;
- Prior removal of other children by the courts;
- Lack of preparations for the care of the infant;
- Intellectual limitations that may impair the mother's ability to nurture or physically care for the child;
- Major psychiatric illness;
- Home environment that presents safety or health hazards;
- Evidence of financial instability that affects the mother's ability to nurture or physically care for the child;
- Limited or no family support;
- Young age, coupled with immaturity;
- Parenting skills demonstrated in the health care setting that suggest a lack of responsiveness to the newborn infant's needs (i.e., little or no response to infant's crying, poor eye contact, resistance to or difficulties in providing care);
- Domestic violence

Substance use, either during pregnancy or after the birth of an infant, does not in itself constitute evidence of abuse or neglect in Maryland. Some parents use drugs, including legal and illegal drugs and alcohol, to varying degrees. In some cases, these parents may remain able to care for their child without harming the child. It is commonly acknowledged, however, that the use or abuse of drugs by parents increases the concern for the child's immediate safety and for risk of harm to the child. When identified, a careful evaluation needs to be made of the impact that the substance use has on the parent's capacity to care for the child and the ability to ensure the child's safety and well-being. Such an evaluation will determine whether the child is at substantial risk of harm. Reports from hospitals or other medical providers regarding drug-exposed newborn infants suspected to be at high risk for risk of harm due to their own special needs and their mother's condition or behaviors shall be investigated by an intake and assessment caseworker.

Maryland Social Services Administration policies require that the investigation and follow-up include:

- Contacting the reporting person to determine whether laboratory tests confirm that the newborn infant has been exposed to illegal drugs; to identify any needed medical treatment for the child or mother; to assess the mother's attitude and behavior with the infant; to determine the expected discharge dates of the mother and infant; and to determine whether there are other children in the home at risk.
- Completing a MD CHESSIE check to obtain history of CPS involvement with the mother.
- Interviewing the parents to determine their willingness and capacity to provide adequate care of the newborn infant and any other children in the home.
- Referring the mother, and if necessary, the father for a substance abuse assessment if not completed in the hospital.
- Contacting relatives of the parents to determine their suitability as resources if placement is needed.
- Completing a Safety Assessment for Every Child (SAFE-C) prior to the discharge of the infant from the hospital, or if not possible, within five (5) days of discharge. When a safety plan is developed, the caseworker must take the necessary steps to assure the safety and well-being of the child. If the infant is in need of the protection of the Juvenile Court, and follow normal procedures for removal and petitioning the court.

Standard neglect investigation procedures in all cases accepted for investigation, including an assessment of any other children in the home and under the care of the birth mother. If circumstances warrant, the case is transferred to continuing services. When children must be removed from their birth families for their protection, the first goal is to achieve reunification as safely as possible. Multifaceted strategies build on strengths and address concerns about safety and well-being. Returning children home often requires intensive, family-centered services to support a safe and stable family.

The ADAA strives to attain its goal of aligning State and federal resources to improve the quality of life of pregnant and parenting women, and to reduce infant mortality in Maryland. To this end, the ADAA continues to collaborate with the Department of Human Resources (DHR) for the provision of cross-training for Department of Social Services (DSS) personnel and substance abuse professionals. The ADAA will continue to collaborate with DHMH Family Health Services (FHS) implement enhanced medical services in three jurisdictions in the state. The ADAA will continue to collaborate with the DHMH FASD office to present FASD training to providers at the individual and population levels. The ADAA women's treatment coordinator will continue to work in collaboration with DHMH Child and Maternal Health to ensure that factors that have lead to high infant mortality rates are eliminated. This partnership aims to enhance prenatal care for pregnant women in residential addictions treatment programs.

The Infant Mortality Initiative provides a model for development of strategies to "improve coordination and collaboration..." intended by this objective. Focusing on women prior to, during, and after pregnancy, the Initiative is designed to address the impact of substance abuse

on infant mortality in Maryland, by improving access to care and outcomes for substance dependent women. See DHMH website <http://dhmh.maryland.gov/babiesbornhealthy>. The most relevant accomplishments (as shown on the Governor's Delivery Unit (GDU) Infant Mortality Dashboard April 2011) to date include:

- Referral mechanisms have been established between behavioral health and substance abuse programs; and are being used by all substance abuse programs. Of the 379 pregnant women admitted to treatment programs, 112 were from GDU target jurisdictions.
- New Medicaid Accelerated Certification for Eligibility (ACE) protocols have been implemented in all jurisdictions; 100 Family Investment Aides (FIA) have been trained to assist in ACE screenings; and 93 FIAs hired statewide.

Gender-Specific Services: It is planned in FY 2012-2013 to provide gender-specific services to approximately 750 pregnant women and women with dependent children annually. These women will be served in up to 11 programs that deliver a variety of types of services (intermediate care-ICF, long-term residential, halfway house, and intensive outpatient-IOP). These 11 programs serve women in Baltimore City and ten counties (Allegany, Anne Arundel, Baltimore [County], Carroll, Frederick, Montgomery, Prince Georges, St. Mary's, Washington, and Worcester), but also accept statewide referrals from the other 12 counties in the state based on need. If current trends continue, nearly 60% of these women will receive IOP services, another 30% will be served in halfway houses, nearly 7% will be served in ICF and 2-3% will be served in long-term residential. We intend to continue to fund these services in eligible programs via contractual agreements directly with the programs, or via purchase of service agreements between the programs and local jurisdictions. We intend to maintain this level of support in FY 2012 and FY 2013. *(Formerly Goal 3, from FFY 2012-2013 Intended Use Plan)*

Priority Admission and Requirements for SAPT-BG Subrecipients: During FY 2012-2013, the ADAA will continue to ensure that pregnant women to receive priority admission to substance abuse treatment programs by supporting the development and maintenance of specialized gender-specific treatment services for women, pregnant women, and women with dependent children. This will be accomplished by continuing the development of ancillary services/activities that support, and by providing ongoing funding for, gender-specific programs and gender-specific treatment services. *(Formerly Goal 3, from FFY 2012-2013 Intended Use Plan)*

During FY 2012-2013, as in FY 2010-2011, the Administration will continue to ensure priority admission within 24 hours for pregnant women and women with dependent children, by including the following requirements in its conditions of grant award to local health departments and sub-contractors:

“If the program receives Block Grant funds set aside for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must adhere to items (1.) through (7.).

1. *The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate.*
2. *The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.*
3. *The program provides or arranges for child care while the women are receiving services.*
4. *The program provides or arranges for primary pediatric care for the women's children, including immunizations.*
5. *The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.*
6. *The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, neglect and FASD.*
7. *The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above”.*

Workforce Development: To achieve its goal of training providers on evidence based practices for the entire family unit, the ADAA will continue to host trainings for residential treatment providers regarding services for the children of women with substance use disorders. The trainings will focus on improving provider skills for performing comprehensive assessments and implementing therapeutic plans of care that address the children's needs.

⇒ **MILITARY PERSONNEL (Veterans, Active Duty Military, Reservists and Families)**

Veterans, active duty military, and their families need expanded access to high quality, evidence-based mental health and substance use disorder prevention and treatment services, provided by a well trained addictions services provider workforce that understands military culture and the unique needs of veterans, active duty military, reservists and their families (SAMHSA, *Leading Change*, 2011). The problems associated with insufficient access to care for this population include serious emotional distress, mental illness, substance use disorders (SUDs), homelessness and suicide. Within this population, ethnic minorities, females and those with non-majority sexual orientation experience even more hardship (SAMHSA, 2007).

National data indicate that among military service members returning from deployments in Iraq and Afghanistan, 18.5 percent have posttraumatic stress disorder (PTSD) or depression, and 19.5 percent report experiencing a traumatic brain injury (TBI) during deployment (SAMHSA, 2011; Tanielian, 2008a). In the five years from 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours (Dept. of Defense, 2010). The Army's suicide rate dropped slightly in 2009-2010, but the numbers of suicides in the National Guard and Reserve increased by 55 percent during that time period; half of those in the National Guard had never been deployed (Army Times, 2011). Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder (SAMHSA/OAS, 2007). In

2007, 8 percent of soldiers in Afghanistan reported using alcohol and 1.4 percent reported using illegal drugs/substances during deployment (Office of the Command Surgeon and Office of the Surgeon General U.S. Army Medical Command, 2008). Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause (SAMHSA, 2011; Zoroya, 2010). However, only half of returning service members who need treatment seek it, and only slightly more than half who receive treatment receive adequate care (SAMHSA, 2011; Tanielian, 2008b).

In 2010 the Maryland SEOW identified approximately 461,000 veterans in Maryland. In total, an average of 45,000 veterans were estimated to have been dependent or abused a substance in the past year. Data indicates that these individuals are similar to non-veterans in past month alcohol and illicit drug use and past year dependence or abuse of these substances. Compared to total treatment admissions, data from July-December 2009 showed that veterans had a greater proportion of admissions for primary alcohol problems. Additionally, 38% of veterans admitted had co-occurring psychiatric conditions and 7% were homeless.

Recovery Support Services: The Maryland Department of Veterans Affairs estimates that approximately 800 veterans were discharged from their residential treatment programs at Perry Point Medical Center in 2009, and identified approximately 10-20% of those discharges as veterans returning from Iraq or Afghanistan. The identified Veteran population in Baltimore City is one of the target populations for Maryland's *RecoveryNet* (Access to Recovery) program. The veteran population is represented in higher numbers in Baltimore (approximately one-third of the targeted population resides in that jurisdiction). Maryland's *RecoveryNet* program has obtained CSAT technical assistance (TA) to refine its intake and referral processes and minimize barriers to recruitment of this population. The TA resulted in a recommendation that *RecoveryNet* attend VA health fairs to improve linkages with the residential treatment program at Perry Point. Subsequently, the ADAA and the VA identified obstacles in the *RecoveryNet* intake processes. Procedural and data collection adjustments are being made so that the Care Coordinators can meet referred veterans onsite to enroll them into recovery support services.

Housing: The ADAA recognizes that like any recovering individuals and their families, housing for military families is a priority need. During FY 2012-2013, the ADAA intends to allow jurisdictions to use grant dollars to include supportive and recovery housing as part of an overall continuum of care, as well as to encourage creation of supportive and recovery housing as one of the recovery support services offered by *RecoveryNet*. Last year, the Recovery Oriented Systems of Care Steering Committee recognized that in order to achieve these goals and establish a mechanism to insure accountability, recovery housing standards needed to be developed. A Recovery Housing Standards Workgroup was formed as a workgroup of the ROSC Steering Committee, Standards Subcommittee. The workgroup has been developing a set of standards for two levels of Housing, Supportive (staffed) and Recovery (peer operated). Eligible members of the military community will have improved access to housing through *RecoveryNet*.

SAMHSA's Military Families Strategic Initiative: During 2012-2013, the ADAA will coordinate with the MHA to develop DHMH's strategies for accomplishing the major behavioral health goals of SAMHSA's Military Families Strategic Initiative. These goals include improving access to behavioral health care, improving coordination between different routes of

health care (civilian, military and veteran), preventing suicide, expanding emotional health promotion activities to reduce mental health and SUDs, and ensuring that military families have housing (SAMHSA, *Leading Change*, 2011). See Subsection 3b, Table 3 for Maryland's Military Families Strategic Initiative.

⇒ AMERICAN INDIANS/ALASKA NATIVES

There are no federally recognized Tribes or Tribal lands in the State of Maryland, and the ADAA is waiving its right for a consultation request.

There are very few American Indians or Alaska Natives served in state-funded AOD treatment programs. In CY 2010, there were only 121 American Indian admissions among the 43,843 total admissions to state-funded AOD treatment programs (0.3 percent). Two jurisdictions served no American Indians that year (Dorchester and Worcester counties). Most of the State's 24 jurisdictions had only 1-4 American Indian admissions. The largest numbers of American Indian admissions were in Baltimore City (n=43, 0.3 percent) and Baltimore County (n=19, 0.5%). Anne Arundel County had eight (0.2 percent) and Charles County had nine (0.8 percent). To improve outreach efforts to recruit more Native Americans in need of treatment, in FY 2012, the ADAA will:

- 1) Request that the Baltimore City and Baltimore County jurisdictions coordinate to communicate with the **Baltimore American Indian Center** (113 South Broadway, Baltimore, MD, 21231) and report back regarding the potential for enhanced outreach efforts to urban American Indian populations in need of treatment for alcohol and/or drug addiction.
- 2) Forward a guidance letter to the Substance Abuse Coordinators (local SA directors) in each of the 24 jurisdictions, encouraging them to include Native American populations in their outreach/recruitment efforts to the greatest extent possible.
- 3) Ensure that the unique cultural needs of Native American/Alaskan Natives with substance use disorders are included, when appropriate, in any cultural competence or special populations training curricula approved or delivered through the ADAA's Office of Education and Training for Addiction Services (OETAS).

SERVICES FOR PERSONS AT RISK OF COMMUNICABLE DISEASES

⇒ INDIVIDUALS WITH TUBERCULOSIS & OTHER COMMUNICABLE DISEASES

During FFY 2012 - 2013, the ADAA will continue to require that a tuberculosis risk assessment be performed on all patients receiving services. The ADAA will continue to require that individuals in all levels of care that are identified to be at risk receive further testing to be made available either on-site and/or by referral. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and the

Administration's Compliance Section will continue to review tuberculosis assessments and referral services for patients during the biannual certification process.

Regulations for Addiction Treatment Programs: Per the Code of Maryland Regulations (COMAR), Title 10, Subtitle 47 (10.47.01.04.D):

“Within the first 30 days of treatment, a program shall ensure and document in the patient record that human immunodeficiency virus, hepatitis, sexually transmitted diseases, and tuberculosis education was completed, including: (1) Risk assessment, (2) Risk reduction, and (3) If appropriate, referral for counseling and testing.”

⇒ **PERSONS WITH OR AT RISK FOR HIV/AIDS**

The ADAA works closely with the Maryland Infectious Disease and Environmental Health Administration (IDEHA), its sister administration within the Department of Health and Mental Hygiene (DHMH) works under a set of prevention goals and priorities to provide HIV prevention programs to local communities through local health departments and community based organizations. Maryland's HIV prevention goals and priorities (<http://ideha.dhmh.maryland.gov/CHP/md-goals-and-priorities.aspx>) are based on available information about the distribution of the epidemic within the State, efficacy studies, and relevant behavioral literature.

An Institute of Medicine report, “No Time to Lose: Getting More from HIV Prevention” (<http://www.iom.edu/Reports/2000/No-Time-to-Lose-Getting-More-From-HIV-Prevention.aspx>) presents a strategy for the prevention of HIV in an era of new advances in treatment and greater prevalence of individuals at risk for contracting and spreading HIV. The strategy seeks to accomplish goals in prevention through the use of cost-effectiveness data in allocating resources, proven prevention programs, new surveillance and prevention technologies, greater translation of prevention science to community-level action, and the elimination of social barriers that impede prevention effectiveness.

The CDC's (Centers for Disease Control and Prevention) initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, published in 2003, articulates CDC's vision for fighting the spread of HIV during the third decade of the epidemic. CDC's initiative includes reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV. CDC's website for the Advancing HIV Prevention initiative (http://www.cdc.gov/hiv/topics/prev_prog/AHP/default.htm) includes descriptions of the initiative and how it is to be implemented, as well as other guidance and information critical to its success.

Maryland Community Planning Group (CPG): In 1993, the U.S. Centers for Disease Control and Prevention (CDC) mandated that state health departments seek input from communities infected with and affected by HIV when planning HIV prevention programs. In response, the Maryland Department of Health and Mental Hygiene formed a statewide Community Planning Group (CPG) at the beginning of 1994. CPG membership is determined by appointment, based on specific criteria designed to ensure that the composition of the CPG reflects the HIV epidemic

in Maryland. CPG representation is sought from HIV-infected persons, members of affected communities, families affected by the virus, advocates of target populations, prevention workers at community based organizations and local health departments, and other professionals working with at-risk populations. In the current national climate, planning is very important. It is important that the federal HIV prevention resources in Maryland respond to the diverse needs for HIV prevention in the state (<http://ideha.dhmh.maryland.gov/chp/md-prevention-community-planning-group.aspx>).

The Maryland CPG develops a set of statewide HIV prevention priorities that are focus on HIV/AIDS prevalence and other statistics, evidence regarding behavioral science, and input from affected communities. The CPG's Plan is used by IDEHA for Maryland's application to the CDC for funding to support HIV prevention programs across the state.

The CPG approved Maryland's 2010-2011 HIV prevention priorities were ranked as follows:

1. *HIV Positive Persons*
2. *Men who have Sex with Men (72% African American)**
3. *Heterosexual (83% African American)**
4. *Injection Drug Users (IDU) (86% African American)**
5. *Deaf and Transgender persons*

*These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized.

These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized. Within each risk group African Americans are emphasized, given the disproportionate impact of HIV in this group. When aggregated, the HIV prevention projects targeting each risk group should serve mostly African Americans. Individual projects do not have to meet these racial goals (e.g., when client level data from all injection drug users (IDU) projects are added together, 86% of the IDU served should be African American IDU).

These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized. Furthermore, within each risk group African Americans are emphasized, given the disproportionate impact of HIV in this group.

Regulations for Addiction Treatment Programs: Per the Code of Maryland Regulations (COMAR), Title 10, Subtitle 47 (10.47.01.04.D):

“Within the first 30 days of treatment, a program shall ensure and document in the patient record that human immunodeficiency virus, hepatitis, sexually transmitted diseases, and tuberculosis education was completed, including: (1) Risk assessment, (2) Risk reduction, and (3) If appropriate, referral for counseling and testing.”

During FY 2012-2013, the ADAA will continue to ensure that all individuals admitted to treatment in Maryland's certified treatment programs receive risk assessment, risk reduction and referral for counseling and testing if appropriate, within the first 30 days of treatment (*Formerly Goal 6, from FFY 2012-2013 Intended Use Plan*). As a designated State, all Maryland jurisdictions must, as a Condition of Award, make available HIV Early Intervention Services (HIV-EIS) for individuals in treatment for substance use disorders. In accordance with **45 CFR §96.128**, Maryland's Treatment Conditions of Award state that as a condition of acceptance of ADAA funding, the 24 jurisdictions (Baltimore City and 23 counties) must ensure that programs which they directly administer and/or sub-contract with must:

- *Make available appropriate pretest counseling for HIV and AIDS available at the sites at which the individuals are undergoing treatment for substance abuse;*
- *Make available, at the sites at which the individuals are undergoing treatment for substance abuse, appropriate HIV/AIDS testing, including tests to diagnose the extent of the deficiency in the immune system and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease available;*
- *Make available appropriate post-test counseling at the sites at which the individuals are undergoing treatment for substance abuse;*
- *Make available, at the sites at which individuals are undergoing treatment for substance abuse, therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;*
- *Establish linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and to facilitate referral;*
- *Ensure that HIV early intervention services are undertaken voluntarily, provided with patients' informed consent, and are not required as a condition of receiving substance abuse treatment or any other services."*

HIV Early Intervention Services (HIV-EIS) Set Aside: Funding to support these services is provided to the local jurisdictions through the 5% HIV-EIS Set Aside. A portion of the 5% HIV-EIS Set Aside (approximately \$405,000) will be awarded annually via an MOU with the Maryland Infectious Disease and Environmental Health Administration (IDEHA, formerly the "AIDS Administration"). IDEHA will provide HIV testing services (pre-test counseling, testing and post-test counseling) to individuals within the areas of the State with greatest need, at the locations at which they are receiving treatment.

The remaining portion of the 5% Set Aside will be allocated to the 24 jurisdictions to support risk assessment, risk reduction and coordination of referrals for HIV testing if appropriate. This may include referrals for testing in local health departments, community health centers, primary care providers, or AIDS Services Organizations (ASOs). Since HIV risk assessment, risk reduction and coordination of referrals for HIV testing is required for all treatment admissions, the ADAA estimates that these services will be provided to approximately 42,000 individuals to

be admitted annually during FY 2012-2013. However, pre-test counseling, HIV testing and post-test counseling will occur at variable frequencies within each jurisdiction, depending on identified patient need.

For some time, the ADAA experienced difficulty in tracking the HIV Set Aside funding expenditures, but, starting in FY 2012, the ADAA has required that all jurisdictions and sub-recipient programs provide evidence of how the HIV Set Aside funding was expended. To standardize the reporting method across the State, ADAA staff first worked with local providers to estimate the average length of time required to complete the infectious disease assessment. Then, a formula was developed which multiplies the annual number of admissions within each jurisdiction that are paid for with Federal grant dollars by a per unit cost which is based on Medicaid's approved reimbursement rate for that type of activity (individualized counseling). This method provides more accurate reporting of expenditures for HIV services required under the HIV-EIS Set Aside.

We will maintain this level of support during FY 2012-2013. We intend to continue to fund these services via contractual agreements directly with the jurisdictions, or via purchase of service agreements between the jurisdictions and their sub-recipient programs. The ADAA will continue to identify key staff responsible for linkages with IDEHA regarding training and implementation of procedures, and will continue to collaborate with IDEHA regarding the training and implementation of the HIV rapid testing procedures.

The State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality will continue to review compliance with the COMAR requirements for HIV risk assessment and referral services during the annual/biannual certification process. The Maryland ADAA Compliance Division will continue to review documentation in each of the twenty-four jurisdictions receiving SAPT Block Grant funding for compliance with the Treatment Conditions of Award. The ADAA Statewide Projects Division will monitor the MOU with IDEHA.

TARGETED SERVICES:

⇒ **Individuals with mental and/or substance use disorders who are HOMELESS or involved in the CRIMINAL OR JUVENILE JUSTICE SYSTEMS**

Homeless: It is the ADAA's intention to allow jurisdictions to use grant dollars to include supportive and recovery housing as part of an overall continuum of care, as well as to encourage creation of supportive and recovery housing as one of the recovery support services offered by the Access to Recovery grant (RecoveryNet).

Last year, the Recovery Oriented Systems of Care Steering Committee recognized that in order to achieve these goals and establish a mechanism to insure accountability, recovery housing standards needed to be developed. The ADAA Recovery Housing Standards Workgroup was formed as a workgroup of the ROSC Steering Committee, Standards Subcommittee. The goal of the workgroup was to develop a set of standards for two levels of Housing, Supportive (staffed) and Recovery (peer operated). The workgroup met 5 times over 6 months from January through

July of 2010. There were a total of 18 participants whose attendance varied over the meetings; the average meeting had ten participants. There was representation from varying levels of clinical treatment providers, consumers, current supportive housing providers, and recovery housing providers. The workgroup voted to accept the Baltimore Area Association of Supportive Housing providers' voluntary standards (which were modeled after COMAR) as a starting point for their task. A draft set of standards were produced and provided to ADAA Administration for review and approval. These standards are currently in use in the *RecoveryNet* program.

The MHA's Shelter Plus Care Housing Program, established in 1995 and operational in 20 counties, has been successful in breaking the cycle of recidivism by providing funding for transitional housing, linkages to permanent housing, supported employment and benefits such as tenant and sponsor-based rental assistance, case management and other community supports to homeless individuals who have a serious mental illness. Currently over 600 persons are being housed through the program with over 50% with criminal justice involvement prior to placement in housing.

Criminal Justice System: The ADAA and the MHA meet regularly with the Department of Public Safety and Correctional Services (DPSCS) to improve the quality of services provided to individuals with behavioral health disorders who are involved in the criminal justice system. One of the priorities of the Criminal Justice Team in FY 2011 was to make recommendations about ways to improve interactions between the criminal justice, mental health and substance abuse systems.

The Criminal Justice Team adopted the Sequential Intercept Model (Munetz and Griffin, 2006), a best practice model for pre-trial coordination with community mental health and substance abuse designed to identify where to intercept individuals with mental health and substance use disorders as they move through the criminal justice system, and to suggest ways to target individuals within the system at each point of interception. Intercept points in the Sequential Intercept Model include 1) Law Enforcement and Emergency Services; 2) Initial Detention/Initial Court Hearings; 3) Jails and Courts; 4) Re-entry; and 5) Community Supervision/Community Support.

The Maryland Criminal Justice Team's best practice recommendations for effective state and local pre-trial practices focus on Intercept 2: Initial Detention; Intercept 3: Jails/Courts; and Intercept 4: Re-entry. The recommendations include:

- 1: Screening by somatic providers at the earliest opportunity using validated and simple instruments, referral to behavioral health providers in the jail for in-depth assessment and development of treatment plans to address needs, and coordination of services for co-occurring populations using a multidisciplinary approach.
- 2: Maximizing opportunities for pre-trial release and assist defendants with complying with conditions of pre-trial diversion, by developing diversionary programs such as the Forensic Alternative Services Team (FAST) in all jurisdictions, and by including staff for both substance abuse as well as mental health jail diversion.

3. Maximizing potential for diversion through problem solving courts and mental health courts (Court Coordination), by utilizing case coordinators and case managers working with defendants in the court. Currently, these services are provided with MHA funding by Baltimore City, Harford, and Prince George's counties. Additionally, mental health liaisons to aid in diversion/reentry process are funded through the MHA in Calvert and Carroll counties and the Mid Shore Region.
4. Performing case reviews and linking inmates to comprehensive services, including care coordination, access to medication, integrated treatment, prompt access to benefits, and housing; and funding specialized parole/probation agents who are knowledgeable about mental health and substance use disorders.
5. Sharing data and improving communication among service providers, detention centers, local jurisdictions, and State divisions; utilizing Data Link to improve communication between the correctional and mental health systems to promote continuity of care for individuals with serious mental and substance abuse who have received services in the public mental health system before becoming involved with the criminal justice system.

Data Link began in Baltimore City. The City's Central Booking staff electronically submitted information on all arrestees for each 24-hour period to the Administrative Services Organization (ASO) for the Public Mental Health System. This information is cross referenced to identify Baltimore City residents who were Public Mental Health System enrollees and transmits the names to BMHS and the Department of Corrections. Data link will increase the continuity of care for identified individuals by increasing FAST program referrals for diversion, by informing medical staff in the jail of an individual's diagnosis, medications and past treatment provider, and by developing mechanisms for data sharing between the MHA, the ADAA and the DPSCS to facilitate effective discharge planning.

Existing CJS programs/activities include:

- ADAA Justice Services: The Justice Services Section (JSS) is an essential component of the Statewide Projects Division. JSS staff collaborate with the judiciary, local health departments, local detention centers, Department of Public Safety and Correctional Services (DPSCS) Division of Parole and Probation and substance use disorder treatment programs to ensure efficient services for the court ordered criminal justice population. JSS staff are responsible for coordinating the Administration's functions related to the compliance with the legislatively mandated Health General 8-505 and 8-507. In FY 2011, ADAA-funded staff conducted 1,222 court-ordered (HG 8-505) substance abuse evaluations, and provided 68 court-ordered (HG 8-507) placements into community-based substance abuse treatment services.
- RecoveryNet: As mentioned previously, the DPSCS operates five Residential Substance Abuse Treatment (RSAT) programs within the Maryland correctional system. These programs are managed by a contractor, Gaudenzia, Inc., and are Level III.5 modified

therapeutic communities. One of the RSAT programs within the system is a *RecoveryNet* (Maryland Access to Recovery-ATR) referral portal program. Designated staff are trained to help eligible individuals apply for *RecoveryNet* services, and to arrange for client meetings with Care Coordinators prior to discharge from the correctional system.

RecoveryNet program eligibility criteria include inmates participating in RSAT who are scheduled for release from prison within 60 days of treatment program completion, who are determined to need program services, who meet income eligibility requirements, and who will be residing in Maryland after discharge.

- Juvenile Justice Services: The ADAA and the Department of Juvenile Services (DJS) have a long-standing partnership to address the substance abuse needs of adolescents in the State of Maryland. A memorandum-of-understanding (MOU) is renewed annually which provides funding to support the salaries of two detention-based clinicians who screen and provide drug education for all youth that are detained, provide substance abuse assessments for all youth admitted to the residential detention facility, deliver and brief addictions counseling services that focus on treatment readiness for youth who have been identified as having a substance use disorder (SUDs). Seven facility-based clinicians provide substance abuse services to youth in residential settings (Backbone Mountain Youth Center, Meadow Mountain Youth Center, Green Ridge Regional Youth Center, Savage Mountain Youth Center and the Donald Schaefer House) who have been identified as needing counseling for SUDs. The clinicians provide at least 1.0 hour per week of individual counseling for all youth assigned to their caseloads, as well as group counseling to include at least 3.0 hours of a Seven Challenges group three times per week, and drug education at least 1.0 hours per week. Under this agreement, the Director of DJS oversees and/or manages the certification of all DJS substance abuse treatment programs, and facilitates the integration of standards, regulations, and policies of the ADAA and the DJS.
- Forensic Alternative Services Team (FAST): Baltimore City mental health jail diversion program, operated by the Medical Services Division of the Circuit Court for Baltimore City and funded by MHA that diverts eligible defendants with serious mental illness and/or trauma related disorders from incarceration to appropriate community treatment support.
- The Maryland Community Criminal Justice Treatment Program (MCCJTP): The MCCJTP is funded by the MHA to screen for mental and substance disorders at the initial stage of incarceration, and to treat symptomatic individuals while incarcerated. It is implemented in 22 Counties and reaches over 7,000 individuals annually. Additionally, Allegany, Baltimore, Charles, Carroll, and Garrett Counties fund case management services focusing on re-entry helping individuals with housing, supported employment, and obtaining benefits.
- The Trauma, Addictions, Mental Health and Recovery Project (TAMAR): TAMAR is funded by MHA, is implemented in 9 Counties and reaches over 500 individuals annually. TAMAR staff screen for trauma, mental health and substance use disorders and provides

education on trauma through a standardized 20 lesson program. Aftercare planners engage with participants for 90 days post release. Although it does not provide treatment, TAMAR aids in the identification and treatment referral process.

- HB 990 Workgroup/Mental Health Criminal Justice Partnership: This collaboration resulted in policy changes to expedite Medicaid benefits for individuals sentenced to long term incarceration; provide a 30-day supply of medication for prison inmates with mental illness who are returning to the community; expedite outpatient mental health visits; and ensure that state Motor Vehicle Administration (MVA) identification cards are provided to enable inmates leaving prisons to have access to necessary community supports.

⇒ **Individuals with mental and/or substance use disorders who live in RURAL AREAS.**

The Maryland Department of Health and Mental Hygiene Office of Health Policy and Planning has published *The Maryland Rural Health Plan* which provides a broader discussion of rural health issues in Maryland. The following are excerpts from that plan to assist us in identifying and addressing rural mental health issues in this analysis.

“The challenges to providing quality health care services and delivery to rural Maryland largely result from their geographic isolation and lack of the critical population mass necessary to sustain a variety of primary and specialty services. Efforts to address health care disparities in rural areas are often made difficult by struggling economies and limited financial and human resources. Compared with the state overall, Maryland’s rural communities tend to have fewer health care organizations and professionals, higher rates of chronic disease and mortality, and larger Medicare and Medicaid populations. Evidence indicates that rural populations fare worse in many health and economic indicators, and do not receive the same quality, effective, and equitable care as their suburban counterparts. Rural populations tend to be older and exhibit poorer health behaviors such as higher rates of smoking and obesity, relative to the State, although there is variability in health behaviors among rural communities.”

The DHMH Office of Rural Health has convened a steering committee to create the Maryland Rural Health Plan. Among the top priority areas for rural health in Maryland identified by the Steering Committee were behavioral health (mental health and substance abuse) and improvement in behaviors leading to a healthier lifestyle.

Maryland is a geographically diverse state with two high density areas (Baltimore-Annapolis, and the Washington D.C. suburban area) while the majority of the geography of the state is extremely rural (southern, western, and eastern shore). While the majority of the high density areas are serviced by private providers contracting with local jurisdictions, in the rural areas the local health departments are the primary providers of behavioral health care services. All of the rural jurisdictions provide a minimum of Level 0.5, I, and II.1 outpatient services. The rural

residential needs are provided by a network of regional residential programs. All Maryland jurisdictions provide access to the full continuum of outpatient and residential treatment.

In addition, many of the rural areas have access to telemedicine technology, in which a physician or counselor can meet directly with the patient, family, etc., via visual tele-conferencing in real time. This facilitates rural access to medical and behavioral health specialists that would otherwise not be available.

The state, with private partners, is also pursuing the use of "avatar" virtual counseling technology which would further make behavioral health services available to those who otherwise would not have access to care. This would be available regardless of the urban or rural environment in which the patient resides. The virtual counseling environment will remove existing barriers to accessing treatment such as transportation, fear of stigma, or physical handicaps.

⇒ **UNDERSERVED RACIAL/ETHNIC MINORITY AND LGBTQ POPULATIONS:**

The ADA values the fundamental right of all individuals to high quality healthcare regardless of race/ethnicity, sexual orientation or disability status, and believes that elimination of disparities in health and healthcare provides personal, social and economic benefits for all individuals, the communities they live in, and the State (Maryland Office of Minority Health and Health Disparities-MHHS, 2006; Sullivan Commission, 2004). In 2006, the MHHS within the Maryland Department of Health and Mental Hygiene (DHMH) released the *Maryland Plan to Eliminate Minority Health Disparities*, developed with the input of more than 1,200 citizens, health professionals, academia, and public & private health groups (MHHS, 2006). The *Plan* promotes strategies to eliminate *health disparities* (the disproportionate distribution of the burden of illness, injury, disability or mortality of minorities in relation to a reference group) and *healthcare disparities* (differences in insurance coverage, access to or quality of healthcare services) (Kaiser, 2005a).

Racial minorities, including African-Americans, suffer disproportionately from homelessness, incarceration, child welfare involvement, trauma and poverty. Nearly one in three African American males will serve time in prison during their lifetime (Iguchi et al, 2005); and their incarceration rates are 5-7 times greater than for Whites (Williams & Jackson, 2005). Drug addiction and incarceration increase their risks for mental illness (anxiety, depression, PTSD) and infectious diseases (HIV, TB, hepatitis). Nationwide, African-Americans represent 13% of the population yet account for 49% of new AIDS cases (Kaiser, 2005b). Minorities and veterans with addiction disproportionately face unemployment, disenfranchisement, limited housing, poor access (Iguchi, 2005). Maryland's community-based treatment services system helps reduce disparities through programs like *RecoveryNet*, which enrolls minorities and other individuals with addiction into the Access to Recovery program via portal programs—residential treatment programs, the Dept of Corrections (DOC) and Veterans Affairs (VA)—and by providing these individuals with enhanced treatment and recovery supports.

Culturally competent healthcare providers are major factors in reduction of disparities (Mitchell & Lassiter, 2006). MD will continue to sustain a culturally competent infrastructure and

promote the health of racially diverse populations and individuals with other minority status (gay/lesbian, deaf, disabled) by supporting training and supervision for a culturally competent workforce; soliciting feedback about programming and policies from vulnerable populations via surveys and focus groups; providing for representation of minority populations on committees including State and Local Drug and Alcohol Abuse Councils (DAAC, LDAACs); ensuring that hiring practices include recruitment of minority professionals; and building in expectations for cultural competence into contractual agreements with providers, evaluation instruments, consent forms, and other written materials.

In addition, the ADAA has adopted measures from the Cultural Competence Health Practitioner Assessment (CCHPA) and other tools developed by the National Center for Cultural Competence (NCCC) for the Health Resources and Services Administration (<http://www.hrsa.gov/culturalcompetence/>) to provide objective evidence of cultural and linguistic competence at the provider agency level for its ATR and other categorical grants. These measures are incorporated into Client Satisfaction Surveys, and the Monitoring Forms used by the Regional ATR Coordinators during quarterly visits to participating programs. To the extent possible, the ADAA plans to incorporate these cultural competence measures into all training, technical assistance and program monitoring opportunities.

The Minority Outreach and Technical Assistance (MOTA) office has been a component program of the Maryland Department of Health and Mental Hygiene's Cigarette Restitution Fund Program (CRFP) since July 2000. MOTA focuses on education, enlightening and empowering ethnic minorities to impact cancer and tobacco health care decisions in their local jurisdictions. To date, MOTA has assisted over 300 organizations with funding to community-based, grass-root, minority or minority-serving faith-based organizations to provide outreach services statewide for African Americans, Asian Americans, Latino/Hispanic Americans, Native Americans and women.

In 2010, DHMH provided MOTA funds to one organization in each of the following jurisdictions:

- Anne Arundel County
- Baltimore City
- Caroline County
- Charles County
- Dorchester County
- Frederick County
- Harford County
- Howard County
- Kent County
- Montgomery County
- Prince George's County
- St. Mary's County
- Wicomico County

MOTA grantees conduct a variety of activities designed to increase awareness among minority populations, increase participation with local health departments, and promote alliances with organizations within jurisdictions to prevent tobacco use and decrease cancer incidence. The ADAA partners with MOTA to identify communities in which tobacco use by minority youth is particularly prevalent, and to target for inspection certain establishments identified by those community-level organizations as being known or suspected to sell tobacco products to youth.

The DHMH Infectious Disease and Environmental Health Administration (IDEHA) is involved in a number of communicable disease surveillance studies for public health purposes. One such study is the CDC-funded National HIV Behavioral Surveillance (NHBS) project, which is based on methods developed in the Young Men's Survey (YMS), and is being conducted in metropolitan areas with the greatest number of HIV/AIDS cases. DHMH is in its third cooperative agreement through the CDC, and in 2011, began Year 1 of a new 5 year agreement. The NHBH Baltimore study is conducted under a DHMH contract with Johns Hopkins Bloomberg School of Public Health. The study assesses HIV risk behaviors, HIV testing behaviors and exposure to and use of prevention services among individuals at high risk. NHBS target populations include men who have sex with men (MSM), injection drug users (IDUs) and heterosexuals at risk for HIV (HET). Approximately 24% of living HIV cases in Baltimore-Towson include MSM, and 43% are IDUs. MHBH researchers conduct venue-based sampling in areas where at risk individuals can be recruited to participate in the study (including bars, dance clubs, businesses, health clubs, adult bookstores, bathhouses, parks, beaches, gay pride events, etc.).

The MHA Office of Consumer Affairs (OCA) works to gradually increase the sustainability and accountability of the 25 peer-run Wellness & Recovery Centers (formerly known as drop-in centers) currently established across the State. Many of these centers address issues of co-occurring disorders of mental illness and substance abuse within their programming. The LGBTQ Wellness & Recovery Center has offered several outreach sessions during the fiscal year on topics such as: "The Gay Community and Stereotypes"; Mental Health First Aid; and a workshop on community resources for the LGBTQ consumer for individuals who are homeless with mental illness. There will be an increased focus on the involvement of the Wellness and Recovery centers in surrounding community organizations and activities to allow the centers and their members to become active members of the greater community. In FY 2011, an annual meeting of the local agency directors and the directors of Wellness & Recovery centers was held to re-establish effective communication and continue to develop cohesive strategies to enhance the recovery process through collaborative leadership training. Many other consumer-run support groups are held in the centers on a regular basis.

⇒ **Persons with DISABILITIES**

Under Code of Maryland Regulations (COMAR) 10.47.01, all addiction treatment programs that are certified by the Dept of Health and Mental Hygiene (DHMH) Office of Health Care Quality (OHCQ) must have protocols, which may include referral agreements with other programs, that provide for admission and treatment of individuals with limited English proficiency, and physical, mental, hearing or speaking disabilities. These conditions are assessed during compliance visits and on an as needed basis. The OHCQ will initiate administrative action if problems are noted or if individuals complain of access issues, and programs that fail to correct problems may face sanctions as described in the previous section.

⇒ **Community populations for ENVIRONMENTAL PREVENTION ACTIVITIES**

Prevention Set Aside: Beginning in FY 2012, ADAA is requiring that the prevention coordinator network and colleges to utilize 50% of the SAPT Prevention Funds for the implementation of Environmental Strategies. This will enable each of the Maryland 24 jurisdictions to create lasting change in community norms and systems, producing widespread behavior change and, in turn, reducing problems for the entire communities.

A minimum of 20% of the Substance Abuse Prevention /Treatment Block Grant (SAPT) funds supports primary prevention activities. An estimated 250,000 Maryland residents will participate in these activities. SAPT Block Grant funds enable the Alcohol and Drug Abuse Administration (ADAA) to support the Prevention Coordinators Network. This prevention network provides the infrastructure for the provision of technical assistance support and funding to community groups and/or organizations to plan and implement prevention services thru the state of Maryland.

The statewide network utilizes a community development model with a focus on the community and agency collaboration to address alcohol and other drug issues. Through this process, 200 community-based prevention programs will be maintained. These are evidence-based that include Across Ages, All Stars, Communities Mobilizing for Change Against Alcohol, Life Skills, Second Step, and Strengthening Families Program. In addition, these programs will provide services and activities within the Center of Substance Abuse and Prevention's (CSAP) six strategies that include information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental strategies.

Four university campuses, regionally placed throughout the State of Maryland, continue to maintain AOD Prevention Centers that includes Towson University, Bowie State University, University of Maryland Eastern Shore, and Frostburg University. The primary focus of these centers is to provide education and training for college students regarding AOD prevention by creating and/or enhancing peer education networks. Each college prevention center is also responsible for the collaboration and development of AOD campus policies and to provide a process for linkages with other colleges within the region to promote AOD prevention strategies.

The ADAA will participate in a new effort-the National College Health Improvement Project's Learning Collaborative (NCHIP) on High-Risk Drinking- designed to bring a new approach to provide services to college students who engage in High-risk drinking. NCHIP is a joint undertaking between Dartmouth College and the Dartmouth Institute for Health Policy and Clinical Practices (TDI) aimed at bringing population health improvement methods to bear on the many problems affecting student health at post-secondary institutions in the United States. NCHIP's inaugural endeavor is a learning Collaborative on High-Risk Drinking. The objective of this Learning Collaborative will be to work together to effect measurable change by reducing the rate of high-risk drinking at participant institutions, as well as the harm that results from this behavior.

It should be noted that due to the increase emphasis in environmental strategies, the ADAA will experience a significant reduction in selective and indicated programs.

Maryland Strategic Prevention Framework (MSPF): On July 1, 2009, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) awarded the Maryland Alcohol and Drug Abuse Administration (ADAA) funds to establish the Strategic Prevention Framework (MSPF). The MSPF goals are the following: Expand capacity to address specific prevention needs in jurisdictions and communities; Measure/document population-level impact at state, jurisdictional and community levels; Develop state, jurisdictional and community level prevention services infrastructure.

Since the MSPF is a comprehensive substance abuse prevention planning process (Assessment, Capacity, Planning, Implementation, Evaluation), the ADAA will continue its mission to implement the planning process, build and sustain a cross-system prevention data infrastructure and expand state and local capacity for the provision of effective and culturally competent substance abuse prevention services.

With the hiring of the MSPF Project staff that includes the Program Manager, Technical Assistance Coordinator and the Office Support Coordinator along with the Lead Epidemiologist and MSPF Evaluator, the ADAA is positioned to provide oversight of state, jurisdictional and community efforts of the implementation of environmental activities that will produce population change. The state will adhere by trusting the process of the five-step MSPF planning process the modeling the process for the jurisdictions and the selected local communities as a result of the jurisdiction's needs and planning assessments.

Upon approval of a jurisdiction's Assessment and Planning Final Report, the state will award all 24 jurisdictions MSPF Community Implementation grant funding. The MSPF Community Implementation Grants will support the implementation of the 5-step MSPF process in the approved high-need communities.

Community –based activities and environmental strategies will be utilized upon the completion of the selected community's strategic plan. Technical assistance in the form of workshops and trainings are currently being provided by the ADAA MSPF staff, CSAP's NECAPTS, and CADCA.

The state will be responsible for awarding the SPF funds to the community by way of the local jurisdiction and providing guidance documents that will include specific language about requirements such as following the proscribed MSPF planning process; infusing cultural competence and inclusion in all local MSPF activities; implementing evidence-based programs, practices and policies; evaluating program performance and outcomes; and developing sustainability strategies.

Activities that will affect policy, behavior, community, school, family and business norms through laws, policy, guidelines, and enforcement will be determined based on the completion and approval of the community strategic plan. The selection and implementation of evidence-based strategies and activities will include intensive training and technical assistance by the ADAA's Prevention Staff.

⇒ **Community settings for UNIVERSAL, SELECTIVE AND INDICATED PREVENTION INTERVENTIONS**

Prevention Set-Aside: Because the ADAA is requiring that the prevention coordinator network and colleges utilize 50% of the SAPT Prevention Funds for the implementation of Environmental Strategies, all twenty-four (24) jurisdictions will be selecting programs and strategies designed to target the entire population of a community. If the jurisdictions have any funds remaining, depending on its assessment outcomes and the recommendations of the Local Drug and Alcohol Abuse Councils (LDAAC), the remaining funds can be utilized to include both indicated and selected programs.

In July 2008, Governor Martin Malley issued an Executive Order re-establishing the Maryland State and Alcohol Abuse Council and mandated that the group “develop a comprehensive , coordinated and strategic approach to the use of State and local resources for prevention, intervention, and treatment of drug and alcohol abuse among the citizens of the state”. Each of the twenty-four (24) jurisdictions have a Local Drug Alcohol and Drug Abuse Council that is tasked to develop a strategic plan that includes prevention, intervention, treatment and recovery services. The local strategic plans will be updated every two years.

An example of a universal program that the state will be funding that targets the entire population of a community is called Communities Mobilizing for Change on Alcohol (CMCA). At least nine (9) of the twenty-four (24) jurisdictions are currently utilizing this evidence-based program that is designed to reduce teen (13 to 20 years of age) access to alcohol by changing community policies and practices. CMCA seeks both to limit youths’ access to alcohol and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable.

If funding holds firm for the prevention coordinator network, some will implement selective programs and/or strategies that target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment. An example of an selective program that several of the jurisdictions will be implementing is the Strengthening Families Program (SPF). This is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children ages 3-16 years. Parenting skills sessions are designed to help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting.

Based on the jurisdiction’s needs assessment and strategic plan, the ADAA will fund indicated prevention programs and strategies that are “designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol, tobacco, and and/or inhalants”. An example of a indicated program that will be funded by the ADAA IS THE Creating Lasting Family Connections (CLFC). This is a family –focused program that aims to build the resiliency of youth aged 9 to 17 years and reduce the frequency of their AOD use. The CLFC is designed to be implemented through a community system, such as churches, schools, recreation centers, and

court-referred settings. Currently, at least two jurisdictions are using this evidence-based program.

All environmental strategies and programs that are implemented in community settings that utilizes universal, selective and indicated prevention interventions will be closely monitored by the ADAA's Prevention Staff. This will include providing both training and technical assistance to the jurisdictions and communities receiving block-grant funding.

Maryland Strategic Prevention Framework (MSPF): With the goal of facilitating a systematic, data driven approach to generating and monitoring priorities for prevention in Maryland, the Maryland Alcohol and Drug Abuse Administration's (ADAA) state strategic plan was developed. The State's priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by the following indicators:

- *Reduce the number of youth, ages 12-20, reporting past month alcohol use*
- *Reduce the number of young persons, ages 18-25, reporting past month binge drinking*
- *Reduce the number of alcohol-related crashes involving youth ages 16-25*

In order to carry out this priority and its three (3) measurable indicators, the state will fund all twenty-four (24) jurisdictions and the community-led coalitions to apply the Strategic Prevention Framework (SPF) to their planning process to assess, build capacity, plan, implement, and evaluate the environmental strategies that were selected to reduce alcohol use among the youth. The setting will be universal because it is the goal of SPF to bring about population change, thus addressing the needs of the entire population of the jurisdiction's selected community.

⇒ **Low-incomes who CURRENTLY ARE UNINSURED but will be covered by Medicaid or private insurance in FY 2014:**

Expanding Access and Capacity for Uninsured Low-Income Individuals Without Insurance After 2014:

Currently over 700,000 Marylanders—or 15 percent of the non-elderly—are without insurance coverage, a rate slightly lower than the national average of 17 percent. When the Affordable Care Act is fully implemented, Maryland's uninsured rate is estimated to be cut by more than half (Maryland Health Care Reform Coordinating Care Council, *Interim Report*, July 2010). Many of the currently uninsured will obtain coverage through the new health benefit exchange with the help of federal premium subsidies. Others will receive coverage through Medicaid Expansion. In addition, baby boomers becoming eligible for Medicare will also decrease the numbers of uninsured. Finally, many people newly uninsured or on Medicaid because of job loss are projected to return to employer-sponsored insurance as the economy recovers and stronger job growth takes hold.

A comparison between the health coverage status of Maryland’s population today and after full implementation of health care reform is shown below:

Insurance Status	2010 (Total 5.8 million Marylanders)	2017 (Total 6.2 million Marylanders)
Uninsured	14.0%	6.7%
Medicaid	14.1%	14.3%
Private	59.4%	61.1%
Subsidies/Exchange	0.0%	2.9%
Medicare	12.5%	15.0%

Planning Steps: During FY 2012 and 2013, the ADAA’s senior leadership, in conjunction with the leadership of the Mental Hygiene Administration (MHA), will develop a plan for transitioning SAPT-Block Grant funds towards a statewide system of prevention, recovery support and other services to support services not covered by Medicaid or private insurance.

The two administrations will:

- 1) Explore the potential impact of healthcare reform on substance abuse treatment, and will determine who will need to be served, including individuals who have not previously been served by the system;
- 2) Identify the substance abuse services that should be retained in an essential benefit package, particularly services not paid for in any other system; and
- 3) Establish parameters for assuring that funded services are evidence-based.

Maryland’s plan will determine how the funds will be directed towards:

- 1) Priority treatment and support services for individuals without insurance after 2014 or for whom coverage is terminated for short periods of time;
- 2) Priority treatment and support services for low income individuals not covered by Medicaid, Medicare or private insurance; and
- 3) Services that demonstrate success in improving outcomes and/or supporting recovery.

Treatment and Support Services Covered by Medicaid, Medicare or Private Insurance:

On January 1, 2010, the ADAA and the Maryland Medical Assistance Program implemented numerous changes to improve access to substance abuse services under the Maryland Medicaid Program, the HealthChoice Program, and the Primary Adult Care Program (PAC). Major improvements included adding certain community-based services to its fee-for-service program for all Medicaid beneficiaries, adding certain substance abuse treatment services to the PAC benefit package, and increasing payment rates for other previously covered services such as methadone maintenance.

Beginning January 1, 2010, community-based certified addictions programs were eligible to bill for the following services at the increased reimbursement rates:

- Comprehensive Substance Abuse Assessment (CSAA)
- Individual Counseling
- Group Counseling
- Intensive Outpatient
- Methadone Maintenance

Billing and Reimbursement: Conditions of Award for grantees (local jurisdictions) and their subrecipients require that each jurisdiction develop a plan for meeting the treatment needs of uninsured individuals. The Conditions stipulate the following:

Grantee and all sub-recipients providing treatment services shall:

- a) assess every patient upon admission for eligibility for Primary Adult Care (PAC) and Medical Assistance (MA);*
- b) retain proof of application for these entitlements;*
- c) for eligible recipients, bill PAC and MA for services covered by those entitlements; and*
- d) no longer use ADAA funds for services covered by third party payors.*

Managed Care Organizations (MCOs) are responsible for paying the cost-based rates established by DHMH for HealthChoice enrollees. With the exception of Federally Qualified Health Centers (FQHCs), the new rates are paid to both private and public providers for services rendered in the community. The FQHCs continue to be reimbursed at their established prospective rates for fee-for-service patients and patients enrolled in HealthChoice.

The Substance Abuse Improvement Initiative (SAII), effective January 1, 2010, offers patients greater choice in the provider selection and the ability to self-refer to treatment. Through the SAII, Health Choice and PAC enrollees may select their own providers for substance abuse treatment, even if the provider does not have a contract with an MCO. The SAII initiative uses ASAM Patient Placement Criteria for evaluation of level-of-care for placement, continued stay, and discharge assessments. Self-referral protocols are listed by ASAM level and do not lay out benefit limitations, but services beyond these must be based on medical necessity according to ASAM. Providers must follow notification requirements listed in the protocols in order to obtain authorization and to assure payment for services rendered.

ADAA Services Covered and Not Covered by Medicaid (Medical Assistance—MA and Primary Adult Care—PAC) and FY 2011 Discharges from ADAA-funded Services

FY 2011	Services Covered By MA/PAC effective 1/1/2010	Services NOT covered by MA/PAC
Medicaid YES	<ul style="list-style-type: none"> • Individual Counseling • Group Counseling • Intensive Outpatient • Methadone Maintenance 	<ul style="list-style-type: none"> • Level 0.5 Early Intervention • Level II.5 Partial Hospitalization • Level III.1 Clinically Managed Low Intensity Residential • Level III.3 Clinically Managed Medium Intensity Residential • Level III.5 Clinically Managed High Intensity Residential • Level III.7 Medically Monitored Intensive Residential • Level IV Medically Managed Intensive Inpatient Services
Medicaid NO (ADAA-funded)	10,404 individuals served 213,600 units of services delivered	No individuals served No units of services delivered
	12,839 individuals served 210,135 units of services delivered	9,602 individuals served 548,041 units of services delivered

Individuals with pre-existing conditions: Like other states, Maryland has a plan that offers comprehensive health coverage for uninsured individuals with pre-existing conditions. Individuals without health coverage for at least the last six months are eligible for the Maryland Health Insurance Plan—MHIP (see <http://www.marylandhealthinsuranceplan.state.md.us/>). The Maryland General Assembly established the Maryland Health Insurance Plan under the Health Insurance Safety Net Act of 2002. A Board of Directors governs the plan, which operates as an independent unit of the Maryland Insurance Administration. MHIP is a state-managed health insurance program for Maryland residents who have been unable to obtain health insurance from other sources.

MHIP offers its participants access to both CareFirst BlueChoice HMO and CareFirst Blue Preferred PPO networks. These plans are administered by Care First Blue Cross Blue Shield and Care First Blue Choice, Inc. There are three types of plans:

- MHIP: A state health insurance plan that provides coverage to Maryland residents who are unable to obtain health insurance due to a health condition or have recently lost group coverage.
- MHIP Federal: A federal health insurance plan administered by MHIP that provides individual coverage to Maryland residents who are unable to obtain health insurance due to a health condition and have been uninsured for at least six months. Plan options include:
- MHIP +: MHIP+ provides discounted premiums and, in some cases, cost sharing to MHIP members with limited income. (MHIP+ is not available to members of MHIP Federal.)

Long Term Care Needs of Individuals with Mental and Substance Use Disorders: The field of substance abuse had been moving towards coordinated, comprehensive service delivery even before the 2010 passage of Affordable Care Act (ACA) and the recommendations of the Maryland Health Care Reform Coordinating Council (HCRCC). In fact, the SDAAC Strategic Plan posits a recovery-oriented system of care as its “intended outcome...consistent with the vision for the Council articulates by its members on December 9, 2008 (Maryland State Drug and Alcohol Abuse Council, August 2009: *Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland 2010 to 2012*”, p. 7.

To help inform this process, Maryland can refer to the concept and definition of recovery refined by leaders in the behavioral health field. In May 2011, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) published the group’s working definition of, and set of principles for, recovery to “assure access to recovery-oriented services...as well as reimbursement to providers” (SAMHSA, May 2011: *Recovery Defined – A Unified Working Definition and Set of Principles*). The group defined recovery as “a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential.” Infused throughout the Principles of Recovery are a focus on individual strengths, on relationships with peers, family and community, on hope and respect.

Another “call for collaboration and coordination” arises from the U.S. Department of Health And Human Services’ Strategic Framework on Multiple Chronic Conditions, which identifies behavioral health problems “such as substance use and addictions disorders, mental illness, dementia and other cognitive impairment disorders, and developmental disabilities” as “multiple chronic conditions”(<http://www.hhs.gov/ash/initiatives/mcc/>).

Emphasis on Wellness and Prevention of Mental, Emotional and Behavioral Disorders:

A coordinated approach to substance abuse prevention has also been emerging over the past few years, and in response to the ACA and its “heavy focus on prevention and promotion activities...” Goal 1 of SAMHSA’s Strategic Initiatives reflects attention on development of a

more comprehensive focus on the “infrastructure for prevention of substance abuse and mental illness. Goals 1.1 and 1.2 are specifically relevant here:

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

As well, subsequent to development of the SDAAC Strategic Plan, Maryland’s Alcohol and Drug Abuse Administration (ADAA) was awarded a multi-year Strategic Prevention Framework (SPF) grant from the federal Center for Substance Abuse Prevention (CSAP). The Maryland SPF Priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by: reduction of the number of youth, ages 12-20, reporting past month alcohol use; the reduction of the number of young persons, ages 18-25, reporting past month binge drinking; and the reduction of the number of alcohol-related crashes involving youth ages 16-25. SPF funding guidelines required that ADAA develop a statewide comprehensive plan before funded prevention services can begin. (Appendix A: SPF-SIG Prevention Plan) In April 2011, Maryland’s local jurisdictions submitted applications for MSPF funding to develop community-level, and community-driven prevention systems.

Maryland is increasingly emphasizing environmental prevention, which has the potential to reach a broader population than targeted programming. Beginning in FY 2012, fifty (50) percent of the ADAA’s prevention dollars awarded to local jurisdictions must be spent on environmental prevention activities. One such endeavor, supported by a renewable federal Department of Health and Human Services’ (DHHS) Food and Drug Administration (FDA) contract will strengthen Maryland’s statewide comprehensive youth tobacco program and promote healthy communities in Maryland. Specific objectives of the contract include conduct of inspections in retail outlets that sell and advertise cigarettes and smokeless tobacco products to determine compliance with relevant provisions of the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act); and collection, documentation, and preservation of evidence of inspections and/or investigations.

⇒ **Provision of RECOVERY SUPPORT SERVICES for individuals with mental or substance use disorders.**

The State Drug and Alcohol Abuse Council (DAAC) Plan includes “A Coordinated, State-Mandated Recovery-Oriented System of Care (ROSC)” as one of its primary planned outcomes. To achieve that outcome, the DAAC Plan includes a strategic goal to “establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention-prepared communities and comprehensive recovery-oriented services.” Objectives include involving all relevant agencies in developing ROSC, and improving coordination and collaboration among departments and agencies that provide services to individuals with substance use conditions to reduce the gap between the need for services and available services and promote the establishment of recovery oriented support services. The Recovery Workgroup recommended, and the 2010 update described, establishment of a ROSC Steering Committee

which meets monthly and guides multiple ROSC transformation processes. Progress on the stated ROSC implementation goal has been substantive.

Thus, the ADAA has embarked upon a multi-year process of transforming Maryland's addiction service system into a recovery oriented system of care (ROSC). A ROSC Division has been created within the ADAA; it is responsible for planning, standards development, technology transfer, and technical assistance. A ROSC implementation plan was developed which included goals emphasizing the development of recovery oriented standards both for existing services and new recovery support services such as recovery housing, recovery coaching, and recovery community centers. Other goals focused on implementing technology transfer processes, development of outcomes measurement and funding strategies, and facilitating interagency collaborations to provide integrated services at the state and local levels.

Through the ROSC Initiative, the ADAA has supported creation of provider and consumer advisory boards, and local (county level) Change Teams comprised of relevant stakeholders, members of the recovery community, family members, treatment providers, and other service providers (including providers of Recovery Support Services—RSS).

As a Condition of Award, each jurisdiction is responsible for designating a ROSC coordinator to guide local ROSC transformation, for completing program level and jurisdiction level self assessments comparing available services to ROSC elements, and for creating ROSC Change Plans based on the results of the self-assessments. The ROSC Coordinators meet regularly at the ADAA to receive training and technical assistance in the ROSC model and change process, and to receive guidance about implementing their plan.

The ROSC Technology Transfer Subcommittee identified the need to organize and develop a group of trainers to conduct trainings on a wide variety of topics in support of ROSC implementation. To that end, a training network (the Learning Collaborative) comprised of approximately 15 trainers was created and plans developed to increase the number of available trainers each year. ADAA/OETAS faculty will train the participants in the basic ROSC model, provide them with support resources, and encourage them to meet regularly as a group to receive additional training in and support of the ROSC model. The ADAA offers meeting space and facilitation for these training network meetings, and looks to this group for curriculum development and meeting the State's needs for ROSC training.

The ROSC Standards Subcommittee has three workgroups—Continuing Care, Recovery Housing and Peer Recovery Support. The ADAA now allows grant funds to be used for Continuing Care (offered by outpatient programs, and including telephone support and relapse risk assessment) and Recovery Housing (paid for on a fee-for-service basis).

RecoveryNet, an Access to Recovery grant, providing \$3.2 million statewide each year for four years, assures clinical and recovery support services for individuals leaving residential treatment programs, including halfway house treatment, marital/family counseling, recovery housing, pastoral counseling, care coordination, childcare, transportation, and job readiness counseling. The ATR grant enables providers to offer services to individuals within the Department of Public Safety and Correctional Services and the Department of Veterans Affairs systems upon discharge

from residential facilities. An RFP to fund a Recovery Community Center is in process. Services will be determined by the target population and must be operated by a Recovery Community organization. The target date for implementation of this Center is January 2012.

There have been several changes to the SMART data system in support of ROSC implementation and performance measurement. For example, an episode of treatment is now considered to include the entire time a patient spends in treatment with no break in service longer than 30 days; linkages between detoxification and subsequent care, and linkages between intensive outpatient and subsequent care. Data about self-help group participation is captured at the time of disenrollment; and Continuing Care data tracks recovery activity past Level I treatment.

⇒ **CO-OCCURRING MENTAL AND SUBSTANCE USE DISORDERS.**

A significant number of individuals in Maryland's public addictions treatment and mental health care systems have co-occurring mental illness and substance use disorders, and the percentages of adults served in each system have grown steadily over the past several years. In FY 2010, the ADAA estimated that more than a third of adolescents in addictions treatment had co-occurring mental illnesses, and the rate for adults with co-occurring mental illnesses in addictions treatment was over 40 percent in FY 2010, an increase from 35 percent in FY 2008. Additionally, the MHA reported that 15 percent of those served in the public mental health system (PMHS) in FY 2010 had co-occurring substance use disorders.

The DHMH Deputy Secretary for Behavioral Health and Developmental Disabilities has established a workgroup to determine how data can be used in efforts to eliminate disparities in behavioral health treatment services. The workgroup is headed by the Deputy Secretary and has representation from the ADAA, the MHA and the Developmental Disabilities Administration. Additionally, the State Program Administrator for Co-Occurring Disorders is a key member of the workgroup. The workgroup produced and reviewed a data commonality report that identified data fields collected by the three agencies stratified into data categories. All fields that were collected in more than one dataset were highlighted in order to determine analyses that could be completed across systems. The workgroup is currently working on identifying the number of patients appearing in more than one of the systems to see how closely this matches with our knowledge of the population and the prevalence of comorbidity.

In 2009 and 2010, Maryland's Summit and Listening Forums on Adolescent Co-Occurring Disorders resulted in a number of themes and recommendations with associated timelines, levels of investment, and degree of difficulty. Following the Summit, the DHMH Deputy Secretary for Behavioral Health instructed representatives from the MHA and ADAA to create a "virtual office" for adolescent co-occurring disorders in anticipation of an eventual legislative mandate for the full integration of the two administrations. This office is operating via a steering committee on youth with co-occurring disorders to create an action plan based upon the recommendations. This committee is chaired by Peter R. Cohen MD, ADAA Medical Director and Al Zachik MD, MHA Director, Child & Adolescent Services. Drs. Cohen and Zachik are board certified child and adolescent psychiatrists. Dr. Cohen is also certified in addiction medicine. The operations of the workgroup are coordinated by Rena Z. Mohamed, M.A., from the MHA and the University of Maryland Innovations Institute.

The ADAA and the MHA continue to work with other state agencies, local health departments, core service agencies and other stakeholder groups to increase Maryland's focus on the needs of co-occurring populations and to strengthen coordination and service integration efforts, which will result in improved access to clinically sound services.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

STEP 2 - Identify Unmet Service Needs and Critical Gaps Within the Current System

Data Driven Processes for Identification of Needs and Gaps for Specific Populations:

Maryland utilizes a data-driven strategic planning process to address identified needs, thus enabling Maryland to develop and implement a strong, viable prevention *and* treatment network. The ADAA collects and utilizes extensive amounts of data from numerous sources to assess gaps and needs, to measure and report on performance, and to inform stakeholders. These primarily include the National Survey on Drug Use and Health (NSDUH), and social indicator data collected and compiled by the Statewide Epidemiologic Outcomes Workgroup (SEOW). The SEOW was formerly coordinated by the University of Maryland-College Park Center for Substance Abuse Research (CESAR), but is now under the direction of the University of Maryland-Baltimore School of Pharmacy (UMB-SOP).

The Maryland SEOW oversees the collection, interpretation and dissemination of statewide and local data that quantify substance use and its consequences for the State. The SEOW tracks, monitors and analyzes trends and patterns for legal and illegal substances throughout Maryland, with detailed focus on the 23 counties and Baltimore City. The SEOW was formed under the oversight of the ADAA in March 2006, with SAMHSA funding through March 2009. The SEOW has been funded through Maryland's 20% Prevention Set Aside since then, in accordance with the ADAA's sustainability plan for prevention services. In its second year, Maryland's SEOW was expanded to include the needs of local jurisdictions as well as the State.

Throughout 2009 and 2010, the ADAA worked with its local prevention coordinators to generate input into the implementation of Maryland's Strategic Prevention Framework (MSPF). In FY 2011, Assessment/Planning grants were made to all Maryland jurisdictions to enable them to carry out jurisdiction-wide prevention needs assessment activities, resulting in the selection of their jurisdictional priorities as well as target communities for MSPF resources. Local communities have received MSPF Implementation grants to implement prevention services designed specifically towards reducing the State's priority substance use and consequence indicators in highest need communities.

The ADAA obtains sub-state level data through the SEOW from other state agencies concerning substance-related deaths, arrests, auto crashes, school suspensions and HIV/AIDS incidence and prevalence. Other sub-state level data are collected through the State of Maryland Automated Record Tracking (SMART) system, and an array of ancillary sub-state level data is used to determine areas of highest incidence, prevalence and need. SMART data and data from other State and Federal resources are used for utilization and categorical analysis and monitoring (e.g. pregnancy, adolescent, prevention, certification, and capacity/waiting list).

The ADAA periodically employs probability models to estimate treatment needs by subdivision, and routinely shares, through its JurisStat program, regional- and sub-state level performance data with local coordinators for analysis and feedback. Sub-state level analyses are conducted throughout the year to examine trends in demographics, patient profiles, substances used and provider service delivery and performance. For example, the ADAA utilizes incidence-of-first-use analyses to track sub-state changes in Maryland's extensive heroin problem; and performed a

“high-end services user analysis” which examined characteristics of patients with multiple residential treatment episodes over the past three years.

The ADAA partners with SAMHSA regarding data reporting requirements for the Treatment Episode Data Set (TEDS), the National Survey of Substance Abuse Services (N-SSATS) and the National Survey on Drug Use and Health (NSDUH) to prepare sub-state level estimates of substance use measures. During the 2007 legislative session, Maryland delegates sponsored HB 850, which required the ADAA to conduct a substance abuse needs assessment. This needs assessment was conducted by the University of Maryland-College Park Center for Substance Abuse Research (CESAR). In FY 2008, the ADAA released the Need for Substance Abuse Treatment in Maryland Final Report.

Throughout 2009 and 2010, the ADAA worked with its local treatment coordinators regarding the implementation of a Recovery Oriented System of Care (ROSC). The ADAA has begun analyses of available recovery-oriented outcomes data to develop recommendations for recovery support services and expansion of data collection to satisfy additional NOMs measures (i.e., social support). These data inform and incentivize elements of ROSC and the Access to Recovery (ATR) program.

Coverage:

Between FY 2008 and FY 2010, State-funded admissions increased 5 percent while non-funded admissions were halved. Total treatment admissions fell by about 14 percent. Whereas State-funded admissions made up about two thirds of the total in FY 2008, they made up 80 percent in FY 2010. This shift is a result of reconciliation and realignment of funding sources, and there has been some erosion of reporting by programs that receive limited or no public dollars. The 43,001 funded admissions were accounted for by 34,760 unique individuals (1.24 admissions per individual).

The distribution of funded enrollments/dis-enrollments in various levels of care has changed over recent years. Admissions reflect the initial enrollments in treatment episodes; subsequent enrollments during the episodes (transfers to other levels of care) are not counted as admissions. The ratio of enrollments to admissions was 1.21 in FY 2010 compared to 1.16 in FY 2008, indicating increased reliance on the comprehensive continuum of care. Enrollments in Level 0.5 (Early Intervention) went up by 59 percent; Level II.5 increased by 70 percent, reflecting increased funding for that level of care. Total III.3 and III.5 enrollments increased 54 percent while enrollments in III.7.D increased by 22 percent. Dis-enrollments increased nearly 10 percent between FY 2008 and FY 2010, again reflecting greater reliance on the continuum of care as more patients are served in multiple levels of care.

Review of the distribution of initial ASAM level at admission shows that in FY 2010, just under 70 percent of admissions were to ambulatory levels of care. Most of those seeking State-funded treatment in Maryland had fewer than five days between their initial request for treatment and the admission date. For Levels I.D, II.5, III.1, III.3 and III.5 the median wait to enter treatment was zero days, indicating more than half the admissions to those levels involved immediate entry.

The percentage distribution of number of prior admissions is shown in Figure 10. Nearly two-thirds of FY 2010 treatment admissions had prior treatment experience. This reflects greater reliance on a continuum of care as ADAA moves toward a recovery-oriented system of care.

During FY 2010, fifty-two percent of all discharges involved successful completion of the treatment plan and 28 percent were referred after completion of the immediate treatment plan. Nearly 30 percent left before completing treatment and 8 percent were discharged for noncompliance with program rules.

Successful completion without need for further treatment was most common in Levels 0.5 (75 percent), I (40 percent) and III.1 (27 percent). Transfer/Referrals made up over 80 percent of dis-enrollments from Levels II.5, I.D/II.D, III.7 and III.7.D.

The levels of care with the greatest percentages of dis-enrollments for non-compliance were III.1 at 23 percent, III.3 at 18 and OMT at 17 percent. Also in OMT, 38 percent of the dis-enrollments involved patients leaving treatment early, which was also fairly common in Level II.1 (39 percent) and Level I (34 percent). OMT discharges tend to be weighted with many of the less successful cases, as those achieving stability remain in treatment for extended time periods.

About 62 percent of patients leaving short-term residential detox due to completion, transfer or referral during FY 2010 entered Level III.7 within 30 days, and another 21 percent entered intensive outpatient or some other type of service. Dis-enrollments from III.7 were most likely to enter intensive outpatient (16 percent) and III.1 halfway house (9 percent). Over half of completers, transfers and referrals from intensive outpatient entered Level I within 30 days; about 15 percent entered another level of care.

Analysis of length of stay (LOS) data indicated that in FY 2011, the average LOS for Level I was over four months, although detention center patients stayed a mean 98 days. The LOS for residential levels III.1, III.3 and III.5 was between 98 and 108 days on average. The average OMT discharged patient spent about 19 months in their programs. OMT patients active in treatment on the last day of FY 2010 averaged 4.7 years in treatment, and 14 percent had been in treatment ten years or more. During FY 2010, 58 percent of Level I and 56 percent of Level III.1 patients discharged stayed in those levels of care at least 90 days.

Patient Population:

Demographics: The age breakdown of the treatment admission population remained fairly stable in FY 2010 although there was a slight decline in the under-18 group. Seventeen percent of admissions were under 21 and 35 percent were over 40. Over the past few years there was a gradual trend toward more problem drug and alcohol use by older adults, but during FY 2010 there was a small shift back toward admissions in their twenties. Overall about 32 percent of FY 2010 admissions were female. About 65 percent of admissions were fairly evenly split between black and white males, but the white female total was 50 percent higher than the black female

total. Surprisingly the percentage of Hispanic admissions fell from about 4 in FY 2009 to 3.2 in FY 2010. While the male/female ratio was 1.88 for whites and 2.55 for African Americans, it was 2.87 for Hispanics.

Education and Employment: Only about 62 percent of adult FY 2010 treatment admissions had high school diplomas. Considering jointly the items on highest school grade completed, employment and attending grades K through 12 reveals about 35 percent of adults admitted could be classified as high school drop outs. Only 17 percent of FY 2010 adult admissions were employed full-time and 6 percent part-time as they entered treatment, compared to nearly a third of adult admissions having employment in FY 2006. This decline is largely due to the economic difficulties facing the state and nation.

Source of Referral: Criminal justice sources accounted for 43 percent of admissions in FY 2010. Approximately one fourth of referrals were self or family and 21 percent were from substance abuse or other health care providers.

Arrests: In FY 2010, over half of adult and 62 percent of adolescent treatment patients had been arrested in the year preceding admission to treatment. The higher rate for adolescents is related to the finding that 57 percent of adolescents were referred by the juvenile justice system.

Alcohol and Drug Use: In FY 2010, alcohol was involved in about 54 percent of all admissions, and nearly forty percent involved both alcohol and illicit drugs. Fifty-eight percent of admissions involved problems with multiple substances.

Between FY 2008 and FY 2010, there were significant increases in the use of the following substances:

- Oxycodone (91.7 percent);
- Other Opiates (62.0 percent);
- Benzodiazepines (57.8 percent);
- PCP (30.4 percent); and,
- Non-prescribed Methadone (18.7 percent).

Heroin-related admissions increased by 8.2 percent and those involving marijuana by 9.5 percent. The largest decrease occurred among cocaine-related admissions (19.4 percent).

In FY 2010, eighty-nine percent of adolescents admitted had problems with marijuana and 45 percent had problems with alcohol; 40 percent had problems with both. With each succeeding age group the prevalence of marijuana problems drops sharply while that of alcohol problems generally increases. Both heroin and crack cocaine problems are most prevalent in the 41-to-50 age group. Other opiate problems peak at about 25 percent in the 18 to 30 age range.

White females had the highest percentage with other opiate problems (31.4) while black females had the highest percentages with crack cocaine (46.2) and/or heroin (42.2) problems. Previous research in Maryland's substance abuse treatment population has revealed that females entering the treatment system tend to have more severe problems with harder drugs than do males.

Hispanic males were least likely to present with cocaine and heroin problems and most likely to present with alcohol (69.9 percent) and/or marijuana problems (48.3 percent).

Among FY 2010 admissions, about two-thirds of the cocaine-related admissions involved crack cocaine, or smoking the drug. In FY 2008 heroin-related admissions were evenly split between injectors and inhalers, but in FY 2009 and 2010 the balance shifted toward injection. This trend correlates with a shift toward more white and fewer black heroin-related admissions. In FY 2008 38.5 percent of heroin cases involved whites and 59.8 percent blacks. The respective percentages for FY 2010 were 46.6 and 52.1.

Analysis of the interaction of age, race and route of administration of heroin revealed the two large components of FY 2010 heroin-related cases: white injectors in their twenties and early thirties and black inhalers in their late thirties, forties and early fifties. Black injectors were the oldest group on average, peaking at age fifty.

Tobacco Use: In FY 2010, large portions of the patient population used tobacco in the month preceding admission. Forty-five percent of adolescent and over 70 percent of adult admissions were smokers, far exceeding the rates in the general population. Previous research in Maryland has demonstrated a strong relationship between cigarette smoking and failure to complete substance-abuse treatment.

Co-Occurring Mental Illness: There has been a continuing increase in the number and percentage of admissions identified as having mental health problems. In FY 2008, 35 percent of admissions were identified, compared to 40% in FY 2010, and ___% in FY 2011. These figures reflect greater awareness and increased initiatives focused on the co-occurring population. In FY 2010, more than a third of adolescents and over 40 percent of adults had mental health issues.

Unmet Need and Critical Gaps: Gaps in Maryland's services continuum are evident in some jurisdictions by the absence of Levels II.1 and III.1 (see **Table 1**), and by the lack of funding for recovery support services, although this is partially remediated by SAMHSA's 2011 ATR funding. Barriers to access include inadequate transportation to services and childcare for patients with parenting responsibilities (Donovan, et al, 2001; Greenfield, et al, 2007). Further, the ADAA identified gaps in terms of workforce development and capacity, supported employment, and housing resources.

Tables 2 and 3 provide sub-state estimates of need, and are derived from the 2004-2006 National Surveys on Drug Use and Health-NSDUH (SAMHSA-Office of Applied Studies, 2008).

NOTE: When referred to in the following tables:

- North Central includes Carroll and Howard counties.
- Northeast includes Caroline, Cecil, Harford, Kent, Queen Anne's and Talbot counties.
- South includes Calvert, Charles, Dorchester, St. Mary's, Somerset, Wicomico and Worcester counties. West includes Allegany, Frederick, Garrett and Washington counties.

Table 2 demonstrates the gap between need for treatment and system capacity by comparing need to the number who received ADAA-funded treatment in SFY 2009 (see far right column).

Table 3 shows estimates of use, abuse and dependence for selected substances. Notably, during 2009, 46 percent of 47,000 publicly funded admissions had heroin and other opiate problems, 35 percent had cocaine problems, 38 percent had marijuana problems and 55 percent had alcohol problems.

Table 4 illustrates the numbers of patients that were discharged from the most intensive levels of treatment in the ADAA funded system in Maryland in 2009. These were diagnosed with SUD severity that warranted treatment in a residential program. In addition to 6,453 patients from the ADAA funded system, approximately 1,300 inmates completed Level III.5 residential treatment within Maryland Department of Public Safety and Correctional Services (DPSCS) programs that year. The Maryland Department of Veterans Affairs estimated that approximately 800 veterans were discharged from their residential treatment programs at the Perry Point Medical Center that year, and identified approximately 10-15% of those discharges as veterans returning from Iraq and/or Afghanistan.

Transition from residential treatment into continuing care is highly desirable for this patient population because linkage to continuing care is predictive of improved outcomes (Dennis, Foss, and Scott, 2007). Despite the significant investment made in the treatment of these patients, the percentage that successfully transitioned from residential treatment into continuing care was disappointing (see Table 6). Even among patients who successfully transitioned to continuing care, publicly funded continuing care in Maryland consists primarily of clinical services because the developing SAMHSA-funded Access to Recovery (*RecoveryNet*) program provides access to almost all publicly funded recovery support services. The provision of collateral services is associated with better patient outcomes and a reduction in relapse rates (McLellan et al, 1994, 1998).

Maryland has therefore chosen *patients being discharged from residential treatment* as a target population for recovery support services supported with ATR and other state or federal funding. This focus will enable Maryland to increase the types and amounts of clinical and recovery support services being offered to a high severity SUD population that currently consumes significant system resources, yet has poor outcomes. In 2009, 64 percent of patients admitted into Maryland's publicly funded treatment system reported one or more prior admissions to addiction treatment. Enhanced services to this population may result not only in improved recovery rates, but also a reduction in treatment re-admissions, particularly re-admissions to intensive and expensive levels of care. A reduction in treatment re-admissions will expand Maryland's system's capacity for treating new patients.

Table 1: FY 2010 ADA-A-Funded Treatment Slots by Subdivision and Region

Subdivision/ Region	Level I OP	Level II.1/II.5 Intensive OP	Level III.1 Halfway House	Level III.3 Long- Term Resid	Level III.5 Thera- peutic Com- munity	Level III.7 Short- Term Resid	OMT
Baltimore City	1316	436	210	21	180	103	6609
Baltimore Co.	713	63	8	45	2	23	620
Harford	375	50	0	0	0	0	140
Howard	269	22	0	3	0	0	0
Central	1357	135	8	48	2	23	760
Caroline	135	0	0	0	0	0	0
Cecil	218	30	10	0	0	0	0
Dorchester	175	49	0	0	10	0	0
Kent	145	0	25	0	0	20	0
Queen Anne's	146	0	0	0	0	0	0
Somerset	178	10	0	0	0	0	0
Talbot	180	0	0	0	0	0	0
Wicomico	306	80	6	0	0	0	90
Worcester	271	105	13	0	0	12	0
E. Shore	1754	274	54	0	10	32	90
Anne Arundel	128	77	21	7	3	43	333
Calvert	394	31	0	10	0	0	0
Charles	389	61	0	25	0	0	0
Prince George's	857	147	11	0	0	17	222
St. Mary's	205	39	37	0	0	23	0
Southern	1973	355	69	42	3	83	555
Allegany	206	44	11	0	0	68	88
Carroll	339	29	0	0	0	30	0
Garrett	152	15	0	0	0	0	0
Frederick	207	73	33	0	0	0	105
Montgomery	134	97	5	10	2	20	40
Washington	375	43	29	8	20	0	0
Western	1413	301	78	18	22	118	233

Geo- graphical Area	Population Over Age 12	Est. Total Treatment Need¹	Est. Percent of Population Over 12 in Need	Treated in Maryland Certified Programs FY 2009	Total Est. Unmet Treatment Need²	Est. Percent of Population Over 12 in Unmet Need
Maryland	4,605,083	420,420	9.1	70,434	349,986	7.6
Anne Arundel	428,334	37,745	8.8	5,620	32,125	7.5
Baltimore City	518,250	69,314	13.4	21,583	47,731	9.2
Baltimore County	661,260	59,543	9.0	8,494	51,049	7.7
Montgomery	779,708	59,580	7.6	5,390	54,190	7.0
North Central	354,856	31,265	8.8	3,338	27,927	7.9
Northeast	375,554	35,822	9.5	6,641	29,181	7.8
Prince George's	691,561	55,417	8.0	4,380	51,037	7.4
South	416,114	37,605	9.0	8,602	29,003	7.0
West	379,446	34,124	9.0	6,386	27,738	7.3

¹Includes NSDUH estimate of unmet need from the 2004-2006 surveys and actual numbers of individuals treated in certified Maryland treatment programs during FY 2009.

²The NSDUH report provides separate estimates of unmet need for alcohol treatment and unmet need for illicit drug treatment. Since all providers in Maryland serve both populations the percentage overlap between the estimates of those dependent on or abusing alcohol and those dependent on or abusing illicit drugs and those dependent on or abusing alcohol or drugs was used to develop the estimate of total unmet need.

Table 3: Percentage Estimates for the Population Over Age 12 from the 2004-2006 National Survey on Drug Use and Health (NSDUH)

Geographical Area	Marijuana Use Past Month	Cocaine Use Past Year	Nonmedical Pain Relievers Use Past Year	Binge Alcohol Use Past Month	Dependence or Abuse of Alcohol or Drugs
Maryland	4.69	2.18	3.71	20.09	8.21
Anne Arundel	4.51	2.19	3.91	21.68	8.08
Baltimore City	6.68	3.46	4.02	20.79	9.76
Baltimore County	4.56	2.13	3.9	19.86	8.19
Montgomery	4.84	1.85	3.33	18.48	7.63
North Central	4.37	2.02	3.86	22.36	8.55
Northeast	4.52	2.44	4.71	22.87	8.48
Prince George's	4.38	1.77	2.74	17.02	8.16
South	4.23	2.05	4.02	21.59	7.32
West	3.7	1.93	3.74	20.15	7.96

Table 4: ADAA-Funded Residential Treatment: Unduplicated FY 2009 Adult Dis-Enrollments

Region of Residence	Level III.3	Level III.5	Level III.7	Total
Baltimore City	139	475	1390	2004
Central Maryland	185	50	630	865
Eastern Shore	27	45	605	677
Southern Maryland	187	125	1133	1445
Western Maryland	126	46	1290	1462
Total	664	741	5048	6453

Table 5: Average Length of Stay (LOS) in Days and Average Cost per Episode for ADAA-Funded Treatment

Level III.3 Long-Term Residential		Level III.5 Therapeutic Community		Level III.7 Short-Term Residential	
Cost Per Episode	Ave. LOS (Days)	Cost Per Episode	Ave. LOS (Days)	Cost Per Episode	Ave. LOS (Days)
\$34,849.25	109.0	\$35,120.32	87.8	\$43,141.86	19.0

Table 6: Undupl. Adult Dis-Enrollments from ADAA-Funded Levels III.3, III.5 and III.7 in FY 2009 & Subsequent Enrollment in Selected Levels of Care w/in 30 Days

Subdivision/ Region	Un- dup- licat- ed Dis- en- roll- ments	Subsequent Enrollment in the Following Levels of Care Within 30 Days								Percent En- rolled Within 30 Days
		Level I		Level II.1/II.5		Level III.1		OMT		
Baltimore City	1922	16 7	8.7	139	7.2	108	5.6	7	0.4	21.9
Baltimore Co.	683	29	4.2	47	6.9	22	3.2	3	0.4	14.8
Harford	79	8	10.1	6	7.6	3	3.8	1	1.3	22.8
Howard	97	6	6.2	7	7.2	17	17.5	0	0.0	30.9
Central	859	43	5.0	60	7.0	42	4.9	4	0.5	17.3
Caroline	65	9	13.8	1	1.5	4	6.2	0	0.0	21.5
Cecil	144	13	9.0	4	2.8	4	2.8	2	1.4	16.0
Dorchester	55	1	1.8	6	10.9	1	1.8	0	0.0	14.5
Kent	48	13	27.1	0	0.0	4	8.3	0	0.0	35.4
Queen Anne's	97	21	21.6	0	0.0	1	1.0	0	0.0	22.7
Somerset	24	0	0.0	4	16.7	1	4.2	0	0.0	20.8
Talbot	70	14	20.0	6	8.6	1	1.4	0	0.0	30.0
Wicomico	110	11	10.0	29	26.4	2	1.8	0	0.0	38.2
Worcester	63	5	7.9	9	14.3	0	0.0	0	0.0	22.2
E. Shore	676	87	12.9	59	8.7	18	2.7	2	0.3	24.6
Anne Arundel	561	29	5.2	54	9.6	48	8.6	3	0.5	23.9
Calvert	100	17	17.0	10	10.0	5	5.0	0	0.0	32.0
Charles	136	6	4.4	7	5.1	8	5.9	0	0.0	15.4
Prince George's	438	13	3.0	36	8.2	41	9.4	0	0.0	20.5
St. Mary's	183	10	5.5	36	19.7	18	9.8	0	0.0	35.0
Southern	1418	75	5.3	143	10.1	120	8.5	0	0.0	23.8
Allegany	73	4	5.5	17	23.3	10	13.7	1	1.4	43.8
Carroll	177	20	11.3	7	4.0	22	12.4	2	1.1	28.8
Frederick	190	16	8.4	10	5.3	32	16.8	1	0.5	31.1
Garrett	19	2	10.5	3	15.8	2	10.5	0	0.0	36.8
Montgomery	852	21	2.5	129	15.1	52	6.1	9	1.1	24.8
Washington	112	4	3.6	6	5.4	16	14.3	0	0.0	23.2
Western	1423	67	4.7	172	12.1	134	9.4	13	0.9	27.1
State Total	6298	43 9	7.0	573	9.1	422	6.7	26	0.4	23.2

State SAPT-BG Priorities and Activities for FY 2012-2013: In September 2010, the ADAA prepared a three-year plan that was submitted to SAMHSA as a part of the FY 2011 SAPT-BG application. The ADAA incorporated Federal, State and local priorities and activities into the list of Maryland's top ten priorities. These were unranked and not in priority order, but they represented, and were developed in concert with, the partners described in the "Facilitation of Public Comment" section. The priorities listed in **Step 3, Table 2 and Step 4, Table 3** have been reviewed and updated as a part of the 2012-2013 planning process undertaken during the preparation of this submission.

In developing this list of priorities, the ADAA considered the following:

- SAMHSA's 8 *Strategic Initiative*;
- SAPT-Block Grant requirements and regulations (<http://tie.samhsa.gov/SAPT2011.html>);
- U.S. Dept. of Health and Human Services (DHHS) *Healthy People 2020* (<http://www.healthypeople.gov/>);
- Office of National Drug Control Policy (ONDCP) *National Drug Control Strategy* (<http://www.whitehousedrugpolicy.gov/strategy/>);
- Maryland Dept. of Health and Mental Hygiene (DHMH) *Plan To Expand Access To Substance Abuse Services In Maryland By 25% By 2012*; (<http://www.statestat.maryland.gov/GDU/15SubstanceAbuseDeliveryPlan.pdf>);
- Maryland Drug and Alcohol Abuse Council (DAAC) "2012-2014 Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland"
- Partnerships with other Maryland DHMH Offices and Administrations (i.e. Office on Infant Mortality for FASD and other substance exposed infant initiatives, Infectious Disease and Environmental Health Administration for HIV and TB initiatives, etc.).

Further, we concluded that when the ADAA pursues Federal funding for specific initiatives (i.e., the CSAP Strategic Prevention Framework—SPF; the CSAT Access to Recovery grant—ATR; and the Food and Drug Administration [FDA] Tobacco Retail Inspections contract), Maryland is partnering with the Federal government for continued improvements in the delivery and financing of services, and other enhancements that protect the Nation's health.

Need for Renewed Needs Assessment Efforts: The last formal needs assessment to be conducted in Maryland was in 2007-2008. During the 2007 legislative session, Delegate Peter A. Hammen, Chair of the Health and Government Operations Committee, and 22 of his colleagues sponsored HB 850. This bill required the ADAA to conduct a needs assessment to "identify the financial and treatment needs of each jurisdiction and of each drug treatment program operated by the State." The ADAA contracted with the Center for Substance Abuse Research (CESAR) at the University of Maryland, College Park, to conduct the treatment needs assessment. CESAR staff had previously conducted needs assessments for Maryland in 1998 and 2002 as part of the Substance Abuse and Mental Health Services Administration's (SAMHSA) national program for assessing state treatment needs. Dr. William McAuliffe of the Department of Psychiatry at Harvard Medical School was funded by SAMHSA to direct the National Technical Center in order to advise all of the states as they conducted their needs assessments. CESAR engaged him to collaborate with its staff and to direct Maryland's treatment needs assessment.

The report of that needs assessment is found on the ADAA website at http://maryland-adaa.org/content_documents/NeedAssessmentFINAL.pdf.

The 2008 McAuliffe study group created a composite of validated substance abuse indicators, then used the resulting Substance Need Index (SNI) as an independent variable in a statistical equation to estimate relative gaps in treatment services among the state's counties. The need indexes had substantial levels of reliability and validity, but the study was costly, complicated, and difficult to reproduce for periodic updates.

The ADAA is notifying SAMHSA that it is unable to complete additional needs assessment activities before the 10/1/11 submission date. However, the ADAA intends to conduct additional needs assessment activities during FY 2012, although completed reports may not be available until FY 2013.

The ADAA intends to conduct periodic assessments to provide better information about unmet need and critical gaps in Maryland. ADAA staff are currently researching various needs assessment methodologies used in other states, and the SSA Director and Deputy Director are involved in discussions and negotiations with universities within the State regarding potential strategies. The ADAA is exploring alternatives for less costly and more convenient, timely and helpful needs assessment methodologies, such as Multiple Indicator Analyses to assess patterns and trends and the nature and extent of substance use in selected geographical areas, using processes like those utilized by the Statewide Epidemiologic Outcomes Workgroup (SEOW). This will also facilitate focusing on the needs of populations that are not well represented in surveys. In addition to secondary data set analyses, the needs assessment methodologies to be proposed will incorporate analyses of primary data collected from stakeholder focus groups, consumer satisfaction surveys, surveys of local program directors, etc. Further, the ADAA will continue to work with the Department's Family Health Administration to develop a Maryland version of the Youth Risk Behavior Survey that will general valid subdivision-level prevalence estimates.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

Page 23 of the Application Guidance

Start Year:

2012

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	Assessment and Analysis of Unmet Need and Critical Gaps in the Service System	Perform/update needs assessments and analyses of unmet need/gaps in the service system with focus on 1) hard to reach substance-using populations and communities with elevated measures of alcohol and drug use or consequences; 2) individuals in need of treatment who require access to a level of care that may not be available; and 3) individuals who misuse prescription drugs.
2	Health Care Reform	Infrastructure enhancements and re-engineering of finance mechanisms to support Medicaid/PAC expansion and the provision of a comprehensive continuum of priority treatment and support services for 1) individuals who lack insurance coverage or have interruptions in coverage; and 2) low-income individuals who require services that are not covered by Medicaid, Medicare or private insurance.
3	Expand Access to Substance Abuse Treatment Services	Expand access to addictions treatment for hard to reach populations 1) based on needs assessment(s) to be conducted under Priority 1 (above); 2) improved utilization of tele-behavioral and other technological advances; 3) expansion of pharmacologic therapies; and 4) improved financing and monitoring mechanisms to redirect funding or increase efficiencies.
4	Recovery-Oriented System of Care (ROSC)	Transformation of Maryland's addiction services system into a more recovery-oriented system of care by conducting jurisdictional level assessments and developing local ROSC change plans; integrating addictions treatment and recovery support services into local communities; and expanding access to continuing care, recovery housing and supported employment.
5	Strategic Prevention Framework (SPF)	Prevention or reduction of the consequences of underage drinking and adult problem drinking; expansion of SPF methodologies to address prevention of the use and consequences of tobacco and other drugs; and utilization of the SPF framework to integrate efforts to prevent substance use disorders (SUDs) and mental illnesses (MI).

6	Quality Improvement: Pharmacotherapy	Expanded use and improved quality of pharmacotherapies in addiction treatment programs and other health care settings, including evidence-based pharmacological treatments for opioid, alcohol and nicotine dependence.
7	Integration of Behavioral Health and Medical/Somatic Care	Improved coordination between primary care and the specialty behavioral health care services system, and improved somatic health of behavioral health patients, through the formation of partnerships, training of case managers and peer support specialists, and requirements for smoking cessation plans to be included in the individualize treatment plans of patients in addictions treatment programs.
8	Youth Access to Tobacco	Utilization of environmental strategies to reduce underage access to tobacco products, including 1) Continuation of the ADAA's contract with the Food and Drug Administration (FDA) for enforcement of youth tobacco access laws (which includes a statewide consummated buy strategy and performing advertising and labeling inspections); and 2) Compliance with Synar regulations through random and year-round inspections that utilize an unconsummated buy strategy.
9	Special Populations (Military Personnel, Older Adults, Deaf/Hard of Hearing, LGBTQ)	Reduced substance use among, and improved somatic and behavioral health of a number of targeted Special Populations, including 1) Military Personnel (veterans, active duty military, reservists) and their families; 2) Older adults, especially those with or at risk of prescription drug misuse, and those with long histories alcohol or other drug disorders; 3) Individuals that are Deaf or Hard-of-Hearing; and 4) Individuals who are lesbian, gay, bisexual, transgendered and/or questioning (LGBTQ).
10	Adolescent Substance Users	Improved somatic and behavioral health, expanded service capacity and access, and improved quality of care for substance using adolescents, including those with co-occurring disorders (COD).
11	Behavioral Health Prevention and Treatment Workforce Development	Development and support of a sound infrastructure for a skilled and competent behavioral health prevention and treatment workforce that provides accessible and effective services to improve behavioral and somatic health and reduce the risks and harms resulting from substance use.
12	Information Technology	Improved use of information technology for 1) Data integration within Maryland's publicly funded behavioral health care system; 2) Implementation and maintenance of a certified and efficient Electronic Health Record (EHR) that streamlines and automates workflow while improving patient care and safeguarding patient privacy and confidential information; and 3) Increasing the capability of programs to bill for obtain 3rd party reimbursement, so as to decrease their reliance on ADAA grant funding when other reimbursement opportunities are available.
13	Federal Block Grant Mandated Target Population: Pregnant	Treat the family as a unit and provide a comprehensive range of services designed to address important health issues related to the addiction treatment needs of pregnant and parenting women and their children. Approach includes preferential admission to treatment for pregnant women; the provision of primary medical care and prenatal care for the women; pediatric health care, counseling and developmental services and child care for

Women and Women with Children the children; gender-specific addictions treatment and other therapeutic interventions for the women that address relationships, sexual and physical abuse and parenting issues; and sufficient case management and transportation services to ensure that the women and children have access to those services.

14 Federal Block Grant Mandated Target Population: Intravenous Drug Users (IVDU) and Individuals With, or At Risk of HIV Infection Reduce the transmission of HIV/AIDS and other adverse health effects of substance use and injection drug use, through capacity management and the provision of HIV Early Intervention Services, interim substance abuse services, and outreach activities to encourage individuals in need of treatment for substance use disorders to undergo such treatment.

15 Federal Block Grant Mandated Target Population: Individuals With or At Risk of Tuberculosis Infection Prevent the transmission of tuberculosis (TB) among individuals in treatment for substance use disorders by routinely making available tuberculosis services as defined by 45 CFR Part 96, §96.121 and as required by §96.127, in cooperation with the Maryland Dept. of Health and Mental Hygiene (DHMH) Center for Tuberculosis Control and Prevention, local health departments and treatment providers.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:

2012

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Assessment and Analysis of Unmet Need and Critical Gaps in the Service System	Conduct an assessment and analysis of unmet need and critical gaps in the service system.	1. Examine the discrepancy between indicated level of care for individuals entering treatment, based on assessment information and placement criteria, relative to the level of care actually available or provided. 2. Expand SEOW methodology to include collection, surveillance and analyses of data regarding use and consequences of substances by hard to reach populations and communities to supplement ongoing analyses of Arrest, Vital Statistics, Highway Crash, Medical Examiner, School Suspensions, Treatment Admissions,	1. More individuals that have received assessed (needed) level of care according to placement criteria; 2. Emerging substance problems identified; 3. Patterns indicative of potential diversion, overuse or misuse of prescription drugs identified.	1. SMART data reported by treatment providers; 2. SEOW administrative records (Key informant interviews conducted); 3. PDMP data reported (once operational) by prescription dispensers.

HIV Surveillance, BRFSS and NSDUH data. 3. Identify trends in prescription drug misuse by analysis of data to be captured by the new Prescription Drug Monitoring Program (PDMP), once operational.

1. With support from Maryland Medical Assistance (MA), provide training to increase provider competence in assisting patients in completing applications for insurance coverage (Medicaid, Medicare, and after 2014, the Health Insurance Exchange). 2. Eliminate reliance on the SAPT-Block Grant when other sources of 3rd party reimbursement

Health Care Reform

Fund priority addictions treatment and support services for individuals without insurance, and for low-income individuals who require services that are not covered by Medicaid, Medicare or private insurance.

are available by requiring jurisdictions and treatment programs to: a) Assess every individual, upon admission, for Primary Adult Care (PAC) and Medical Assistance (MA) eligibility, and after 2014, eligibility for Maryland's Health Insurance Exchange; b) Retain proof of application for these entitlements; and c) Bill MA/PAC or other insurance and process claims for all services provided to eligible recipients. 3. Ensure that the public addictions treatment system is designed to fully support recovery and minimize relapse by requiring that jurisdictions provide, purchase or otherwise provide access to a full continuum of care, defined, at a minimum, as Level I, Level II.1, Level III.1, Level III.7, as well as continuing care and other recovery support services, and for adults only, maintenance treatment for opioid addiction.

1. Staff trained in intake application procedures; 2. Increased 3rd party reimbursement and SAPT-BG used for services not covered by insurance; 3. Increased percentages of admissions with insurance coverage; 4. Increased utilization of a broader continuum

1. ADAA Administrative records (documentation of meetings with other State agencies, application procedures modified; staff trained); 2. ADAA Administrative records (jurisdictional grant applications for block grant funding of a broader array of services that are not covered by insurance; SMART data from providers and Compliance Review reports to document increased 3rd party reimbursement); 3. SMART data from providers (to document increased percentages of admissions with insurance coverage); 4. ADAA Administrative records (analyses of SMART data that demonstrate increased utilization of a broader continuum of services, among diverse population groups, with improved geographical representation across the State).

1. Develop outreach and engagement strategy for hard to reach populations based on information obtained through the

Needs Assessment processes described in Priority # 1 Assessment & Analysis of Unmet Need & Critical Gaps in Service System; 2: Support virtual counseling project and other tele-behavioral advances to reach individuals in rural or otherwise remote locations; 3: Expand buprenorphine treatment access by: a) Continuing to fund buprenorphine medication and treatment services through the Statewide Buprenorphine Treatment Initiative; b) Supporting certified physicians in the treatment of opioid dependence by promotion of physician involvement in the Physician Clinical Support System for Buprenorphine (PCSS-B); c) Ongoing monitoring of CSAT data on the monthly and cumulative numbers of physicians certified (StateStat); and d) Educating policy makers about the importance of

1. ADAA Administrative records (outreach and engagement strategy for hard to reach populations developed, following completion of Needs Assessment described in Priority # 1). 2: ADAA Administrative records and jurisdictional grant applications (documentation of virtual counseling projects and other tele-behavioral advances); 3: ADAA Administrative records (buprenorphine funds allocated to jurisdictions; committee

Expand Access to Substance Abuse Treatment Services

Expand access to substance abuse treatment services in Maryland

expanding buprenorphine treatment capacity through amendment of federal legislation which currently prohibits the prescribing of buprenorphine products by Advanced Practice Nurses (APNs, including Nurse Practitioners) who may legally prescribe scheduled medications under existing Scope of Practice laws in their respective states. 4. Expand use and improve quality of other pharmacotherapies in addiction treatment programs as described in Priority #6 Quality Improvement: Pharmacotherapy; 5. Increase efficiencies in the existing system of care by: increasing slot assignment for Level I adult standard outpatient treatment to 40 slots per counselor; decreasing length of stay for high level (high cost) residential treatment services; and monitoring jurisdictional performance and outcome measures (JuriStat). 6. Redirect payment for outpatient care from

1. Outreach/engagement strategy; 2. Virtual counseling/tele-behavioral services; 3 & 4. Increased # served with buprenorphine and other pharmacotherapies; 5. Increased # admissions to treatment; 6. Increased # served through PAC/Medical Assistance.

minutes to document promotion of physician involvement in PCSS-B; StateStat reports of numbers of numbers of buprenorphine-certified physicians; meeting minutes to document education about role of Advanced Practice Nurses/Nurse Practitioners; 4. See Performance Indicators for Priority #6 Quality Improvement: Pharmacotherapy; 5. ADAA Administrative records (policies/procedures for documenting increased slot assignment); SMART data (for documenting increased outpatient utilization, decreased length of stay for high cost residential treatment services, and other JurisStat performance and outcome measures). 6. ADAA Administrative records (documentation of transfer of general or special funds to the Medical Care Programs Administration for substance abuse treatment); Medical Assistance data (for PAC/Medical Assistance substance abuse treatment services utilization data).

state-funded grants to Medicaid payments by transferring general or special funds to the Medical Care Programs Administration, to fund the substance abuse treatment benefit through the Primary Adult Care Program (PAC) and the Maryland Medical Assistance Program.

Recovery-Oriented System of Care (ROSC)

Transform Maryland's addiction service system into a recovery-oriented system of care (ROSC).

1: Transform Maryland's treatment delivery practices to conform to ROSC principles by requiring that each jurisdiction complete annual ROSC self assessments, and develop, update and implement ROSC change plans annually.
2: Offer recovery support services within the service system by providing protocols for implementation of continuing care, purchase of recovery housing and supported employment. 3: Integrate addictions treatment and recovery support services into local communities by requiring that each jurisdiction create a ROSC Change Team composed of community stakeholders; and by requiring that each

1. ROSC change plans reflecting results of ROSC self assessments; 2. More individuals enrolled in continuing care, recovery housing and supported employment; 3. ROSC Change Teams created and jurisdictions attending ATR network meetings.

1, ADAA Jurisdiction Grant Applications; 2. SMART data reported by treatment providers; 3. ADAA Jurisdiction Grant Applications.

jurisdiction participate in ATR network meetings with recovery support providers.

Strategic Prevention Framework (SPF)

Prevent/reduce consequences of underage drinking (ages 12+) and adult problem drinking (ages 21-25); extend MSPF methodology to the prevention of tobacco and other drugs; and integrate SA and MH Prevention by utilizing MSPF framework as planning model.

1. Award MSPF funds to the 24 jurisdictions upon approval of their MSPF prevention plans; 2. Provide capacity building technical assistance (TA) to local communities to help them effectively implement the MSPF process. 3. Expand the MSPF process to include prevention of tobacco and other drug use, in addition to alcohol use and consequences. 4. Update and revise Governor's Drug and Alcohol Abuse Council (DAAC) two-year plan to incorporate MSPF Advisory Committee recommendations for behavioral health prevention planning. 5. Coordinate behavioral health prevention, health promotion and health protection efforts by implementing a collaborative planning process that utilizes the MSPF framework and that involves both the MHA and the ADAA.

1. Jurisdictions with approved local MSPF plans; 2. Jurisdictions receiving capacity building TA; 3. Allocation of SAPT Block Grant/other prevention funds; 4. MSPF recommendations in DAAC Plan; 5. At least 3 meetings with ADAA/MHA and Plan drafted.

1. Administrative records (ADAA Prevention Services program files) for approved local MSPF Plans; 2. Administrative records (ADAA Prevention Services program files) for record of jurisdictions receiving capacity building TA; 3. Administrative records (ADAA Prevention Services program files) for allocations; MSPF Community Implementation Workgroup records for methodologies; 4. Approved DAAC Plan; 5. Administrative records (ADAA/MHA Prevention Integration Task Force meeting minutes and Draft Plan).

Quality Improvement: Pharmacotherapy

Expand use and improve quality of pharmacotherapies in addictions treatment programs and other health care settings.

Condition of Award, that programs offer pharmacotherapy as a part of the treatment regimen, if indicated, for individuals with primary opioid dependence disorders, and require justification when eligible patients are not provided or referred for pharmacotherapy. Encourage jurisdictions to provide case management for all patients on pharmacotherapy, in order to pursue insurance coverage, create linkages with somatic care and community mental health care, and refer for ancillary services (housing, education, employment, etc.) if indicated. 2. Develop criteria for the treatment of alcohol dependence with naltrexone extended release(Vivitrol) as adjunctive therapy; and continue funding for targeted jurisdictions to provide naltrexone for criminal justice system clients. 3. Require, as a Condition of Award, that local jurisdictions and their sub-contracted programs include smoking

1. More individuals with primary opioid disorders on buprenorphine/methadone; 2. Naltrexone criteria developed and more individuals with alcohol dependence on naltrexone; 3. Tx. plans w/ tobacco cessation; more individuals w/ nicotine replacement.

1. SMART data reported by treatment providers; PDMP data reported by dispensers (once operational) for buprenorphine/methadone prescribed; 2. Administrative records for criteria developed; SMART data for naltrexone prescribed; 3. Compliance Reviews for treatment plans that include tobacco cessation; and SMART data from treatment providers to document that individuals in treatment have received nicotine replacement therapy if indicated.

cessation plans for all smokers in addictions treatment programs; and develop a strategy for optimizing the numbers of smoking individuals admitted to addictions treatment who are able to access tobacco cessation pharmacotherapy if indicated; and modify the SMART data system to make the data element for nicotine replacement therapy required (not optional).

1. Encourage the formation of partnerships between behavioral health care and somatic health care providers. Encourage jurisdictions to provide case management services for substance using patients in order to pursue insurance coverage, create linkages with somatic care and community mental health care, and refer for ancillary services (housing, education, employment, etc.) if indicated. Train case managers and peer support specialists to link patients to somatic health providers and support addressing somatic

1. ADAA Administrative records (ex. meeting minutes, agreements, learning modules) to document that Learning Collaborative is operational; Office of Education and Training for Addiction Services—OETAS

Integration of Behavioral Health and Medical/Somatic Care

Improve somatic and behavioral health improving coordination between the primary care and specialty behavioral health care systems.

health issues as a part of recovery; 2. Develop confidentiality standards and establish connectivity with the Maryland Health Information Exchange (HIE); modify the SMART electronic medical record (EHR) to make the data element for linkage to somatic health care required (not optional); 3. Require, as a Condition of Award, that local jurisdictions and their sub-contracted programs include smoking cessation plans for all smokers in addictions treatment programs; and develop a strategy for optimizing the numbers of smoking individuals admitted to addictions treatment who are able to access tobacco cessation pharmacotherapy if indicated; and modify the SMART data system to make the data element for nicotine replacement therapy required (not optional).

1. Learning modules on bi-directional integration; jurisdictions with linkages to Health Homes; 2. HIE connectivity; more individuals in treatment linked to somatic care; 3. Treatment plans including cessation; more individuals with nicotine replacement.

curricula and attendee records) to document training of case managers and peer support counselors; ADAA Jurisdiction Grant Applications (for reporting linkages to Health Homes); 2. ADAA Administrative records (confidentiality standards developed; SMART modifications and HIE connectivity documented); SMART data from treatment providers (documentation that individuals in treatment have linkages to somatic care); 3. Compliance Reviews for treatment plans that include tobacco cessation; and SMART data from treatment providers to document that individuals in treatment have received nicotine replacement therapy if indicated.

1: Continue to enforce federal youth access tobacco laws by maintaining the ADAA's contract with the Food and Drug Administration (FDA)

Youth Access to Tobacco

Utilize environmental strategies to reduce underage access to tobacco products.

for performing statewide inspections that utilize a consummated buy strategy, and for performing advertising and labeling (A&L) inspections. 2: Maintain compliance with federal Synar regulations by continuing to utilize teams of adult and youth inspectors that utilize an unconsummated buy strategy for inspecting randomly selected establishments during the summer months (Synar period) and for conducting year-round routine inspections.

1: Compliance with all requirements of the FDA contract (percent of retailer list inspected, inspection result data uploaded accurately within designated time frames, etc.); 2. Synar non-compliance rates below 20%.

1: FDA Tobacco Inspection Management System (TIMS); 2: Synar database (Federal SSES software system)

1. Focus attention on the needs of military personnel and their families at the State and system level to improve that quality of behavioral health focused prevention, treatment and recovery support services by helping providers respond to their needs and understand military culture. Include standard definitions for military/veteran status in ADAA/MHA data sets and surveys; require providers to collect military/veteran status data; and

<p>Special Populations (Military Personnel, Older Adults, Deaf/Hard of Hearing, LGBTQ)</p>	<p>Promote reduced substance use among, and improved somatic and behavioral health of a number of Special Populations, including military personnel/families; older adults; individuals that are deaf or hard-of-hearing; and individuals who are LBGTO.</p>	<p>include military culture/unique needs in training curricula. 2. Support a collaborative “As You Age” and “Do the Right Dose” program to curb the tide of prescription drug abuse among older adults, involving primary care and other health care providers, pharmacists, the Maryland Department of Aging, residential housing providers, and other agencies that serve older adults. Incorporate information from SAMHSA’s Treatment Improvement Protocol (TIP) #26 “Substance Abuse Among Older Adults” into workforce development plans for training healthcare providers about the need to identify, refer, treat older adults with SUDs, and training addiction treatment program staff about somatic and behavioral health changes associated with the process of aging. 3. Enter into a cost-reimbursement contract with one qualified, comprehensive, certified, non-profit addiction treatment</p>	<p>1. Data collected with standard definitions; military culture/unique needs in curricula; 2. Program for older adults implemented and staff trained; 3. More deaf/hard of hearing individuals receive appropriate treatment; 4. LGBTQ information in curricula.</p>	<p>1. ADAA Administrative Records (for standard definitions of military/veteran status); and ADAA Office of Education and Training for Addiction Services—OETAS records for curricula and attendee records to document training; 2. ADAA Administrative Records (planning meetings for “As You Age” and “Do the Right Dose” program implementation); and ADAA Office of Education and Training for Addiction Services—OETAS records for curricula and attendee records to document trainings; 3. Contract executed with treatment provider for individuals who are deaf or hard of hearing. 4. ADAA Administrative Records (Office of Education and Training for Addiction Services—OETAS records for LGBTQ curricula and attendee records to document trainings).</p>
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agency that can accept statewide referrals for substance using individuals who are deaf or hard of hearing. 4. Improve treatment effectiveness and outcomes among individuals that are lesbian, gay, bisexual, transgendered and questioning (LGBTQ) by providing training for providers to increase their knowledge and awareness about the unique needs of LGBTQ patients and steps they can take to improve access, promote inclusion, provide culturally competent care and reduce stigma. Include content from SAMHSA's publication called "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals".

1. Enhance services infrastructure and financing mechanisms to better accommodate the needs of substance using adolescents and those with COD, by working with the MHA to: a) Create integrated, collaborative

Adolescent
Substance Users

Increase capacity and access and improve quality of care provided for substance using adolescents, including those with co-occurring disorders (COD).

interagency bodies (multidisciplinary teams, family involvement meetings, etc.) for families to discuss particular problems; b) Realign ADAA and MHA service regions across the State to better serve children and families; c) Explore the feasibility of a pilot program to pool money for youth with COD who are the greatest utilizers of high cost services across systems; d) Adopt placement criteria to be used for authorization of services for youth with COD in ADAA- and MHA-funded programs; e) Develop a plan for incorporating recovery support services (RSS) and recovery management into the services designs of community behavioral health (MH & SA) treatment services for adolescents; and 2. Implement other adolescent-focused special initiatives, including: a) Smoking Cessation for Adolescents—Work with the Smoking Cessation Academy to develop a plan for addressing adolescent

1. Improved utilization by adolescent substance users; family involvement teams in place; service regions realigned; placement criteria adopted; and adolescent RSS plan developed. 2. Adolescent smoking cessation plan and SBIRT interactive module.

1. SMART data from treatment providers to document improved utilization by adolescent substance users; ADAA Administrative records (planning committee minutes to document development of interagency family involvement team; correspondence about realigned service regions; completed adolescent placement criteria; planning committee minutes to document steps in development of plan for adolescent RSS); 2. ADAA Administrative records (planning committee minutes to document steps in development of adolescent smoking cessation plan, completed plan); and completed SBIRT interactive module.

smoking cessation within ADAA and MHA funded programs; b) Adolescent SBIRT (early detection/intervention) —Develop an interactive continuing education module for health care providers that work with adolescents;

1. The ADAA will continue to collaborate with the MHA and the DDA on the DHMH Behavioral Health Workforce Development workgroup to develop an action plan for developing and sustaining an effective behavioral health workforce, and promoting service integration. 2. The ADAA Office of Education and Training for Addiction Services (OETAS) will continue to collaborate with and provide technical assistance (TA) to the Maryland Addictions Directors Council (MADC) to plan, develop, obtain external funding for and support the work of MADC's Behavioral Health Workforce Institute's training and workforce development efforts. 3.

1. DHMH Workforce Development Workgroup meeting minutes and completed plan. 2. MADC Behavioral Health Workforce Institute external funding

Behavioral Health Prevention and Treatment Workforce Development

Provide a coordinated approach to increase employment and promote integration of services and training to develop and sustain an effective behavioral health workforce.

The ADAA will continue to provide representation on the Child and Adolescent Mental Health Workforce Committee chaired by MHA and MSDE; will assist in the development of a behavioral health training model based on established core competencies, for educators and providers that serve children and adolescents; will ensure that this training model includes appropriate content about adolescent SUDs, CODs and recovery from AOD use; and will incorporate content from this curriculum when providing trainings through OETAS. 4. The ADAA will continue to collaborate with the Office of Special Needs Populations within the MHA and the DDA to provide information and extend technical assistance through training and promotional materials to health agencies regarding the identification, education, and treatment of individuals with

Plans developed and trainings provided by:
1.DHMH Workforce Development Workgroup;
2.MADC Behavioral Health Workforce Institute; 3.Child and Adolescent Behavioral Health Workforce Committee; & 4.Behavioral Health and Trauma collaborative planning group.

applications if any; available administrative records (i.e., planning committee meeting minutes and plans, curricula, OETAS/MADC training announcements, attendee lists, pre/post evaluations, etc.). 3. Child and Adolescent training model and completed curriculum and administrative records (planning committee meeting minutes and plans, training announcements, attendee lists, pre/post evaluations, etc.). 4. Behavioral Health and Trauma collaborative planning group training/promotional materials and administrative records (planning committee meeting minutes and plans, training announcements, attendee lists, pre/post evaluations, etc.).

Information Technology

Improve use of information technology for data integration, implement an Electronic Health Record (EHR), improve providers' billing/reimbursement capability, and eliminate reliance on ADAA grant funding when other reimbursement opportunities are available

1. Maintain involvement in the DHMH Deputy Secretary's Behavioral Health Data Integration Workgroup (involving the ADAA, the MHA and the Developmental Disabilities Administration) to determine how data can be used in efforts to eliminate disparities in behavioral health treatment services. Workgroup activities include a data commonality report, cross-system data analyses, and identification of individuals with co-morbid conditions that are served by more than one of the systems. 2. Maintain an EHR system available to all certified addictions treatment providers, and promote utilization of technology to streamline and automate workflow as much as possible. The SMART vendor will obtain EHR certification, and the ADAA will develop standards for its EHR that go beyond EHR certification. Providers

1. ADAA participation in Behavioral Health Data Integration Workgroup; 2. Standards developed and certified EHR system available to providers; 3. Increased 3rd party reimbursement by providers.

1. DHMH Administrative Data (Data Integration Workgroup minutes, reports and work plans). 2. ADAA Administrative Records (for ADAA standards in place and documentation that provider's own EHR meets State standards) and SMART data (for documentation that certified EHR system is available to and being used by all certified addictions treatment providers); 3. ADAA Administrative Records (SMART data and Jurisdiction Grant Applications) to document capability of programs to bill for and obtain 3rd party reimbursement for services delivered; ADAA fiscal records to document diminished reliance of jurisdictions on ADAA grant funding when other reimbursement opportunities are available; mechanism in place for obtaining utilization data from Medical Assistance for Medicaid-funded services delivered to individuals within the ADAA system of care.

will be allowed to use the State EHR system or their own EHR system as long as it meets State standards.
3: Increase the capability of programs to bill for and obtain 3rd party reimbursement for services delivered; and eliminate programs' reliance on ADAA grant funding when other reimbursement opportunities are available.

1. Preferential Admission for Pregnant Women: Maryland will continue to provide preferential admission for all pregnant women in accordance with §96.131. The ADAA will continue its October 2009 policy which requires that all programs receiving ADAA-grant funding provide admission to pregnant women within 24 hours of the request for services. Treatment programs will continue to encourage pregnant women to accept admission within 24 hours, maintain them in treatment for the duration of the pregnancy, refer them to different levels of

Federal Block Grant Mandated Target Population: Pregnant Women and Women with Children

Minimize risk to women and children related to alcohol/drug use and associated complications; promote family health through the provision of specialized services addressing gender, development, abuse/neglect, custody and other recovery-related issues.

care if necessary, and maintain linkages with medical and other services. If pregnant women disengage from treatment, programs are expected to attempt to re-engage them. 2. Gender-Specific Services: The ADAA will continue to support gender specific services as described in Goal #3 and as listed in Appendix B of the SAPT-BG Report. Services provided by these programs include trauma-informed services for substance abuse treatment; case management; parenting skills classes; educational and vocational services; prenatal, post-partum and gynecological health and child care services; and family therapy. To ensure continued awareness of the availability of gender-specific services, the ADAA will continue to post on its website a Directory of Drug and Alcohol Treatment Services for Women, Infants and Children in Maryland. 3: Case-Finding: Maryland will continue the Identification and

1) Pregnant at admission & # days waiting for admission; 2) Gender-specific programs funded; 3)SB-512 & HB-1160 referrals; 4) # women completing treatment, # entering another level of care upon discharge; 5) Complaints made & compliance issues identified.

1. SMART data 2. Jurisdiction grant applications (Treatment Matrix) 3. SMART data and reports to Women's Services Coordinator 4. Administrative records (contracts), SMART data 5. Administrative records (compliance monitoring data)

Referral Services required by Maryland Senate Bill 512 (Drug Affected Newborns) and House Bill 1160 (Welfare Innovation Act of 2000), whereby addiction specialists are hired in local jurisdictions to identify and refer women in need of treatment. 4. Residential Capacity for Pregnant Women and Women with Dependent Children: The ADAA will continue to maintain statewide contracts for five (5) gender-specific residential programs in the central, southern and western regions of the state. 5. Compliance Monitoring: The ADAA will continue to maintain compliance with these requirements through the bi-annual certification process and through routine site visits conducted by the ADAA Compliance Unit.

1. Continue to routinely make available HIV Early Intervention Services, as defined by §96.121 and as required by §96.128, to each individual receiving treatment for

Federal Block Grant Mandated Target Population: Intravenous Drug Users (IVDU) and Individuals With, or At Risk of HIV Infection

Reduce the transmission of HIV/AIDS and other adverse health effects of substance abuse and intravenous injection.

substance use disorders: including screening and appropriate pre-test counseling for HIV and AIDS; testing with respect to HIV/AIDS to confirm the presence of the diseases and appropriate therapeutic measures; post-test counseling; and providing or referring individuals for appropriate medical evaluation and treatment. 2. Continue to maintain policies that require interim services to be provided on an as needed basis, as defined by §96.121 (including counseling and education about HIV and TB; the risks of needle-sharing; the risks of transmission to sexual partners and infants; steps to ensure that HIV and TB transmission does not occur; and referral for HIV or TB treatment if necessary), until individuals are admitted to treatment, if they are not able to be admitted to treatment within the timeframes specified by §96.126. 3. Continue to manage capacity by requiring programs to report to the ADAA when they reach 90%

1) Individuals screened at admission and at risk individuals tested by IDEHA; 2) ADAA Capacity Management Policies and Conditions of Award; 3) Reports of programs exceeding 90% capacity; 4) Outreach activities provided.

1. ADAA and IDEHA Administrative Records (# admissions screened, # individuals tested by IDEHA) 2. ADAA Administrative Records (policies, Conditions of Award) 3. SMART data from treatment providers; 4. ADAA Administrative Records (survey of local jurisdictions for outreach activities provided).

capacity, and to maintain continually updated records of such reports to ensure that individuals in need of treatment for injection drug use are able to access treatment within the time frames specified by §96.126. 4. Continue to require that jurisdictions that receive funding for the treatment of intravenous drug use provide scientifically sound outreach activities (as outlined in §96.126) to encourage individuals in need of treatment for substance use disorders to undergo such treatment.

1. Continue to routinely make available tuberculosis services, as defined by §96.121, to each individual receiving treatment for substance use disorders: including counseling with respect to TB; testing to determine if the individual has been infected with TB and to determine the appropriate form of treatment for the individual; and providing or referring individuals for

Federal Block Grant Mandated Target Population: Individuals With or At Risk of Tuberculosis Infection

Prevent the transmission of tuberculosis among individuals in treatment for substance use disorders.

appropriate medical evaluation and treatment. 2. Work with DHMH Center for TB Control to revise and implement standardized screening instrument statewide, and continue to implement infection control procedures established by the ADAA and TB Control regarding screening of patients; identification of those at high risk of becoming infected; meeting all State requirements while maintaining Federal and State confidentiality requirements; and conducting case management to ensure that individuals receive necessary services. 3: Continue monitoring program compliance with procedures for tuberculosis services and other infection control procedures.

1) Standardized screening tool implemented statewide.2) Risk forms to TB Control for patients in ADAA funded programs. 3) Trainings made available to providers to ensure that TB services are routinely made available to each individual in treatment for SA.

1. ADAA Administrative Records (for notices when revised tool is released to the field). 2. TB Control Administrative Records (for counts of patients referred from treatment programs). 3. ADAA and/or TB Control Administrative Records (for trainings provided to treatment staff).

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy	Other
Encounter based reimbursement	Level II.1 Services Level III.1, III.3, III.5, III.7 Services Recovery Housing	
Grant/contract reimbursement	Level 0.5 Services Level I Services Level II.1 Services Level II.5 Services Level III Services (1,3,5,7) Detox at all levels Continuing Care Services Case Management Services Assessment Services Primary Prevention Services	
Innovative Financing Strategy	Level I Services Level II.1 Services	

Footnotes:

Maryland has directed several changes designed to improve access to substance abuse services under the Maryland Medicaid Program, the HealthChoice Program, and the Primary Adult Care Program (PAC).

Legislation passed by the 2009 Maryland General Assembly authorized an annual transfer of state funds from the ADAA grant program to the Medicaid program to expand the PAC benefit package to include outpatient substance abuse treatment. This transfer enabled Maryland Medicaid to draw-down federal matching funds and thereby expand the total funding in the system.

As a result of this innovative financing strategy, Maryland Medicaid has been able to add certain community-based services to its fee-for-service program for all Medicaid beneficiaries; add certain substance abuse treatment services to the PAC benefit package; and increase payment rates for other previously covered services such as methadone maintenance. Medicaid-covered services now include substance abuse assessment, individual counseling, group counseling, intensive outpatient and methadone maintenance.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 	<10% <input type="text" value="6"/>
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	10-25% <input type="text" value="6"/>
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 	26-50% <input type="text" value="6"/>
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 	<10% <input type="text" value="6"/>
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 	<10% <input type="text" value="6"/>
Recovery Supports	<ul style="list-style-type: none"> • Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care 	<10% <input type="text" value="6"/>
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services 	<10% <input type="text" value="6"/>

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

<10% 

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

10-25% 

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

26-50% 

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

<10% 

System improvement activities

<10% 

Other

N/A 

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

Page 36 of the Application Guidance

Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$1,208,622	\$	\$	\$	\$
Information Dissemination	Selective	\$63,311	\$	\$	\$	\$
Information Dissemination	Indicated	\$	\$	\$	\$	\$
Information Dissemination	Unspecified	\$	\$	\$	\$	\$
Information Dissemination	Total	\$1,271,933	\$	\$	\$	\$
Education	Universal	\$381,670	\$	\$	\$	\$
Education	Selective	\$222,641	\$	\$	\$	\$
Education	Indicated	\$31,806	\$	\$	\$	\$
Education	Unspecified	\$	\$	\$	\$	\$
Education	Total	\$636,117	\$	\$	\$	\$
Alternatives	Universal	\$445,282	\$	\$	\$	\$
Alternatives	Selective	\$159,029	\$	\$	\$	\$
Alternatives	Indicated	\$31,806	\$	\$	\$	\$
Alternatives	Unspecified	\$	\$	\$	\$	\$
Alternatives	Total	\$636,117	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$	\$	\$	\$	\$
Problem Identification and Referral	Selective	\$	\$	\$	\$	\$
Problem Identification and Referral	Indicated	\$	\$	\$	\$	\$
Problem Identification and Referral	Unspecified	\$	\$	\$	\$	\$
Problem Identification and Referral	Total	\$	\$	\$	\$	\$

Community-Based Process	Universal	\$ 604,311	\$	\$	\$	\$
Community-Based Process	Selective	\$ 31,806	\$	\$	\$	\$
Community-Based Process	Indicated	\$	\$	\$	\$	\$
Community-Based Process	Unspecified	\$	\$	\$	\$	\$
Community-Based Process	Total	\$636,117	\$	\$	\$	\$
Environmental	Universal	\$ 3,180,585	\$	\$	\$	\$
Environmental	Selective	\$	\$	\$	\$	\$
Environmental	Indicated	\$	\$	\$	\$	\$
Environmental	Unspecified	\$	\$	\$	\$	\$
Environmental	Total	\$3,180,585	\$	\$	\$	\$
Section 1926 Tobacco	Universal	\$	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$	\$	\$	\$	\$
Other	Universal	\$	\$	\$	\$	\$
Other	Selective	\$	\$	\$	\$	\$
Other	Indicated	\$	\$	\$	\$	\$
Other	Unspecified	\$	\$	\$	\$	\$
Other	Total	\$	\$	\$	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year:

End Year:

Date of State Expenditure Period From:

Date of State Expenditure Period To:

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$22,354,384	\$6,599,944	\$	\$135,808,563	\$12,646,676	\$16,772,102
2. Primary Prevention	\$6,361,169	\$	\$	\$	\$	\$
3. Tuberculosis Services	\$	\$	\$	\$9,000	\$	\$
4. HIV Early Intervention Services	\$1,590,292	\$	\$	\$1,500,000	\$	\$
5. State Hospital		\$	\$	\$	\$	\$
6. Other 24 Hour Care	\$	\$	\$	\$	\$	\$
7. Ambulatory/Community Non-24 Hour Care	\$	\$	\$	\$	\$	\$
8. Administration (Excluding Program and Provider Level)	\$1,500,000	\$	\$	\$9,151,916	\$	\$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$31,805,845	\$6,599,944	\$	\$146,469,479	\$12,646,676	\$16,772,102
10. Subtotal (Rows 5, 6, 7, and 8)	\$1,500,000	\$	\$	\$9,151,916	\$	\$
11. Total	\$31,805,845	\$6,599,944	\$	\$146,469,479	\$12,646,676	\$16,772,102

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

Page 40 of the Application Guidance

Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
2. Quality Assurance		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
3. Training (Post-Employment)		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
4. Education (Pre-Employment)		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
5. Program Development		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
6. Research and Evaluation		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
7. Information Systems		\$ <input type="text" value="0"/>		\$ <input type="text" value="0"/>		\$0
8. Total	\$	\$0	\$	\$0	\$	\$0

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

Narrative Plan D – Activities that Support Individuals in Directing Their Services

The ADAA employs a number of strategies that support individuals in directing their services.

First, the ADAA has embarked upon a multi-year process of transforming Maryland's addiction service system into a **recovery oriented system of care (ROSC)**. A ROSC Division has been created within the ADAA; it is responsible for planning, standards development, technology transfer, and technical assistance. Local (county level) ROSC Change Teams, which are required as an ADAA Condition of Grant Award, are comprised of relevant stakeholders, members of the recovery community, family members, treatment providers, and other service providers, including providers of recovery support services. Individuals in recovery and their families are encouraged to join local ROSC Change Teams, which are tasked with planning and evaluating local systems of care, and facilitating change at the local level. The ADAA has developed trainings for clinicians and treatment program managers that focuses on strategies for involving individuals and their family members in planning and directing their care and in engaging them in the treatment and support services critical for sustaining their recovery progress. In an associated effort, the ADAA is in the process of convening a **Consumer Advisory Board** which will solicit and include individuals in recovery and their family members as participants. This Board will advise ADAA on new policies and initiatives.

Next, Maryland assists individuals in directing their care and ensures that they have free and genuine choice in their selection of recovery support services providers through the **Access to Recovery (ATR) funded RecoveryNet program**. Through *RecoveryNet*, the ADAA is developing and implementing a voucher management system within the State of Maryland Automated Record Tracking (SMART) electronic behavioral health record. Individuals in portal programs meet with referral liaison clinicians to assist them in deciding the types of clinical and recovery report services required after discharge from residential treatment. The referral liaison clinicians assist clients in freely selecting their Care Coordinators and vendors for authorized services from a panel of available providers.

Additionally, the **Substance Abuse Improvement Initiative (SAII)**, effective January 1, 2010, offers expanded access to community-based services Medicaid beneficiaries in need of treatment by providing greater choice in provider selection, and the ability to self-refer to treatment. The ADAA has worked with Medical Assistance to set up the conditions (rate structure, fee-for-service billing, authorization requirements, necessary forms, etc.) under which community-based providers can participate in **Medicaid and Medicaid Primary Adult Care (PAC)**. Health Choice and PAC enrollees may select from any certified outpatient and opioid maintenance therapy (OMT) provider, even if the provider does not have a contract with a managed care organization (MCO), provided that the enrollee meets American Society of Addiction Medicine (ASAM) Patient Placement Criteria for level of care and continued stay.

As a result of the ADAA's transformation to ROSC and the other patient-oriented processes described above, all patients whose services are funded through SAPT-Block Grant dollars are involved in directing their services.

IV: Narrative Plan

E. Data and Information Technology

Page 42 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Narrative Plan E - Data and Information Technology

Data Management: The ADAA receives technology support from the following:

- **ADAA Information Technology Division (IT):** The IT Division manages the development, implementation, and maintenance of information technology initiatives in support of substance-abuse prevention, intervention, treatment, and recovery services. The division is responsible aligning IT objectives and programs with local, state, and federal strategies, and acts as a liaison with local health departments (LHDs) and other providers.
- **Maryland DHMH Office of Information Technology:** The OIT acts as a liaison to the Maryland Department of Information Technology (DOIT) described below, and sets overall departmental policy.
- **Maryland Department of Information Technology (DOIT):** The DOIT maintains statewide centralized servers and sets policies around software and procurement.
- **University of Maryland Institute for Governmental Service and Research (IGSR):** IGSR develops and maintains the State of Maryland Automated Record Tracking (SMART) system, which the ADAA uses to collect addictions treatment client data, including the Treatment Episode Data Set (TEDS).

State of Maryland Automated Record Tracking (SMART): SMART is a web-based program similar to the Web Infrastructure for Treatment Services (WITS). SMART includes mandatory admission and discharge modules, and these modules include all required TEDS data. SMART also includes a variety of other, sometimes optional modules, including consent/referral, assessment, treatment planning, progress and group notes, and encounters.

The SMART system collects treatment data based on the American Society of Addiction Medicine (ASAM) levels of care. The ADAA crosswalks these data to Treatment Episode Data Set (TEDS) services data. SMART requires discharge data to be reported using TEDS guidelines. However, providers may also maintain data about patients who are in recovery. SMART captures information about patients who are receiving recovery services, but these are not reported to TEDS and the data do not necessarily specify the types of recovery services received.

The SMART system does not have import capabilities, therefore SUDs treatment providers must enter data directly. Providers may use a variety of processes to capture and transmit SMART data to the ADAA. Some providers collect information on paper forms and use data entry staff. Other providers have counselors enter the data directly (preferred method), and other providers use a combination of methods. Most providers enter data into the SMART system on a daily basis. Providers are required by contract to release SMART data to the State at least once per month. The ADAA downloads all released data weekly from the SMART system.

The SMART system creates a unique identifier for all patients so the patients can be unduplicated, tracked, and matched across providers. While SMART collects full name, this information is not included in the data downloaded by the ADAA.

Providers that are publicly funded are required to report data for all patients using the SMART system. Previously, non-publicly funded providers were also required to report all patients treated to SMART. However, the ADAA now allows non-funded providers to use SMART on a voluntary basis, partly because ADAA staff are not available to assure compliance, and partly because non-funded providers are assumed to report patient data at very low rates, if at all. The number of TEDS admissions decreased after 2007 when non-funded reporting was made voluntary.

Publicly funded providers (including Medicaid and non-Medicaid providers) report client characteristic, service utilization and performance indicator data via the SMART system. Therefore, the ADAA can capture and aggregate all Medicaid and non-Medicaid client-level treatment service data, including provider name. Matching Medicaid billing data to SMART data can be done at the client level. This gives ADAA the ability to verify payment source given in SMART and to identify patients receiving other Medicaid services.

Currently, the Medicaid provider ID is not captured in SMART. Therefore, matching at the provider level is performed manually based on provider names. This makes it difficult for the ADAA to link billing data to clinical data at a provider level (for example, to identify providers who have billed Medicaid but are not reporting service/performance data in SMART). The ADAA is currently exploring options for capturing the Medicaid provider ID in SMART, so as to enable an automated linkage at the provider level. This will help improve provider accountability and performance, as well as enhance the ADAA's ability to perform more comprehensive program monitoring and improve detection of fraud, waste and abuse (FWA).

The ADAA uses a variety of mechanisms to ensure the timeliness, accuracy, and completeness of SMART data. These include an ongoing training program for provider clinical and data entry staff; regular reports distributed to the ADAA and jurisdiction management staff; and data quality and accuracy monitoring. The ADAA uses SMART data to generate regular (at least quarterly) reports showing patient characteristics, services needed, services provided, client progress and outcomes, and provider performance.

The ADAA is in the process of making a reporting server available to all providers in the SMART system. The reporting server is a replica of the SMART system database. It will allow for users to run real-time canned and ad-hoc reports. Included in the canned reports will be NOMS-based performance metrics, re-admissions with drug use, continuum of care utilization, length of time in treatment, counselor productivity, and timeliness of reporting.

The ADAA uses data to effectively meet Federal mandates; to initiate internal projects and strategies; to demonstrate the effectiveness and efficiency of SUD treatment; to make provider performance comparisons; for policymaking and for evaluation of policy decisions; and for service quality improvement initiatives, strategic planning and general oversight purposes.

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

Narrative Plan F – Quality Improvement Reporting

Office of Health Care Quality (OHCQ): Programmatic functions in all State and privately funded treatment programs, from assessment through every level of care in the continuum, are governed by the Code of MD Regulations (COMAR). State laws and regulations require that all SUD treatment programs in Maryland be certified by the Department of Health and Mental Hygiene (DHMH) Office of Health Care Quality (OHCQ). The OHCQ is charged with monitoring the quality of care in Maryland’s 9,900 health, mental health and SUDs programs and agencies. The OHCQ licenses and certifies the state’s health care facilities, and certifies all addiction treatment programs. The OHCQ uses state and federal regulations, which set forth minimum standards for provision of care and conducts surveys to determine compliance. When problems or deficiencies are noted, the OHCQ initiates administrative action against facilities that violate State rules and regulations. If a facility fails to correct problems and is unable or unwilling to do so, the OHCQ may impose sanctions such as license revocation, fines, bans on admission, or other restrictions on the operating license.

ADAA’s Division of Quality Assurance: Maryland utilizes a two-tiered level of monitoring and improving quality and compliance with Conditions of Award. First, the ADAA’s Division of Quality Assurance regulatory compliance staff review and audit the jurisdictional health departments and the Baltimore Substance Abuse Services (BSAS) regarding the services that they directly provide. Compliance with policies and practices for performance measurement are evaluated by the Quality Assurance Division during annual compliance reviews, and by the Recovery Oriented Systems of Care (ROSC) Services Division whose regional coordinators provide technical assistance on an as needed basis.

The ADAA has required, as a Condition of Award, that each jurisdiction (“grantee”) be held responsible for monitoring programs from which they subcontract for additional services (“sub-grantees”). Previously, jurisdictions submitted sub-grantee program monitoring data to the ADAA on a quarterly basis. In an attempt to maximize jurisdictions’ monitoring resources, the ADAA revised its monitoring requirements to focus more on newly-funded facilities and facilities with prior findings of non-compliance. The jurisdictions conduct monitoring activities via on-site visits using an ADAA-provided monitoring tool.

The Graduated Program Monitoring Schedule went into effect on July 1, 2011. Programs can now progress from quarterly monitoring visits for one year, to two monitoring visits at six month intervals and then to annual visits if they have not required Corrective Action Plans for at least a year, and have had no change in clinical supervisor or administrator within the past year. ADAA staff members perform second tier audit functions as they continually monitor jurisdictional-level program data reports to ensure that services are provided in communities with highest need. Compliance review teams audit those reports during routine compliance or problem investigation review visits.

Performance Measurement: One of Governor Martin O’Malley signature initiatives is called StateStat – a system of performance-based management to improve accountability and efficiency. The Governor’s Delivery Unit (GDU) is an extension of StateStat that works with

state agencies to align State and Federal resources around 15 strategic and visionary goals to improve the quality of life in Maryland.

During FY 2010, the ADAA implemented JurisStat to bring performance measurement to the local community level. The ADAA conducts monthly regional JurisStat meetings with treatment coordinators from local jurisdictions to present them with their data and to solicit input for the State's planning processes. The ADAA directly funds residential treatment services to expand access to certain high risk populations, including: pregnant women, women with dependent children, individuals with co-occurring mental and substance use disorders, and corrections, for which the ADAA has established three required performance measures and two incentive measures. JurisStat measures mimic SAMHSA's National Outcome Measures (NOMs), as do the Managing for Results (MFRs) measures that the ADAA generates twice yearly for funded providers.

FY 2012 SAPT-BG Application Priorities:

All of the 12 Priority Areas in Maryland's 2012 SAPT-BG Application are designed to improve the quality of services delivered to, or the quality of life experienced by, Marylanders with or at risk of substance use disorders and co-occurring mental or somatic illnesses. However, some of the 12 Priority Areas address quality in a more clear and precise manner. These include:

#4. Recovery-Oriented System of Care (ROSC): Transformation of Maryland's addiction services system into a more recovery-oriented system of care by conducting jurisdictional level assessments and developing local ROSC change plans; integrating addictions treatment and recovery support services into local communities; and expanding access to continuing care, recovery housing and supported employment.

#6. Quality Improvement: Pharmacotherapy: Expanded use and improved quality of pharmacotherapies in addiction treatment programs and other health care settings, including evidence-based pharmacological treatments for opioid, alcohol and nicotine dependence.

#7. Integration of Behavioral Health and Medical/Somatic Care: Improved coordination between primary care and the specialty behavioral health care services system, and improved somatic health of behavioral health patients, through the formation of partnerships, training of case managers and peer support specialists, and requirements for smoking cessation plans to be included in the individualize treatment plans of patients in addictions treatment programs.

#10. Adolescent Substance Users: Improved somatic and behavioral health, expanded service capacity and access, and improved quality of care for substance using adolescents, including those with co-occurring disorders (COD).

#11. Behavioral Health Prevention and Treatment Workforce Development: Development and support of a sound infrastructure for a skilled and competent behavioral health prevention and treatment workforce that provides accessible and effective services to improve behavioral and somatic health and reduce the risks and harms resulting from substance use.

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Narrative Plan G - Consultation with Tribes

Not applicable; there are no federally designated tribes in Maryland.

IV: Narrative Plan

H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

Narrative Plan H - Service Management Strategies

The ADAA is the SSA and state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention and treatment services. The ADAA awards State and Federal substance abuse prevention, treatment and recovery funds to the 24 jurisdictions to support the services infrastructure for Maryland's uninsured or under-insured patient population. Public funding through the ADAA is therefore the safety net for individuals in need of services who would otherwise lack the ability to pay, which is a particularly important consideration in view of the number of court commitments and other justice system referrals. The conditions of award for these grants provide contractual parameters for the sub-recipient jurisdictions (23 counties and Baltimore City) to ensure that SAPT-BG and other Federal and State requirements are met and that services are delivered in the right scope, amount and duration.

Maryland is a geographically diverse state with two high-density areas (Baltimore-Annapolis, and the Washington D.C. suburban area) while the majority of the geography of the state is rural (southern, western, and eastern shore). The high-density areas are serviced primarily by private providers contracting with local jurisdictions. In the rural areas the local health departments are the primary providers of behavioral health care services. All of the rural jurisdictions provide a minimum of Level 0.5, I, and II.1 outpatient services. The rural residential needs are provided by a network of regional residential programs. All Maryland jurisdictions provide access to the outpatient and residential treatment.

Maryland Code of Regulations (COMAR) Health General § 8-1001 establishes Local Drug and Alcohol Councils (LDAAC) within each county and Baltimore City (local jurisdictions). Each LDAAC is required to develop and submit a Local Plan to the ADAA every two years, and must report progress towards implementation of the Plan to the ADAA every six months. The Local Plans must include the plans, strategies, and priorities of the county for meeting the identified needs of the general public and the criminal justice system for alcohol and drug abuse evaluation, prevention and treatment services. The Local Plans must also include a survey of all federal, State, local and private funds used in the county for alcohol and drug abuse evaluation, prevention and treatment. Local jurisdictions may only submit applications for substance abuse funding to the ADAA (or other entities) after the applications have been submitted to their respective LDAACs for review. The LDAACs consider whether the grant application is consistent with the Local Plan and the strategies and priorities set out in it, and may recommend that the application be approved.

The local jurisdictions and their LDAACs analyze patterns of utilization from the prior year's grant application and make adjustments to their projections for numbers of patients to be served, slots to be funded, and units of services to be delivered in the upcoming budget cycle. The jurisdictions monitor their utilization and request adjustments in their projections (e.g. number served within each Level of Care in their six month updates).

The first step that Maryland will take in the upcoming funding period to ensure that individuals receive care in the most appropriate scope, amount and duration will be to commence with needs assessments and analyses of unmet need/gaps in the service system as outlined in **Priority Area #1, Step 4 Table 3 "Assessment & Analysis of Unmet Need & Critical Gaps in Service System"**. This will help the ADAA identify individuals in need of treatment who require access to a level of care that may not be available.

Also to ensure that services purchased with public dollars are provided to individuals in the right scope, amount, and duration, Maryland requires, through Code of Maryland Regulations (COMAR-10.47.01.04), that programs utilize guidelines such as the American Society of Addiction Medicine (ASAM) Patient Placement Criteria or other ADAA-approved guidelines when making determinations about Admission Eligibility, Level of Care, Continued Stay, and Discharge.

As of 2/18/11, all Admissions require that the **recommended** ASAM Level of Care be entered into SMART, based on the treatment assessment conducted. This will allow the State to compare the Level of Care the individual **needed** to that which was **actually received**. Data from this comparison will illustrate system limitations and shortcomings, including service gaps. These data will assist the ADAA in making informed management decisions regarding levels of care required by individuals in any geographic area of the State, and will boost Maryland's efforts to promote systems that can support individualized treatment, optimize program capacity, and meet treatment demands. **This also relates to Priority Area #1 in Step 4 Table 3 "Assessment & Analysis of Unmet Need & Critical Gaps in Service System".**

One way the ADAA ensures that individuals receive care in the most appropriate scope, amount and duration is through performance measurement. In SFY 2011 and before, the ADAA's performance standard for assessing patient LOS in treatment measured the percent of patients in ADAA funded outpatient programs that were retained in treatment for at least 90 days, and the percent of patients in ADAA funded halfway house programs that were *retained in treatment* for at least 90 days. Beginning in FY 2012, the ADAA implemented revised standards that measured percent of patients in ADAA funded programs that are *retained in a treatment episode* for at least 90 days. Guidance to the field described "episodes of treatment" as *all treatment enrollments* (excluding Continuing Care and Opioid Maintenance Therapy) for individuals with less than a 60-day gap between enrollments. Any episode of treatment containing at least one enrollment to a funded provider is included in the jurisdictions' calculations. To make treatment episodes a meaningful measure, it is critical that programs accurately *dis-enroll* individuals from various Levels of Care in a timely manner (as soon as they leave a Level of Care) and *discharge* them once treatment services are terminated by the admitting provider. This practice of measuring performance through retention in treatment episodes is more consistent with the Recovery Oriented System of Care (ROSC) model system transformation currently under way in Maryland.

The ADAA also aims to ensure that individuals receive care in the most appropriate scope, amount and duration through policy changes regarding pharmacotherapies and dual enrollment in other Levels of Care. In July 2011, the ADAA notified providers that patients receiving OMT are to be enrolled in OMT as well as the Level of Care in which they are receiving treatment, *except* for when receiving Level I Outpatient Treatment. For example, it is now possible to report that an individual received both methadone treatment from Agency X and Level III.7 residential treatment from Agency Y or Level II.1 Intensive Outpatient from Agency Z. Providers began capturing pharmacotherapies, including methadone, as a part of treatment in the Medications Module in SMART. Once this transition is completed, OMT will no longer be an enrollment. Instead, patients will be enrolled in the appropriate Level of Care indicated for their level of severity, and medications dispensed, prescribed and administered will be recorded in the Medication Module. This expands patient access to pharmacotherapies and reinforces the importance of integrating pharmacotherapy with behavioral and psychosocial treatment services.

The Administration encourages more use of Case Management services, but recognizes that jurisdictions may lack sufficient resources to provide them. ATR-funded *RecoveryNet* care coordinators assist individuals in obtaining necessary addictions treatment and recovery support, health and social services, but this type of assistance is not routinely available to the rest of the people in the publicly funded addictions treatment services system. Case management serves not only to ensure that individuals do not receive care at higher levels or for a longer duration than that which they require, but also that they remain in “episodes” of care that include a comprehensive array of treatment and recovery support services over a sufficient period of time.

The ADAA has developed a number of systems for evaluation of prevention and treatment efforts, and these are included in the Conditions of Award for any jurisdictional grant or other funded program. Maryland utilizes a two-tiered level of monitoring compliance with Conditions of Award. First, the ADAA’s Division of Quality Assurance regulatory compliance staff review and audit the jurisdictional health departments and the Baltimore Substance Abuse Services (BSAS) regarding the services that they directly provide. Compliance with policies and practices for performance measurement are evaluated by the Quality Assurance Division during annual compliance reviews, and by the Recovery Oriented Systems of Care (ROSC) Services Division whose regional coordinators provide technical assistance on an as needed basis.

The ADAA has required, as a Condition of Award, that each jurisdiction (“grantee”) be held responsible for monitoring programs from which they subcontract for additional services (“sub-grantees”). The jurisdictions conduct monitoring activities via on-site visits using an ADAA-provided monitoring tool. Previously, jurisdictions submitted sub-grantee program monitoring data to the ADAA on a quarterly basis. In an attempt to maximize jurisdictions’ monitoring resources, the ADAA revised its monitoring requirements to focus more on newly-funded facilities and facilities with prior findings of non-compliance. The Graduated Program Monitoring Schedule went into effect on July 1, 2011. Programs can now progress from quarterly monitoring visits for one year, to two monitoring visits at six month intervals and then to annual visits if they have not required Corrective Action Plans for at least a year, and have had no change in clinical supervisor or administrator within the past year. ADAA staff members perform second tier audit functions as they continually monitor jurisdictional-level program data reports to ensure that services are provided in communities with highest need. Compliance review teams audit those reports during routine compliance or problem investigation review visits.

Formerly, data regarding percentage of slots filled were only available rolled up to the jurisdictional level (not provider level). Additionally, the ADAA would not receive notification of the actual number of slots that jurisdictions purchased from sub-grantees until monitoring forms were submitted. This resulted in a lag time in terms of monitoring static capacity.

To remedy this, the ADAA now requires (FY 2012) that jurisdictions report the number of slots that it purchases from each treatment facility on the newly revised “Financial Reporting and Allocation Network--FRAN Form.” The SAMHSA Drug and Alcohol Services Information System (DASIS) Inventory of Substance Abuse Treatment Services (I-SATS) unique identification code is used to identify individual certified treatment provider facilities. The ADAA can now produce real time SMART data reports of the average daily census of active patients within each jurisdiction, by provider and by Level of Care. This facilitates more accurate calculations of utilization relative to the number of funded slots (utilization within an established range, and over- or under-utilization of slots for which the ADAA pays).

The revised FRAN Form enables analysis of spending at each Level of Care by funding source. It also helps the ADAA more accurately calculate actual costs per slot, as it helps the jurisdictions remove their System Management Costs (costs of managing their jurisdiction) from calculations of Service Provision Costs (the actual costs associated with providing services to patients). Thus, the ADAA can now be more proactive and informed when making decisions about programmatic issues and funding allocations.

As the ADAA rolled out the new FRAN forms, it became clear that Length of Stay (LOS) data appeared to have many outliers (extremely long Lengths of Stay, most due to data errors). The Administration began sending letters to providers with LOS data that exceeded an acceptable percent of deviation, asking those programs to either dis-enroll the patients or provide verification or justification as to why the patient still required care in that Level of Care. Once the ADAA completes removal of “bad data”, it will begin chart audits to verify that treatment records document continued stay criteria for that Level of Care, and that programs are not being paid for treating “phantom patients” (Waste, Fraud and Abuse). This review process may lead to a Corrective Action Plan for provider agencies whose utilization is less or more than anticipated.

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Assessment and Analysis of Unmet Need and Critical Gaps in the Service System	1. More individuals that have received assessed (needed) level of care according to placement criteria; 2. Emerging substance problems identified; 3. Patterns indicative of potential diversion, overuse or misuse of prescription drugs identified.	€
Health Care Reform	1. Staff trained in intake application procedures; 2. Increased 3rd party reimbursement and SAPT-BG used for services not covered by insurance; 3. Increased percentages of admissions with insurance coverage; 4. Increased utilization of a broader continuum	ⓑ
Expand Access to Substance Abuse Treatment Services	1. Outreach/engagement strategy; 2. Virtual counseling/tele-behavioral services; 3 & 4. Increased # served with buprenorphine and other pharmacotherapies; 5. Increased # admissions to treatment; 6. Increased # served through PAC/Medical Assistance.	€
Recovery-Oriented System of Care (ROSC)	1. ROSC change plans reflecting results of ROSC self assessments; 2. More individuals enrolled in continuing care, recovery housing and supported employment; 3. ROSC Change Teams created and jurisdictions attending ATR network meetings.	ⓑ
Strategic Prevention Framework (SPF)	1. Jurisdictions with approved local MSPF plans; 2. Jurisdictions receiving capacity building TA; 3. Allocation of SAPT Block Grant/other prevention funds; 4. MSPF recommendations in DAAC Plan; 5. At least 3 meetings with ADAA/MHA and Plan drafted.	€
Quality Improvement: Pharmacotherapy	1. More individuals with primary opioid disorders on buprenorphine/methadone; 2. Naltrexone criteria developed and more individuals with alcohol dependence on naltrexone; 3. Tx. plans w/ tobacco cessation; more individuals w/ nicotine replacement.	€
Integration of Behavioral Health and Medical/Somatic Care	1. Learning modules on bi-directional integration; jurisdictions with linkages to Health Homes; 2. HIE connectivity; more individuals in treatment linked to somatic care; 3. Treatment plans including cessation; more individuals with nicotine replacement.	€
Youth Access to Tobacco	1: Compliance with all requirements of the FDA contract (percent of retailer list inspected, inspection result data uploaded accurately within designated time frames, etc.); 2. Synar non-compliance rates below 20%.	€

Special Populations (Military Personnel, Older Adults, Deaf/Hard of Hearing, LGBTQ)	1. Data collected with standard definitions; military culture/unique needs in curricula; 2. Program for older adults implemented and staff trained; 3. More deaf/hard of hearing individuals receive appropriate treatment; 4. LGBTQ information in curricula.	€
Adolescent Substance Users	1. Improved utilization by adolescent substance users; family involvement teams in place; service regions realigned; placement criteria adopted; and adolescent RSS plan developed. 2. Adolescent smoking cessation plan and SBIRT interactive module.	€
Behavioral Health Prevention and Treatment Workforce Development	Plans developed and trainings provided by: 1.DHMH Workforce Development Workgroup; 2.MADC Behavioral Health Workforce Institute; 3.Child and Adolescent Behavioral Health Workforce Committee; & 4.Behavioral Health and Trauma collaborative planning group.	€
Information Technology	1. ADAA participation in Behavioral Health Data Integration Workgroup; 2. Standards developed and certified EHR system available to providers; 3. Increased 3rd party reimbursement by providers.	€
Federal Block Grant Mandated Target Population: Pregnant Women and Women with Children	1) Pregnant at admission & # days waiting for admission; 2) Gender-specific programs funded; 3)SB-512 & HB-1160 referrals; 4) # women completing treatment, # entering another level of care upon discharge; 5) Complaints made & compliance issues identified.	€
Federal Block Grant Mandated Target Population: Intravenous Drug Users (IVDU) and Individuals With, or At Risk of HIV Infection	1) Individuals screened at admission and at risk individuals tested by IDEHA; 2) ADAA Capacity Management Policies and Conditions of Award; 3) Reports of programs exceeding 90% capacity; 4) Outreach activities provided.	€
Federal Block Grant Mandated Target Population: Individuals With or At Risk of Tuberculosis Infection	1) Standardized screening tool implemented statewide.2) Risk forms to TB Control for patients in ADAA funded programs. 3) Trainings made available to providers to ensure that TB services are routinely made available to each individual in treatment for SA.	€

Footnotes:

Narrative Plan I - State Dashboards

Priority #2 Health Care Reform: This priority was selected because its main goal is to fund priority addictions treatment and support services for individuals without insurance, and for low-income individuals who require services that are not covered by Medicaid, Medicare or private insurance. As a result of the Affordable Care Act (ACA) and the Mental Health Parity and Addictions Equity Act (MHPAEA), many of the individuals whose addictions treatment services would have previously been funded by the block grant will soon become eligible for Medicaid or private insurance. However, these will not provide full access to the comprehensive array of prevention, treatment and recovery support services necessary for most individuals to achieve and maintain recovery. Priority #2 measures will help the ADAA ensure that block grant dollars are used exclusively for services required by individuals who lack insurance coverage, and for individuals whose insurance packages do not cover the services that they need.

Priority#4 Recovery-Oriented System of Care (ROSC): This priority was selected for many of the same reasons provided for the rationale to Priority #2. Maryland is in the process of a major transformation from an addiction treatment services system based on an episodic, acute care model, towards one that is based on more a recovery-oriented chronic care model. Most recovery support services are not currently covered, and probably will not be covered under the essential benefits packages for Medicaid, and private insurance. *RecoveryNet*, Maryland's Access to Recovery Project, is laying the groundwork for full expansion of the ROSC model, but the ADAA will continue to rely heavily on block grant dollars to expand access to recovery support and other services necessary for individuals to achieve and sustain recovery.

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Narrative Plan J - Suicide Prevention

The ADAA will collaborate and coordinate with the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) within the Maryland Department of Health and Mental Hygiene (DHMH) Behavioral Health Administration to implement Suicide Prevention strategies as appropriate for our mutual target populations.

The DHMH main goal for Suicide Prevention is to promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span. The ADAA will assist with and promote the MHA's efforts that result from its collaborations with the Governor's Commission on Suicide Prevention, with local jurisdictions and programs, and with other stakeholders.

The MHA's primary strategy Suicide Prevention in Year 1 includes addressing need by providing suicide prevention, intervention and postvention activities for youth, adults, and older adults. Indicator data for this strategy will be used to demonstrate that the MHA has continued to monitor access to and utilization of Youth Suicide Hotlines, and has participated in the Governor's Commission on Suicide Prevention and its workgroups established to focus on the needs of various target populations.

Another MHA Suicide Prevention strategy for Year 1 and Year 2 is to recognize and address the special needs of returning veterans as well as LGBTQ youth and adults. Activities for this strategy include promoting education and outreach activities designed to increase awareness about suicide and related resources. The MHA will continue to monitor utilization and access of the Youth Suicide Hotlines to document the improved access by those populations, and will monitor their input to the Governor's Commission and its workgroups.

The MHA will incorporate recommendations from the Governor's Commission on Suicide Prevention and the Suicide Prevention Resource Center in the development and implementation of Maryland's Plan for Suicide Prevention across the life span and among special population groups. The ADAA will assist the MHA as needed with the development of the Plan, and will support and attend the MHA's Annual Suicide Conference, which will include trainings/sessions on the special needs of the populations described above, as well as the needs of individuals whose increased suicide risk is related to their use of alcohol and/or other drugs. To the extent possible, the ADAA will include Suicide Prevention information and materials in its prevention, outreach and recruitment activities in local communities, and will assist in the dissemination of Suicide Prevention information in schools, on college campuses and in treatment programs.

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Narrative Plan K – Technical Assistance Needs

At the time of submission of the FY 2012 Application, the ADAA has no plans to make a request for technical assistance. However, Maryland's potential need for technical assistance will be revisited upon completion of the needs assessment described in Priority #1.

IV: Narrative Plan

L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Narrative Plan L – Involvement of Individuals and Families

Maryland Regulations for Alcohol and Drug Treatment Programs: Code of Maryland Regulations (COMAR), Title 10, Subsection 47 outline the following requirements for certified drug and alcohol treatment programs in COMAR 10.47.01.04:

C. Treatment Plans: "A program shall develop, with the participation of the patient, based on the comprehensive assessment and placement criteria, that set forth:

a) The patient's individualized needs, including:

- i. Socialization;
- ii. AOD abuse/dependence;
- iii. Psychological;
- iv. Vocational;
- v. Educational;
- vi. Physical health;
- vii. Legal; and
- viii. Family; and

b) Individualized interventions, including:

- i. i. Long-range and short-range treatment plan goals and objectives;
- ii. ii. Strategy for implementation of treatment plan goals and objectives;
- iii. iii. Target dates for completion of treatment plan goals and objectives;
- iv. iv. A schedule of clinical services, including individual, group, and if appropriate, family counseling;
- v. v. Criteria for successful completion of treatment;
- vi. vi. Referrals to ancillary services, if needed; and
- vii. vii. Referrals to self-help groups, if recommended; and

E. Family Involvement and Utilization of Self-Help Groups: "A program shall:

- a) Develop procedures for obtaining an assessment of the treatment needs of the patient's family;
- b) Provide access or referral to family counseling;
- c) Describe how family members are involved in the patient's recovery process; and
- d) Develop procedures to encourage ongoing active participation by the patient and the patient's family in self-help groups and support activities.

The Maryland Department of Health and Mental Hygiene (DHMH) Office of Health Care Quality (OHCQ) is charged with monitoring quality of care and compliance with all State and Federal regulations in Maryland's 9,900 health, mental health and SUDs programs and agencies. The OHCQ licenses and certifies the state's health care facilities, certifies all addiction treatment programs, and conducts survey visits to determine program compliance.

Additionally, the ADAA requires, as a Condition of Award, each jurisdiction ("grantee") be held responsible for monitoring programs from which they subcontract for additional services ("sub-

grantees”). The jurisdictions conduct monitoring activities via on-site visits using an ADAA-provided monitoring tool, and the ADAA’s compliance review teams audit those reports during routine compliance or problem investigation review visits.

Further, the ADAA’s Division of Quality Assurance regulatory compliance staff review and audit the jurisdictional health departments and the Baltimore Substance Abuse Services (BSAS) regarding the services that they directly provide during annual compliance reviews. Regional coordinators in the Recovery Oriented Systems of Care (ROSC) Services Division provide technical assistance about these requirements on an as needed basis.

Additional Activities to Involve Individuals and Families:

The ADAA has embarked upon a multi-year process of transforming Maryland’s addiction service system into a recovery oriented system of care (ROSC). A ROSC Division has been created within the ADAA; it is responsible for planning, standards development, technology transfer, and technical assistance. A ROSC implementation plan was developed which included goals emphasizing the development of recovery oriented standards both for existing services and new recovery support services such as recovery housing, recovery coaching, and recovery community centers. Other goals focused on implementing technology transfer processes, development of outcomes measurement and funding strategies, and facilitating interagency collaborations to provide integrated services at the state and local levels.

Local (county level) ROSC Change Teams are required as an ADAA Condition of Grant Award. Local ROSC Change Teams are comprised of relevant stakeholders, members of the recovery community, family members, treatment providers, and other service providers, including providers of recovery support services. Family members of individuals in recovery are encouraged to join local ROSC Change Teams, which are tasked with planning and evaluating local systems of care, and facilitating change at the local level.

The ADAA is also in the process of convening a Consumer Advisory Board which will solicit and require family members as participants. This Board will advise ADAA on new policies and initiatives.

The ADAA has developed training for clinicians and treatment program managers that focuses on strategies for engaging family members in treatment, and offers workshops and courses on the topic on an ongoing basis. In addition, local jurisdictions are encouraged to spend grant dollars on hiring family therapists and implementing family components within existing treatment programs. Assessment of family treatment needs, provision of family education, and provision or referral for family therapy when indicated is in Maryland regulation governing all addiction treatment programs.

IV: Narrative Plan

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

Narrative Plan M – Use of Technology

Expanded use of technology is a key component of Maryland’s plan for improving rural and urban access to behavioral health services.

Behavioral health (mental health and substance abuse) was among the top priority areas for rural health identified by the DHMH Office of Rural Health Steering Committee. Many rural areas have access to telemedicine technology, in which a physician or counselor can meet directly with the patient, family, etc., via visual tele-conferencing in real time. The ADAA plans to increase the utilization of telemedicine technology to expand rural access to medical and behavioral health specialists that would otherwise not be available.

The ADAA is also, along with private partners, pursuing the use of "avatar" virtual counseling technology to further make behavioral health services available to those who otherwise would lack access, in both rural and urban environments. The use of “avatar” virtual counseling will remove several access barriers, including transportation, fear of stigma, and physical handicaps.

Narrative Plan M – Use of Technology

Expanded use of technology is a key component of Maryland’s plan for improving rural and urban access to behavioral health services.

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The ADAA, along with the help of private and public sector partners, will implement the use of “avatar” virtual counseling technology to make services available to those who otherwise would lack access to treatment. This project will identify up to four agencies and up to 120 patients to receive treatment for substance dependence via the virtual platform. The project will build on an existing virtual platform and develop culturally appropriate environments in which patients will access individual and group counseling and support for their recovery efforts.

An integral component of this effort will be to monitor and evaluate both the patient and provider experience for ease of use as well as outcomes. The project intends to demonstrate the efficacy of the virtual counseling world to third party payors, including Medicaid, commercial and other health care insurance providers.

The potential barriers would include access to internet services due to lack of service or hardware (computer). The administration has purchased 120 “net books” for patients to use once they agree to participate in the virtual counseling experience. The budget also has set funds aside for “access cards” that would create internet hot spots for the participants to be able to access the internet without having a wired connection. The project seeks to work with providers in a variety of demographic settings, i.e., urban, rural, and suburban.

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

Narrative Plan N - Support of State Partners

Collaborations with Other State Agencies: The ADAA continues to interface with other agencies and administrations to support a comprehensive system of addictions, mental health, somatic health, social health and other services and community supports. **The roles of Maryland's SSA, the SMHA and other State agencies are described in detail in Planning Step 1 (pp. 8-12 and throughout).**

- The **Maryland State Drug and Alcohol Abuse Council (DAAC)** is created within the Office of the Governor, and its voting members include representatives from the State legislature, State agencies, and councils (including DHMH, criminal justice agencies, human resources, budget and management, housing and community development, transportation, State Superintendent of Schools, and the Governor's Office for Children), as well as eight appointed members representing geographic regions of the State, at-risk populations, knowledgeable professionals, consumers, family members, and service providers. Portions of this Application and Maryland's Priority Areas, Goals, Objectives and Performance Measures come from the DAAC's *Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland 2010 to 2012*.

The role of the DAAC and its composition are also described in detail in ***Planning Step 1, pp. 8-9***. The DAAC is also referenced in other parts of the Application. Members of the DAAC are listed on ***Table 11, List of Advisory Council Members***; and ***Table 12, Behavioral Health Advisory Council Composition by Type of Member***. Therefore, only summary information is provided in Narrative Plan N.

- The roles and composition of **Local Drug and Alcohol Abuse Councils (LDAACs)**, which are established in each of the 24 jurisdictions, are described in detail in ***Planning Step 1 (pp. 13-14)***. They are mentioned in Narrative Plan N because many of their members are actually representatives of State agencies as well.
- **Other State Agencies:** Other State Agencies with which the ADAA has existing contractual relationships or memoranda of understanding (MOUs) are described in ***Planning Step 1, pp. 9-12***. The descriptions include abbreviated descriptions of the Scope of Work for each agreement. For ease of reference, these State Agencies are listed below:
 - DHMH Infections Disease and Environmental Health Administration (IDEHA)
 - Maryland Department of Public Safety and Correctional Services (DPSCS)
 - Maryland Department of Juvenile Services (DJS)
 - Maryland Department of Human Resources (DHR)
 - Maryland Medical Assistance (MA) Program

- Maryland Office of Health Care Quality (OHCQ)
- Maryland Department of Veterans Affairs
- University of Maryland-College Park Institute for Governmental Service and Research (IGSR)
- University of Maryland-Baltimore (UMB)
 - UMB School of Nursing (SON)
 - UMB School of Pharmacy (SOP)
 - UMB School of Medicine (SOM)

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

Narrative Plan O - State Behavioral Health Advisory Council

As described in Planning Step 1, the **Maryland Alcohol and Drug Abuse Administration (ADAA)** is the division within the **Department of Health and Mental Hygiene (DHMH)** responsible for the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG), and for oversight of publicly funded addictions prevention and treatment services in Maryland.

The **Mental Hygiene Administration (MHA)** is the DHMH division responsible for the Mental Health Block Grant (MHBG), and for oversight of publicly funded mental health services in the State. While SAMHSA encouraged submission of a “unified” application, Maryland is submitting separate block grant applications for FY 2012. However, throughout both documents there are discussions of joint and collaborative efforts of the two administrations.

At the present time, there are two councils responsible for behavioral health in Maryland.

In July 2008, Governor Martin O’Malley signed an Executive Order re-authorizing the Maryland State Drug and Alcohol Abuse Council (DAAC). House Bill 219, Acts of 2010 (Chapter 661) created the **Maryland State Drug and Alcohol Abuse Council (DAAC)** within the Office of the Governor.

The Maryland Advisory Council on Mental Hygiene was created in 1976 to advise the Governor, Mental Hygiene Administration and other State and federal officials on the needs and the provision of services to citizens with mental illness. The Council was expanded in 1989 to comply with the composition requirements of Public Law (PL) 99-660 and subsequently PL 102-321. The Council is now designated as the **Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council** and is often referred to as the **Joint Council**.

The Secretary of Health and Mental Hygiene and the Deputy Secretary of Behavioral Health have appointed a **Behavioral Health Integrated Regulations Committee** (the "Committee") to develop regulations governing providers of Behavioral Health (mental health and substance abuse services). The Committee is charged with developing a process, including identifying **statutory barriers**, to fully integrating mental health and substance abuse regulations. DHMH will revise the current substance abuse (COMAR 10.47) and mental health (COMAR 10.21) regulations to develop a set of behavioral health regulations.

One of the issues that will need to be addressed during the process of integrating the two administrations is how to integrate the work of the two Councils into one Behavioral Health Council, given that both are established under existing Maryland legislation.

In the FY 2012 SAPT-BG Application Narrative Plan Tables 11 and 12, the ADAA lists members of the **Maryland State Drug and Alcohol Abuse Council (DAAC)**. The role of the DAAC and its composition are also described in detail in *Planning Step 1, pp. 8-9*, and the DAAC is also referenced in several other parts of the Application.

In the FY 2012 MHBG Application Narrative Plan Tables 11 and 12, the MHA lists members of the **Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council (Joint Council)**.

IV: Narrative Plan

Table 11 List of Advisory Council Members

Page 51 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Samuel Abed	State Employees	Maryland Department of Juvenile Services		
Thomas Cargiulo	State Employees	Maryland Alcohol and Drug Abuse Administration		
Ted Dallas	State Employees	Maryland Department of Human Resources		
Paul DeWolfe	State Employees	Maryland Public Defender		
T. Eloise Foster	State Employees	Maryland Department of Budget and Management		
Brian Hepburn	State Employees	Maryland - Mental Hygiene Administration		
Rosemary Johnston	State Employees	Maryland Governor's Office for Children		
Kristen Mahoney	State Employees	Maryland - Governor's Office of Crime Control and Prevention		
Gary Maynard	State Employees	Maryland - Department of Public Safety and Correctional Services		

Randall Nero	State Employees	Maryland - Department of Public Safety and Correctional Services
Joshua Sharfstein	State Employees	Maryland Department of Health and Mental Hygiene
Beverly Swaim-Staley	State Employees	Maryland Department of Transportation
Raymond Skinner	State Employees	Maryland Department of Housing and Community Development
Patricia Vale	State Employees	Maryland - Department of Public Safety and Correctional Services
Lori Brewster	Providers	Maryland - Wicomico County
Ann Geddes	Providers	Maryland - Howard County
Carlos Hardy	Providers	Maryland - Baltimore Substance Abuse Systems
Rebecca Hogamier	Providers	Maryland - Washington County
Kim Kennedy	Providers	Maryland - Baltimore County
Kathleen O'Brien	Providers	Maryland - St. Mary's County
Glen Plutschak	Providers	Maryland - Talbot County
Donald Whitehead	Providers	Maryland - Prince George's County
George Lipman	Leading State Experts	Maryland - District Court

Benard Sadusky	Leading State Experts	Maryland State Department of Education
Karill Reznik	Leading State Experts	Maryland House of Delegates
Gale Saler	Leading State Experts	Maryland Addictions Directors Council
Catherine Pugh	Leading State Experts	Maryland State Senate

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Page 52 of the Application Guidance

Start Year:

2012

End Year:

2013

Type of Membership	Number	Percentage
Total Membership	27	
Individuals in Recovery (from Mental Illness and Addictions)	0	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	0	0%
State Employees	14	
Providers	8	
Leading State Experts	5	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	27	100%

Footnotes:

As described in Narrative Plan O, Maryland's Behavioral Health Advisory Council has not yet been formed. Currently, there are two councils responsible for behavioral health in Maryland. These are the Maryland State Drug and Alcohol Abuse Council and the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council ("Joint Council"). The correct name of the Council whose membership is represented in the FY 2012 SAPT-BG Application Narrative Plan Tables 11 and 12 is the Maryland State Drug and Alcohol Abuse Council (DAAC). The role of the DAAC and its composition are described in detail in Narrative Plan O, in Planning Step 1, pp. 8-9, and several other parts of the Application.

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Narrative Plan P - Comment on the State Plan

Maryland's SAPT Block Grant Strategic Plan Development Process: The ADAA solicited public comment regarding the prevention and treatment elements of the State's "Three Year Stand Alone Plan" and the FY 2011-2013 Application for SAPT Block Grant funds (the "Application"), through the Administration's involvement with the Governor's Drug and Alcohol Abuse Council (DAAC), and the 24 Local Drug and Alcohol Abuse Councils—LDAACs (Baltimore City and the 23 county jurisdictions). Additionally, feedback about the prevention elements of the Plan and Application were developed through the work of the Maryland Strategic Prevention Framework (MSPF) Advisory Committee (SPFAC), which is a subcommittee of the DAAC. See the Roles of the SSA, SMHA and Other State Agencies" section (II. Planning Steps) for information about the composition of the DAAC.

The SPFAC and its work groups have representatives from numerous agencies external to the ADAA, and they provided public comment regarding prevention elements of the Plan and Application. The SPFAC and its work groups evaluated the prevention elements of the plan for cultural competence and inclusion of widely diverse populations, and contributed to the MSPF State Prevention Plan by selecting and prioritizing practices and strategies, and by developing Maryland's plan for allocation of MSPF funds. Finally, the prevention aspects of the Plan and Application were presented to the Prevention Coordinators in the 24 jurisdictions for their feedback.

The Maryland State legislature has had input into the development of the Plan and Application through its development of the Maryland StateStat performance measurement system, the ADAA's performance measures and the Governor's Deliverable Units (GDU). The ADAA obtained public input into its plans for local jurisdictional treatment performance measurement through numerous presentations to, and meetings with, local treatment coordinators. The ADAA routinely posts solicitations for public comment on the ADAA website regarding issues such as proposed revisions to the Code of Maryland Regulations (COMAR). Additionally, in FY 2009, the ADAA held two meetings (in Hagerstown and Eastern Shore) to solicit feedback regarding proposed changes to COMAR. Other recent efforts to solicit public feedback for the ADAA's Plan, Application and operations have included web-based surveys regarding stakeholder input regarding Medicaid/Primary Adult Care expansion and the integration of treatment for problem gambling in addiction treatment programs. The ADAA also held numerous meetings with prevention and treatment stakeholders to solicit input into needs assessment, planning and the development of standards for recovery support services and Maryland's transition to a Recovery-Oriented Systems of Care (ROSC).

Maryland's Drug and Alcohol Abuse Council (DAAC) Strategic Planning Process: To date, the Maryland DAAC strategic plan for the organization and delivery of substance abuse services has been prepared based on the quarterly reports of accomplishments submitted by each of the designated workgroups responsible for particular objectives within the plan over the past year. In addition, feedback was solicited and additional accomplishments were prepared by key agencies identified as having responsibilities within the plan. The accomplishments were forwarded to a consultant, Marjorie Rosensweig, who summarized them and put them in the

matrix format. The summaries were then sent back to the workgroups and relevant agencies for review and corrections/additions.

The next step in the process was for the workgroups to review the Goals and Objectives from the initial two year plan, along with the summary of accomplishments and next steps provided in the one year update. The purpose of this review was to determine which if any of the original goals and objectives had been accomplished, which were no longer valid, and which should be carried forward into the new plan. Each workgroup met in the month of May, and were provided these documents in a consolidated format for their review. Directed discussions took place and workgroup members participated in the revision of future goals, objectives and next steps. A working document for each objective was developed and further circulated back to workgroup members and other key partners for additional comments and revisions. Once approved, the information was transferred to the strategic plan document to become the first draft of the "*2012-2014 Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland*".

The first draft of the DAAC's "*2012-2014 Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland*" was circulated on June 9th, 2011 to all of the Council members for review and feedback. Council members were instructed to review what had been prepared, and to come to the June 15th, 2011 State Council meeting prepared to discuss and provide any additional input in order to finalize the plan. Comments, corrections and additions were suggested prior to the 15th meeting. Corrections and additions were incorporated into the document for discussion at the June 15th, 2011 meeting, along with any of the other items for discussion. Discussion and finalization of the plan was an agenda item for the meeting.

Following the meeting on the 15th, a second draft was prepared and posted on the ADAA and the DAAC websites for comments. Local Drug and Alcohol Abuse Council (LDAAC) input was solicited as well. A final plan was distributed for voting in July, 2011. Eleven favorable votes were needed in order to achieve a quorum, and to send it to the Governor's Office by the due date of August 1, 2011.

The ADAA uses its website (<http://dhmh.maryland.gov/adaa/>) to share copies of approved grant applications (block grant, SPF), strategic plans, committee minutes, data reports, presentations and other publications with providers, local jurisdictions, other state agencies, patients and families, and the general public. The ADAA website provides a link to the State DAAC website (<http://www.dhmh.maryland.gov/adaa/>), where the DAAC Strategic Plan, Council and workgroup minutes, reports and other resources are posted. Both the ADAA and the DAAC websites provide links to the 24 local drug and alcohol councils (LDAACs), where each of the 24 jurisdictions post their local strategic plans and resource surveys. The ADAA may send press releases or other emails to inform our partners and stakeholders when new content has been posted to the website, but other forms of media (radio, television, newspapers, PSAs) are not typically used.