

**Maryland**

**UNIFORM APPLICATION  
FY2012**

**SUBSTANCE ABUSE PREVENTION AND TREATMENT  
BLOCK GRANT**

**42 U.S.C.300x-21 through 300x-66**

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**Substance Abuse and Mental Health Services Administration**

**Center for Substance Abuse Treatment**

**Center for Substance Abuse Prevention**

## **Introduction:**

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 454 hours per respondent for Sections I-II, 40 hours per respondent for Section III-A and 42.75 hours per respondent for Section III-B, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at <http://bgas.samhsa.gov>.

Form 1

DUNS Number: 134104855-

**Uniform Application for FY 2012-14 Substance Abuse Prevention and Treatment Block Grant**

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III. State Expenditure Period:

From: 7/1/2009 To: 6/30/2010

IV. Date Submitted:

Date: 12/1/2011 1:25:08 PM Original:  Revision:

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## Form 2 (Table of Contents)

Form 1	pg.3
Form 2	pg.4
Goal #1: Improving access to prevention and treatment services	pg.5
Goal #2: Providing Primary Prevention services	pg.7
Goal #3: Providing specialized services for pregnant women and women with dependent children	pg.10
Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)	pg.12
Goal #4: Services to intravenous drug abusers	pg.15
Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)	pg.17
Program Compliance Monitoring (formerly Attachment D)	pg.24
Goal #5: TB Services	pg.27
Goal #6: HIV Services	pg.29
Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)	pg.31
Goal #7: Development of Group Homes	pg.36
Group Home Entities and Programs (formerly Attachment F)	pg.38
Goal #8: Tobacco Products	pg.40
Goal #9: Pregnant Women Preferences	pg.42
Capacity Management and Waiting List Systems (formerly Attachment G)	pg.44
Goal #10: Process for Referring	pg.47
Goal #11: Continuing Education	pg.49
Goal #12: Coordinate Services	pg.51
Goal #13: Assessment of Need	pg.53
Goal #14: Hypodermic Needle Program	pg.55
Goal #15: Independent Peer Review	pg.57
Independent Peer Review (formerly Attachment H)	pg.59
Goal #16: Disclosure of Patient Records	pg.62
Goal #17: Charitable Choice	pg.64
Charitable Choice (formerly Attachment I)	pg.66
Waivers (formerly Attachment J)	pg.69
Waivers	pg.70
Form 8 (formerly Form 4)	pg.72
Form 8ab (formerly Form 4ab)	pg.73
Form 8c (formerly Form 4c)	pg.74
Form 9 (formerly Form 6)	pg.75

SSA (MOE Table I)	pg.85
TB (MOE Table II)	pg.86
HIV (MOE Table III)	pg.87
Womens (MOE TABLE IV)	pg.88
Form T1	pg.89
Form T2	pg.91
Form T3	pg.93
Form T4	pg.95
Form T5	pg.100
Form T6	pg.105
Form T7	pg.108
Treatment Performance Measures (Overall Narrative)	pg.110
Corrective Action Plan for Treatment NOMS	pg.113
Form P1	pg.115
Form P2	pg.116
Form P3	pg.117
Form P4	pg.118
Form P5	pg.119
Form P7	pg.120
Form P8	pg.121
Form P9	pg.122
Form P10	pg.123
Form P11	pg.124
P-Forms 12a- P-15 – Reporting Period	pg.125
Form P12a	pg.126
Form P12b	pg.127
Form P13 (Optional)	pg.128
Form P14	pg.129
Form P15	pg.130
Corrective Action Plan for Prevention NOMS	pg.131
Prevention Attachments A, B, and C (optional)	pg.133
Prevention Attachment D (optional)	pg.134
Description of Supplemental Data	pg.136
Attachment A, Goal 2	pg.138
Addendum - Additional Supporting Documents (Optional)	pg.140

Provider Address Table	pg.77
Form 9a (formerly Form 6a)	pg.78
Form 10a (formerly Form 7a)	pg.81
Form 10b (formerly Form 7b)	pg.82
Description of Calculations	pg.83

## **Goal #1: Improving access to Prevention and Treatment Services**

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY2009 (Annual Report/Compliance):

### **Goal #1: Improving Access to Prevention and Treatment Services**

**WHO:** Addictions treatment was provided to 32,496 individual males (67%) and 16,093 individual females (33%) in Maryland State-funded programs. Over 220,000 individuals received prevention services.

**WHAT:** The levels of treatment were based on the American Society of Addiction Medicine-Patient Placement Criteria, II or II-Revised (ASAM PPC II or II-R) and included outpatient, intensive outpatient, residential including halfway house, therapeutic community, extended care, intermediate care, medication assistance and detoxification services within various levels.

**WHEN:** Ongoing during FY 2009.

**WHERE:** These services met patient needs identified by Local Drug and Alcohol Abuse Councils found in every Maryland jurisdiction (jurisdictions are defined as the 23 counties of Maryland and Baltimore City).

**HOW:** Substance abuse treatment and prevention services were funded via grant awards to local jurisdictions. Additionally, in an effort to bridge continuum service gaps within Maryland's four regions, the ADAA continued to fund three contracts for statewide long-term residential treatment services. These contracts served 1) pregnant women and post-partum women and women with dependent children; 2) patients referred by the court system who require a therapeutic community milieu; 3) and patients with co-occurring mental health and substance abuse disorders.

## Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. §300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

Primary Prevention: Six (6) Strategies

- **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.
- **Education** – This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.
- **Alternatives** – This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.
- **Problem Identification and Referral** – This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
- **Community-based Process** – This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.
- **Environmental** – This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

- o **Universal:** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
- o **Universal Direct. Row 1** — Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

- o **Universal Indirect. Row 2**—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- o **Selective:** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- o **Indicated:** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (*Adapted from The Institute of Medicine Model of Prevention*)

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY2009 (Annual Report/Compliance):

## **Goal #2: Providing Primary Prevention Services**

**WHO:** Over 220,000 individuals received prevention services.

**WHAT:** The Administration's prevention goal was to utilize not less than 20% of the SAPT Block Grant funds to develop, implement, and oversee ATOD prevention programs and strategies. Direction and technical assistance was provided to Maryland's prevention network through communication, education, program development, coordination, cooperation, funding and advocacy.

The ADAA submitted a proposal to SAMHSA-CSAP for SPF funding in November 2008, and in July 2009, was notified that Maryland would receive SPF funding (MSPF). During the remainder of FY 2009, the ADAA continued to enhance its prevention system structure to incorporate the components of the SAMHSA Strategic Prevention Framework.

**WHEN:** Ongoing during FY 2009.

**WHERE:** Prevention services were conducted in every Maryland jurisdiction (defined as the 23 counties of Maryland and Baltimore City).

**HOW:** The ADAA funded evidence based prevention programs and activities via grant awards to the jurisdictions and four university campuses. Funded programs included Across Ages, All Stars, Communities Mobilizing for Change on Alcohol, Creating Lasting Family Connections, Dare To Be You, Guiding Good Choices, Life Skills Training, Positive Action, Project Alert, Project Towards No Drugs, Second Step and Strengthening Families Program. These programs provided services and activities within the six CSAP strategies. Strategies and activities included ATOD-Free Activities, Community Service Activities, Youth Leadership Activities, Community Team Activities, Training Services Activities, Technical Service Activities, Children of Substance Abuse (COSA) Activities, Classroom Educational Services Activities, Educational Services for Youth, Parent and Family Management Activities, Peer Leader Activities, Small Group Activities, Health Fair Activities, Speaking Engagements, Health Promotion Activities, Employee Assistance Activities, Student Assistance Activities, Preventing Underage Alcohol Sales, Establishing ATOD-Free Policies.

Four university campuses, regionally located throughout the State of Maryland, continued to maintain ATOD Prevention Centers. College students were served through strategies that included information dissemination, education, use alternatives, problem identification and referral, community-based process, and environmental improvements.

All ADAA providers funded with SAPT Block Grant funds used the Minimum Data Set (MDS) as the data collection system to report prevention services and activities.

### **Goal #3: Providing specialized services for pregnant women and women with dependent children**

An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish and/or maintain new programs or expand and/or maintain the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, to make available child care while the women are receiving services (See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)).

*Note:* In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY2009 (Annual Report/Compliance):

### **GOAL # 3: Services for Pregnant Women and Women with Dependent Children**

**WHO:** Funded jurisdictions, programs and treatment providers in Maryland.

**WHAT:** Admission Preference for Pregnant Women, in accordance with §96.124 and §96.131.

**WHEN:** Ongoing during FY 2009.

**WHERE:** All Maryland jurisdictions (23 counties in MD and Baltimore City).

**HOW:** Reduction in infant mortality is one of the Governor's primary health initiatives. The DHMH Family Health Administration (FHA) and the ADAA coordinate their efforts to comprehensively serve pregnant women, including pregnant women that use substances. In FY 2009, 1.8% of statewide admissions to grant funded treatment programs were pregnant women, and 5.5% of females were pregnant or uncertain about their pregnancy status. As it is important to get pregnant women into treatment as quickly as possible, the ADAA began requiring, effective October 12, 2009, that all programs receiving ADAA-grant funding for treatment slots provide admission within 24 hours of the request for services. Treatment program strongly encourage the pregnant woman to accept the immediate appointment. This policy supplants the previous requirement of admission within 48 hours. Treatment programs are expected to maintain pregnant patients in treatment for the duration of the pregnancy, refer them to different levels of care if needed, and maintain linkages with medical and other services. If pregnant patients disengage from treatment, programs are expected to attempt to re-engage them.

In FY 2009, the ADAA expended \$4,273,918 to provide treatment services designed for pregnant women and women with dependent children. These expenditures included support for 11 gender-specific programs. Please refer to Attachment B for details. Services provided by these gender-specific programs included trauma informed services for substance abuse treatment, case management, parenting skills, educational and vocational services, prenatal, post-partum and gynecological health and child care referral services and family therapy. As a result of Maryland Senate Bill 512 (Drug Affected Newborns) and House Bill 1160 (Welfare Innovation Act of 2000), addictions specialists were hired in local jurisdictions to identify and refer women in need of substance abuse treatment, and the State of Maryland provided residential treatment slots to expand services to women identified through these legislative initiatives. To further expand residential treatment capacity for pregnant women and women with dependent children, in FY 2009, the ADAA maintained statewide contracts with five (5) gender-specific residential programs. These 5 programs are located in the central, southern and western regions of the state. At a minimum, all ADAA funded treatment programs provided prenatal care, access to medical services, parenting skills, life skills education and vocational skills to pregnant women and women with dependent children in need of services. Compliance was maintained through the bi-annual certification process and through annual site visits conducted by the ADAA Compliance Unit. To ensure continued awareness of service availability, the ADAA updates and posts on its website a Directory of Drug and Alcohol Treatment Services for Women, Infants and Children in Maryland, a comprehensive guide detailing services offered at all gender-specific addictions treatment programs. This directory is utilized by addictions programs, the Department of Human Resources (DHR), local Departments of Social Services (DSS), local hospitals, appropriate private agencies, and health professionals throughout the State of Maryland.

## **Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)**

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

**For the fiscal year three years prior (FY 2009; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:**

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2009. In a narrative of **up to two pages**, describe these funded projects.

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

**In up to four pages, answer the following questions:**

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2009 Block Grant and/or State funds?
3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2009 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

**Attachment B: Programs for Pregnant Women and Women with Dependent Children**

**1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.**

**Pregnant Women and Women with Dependent Children - Funded Programs FY2009**

<b>PROGRAM</b>	<b>LOCATION</b>	<b>NFR-ID</b>	<b>LEVEL OF CARE</b>	<b>FUNDS</b>	<b>SLOTS</b>
Massie Unit	Allegany	900227	ICF	\$215,719	4
Chrysalis House	Anne Arundel	903759	Halfway House	\$159,810	5
JHH Women's	Baltimore City	902355	IOP	\$749,949	34
A.W.A.R.E.	Baltimore Co.	101834	IOP	\$141,224	18
Shoemaker	Carroll	750564	Detox, ICF	\$461744	8
Avery House	Montgomery	103392	Halfway House	\$411,468	9
P.G. Center	Prince George's	300030	IOP	\$1,209,017	80
Marcy House	St. Mary's	101123	Long Term	\$116,197	14
W House	Washington	101230	Halfway House	\$222,951	17
Hudson Extended	Wicomico	900300	Halfway	\$239,439	6
Center 4 Clean Start	Worcester	901845	IOP	\$346,400	36
<b>Total</b>				\$4,273,918	

**2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2009 block grant and/or State funds?**

In FY 2009, Maryland provided services to pregnant women and women with dependent children in 11 locations on a local basis, as well as long term residential care on a statewide basis. In 2006, the ADAA established a pay for performance project to ensure quality and promote positive outcomes for participants in the statewide long term residential women's programs; this remained in place throughout FY 2009.

The ADAA determined the following performance criteria for retention in treatment and for successful treatment completion:

- a. At least 50% of the program discharges in a contract term will be for "Completed Treatment";
- b. At least 50% of the patients will remain in treatment for a minimum of 210 days.

Programs that met performance criteria received incentive payments as follows:

- i. If 100% of the performance was achieved (if both the discharge status and length of stay measures were met or exceeded), incentive payments of 5% of the total amount paid were authorized;
- ii. If 50% of the performance was achieved (if only one of the measures was met or exceeded), incentive payments of 2.5% of the total amount paid were authorized.
- iii. If neither performance measure was achieved, no incentive payment was authorized.

**3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?**

The Administration monitors treatment program performance in two ways. All programs submit treatment episode data to ADAA monthly. Programs are monitored by the Information Services Division analysts for anomalies in the reported data. These data are analyzed and compared to performance benchmarks of substance use, retention, arrests and employment. All funded programs are visited by the analysts on site for data reconciliation and validation. Programs that fall below the benchmarks or fail a data validation visit are referred to the Regional Team Leaders for technical assistance.

In addition all programs receiving federal funds are monitored on site annually for treatment program performance and adherence to State COMAR regulations and federal conditions of award.

**4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?**

The sources of data include a) the State of Maryland Automated Record Tracking (SMART) system, the electronic record used by all treatment providers to submit data to ADAA; and b) the ADAA Funding Resource Allocation Network (FRAN), used in annual grant applications from the treatment providers.

**5. What did the State do with FY 2009 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?**

The State of Maryland expended \$4,273,918 in SAPT federal funds for 11 gender-specific programs in FY 2009 focused on categorically maintaining and enhancing prevention activities and treatment services for pregnant women and women with dependent children. Programs are itemized in the above matrix (see #1 above).

### **Goal #4: Services to intravenous drug abusers**

An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. §300x-23 and 45 C.F.R. §96.126).

*Note:* In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY2009 (Annual Report/Compliance):

#### **Goal #4: Services to Intravenous Drug Abusers**

**WHO:** Intravenous drug users in Maryland State-funded treatment programs.

**WHAT:** The Administration required, through its Conditions of Award, that any entity that received federal funding for treatment services for IVDUs comply with the capacity notification and record-keeping, interim services and outreach requirements contained in CFR § 96.126 and §96.121 (Definitions).

**WHEN:** Ongoing during FY 2009.

**WHERE:** Every Maryland jurisdiction (defined as the 23 counties of Maryland and Baltimore City).

**HOW:** All Maryland programs that serve IVDUs offer interim services for IVDUs who are on waiting lists for 2 weeks or more. These interim services include, at a minimum, counseling and education about HIV, TB, the risks of needle sharing, the risk of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as the effects of alcohol and drugs on the fetus and referral to prenatal care, as required per 45 CFR Part 96, §96.121 (Definitions). The ADAA recommends that programs deliver this information individually or during pre-admission groups. The rule that programs notify the ADAA when they reach 90% capacity is on the ADAA's Compliance Monitoring form, used by ADAA Compliance Staff who monitor services directly provided by jurisdictional programs, and by jurisdictions who monitor programs from whom they purchase services, in accordance with §96.126. The ADAA further enabled admissions to treatment for IVDUs within 10 days by supporting Baltimore City's central information and referral process to insure methadone treatment admission availability. This not only required that patients be placed on a waiting list if the time between initial contact and admission was longer than 10 days, but also required that patients on the waiting list be provided interim counseling as defined by CFR § 96.126.

Baltimore Substance Abuse Systems, Inc. (BSAS) has supported interim methadone maintenance (IM) since 2005, permitting rapid entry into a low-cost, low threshold treatment as a stopgap alternative to a wait list. The IM pilot project was converted to a standard protocol for opioid-addicted individuals in Baltimore City. In FY 2009, BSAS funded interim methadone maintenance at two programs for 308 individuals. Of those 309 patients, 187 (61%) were successfully transferred to a traditional OTP, 45 (14%) were discharged unsuccessfully, and 56 (88%) had not yet completed 120 days and were carried over to FY 2010. In addition, BSAS provided Johns Hopkins and the University of MD with funding to assist with their interim methadone studies. In FY 2009, the two study sites provided interim methadone services to an additional 74 patients.

## **Programs for Intravenous Drug Users (IVDUs) ( formerly Attachment C)**

See 42 U.S.C. §300x-23; 45 C.F.R. §96.126; and 45 C.F.R. §96.122(f)(1)(ix))

**For the fiscal year three years prior (FY 2009; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:**

1. How did the State define IVDUs in need of treatment services?
2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2009 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).
3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).
4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

## **Attachment C: Programs for Intravenous Drug Users (IVDUs)**

### **1. How did the State define IVDUs in need of treatment services?**

The State of Maryland defines IVDUs in need of services as any intravenous drug abuser who requests drug abuse treatment services. These services may be provided by Opioid Maintenance Treatment Programs, ASAM Level I/outpatient, Level II/intensive outpatient or Level III/residential treatment providers. All addiction treatment programs are mandated to provide HIV risk-reduction counseling to all patients as an integral part of the intake admission process.

### **2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2009 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).**

To specifically ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act, the ADAA requires each program to report monthly on admission and discharge activities. This information is collected and maintained on the Administration's centralized database and is made available to the Information Services Division data analysis section, the Community Services Division, and the Compliance Section of the Quality Assurance Division. The online application provided reports to the programs for self-monitoring and quality improvement. Reports on program data were available to program staff at all times to provide instant feedback regarding capacity status.

To monitor capacity, the ADAA's Information Services staff compared jurisdictional slot allocations data to program admission, discharge and utilization data and determined when 90% capacity was met or exceeded. When anomalies appeared, MIS staff notified both the Community Services Division and the Compliance Section of the Quality Assurance Division, who called or visited to provide technical assistance to remedy the situation.

The requirement that programs notify the ADAA when they reach 90% capacity is in the Conditions of Grant Award, in accordance with §96.126. It is also on the ADAA's Compliance Monitoring form, used by ADAA Compliance Staff who monitor services directly provided by jurisdictional programs, and by local jurisdictions, who must monitor programs from whom they purchase services.

The following is a list of programs treating IVDUs and reported a 90% capacity during FFY 2009.

<i>I-SATS</i>	<i>FACILITY</i>
541	Alch. Drug Intervention
621	Recovery In Community
100018	JHH AddictionTxServ.
100059	Echo House
100083	UofM Drug Treatment
100091	Baltimore Community Resource Ctr
100182	Anne Arundel CHD
100190	Reflective Treatment Center
100986	IBR Reach Mobile Health
101002	Journeys
101003	Gaudenzia
101224	MD Community Health Initiative
101229	Build Fellowship
101230	The W House Foundation Inc.
101258	Druid Heights Treatment and Counseling Center
101282	Powell Recovery
101288	ZZAveryRoadCombinedCare
101292	TurningPoint(Methadone)
101311	ParkWestHealthSys Inc
101329	JHH AddictionTxServ.
101352	A Step Forward Inc.
101468	Transitioning Lives Inc.
101526	Cornerstone Program
101642	Man Alive
101735	UniversalCounselingService
101983	Deale One Step Recovery Srv
102147	IBR Reach Mobile Health
102164	People Encourag People,Inc.
102188	Jude House
102378	ZClosed Sub Hosp Tx Ctr
102428	Carol M. Porto Tx Ctr
102457	Reflective Treatment Center
102667	Pathways
102972	UofM (ADAP)
103079	Powell Recovery
103210	New Hope Treatment Center
103392	Avery House
103533	FerryPoint AssessmentTRT

103798	Addicts Changing Together
103889	Family Health Centers of Baltimore
103962	HealthCareFor TheHomeless
104135	Recovery Network
104150	Harambee Treatment Ctr
105983	ADEPT
106502	WarwickManorBehavi.Health
106619	First Step Recovery
106825	PIR-North Baltimore Ctr
300014	Junction Inc.
300329	Second Genesis Inc
301293	Kent CHD
301350	Glenwood Life Counsel.CTR
301400	Washington Co. HD
750242	Sinai Hosp. Meth. Maint.
750291	Damascus House
750424	Frederick CHD Outpatient
750523	Second Wind
750564	Carroll CHD
750580	Samaritan House
900102	Glass Substance Abuse
900128	Man Alive
900151	ADAPT Cares
900169	Sinai Hosp. Meth. Maint.
900185	New Hope Treatment Center
900227	Allegany CHD
901720	Harbel Prevention Recovery Center
901779	Walden/Sierra INC.
901811	Next Passage
901845	Worcester County Health Dept
901902	BPRU Drug Program
902140	TUERK House
902165	Valley House
902199	Dorchester CHD-Outpatient
902314	Avery Road
902355	JHH Broadway
902389	South Baltimore CAP
902512	Calvert County Health Department
902546	Hudson Health Services
902710	Hope House
902801	Total Health Care Inc.

902934	Wells House
902959	Lawrence Court
902967	Mont Co Health Human Services
903759	Chrysalis House
903874	New LifeAddictCouns.Serv.

**3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).**

Code of Maryland Regulations (COMAR) 10.47.01.04 A (1) (a), requires that all certified programs, upon request for admission: *“(a) Establish an interview date that falls within 10 working days of the individual’s initial contact; (b) Refer or recommend another program to the individual; or (c) Place the individual on a waiting list.”*

The Compliance Section of the ADAA’s Quality Assurance Division conducts random compliance reviews with programs receiving federal funds to assure patients are not only seen for admission within 10 working days from the date of first contact as required by COMAR, but also that ADAA-funded programs are in compliance with specific Federal requirements. These Federal requirements, contained in Conditions of Grant Award, specify that any entity that receives federal funding for treatment services for IVDUs comply with the capacity notification and record-keeping, interim services and outreach requirements contained in CFR § 96.126 and §96.121 (Definitions).

The FY 2009 Conditions of Grant Award specified 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*

The ADAA has maintained a long standing policy that pregnant women, IV drug users, and HIV positive patients be given priority status for admission to all funded programs. In order to get pregnant women into treatment as quickly as possible, the ADAA began requiring, effective October 12, 2009, that all programs receiving ADAA-grant funding for treatment slots provide admission within 24 hours of the request for services (See also Goal #3). Treatment programs strongly encourage pregnant women to accept immediate appointments. The 2009 policy for admitting pregnant women within 24 hours supplanted the previous requirement of admission within 48 hours. This requirement has been added to Conditions of Grant Award. It is also on the ADAA's Compliance Monitoring form, used by ADAA Compliance Staff who monitor services directly provided by jurisdictional programs, and by local jurisdictions, who must monitor programs from whom they purchase services.

All Maryland programs that serve IVDUs offer interim services for IVDUs who are on waiting lists for 2 weeks or more (See also Goal #4). Interim services include, at a minimum, counseling and education about HIV, TB, the risks of needle sharing, the risk of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as the effects of alcohol and drugs on the fetus and referral to prenatal care, as required per 45 CFR Part 96, §96.121 (Definitions). The ADAA recommends that programs deliver this information individually or during pre-admission groups. This requirement has been added to Conditions of Grant Award. It is also on the ADAA's Compliance Monitoring form, used by ADAA Compliance Staff who monitor services directly provided by jurisdictional programs, and by local jurisdictions, who must monitor programs from whom they purchase services.

In FY 2009, the Administration supported 6,178 slots dedicated to opioid maintenance therapy (OMT). These services were provided in nine (9) jurisdictions: Allegany County, Anne Arundel County, Baltimore City, Baltimore County, Frederick County, Harford County, Montgomery County, Prince George's County and Wicomico County.

The ADAA further enabled admissions to treatment for IVDUs within 10 days by supporting Baltimore City's central information and referral process to insure methadone treatment admission availability. This not only required that patients be placed on a waiting list if the time between initial contact and admission was longer than 10 days, but also required that patients on the waiting list be provided interim counseling as defined by CFR § 96.126.

**4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).**

The ADAA directs local jurisdictions to provide outreach activities toward all drug users including IVDUs to increase awareness of treatment services available in their communities through its Conditions of Grant Award.

FY 2009 Conditions of Grant Award specified the following requirements:

*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 confidentially 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”*

These requirements are also on the ADAA’s Compliance Monitoring form, used by ADAA Compliance Staff who monitor services directly provided by jurisdictional programs, and by local jurisdictions, who must monitor programs from whom they purchase services.

## **Program Compliance Monitoring (formerly Attachment D)**

(See 45 C.F.R. §96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. §300x-23(a); 42 U.S.C. §300x-24(a); and 42 U.S.C. §300x-27(b).

**For the fiscal year two years prior (FY 2010) to the fiscal year for which the State is applying for funds:**

In **up to three pages** provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:
  1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)  
(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));
  2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)  
(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and
  3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)  
(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

## Attachment D: Program Compliance Monitoring

### 1. Notification of Reaching Capacity

To specifically ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act, the ADAA requires each program to report monthly on admission and discharge activities. This information is collected and maintained on the Administration's centralized database and is made available to the Information Services Division data analysis section, the Community Services Division, and the Compliance Section of the Quality Assurance Division. During FY 2010, the online application provided reports to the programs for self-monitoring and quality improvement, and reports on program data were available to program staff at all times to provide instant feedback regarding capacity status.

To monitor capacity during FY 2010, the ADAA's Information Services staff compared jurisdictional slot allocations data to program admission, discharge and utilization data and determined when 90% capacity was met or exceeded. When anomalies appeared, MIS staff notified both the Community Services Division and the Compliance Section of the Quality Assurance Division, who called or visited to provide technical assistance to remedy the situation.

The requirement that programs notify the ADAA when they reach 90% capacity is in the Conditions of Grant Award, in accordance with §96.126. It is also on the ADAA's Compliance Monitoring form, used by ADAA Compliance Staff who monitor services directly provided by jurisdictional programs, and by local jurisdictions, who must monitor programs from whom they purchase services.

### 2. Tuberculosis Services

Throughout 2010, all individuals in Maryland addictions facilities/programs were required to be screened for tuberculosis risk and referred for TB testing, per the Code of Maryland (COMAR) 10.47.01.04:

*“Within the first 30 days of treatment, a program shall ensure and document in the patient record that human immune deficiency 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.*

The 2010 ADAA Conditions of Award contained the following requirements:

*16. The program directly, or through arrangements with other public or nonprofit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:*

*(a.) Counseling the individual with respect to TB*

*(b.) Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual*

*(c.) Providing for or referring the individuals infected by mycobacteria TB appropriate medical evaluation and treatment*

*17. For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services.*

*18. The program has implemented the infection control procedures that are consistent with those*

*established by the Department to prevent the transmission of TB and that address the following:*

*(a.) Screening patients and identification of those individuals who are at high risk of becoming infected.*

*(b.) Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2*

*(c.) Case management activities to ensure that individuals receive such services*

*19. The program reports all individuals with active TB to the local health department as required by State Law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2.*

During FY 2010, programs implemented TB screening, testing and education. Case management ensured that individuals needing TB services received them, that treatment requirements were maintained, and that follow-up evaluations are performed. The Department of Health and Mental Hygiene, Office of Health Care Quality performed program compliance monitoring functions biannually. In addition ADAA's web-based clinical record tracked whether the patient received a TB Risk assessment and whether the patient was referred for testing.

In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality (OHCQ) and/or the Administration's Compliance Section reviewed tuberculosis assessment and referral services for patients during the annual/biannual certification process.

### **3. Treatment Services for Pregnant Women**

The ADAA has maintained a specific policy requiring all programs to give priority admission to pregnant women since 1990. As it is important to get pregnant women into treatment as quickly as possible, the ADAA began requiring, effective October 12, 2009, that all programs receiving ADAA-grant funding for treatment slots provide admission within 24 hours of the request for services. Treatment programs strongly encourage the pregnant woman to accept the immediate appointment. This policy supplants the previous requirement of admission within 48 hours.

Treatment programs are expected to maintain pregnant patients in treatment for the duration of the pregnancy, refer them to different levels of care if needed, and maintain linkages with medical and other services. If pregnant patients disengage from treatment, programs are expected to attempt to re-engage them. The State of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality and the Maryland ADAA Quality Assurance Division assessed for adherence to these regulations during the annual/bi-annual certification process and other compliance review site visits.

A variety of women's programs were implemented over the past decade. During FY 2010, these programs provided a full continuum of addiction treatment services and wraparound services which included: child care, transportation, comprehensive prenatal care, pediatric care, GED, vocational assessment and training services, parenting education, treatment and/or referral for mental health issues, Twelve-Step meetings and linkages to other community resources.

## **Goal #5: TB Services**

An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127).

*Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Compliance monitoring; Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY2009 (Annual Report/Compliance):

**Goal #5: TB Services**

**WHO:** All individuals in Maryland State-funded treatment programs.

**WHAT:** In FFY 2009, the Administration continued its requirement that a tuberculosis risk assessment be performed on all patients receiving services.

For individuals at risk, tuberculosis skin testing was made available on-site and/or by referral in all programs and facilities, including Medication Assisted, Outpatient, Intermediate Care Facilities and Therapeutic Community programs.

**WHEN:** Ongoing during FY 2009.

**WHERE:** Every Maryland jurisdiction (defined as the 23 counties of Maryland and Baltimore City).

**HOW:** All individuals in Maryland addictions facilities/programs continued to be screened for tuberculosis risk and referred for TB testing as described in Code of Maryland (COMAR) 10.47.01.04:

*“Within the first 30 days of treatment, a program shall ensure and document in the patient record that human immune deficiency 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.*

In meeting this objective, the State of Maryland’s Department of Health and Mental Hygiene, Office of Health Care Quality (OHCQ) and/or the Administration’s Compliance Section reviewed tuberculosis assessment and referral services for patients during the annual/biannual certification process.

## **Goal #6: HIV Services**

An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. §300x-24(b) and 45 C.F.R. §96.128).

*Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection*

FY2009 (Annual Report/Compliance):

## **Goal #6: HIV Services**

**WHO:** All individuals in Maryland State-funded treatment programs.

**WHAT:** HIV Early Intervention Services as required by 45 C.F.R §96.128 and as defined in §96.121.

**WHEN:** Ongoing during FY 2009.

**WHERE:** Every Maryland jurisdiction (defined as the 23 counties in MD and Baltimore City).

**HOW:** As a designated state, Maryland expended 5% of SAPT Block Grant funds on HIV Early Intervention Services in FFY 2009. Each of the 24 jurisdictions in Maryland received HIV set-aside funds as part of their total SAPT Block Grant allocation. The ADAA continued its requirement that all individuals in Maryland addictions facilities/programs be screened for and counseled regarding HIV risk, as described in Code of Maryland (COMAR) 10.47.01.04:

*“Within the first 30 days of treatment, a program shall ensure and document in the patient record that human immune deficiency 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.*

As a condition of award, the jurisdictions agreed to comply with §96.128, to ensure that counseling and testing services were provided at the sites at which the individuals were receiving treatment. Jurisdictions also agreed to maintain 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. In meeting these objectives, the State of Maryland’s Department of Health and Mental Hygiene, Office of Health Care Quality (OHCQ) and/or the Administration’s Compliance Section reviewed HIV assessment and referral services for patients during the annual/biannual certification process.

The Maryland AIDS Administration (MAA, now known as the MD Infectious Disease and Environmental Health Administration-IDEHA) began implementation of rapid HIV testing in October 2003, and it was fully operational by February 2004. The OraQuick HIV-1 Rapid Testing device, a 20-minute testing technology, has been made available for free and confidential or anonymous testing in 34 of 380 testing sites in Maryland (9%), including two of the three programs supported by the HIV set-aside funds that the ADAA awarded to the Maryland AIDS Administration. The ADAA continued to contract annually with the MAA to provide training regarding HIV counseling and testing and to expand testing capacity among substance abuse service providers and staff of the Maryland Department of Public Safety and Correctional Service’s Division of Parole and Probation. Trainings included HIV 101/Prevention Basics, HIV and Substance Abuse, and HIV Counseling and Testing. Three programs from Baltimore City were categorically funded to provide outreach, assessment, referral and case management services. These programs targeted the areas in Baltimore City that had the greatest need.

## **Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)**

(See 45 C.F.R. §96.122(f)(1)(x))

**For the fiscal year three years prior (FY 2009; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:**

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2009 Uniform Application, Section III.4, FY 2009 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the Single State Agency (SSA) for substance abuse prevention and treatment; and
- the role of the Single State Agency for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. §300x-23(b) and 45 C.F.R. §96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

## Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV

### Tuberculosis (TB)

ADAA policy mandates that all funded addictions treatment programs shall directly, or through arrangements with other public or non-profit private entities, routinely make available tuberculosis services for patients admitted for addictions treatment as well as for their employees. "Program" is defined in Maryland as any organization or individual that provides treatment, care or rehabilitation for individuals who show the effects of drug abuse or alcohol abuse, and represents or advertises itself as an alcohol or other drug abuse treatment program.

Programs must meet all State reporting requirements outlined in COMAR 10.06.03. This requires that reportable diseases, such as active tuberculosis, be reported to the local Health Officer within 48 hours. The State of Maryland Department of Health and Mental Hygiene Office of Health Care Quality reviews compliance of tuberculosis assessment and referral services during the annual/biannual certification process.

Per COMAR, programs shall provide the following services to patients:

- A. Counseling and Education
- B. TB Risk Assessment and Referral
- C. Identification and Management of TB Suspects
- D. Case Management
- E. Record Keeping

Per COMAR, all employees shall receive TB infection control training within one month of employment and annually. "Employee" refers to all persons working in an addictions program, including physicians, nurses, counselors, aides and persons not directly involved in patient care, such as; dietary, housekeeping, maintenance, clerical and janitorial staff. Training shall be appropriate to the job category. Training shall be conducted before initial assignment and annually.

Although the level and detail of this education may vary according to job description, the following elements shall be included in the education of all treatment services employees.

- 1. Basic concepts of TB transmission, disease process, and diagnosis, including the difference between TB infection and active TB disease and the signs and symptoms of TB.*
- 2. Potential occupational exposure to persons with infectious TB in addiction programs.*
- 3. Principles and practices of infection control that reduces the risk of transmission of TB.*
- 4. Purpose of PPD testing, significance of positive results and the importance of participation in the TB testing program*
- 5. Principles of preventive therapy for latent TB infection and the potential adverse effects of the drugs.*
- 6. Employees' responsibility to seek medical evaluation promptly if symptoms develop that may be due to TB or if PPD test conversions occurs.*
- 7. Principles of drug therapy for active TB.*
- 8. Importance of notifying the program if an employee is diagnosed with active TB.*
- 9. Responsibilities of the program to maintain confidentiality of employees' health status while assuring that employees with TB receive appropriate therapy and are non-infectious before returning to duty.*

10. Higher risks posed by TB exposure among individuals with HIV infection or other immunosuppressive disorders.

11. Potential for false-negative PPD skin tests associated with impairment of immune function.

### **Summary of Funded HIV-Early Intervention (HIV-EIS) Projects**

Prevention and treatment of AOD abuse and HIV disease require a multi-disciplinary approach that relies on the strength of a variety of providers and treatment settings to provide a comprehensive range of effective services. Among substance abusers, specific practices such as needle sharing have been clearly identified as an important HIV risk behavior. Understanding the need to address methods that prevent the spread of HIV/AIDS, the ADAA has required all funded providers to provide HIV/AIDS education, assessment and counseling services to their patients.

In FY 2009, staff of the Infectious Disease and Environmental Health Administration (IDEHA) established the HIV Prevention Integration Initiative at Baltimore Substance Abuse Systems, Inc. the entity responsible for publicly funded addiction services in Baltimore City, the jurisdiction with the largest share of Maryland's HIV epidemic.

<b>Agency</b>	<b>Amount</b>	<b>Location</b>
Program Manager and Capacity Building Trainer—salary and fringe benefits	\$177,169	Baltimore City; Parole and Probation
. Glenwood Life Counseling Center	\$ 50,468	Baltimore City
Baltimore SA Services (BSAS) HIV Prevention Integration Initiative	\$195,000	Baltimore City
<b>Total ADAA HIV-EIS Funds to BSAS</b>	<b>\$422,637</b>	<b>Baltimore City</b>

As in previous years, in FY 09, IDEHA staff provided HIV prevention training and capacity building to staff of the Maryland Dept. of Public Safety and Correctional Services Division of Parole and Probation. Over 800 individuals received training in topics including: HIV 101-Prevention Basics; HIV and Substance Abuse; the Graying of HIV; HIV, Hepatitis, and TB; and the Daily Challenges of Living with HIV. Also as a part of the HIV Prevention Integration Initiative, 111 BSAS staff were trained to incorporate HIV prevention programming—including Extra Steps, a behavioral intervention, and HIV Counseling, Testing and Referral (CTR)—in the delivery of substance abuse treatment services in Baltimore City.

In FY 2009, IDEHA staff provided HIV prevention training and capacity building to BSAS staff and to BSAS grantees as follows:

<b>Training Recipient</b>	<b>Curricula</b>	<b># Staff Trained</b>
Parole & Probation Staff	HIV 101/Prevention Basics; Graying of HIV; SA and HIV; HIV/TB and Hepatitis; Daily Challenges of Living with HIV	888
BSAS Substance Abuse Treatment Grantees	Extra Steps	67
BSAS Substance Abuse Treatment Grantees	HIV Level 1 Counseling and Testing; Oraquick	44

Maryland IDEHA collaborated with the Baltimore City Health Department to let an RFP via BSAS for Substance Abuse Vendors to implement an HIV Prevention Intervention Curricula (Project SMART) within substance abuse treatment service venues. The program Manager at the AIDS Administration provided management for projects funded.

Project SMART is a dual HIV risk reduction for drug users in short-term substance abuse treatment. The goals of Project SMART are to reduce the incidence and transmission of HIV among IVDUs and their networks. The curriculum includes an Informational Intervention as well as an Enhanced Intervention. The Informational Intervention utilizes a cognitive-developmental approach to learning and consists of two 1-hour sessions that focus on HIV/AIDS information, AIDS antibody test, and condom use demonstration. The Enhanced Intervention emphasizes a behavioral approach to education. The Enhanced Intervention include six group hours, plus ½ hour final one-on-one session to review a personal plan to reduce harm. Six 1-hour sessions focus on communicating about HIV/AIDS, dealing with difficult and harmful situations, and development of partner norms. Group discussion, experiential learning, and written homework enhance retention of program learning.

<b>Agency</b>	<b>Intervention</b>	<b># Cycles/ Tests Completed</b>	<b># Clients Served</b>
Glenwood Life Counseling Center	Intensive group-level HIV prevention intervention utilizing the project SMART curriculum	13	98
BSAS Substance Abuse Treatment Grantees	Intensive group-level HIV prevention intervention utilizing the project SMART curriculum	38	265
BSAS Substance Abuse Treatment Grantees	HIV Counseling, Testing & Referral	161	161

As a designated state, Maryland expended 5% of SAPT Block Grant funds on HIV Early Intervention Services in FFY 2009. Of this, \$422,637 was awarded to IDEHA for the BSAS projects described above. The remaining balance of the 5% HIV Set Aside was allocated, using an historical allocation formula, to the 24 local jurisdictions (Baltimore City and 23 counties) for the purpose of providing HIV Early Intervention Services in accordance with block grant requirements.

Each of the 24 jurisdictions in Maryland received HIV set-aside funds as part of their total SAPT Block Grant allocation. The ADAA continued its requirement that all individuals in Maryland addictions facilities/programs be screened for and counseled regarding HIV risk, as described in Code of Maryland (COMAR) 10.47.01.04:

*“Within the first 30 days of treatment, a program shall ensure and document in the patient record that human immune deficiency 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.*

Further, Maryland COMAR 10.47.01.04 (D) required every certified substance abuse treatment program in the State to provide these services within 30 days of admission. Recording of these services in the patient record was mandatory. The State of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality and the Maryland ADAA Quality Assurance Division assessed for adherence to these regulations during the annual/bi-annual certification process and other compliance review site visits.

As a condition of award, the jurisdictions agreed to comply with §96.128, to ensure that counseling and testing services were provided at the sites at which the individuals were receiving treatment. Jurisdictions also agreed to maintain 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. Specifically, the conditions of award required that programs:

*--Make 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.*

### **Goal #7: Development of Group Homes**

An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. §300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

*Note: If this goal is no longer applicable because the project was discontinued, please indicate.*

*If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.*

FY2009 (Annual Report/Compliance):

**Goal #7: Development of Group Homes**

Not Applicable

## Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2009 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2009 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

## **Attachment F: Group Home Entities and Programs**

An agreement to continue the provision for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund is optional for States effective FFY 2002. While the Administration continues to view the provision of substance free living environments as a critical component in sustaining recovery efforts, effective FFY 2002, the Administration elected to discontinue the dedicated (set-aside) revolving loan fund in order to increase funding to the existing system of care. The Administration will consider other available options that are provided to identify funding for this effort. It is the intent of the Administration to also continue to strategically evaluate the service needs and available resources for Maryland citizens in recovery.

## **Goal #8: Tobacco Products**

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. §300x-26, 45 C.F.R. §96.130 and 45 C.F.R. §96.122(d)).

- Is the State's FY 2012 Annual Synar Report included with the FY 2012 uniform application? (Yes/No)
- If No, please indicate when the State plans to submit the report: (mm/dd/2011)

Note: The statutory due date is December 31, 2011.

**Goal #8: Tobacco Products**

• **Is the State's FY 2012 Annual Synar Report included with the FY 2012 uniform application? (Yes/No)** No

• **If No, please indicate when the State plans to submit the report: (mm/dd/2011)**  
12/31/2011

**WHO:** Retail outlets in every Maryland jurisdiction (defined as the 23 counties in MD and Baltimore City).

**WHAT:** The State of Maryland maintained its established law that makes it unlawful for any manufacturer, retailer or distributor of tobacco products to sell or distribute any such products to any individual under 18 years of age. This law remains in effect. Administration staff continued to make random unannounced inspections of retail outlets.

**WHEN:** Ongoing during FY 2009.

**WHERE:** The State of Maryland strengthened its local activities by continuing to provide project funding for the development of a statewide network of control activities. Enforcement activities continued to take on unique local application of effort and strategy.

**HOW:** Maryland continued its Synar Compliance by maintaining a rate below the mandated 20% non-compliance rate. The non-compliance rate for FFY2009 was 5.1%, with 586 outlets inspected.

### **Goal #9: Pregnant Women Preferences**

An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. §300x-27 and 45 C.F.R. §96.131).

*Note:* In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY2009 (Annual Report/Compliance):

## **Goal #9: Pregnant Women Preferences**

**WHO:** All pregnant women in Maryland State-funded treatment programs.

**WHAT:** Preference in admission to treatment, as required by 45 C.F.R §96.131.

**WHEN:** Ongoing during FY 2009.

**WHERE:** Every Maryland jurisdiction (defined as the 23 counties in MD and Baltimore City).

**HOW:** In FY 2009, the ADAA ensured that pregnant women were given preference in admission to treatment by continuing to require that programs to admit pregnant women within 48 hours. Conditions-of-award for funded programs continued to include the requirements found in CFR §96.131 regarding preference in admission to pregnant injecting drug users and other pregnant women in need of treatment, as well as the other requirements found in that section.

In FY 2009, there were 16,524 unique women treated in all levels of care by funded providers. Of these, 828 (19.9%) were identified as being pregnant at the time of admission. The ADAA also continued to support residential treatment beds for pregnant women and women with dependent children through its “IFB” programs (statewide programs funded directly through an “Invitation for Bid” solicitation process). In FY 2009, jurisdictions throughout the State made 106 referrals to the Women’s IFB residential programs, and 82 placements were completed. Of these, 17 were pregnant women. The women with dependent children that were admitted to the IFB programs that year had had 111 infants/children accompany them to residential treatment. These infants/children received numerous services including primary pediatric care and immunizations, child care, case management, and therapeutic interventions to address developmental needs and issues related to sexual abuse, physical abuse, neglect and FASD.

In FY 2009, the average waiting time for pregnant women seeking services from funded providers was 7 days, with 31% of pregnant women admitted within 24 hours, 4.4% admitted within 48 hours and 4.4% admitted within 72 hours. The ADAA began planning for a policy change in which programs would be required to admit all pregnant women within 24 hours (not 48 hours), but this change did not officially go into effect until early FY 2010.

In FY 2009, the Administration continued to collaborate with the Department of Human Resources on the development of cross training for local Departments of Social Services personnel and substance abuse professionals. To ensure that local health departments and funded providers were able to access the residential services for pregnant women and women with dependent children, the ADAA women’s services coordinator and contracts coordinator provided 12 in-service trainings in all four (4) regions of the state. These regional stakeholder trainings included information about the women’s residential treatment services, as well as medical, mental health and childcare services for their children that accompany them to treatment.

Throughout FY 2009, the ADAA women services coordinator was the Region III representative on the NASADAD Women’s Services Network (WSN) workgroup to develop guidelines for assistance to states regarding the development of state standards for pregnant women and women with dependent children. The coordinator initiated a process to develop standards for treatment services for pregnant women and women with dependent children, and solicited input from providers around the state. These standards are consistent with the national consensus developed by the NASADAD/SAMHSA expert panel, to ensure that the unique treatment and prevention needs and concerns of women and their families are addressed.

## Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

**For the fiscal year two years prior (FY 2010) to the fiscal year for which the State is applying for funds:**

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. §96.126(c) and 45 C.F.R. §96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

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- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Agency (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment ;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

## **Attachment G: Capacity Management**

All addictions treatment programs must, by State regulations, be certified and report to the Administration's online data collection application, the State of Maryland Automated Record Tracking (SMART) system. SMART is capable of routinely producing the reports necessary for capacity and wait list management; therefore, the ADAA does not calculate capacity and wait list management costs independently of the costs associated with maintaining the entire system.

The ADAA Information Services Division reports admission data on each patient accessing addictions treatment (demographic, drug use, and route of administration, etc.), and program census and wait list data. Average retention rates across different levels of care and programs are computed by tracking incidence data and length of stay for each patient. The Administration tracks and ensures that intravenous drug users (IVDUs) are admitted and retained in treatment as long as possible.

Treatment programs are certified by the Department of Health and Mental Hygiene, Office of Health Care Quality (OHCQ) on a biannual basis. This certification process includes a thorough review of patient records, clinical and medical policies and procedures, and fiscal and personnel practices. These methods combine to ensure that the special needs of IVDUs and pregnant women are met.

Pregnant women must be offered services within 24 hours. The Administration has issued and implemented a waiting list policy requiring that non-pregnant patients be placed on a waiting list if the time between initial contact and admission is longer than 10 days or be referred to another program. Programs assist the persons on the wait list to find other treatment options. All programs are required to submit a Census and Wait List report with their monthly submission of treatment data to the Administration.

### **Pregnant Women**

In July 1989, the administration issued and implemented the Pregnant Addict Policy, which required programs to assign priority admission status to any addicted pregnant woman in any State certified treatment program. In October, 2009, the ADAA issued its "Infant Mortality Reduction Initiative" policy. Whereas programs were previously required to admit pregnant women into treatment within 48 hours, the 2009 policy required that all treatment programs in the State admit pregnant women within 24 hours of the request for service.

The ADAA employs a full time (100% FTE) women's services coordinator that is responsible for managing capacity and coordinating admissions and discharges solely for the ADAA-funded, gender-specific statewide residential treatment programs for pregnant women. This position is funded not through the SAPT Block Grant, but rather entirely with State General Funds through the Maryland Department of Health and Mental Hygiene.

Any complaints from consumers and stakeholders about waiting lists and admission policies are investigated by the Compliance Section of the Administration's Quality Assurance Division. The status of a treatment program's policies for priority admission for pregnant women with addiction is reviewed onsite at every routine OHCQ certification or ADAA-QA compliance visit.

### **Intravenous Drug Users (IVDUs)**

Baltimore City has the highest incidence of IVDUs and opioid users in Maryland. Most OMT programs are at capacity and the great demand for services requires that patients are not kept on waiting lists but can be admitted to treatment in a timely manner. In FFY 2005 Baltimore City ran a SAMHSA funded pilot program for Opioid Maintenance Therapy programs to begin using an Interim Maintenance protocol. When programs reach capacity, they can coordinate with the State Medical Director (who also serves as the State Opioid Treatment Authority-SOTA), to offer patients the option of entering an Interim Maintenance (IM) protocol. The State Medical Director/SOTA is estimated to spend less than 5% of his time coordinating Interim Methadone capacity; therefore, separate calculations of the estimated expenditures necessary to perform those functions have not been performed. Under the IM protocol, patients receive daily doses of opioid maintenance medication for a period of time not to exceed 120 days, at which time the patient must be placed into a permanent treatment slot.

Over the last several State Fiscal Years, there has been a significant improvement in the percentages of patients who are admitted into interim maintenance treatment, retained, and successfully transferred to full OMT care. In SFY 2006 the Administration assumed funding for the Interim Methadone program in Baltimore City and began investigating expanding this practice to other jurisdictions. In SFY 2007, the Administration funded Interim Methadone at IBR Reach and the Sinai – Sharp Program. Of the 59 patients served that year, 17% were transferred to Regular Methadone Maintenance, 15% were discharged unsuccessfully, and 68% had not yet completed 120 days and were carried over to SFY 2008. In SFY 2008, the Administration funded Interim Methadone at IBR Reach and the Sinai – Sharp Program. Of the 243 patients served that year, 43% were transferred to Regular Methadone Maintenance, 26% were discharged unsuccessfully, and 32% were carried over to SFY 2009. In SFY 2009, the Administration funded Interim Methadone at IBR Reach and the Sinai – Sharp Program. Of the 308 patients served that year, 61% were transferred to Regular Methadone Maintenance, 14% were discharged unsuccessfully, and 18% were carried over to SFY 2010. In SFY 2010, the Administration funded Interim Methadone at IBR Reach and the Sinai – Sharp Program. Of the 201 patients served that year, 74% were transferred to Regular Methadone Maintenance, 16% were discharged unsuccessfully, and 10% were carried over to SFY 2011. Also during SFY 2010, Baltimore (City) Substance Abuse Services (BSAS) provided ADAA block grant funding to Johns Hopkins BPRU and the University of Maryland Methadone Program to assist with their Interim Methadone studies within Baltimore City. The studies provided Interim Methadone to 127 patients; 76% (n=97) were transferred to Regular Methadone Maintenance and 24% (n=30) were discharged unsuccessfully.

## **Goal #10: Process for Referring**

An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. §300x-28(a) and 45 C.F.R. §96.132(a)).

*Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.*

FY2009 (Annual Report/Compliance):

## **GOAL #10: Process for Referring**

**WHO:** All individuals in publicly-funded treatment programs in Maryland.

**WHAT:** The ADAA continued to require that all publicly-funded treatment providers in Maryland use the State of Maryland Automated Record Tracking (SMART) clinical record system to better screen, assess and provide the most appropriate treatment placements. The ADAA also continued to require that all certified programs utilize only the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for establishing eligibility and making level-of-care determinations.

**WHEN:** Ongoing during FY 2009.

**WHERE:** Every Maryland jurisdiction (defined as 23 counties Maryland and Baltimore City).

**HOW:** Code of Maryland (COMAR) §10.47.01.04 requires that programs conduct comprehensive, multi-dimensional bio-psycho-social assessments for each patient, and have detailed descriptions of eligibility and patient placement criteria (PPC) for admission to the programs. COMAR regulations (§10.47.01.04 ) prohibit admission to programs unless individuals meet ASAM PPC “or other guidelines approved by the ADAA”. The SMART application, based on the WITS platform, provides several assessment instruments for clinicians to record individual client-level data which are used to make appropriate eligibility and level-of-care determinations. Once the appropriate level-of-care is determined, programs use the SMART application to electronically refer patients to the most appropriate treatment providers.

As the ADAA began its transition to a full electronic medical record (EMR), modifications were made which enabled clinicians to use individual client level data to make appropriate eligibility and level-of-care determinations for adults as well as adolescents. The ADAA procured programming to make four screening instruments and seven assessment instruments available within SMART. The screening tools in SMART include the SA/MH, the South Oaks Gambling Screen (SOGS), the CAGE, and the CSAT-approved SSI/SA. The seven assessment instruments include: the Treatment Assignment Protocol (TAP, which has been required of evaluators that perform assessments for court-ordered defendants in Maryland for several years), the Behavioral Health Assessment, the Juvenile Risk Assessment, two versions of the Addiction Severity Index (ASI--the Dens ASI and the ASI Lite), the E Court Drug and Alcohol Assessment, and the Adolescent Drug and Alcohol Diagnosis Assessment (ADAD). ADAA-funded programs use the instruments in SMART to comply with COMAR as well as Conditions of Grant Award requirements for making level-of-care determinations consistent with ASAM placement criteria.

During FY 2009, the ADAA continued to provide training and technical assistance in best practices and the specific applications of screening, assessment and placement instruments. The ADAA’s Office on Education and Training for Addiction Services (OETAS) continued to routinely offer training on assessment and placement criteria in its course catalogues. Staff from the ADAA’s Information Services, Community Services and Quality Assurance Divisions continued to provide assistance to programs regarding issues related to assessment, level-of-care determination and referral to appropriate levels of care.

## **Goal #11: Continuing Education**

An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. §300x-28(b) and 45 C.F.R. §96.132(b)).

*Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.*

FY2009 (Annual Report/Compliance):

## **Goal #11: Continuing Education**

**WHO:** Employees of facilities that provide prevention activities or treatment services.

**WHAT:** Per CFR 96.132(b), continuing education (training/other educational activities) to expand the scope, functionality and competencies of current and future practitioners who comprise the prevention and treatment systems of care in Maryland.

**WHEN:** Ongoing during FY 2009.

**WHERE:** All Maryland jurisdictions (23 counties in Maryland and Baltimore City).

**HOW:** During FFY 2009, the ADAA Office of Education and Training for Addiction Services (OETAS) continued to provide continuing education through numerous commuter classes and customized trainings for employees of facilities that provide prevention, intervention and treatment services. All OETAS courses have been approved for Continuing Education Units (CEUs) as follows: Alcohol and Drug Counselors (Md. Board of Professional Counselors and Therapists and the Md. Addictions Professional Certification Board); Prevention Specialists (Md. Addictions Professionals Certification Board); Social Workers and Certified Professional Counselors (Md. Board of Social Work Examiners); and Psychologists (State Board of Examiners of Psychologists). OETAS courses emphasized advanced addiction counseling and prevention content that integrated evidence based research into daily clinical processes and prevention activities.

In FY 2009, the OETAS conducted 48 courses, attended by 1,555 individuals. Topics to address the specialized needs of the workforce included, but were not limited to: motivational interviewing, stages of change, screening and assessment, treatment planning, ethics, diversity, compassion fatigue, personality disorders, co-occurring psychiatric disorders, recovery oriented systems of care, resistant patients, grief and loss, grief work with African American males, spiritual work in the therapeutic relationship, gang awareness, mediation and conflict resolution, nutrition and addiction, grant-writing and budgeting, policy issues, stress management, clinical supervision, integrating family therapy in substance abuse treatment, families in recovery, twelve-steps, use of ASAM in the criminal justice system, war/conflict/trauma, combat veterans, trauma, traumatic brain injury and post-traumatic stress disorder, women with SUDs, adolescents, applying county data to the Strategic Prevention Framework, etc. In FY 2009, the ADAA initiated its annual lecture series, the C. Wayne Kempske Lecture Series, which focused on disseminating and promoting innovative research practice(s) in the treatment of substance abuse disorders within the criminal justice population (approximately 200 administrators and managers of criminal justice and treatment systems and agencies attended). The ADAA also sponsored 21 twenty hour (3 ½ day) programs at Salisbury University (approximately 500 participants), and the 2009 Annual Management Conference, which focused on building a recovery oriented system of care in Maryland (approximately 200 participants).

Also during FY 2009, the ADAA, the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) were moved under the direction of a newly created position of Deputy Secretary for Behavioral Health and Developmental Disabilities (BHDD) within the Md. Dept. of Health and Mental Hygiene. This provided an opportunity to work more collaboratively to meet the workforce needs of all three administrations. Planning began for regional workshops to bring the local management and clinical staffs of the three administrations together to develop a more integrated system of care for their shared patients, as well as a clinical supervisor's academy to address the three administrations' needs for training in clinical supervision.

## **Goal #12: Coordinate Services**

An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. §300x-28(c) and 45 C.F.R. §96.132(c)).

*Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of policies for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.*

FY2009 (Annual Report/Compliance):

**GOAL # 12: Coordinate Services**

**WHO:** Recipients of substance abuse prevention and treatment services.

**WHAT:** Per CFR 96.132(c), the ADAA partnered with other State departments, local health departments and healthcare professionals to coordinate its continuum of prevention and treatment services statewide with the provision of other appropriate services.

**WHEN:** Ongoing during FY 2009.

**WHERE:** Throughout Maryland (23 counties and Baltimore City).

**HOW:** During FFY 2009, the ADAA partnered with numerous other State departments, local health departments and healthcare professionals to coordinate its continuum of prevention and treatment services statewide with the provision of other appropriate services. Interagency collaboration included ADAA staff membership or representation on the following committees, task forces and work groups: Maryland HIV Community Planning Group (CPG); Statewide Criminal Justice Coordination Committee to implement improvements in the criminal justice and substance abuse treatment services system (court-ordered evaluation and treatment for criminal defendants and inmates, drug court, and post-release services); Statewide Recovery-Oriented Systems of Care (ROSC) Work Group; the Md. Annual Suicide Prevention Conference Planning Committee (with the Md. Mental Hygiene Administration-MHA, the ADAA's Office of Education and Training for Addiction Services [OETAS] and other agencies); and the Md. Dept. of Health and Mental Hygiene (DHMH) Infectious Disease and Environmental Health Administration (IDEHA) Partnership for Prevention (to promote immunization of healthcare workers against influenza). Additionally, the ADAA Medical Director served on the following committees, task forces and work groups: the Hepatitis Task Force; the Traumatic Brain Injury Task Force; Advisory Council on Prescription Drug Monitoring; the Mental Health Court Oversight Committee of the Problem Solving Courts; Behavioral Health and Developmental Disability Committee on Co-Occurring Disorders Curriculum Development; Managed Care Organization (MCO) Coordination of Care Meetings and Medical Assistance MCO Medical Directors Roundtable Meetings; Md. Advisory Council on Mental Hygiene; the SAMHSA-sponsored Physician Clinical Support System National Steering Committee; the Transitional Youth Policy Academy; the Buprenorphine Task Force of the Center for a Healthy Maryland (MED-CHI); the ADAA/MHA/DDA (Developmental Disabilities Administration) Clinical Case Collaborative Meetings; and the Child Mental Health Blueprint Task Force. Further, the ADAA partnered with other State agencies to provide and enhance services for substance-using populations in Maryland: the Md. Drug Treatment Court Commission and Office of Problem-Solving Courts (a collaborative, comprehensive, multi-disciplinary approach to reducing drug-related crime); IDEHA (to coordinate HIV Set Aside-funded HIV Early Intervention services); the MHA (to promote treatment capacity expansion for individuals with co-occurring disorders); the Md. Dept. of Human Resources-Family Investment Administration (to coordinate interagency funding for screening, assessment and referral services for the Temporary Cash Assistance and Food Supplement Programs, per Maryland's Welfare Innovation Act of 2000/House Bill 1160); the Md. Dept. of Human Resources-Social Services Administration (to coordinate services for pregnant/post-partum women and women with dependent children through Maryland's Senate Bill 512-Drug Affected Newborns – Children in Need of Assistance and House Bill 7-Child Welfare-Integration of Child Welfare Treatment Services); and the DHMH Family Health Administration's Center for Health Promotion, Education and Tobacco Use Prevention (to coordinate tobacco use prevention and cessation services within local health departments, and to support initiatives that enforce existing tobacco control laws and promote clean indoor air policies and practices).

### **Goal #13: Assessment of Need**

An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. §300x-29 and 45 C.F.R. §96.133).

*Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.*

FY2009 (Annual Report/Compliance):

### **Goal #13: Assessment of Need**

**WHO:** Maryland Alcohol and Drug Abuse Administration (ADAA) Office of Research Staff

**WHAT:** The ADAA uses numerous data sources to estimate need for each of the 24 Maryland subdivisions, to prepare budget requests, to populate the treatment NOMS, to educate policy makers and the public, and to allocate available resources to meet need. During FY 2009, the ADAA continued to compile and generate Outlook and Outcomes reports, patient-based data and treatment utilization reports from the State of Maryland Automated Record Tracking (SMART) system, team grant review reports, subdivision-level performance reports and other patient-based analyses of the treatment network. These reports provided details about services delivered in every sector of the State and informed the Administration's decisions about treatment needs and the targeting of resources. The backbone of ADAA's substance abuse prevention needs assessment efforts involved continuation of Maryland's Statewide Epidemiological Outcomes Workgroup (SEOW) for ongoing collection and analysis of relevant epidemiological data to document substance abuse related consequences and consumption patterns.

**WHEN:** Ongoing during FY 2009

**WHERE:** Data analyses addressed need for prevention and treatment services at the local jurisdictional level (23 counties and Baltimore City), as well as at regional and State levels.

**HOW:** During FFY 2009, that ADAA continued its work on an internet reporting initiative in the SMART system, which facilitated patient-based data collection throughout the State, allowed for enhanced needs assessment analyses, and promoted the development of program performance standards. The ADAA continued to improve the accuracy and completeness of its electronic data collection and expand its needs assessment capabilities through enhancements to its service provider network. All publicly-funded treatment programs in Maryland are required to report utilization and performance measure (NOMs) data to SMART, so the data represented the full spectrum of public treatment in Maryland. The Administration's Outlook and Outcomes FY 2008 and 2009 Annual Reports and other selected patient-based data and treatment utilization reports provided details about treatment services delivered in every sector of the State and informed the Administration's decisions about needs and the targeting of resources.

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) provided state and sub-state level estimates of substance use or mental health problems among the civilian, non-institutionalized population of the United States aged 12 years or older. The 2007 and 2008 NSDUH surveys provided state-level estimates of the need for treatment for alcohol and illicit-drug use during FY 2009.

House Bill 850 of the 2007 legislative session required the ADAA to conduct a needs assessment, which was completed in 2008. The ADAA contracted with the Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park to develop a measure of substance-abuse treatment-service needs among Maryland subdivisions, using a composite of validated substance-abuse indicators. The resulting Substance Need Index (SNI) scores were used to estimate relative gaps in treatment services among the state's jurisdictions, and informed much of the ADAA's decision-making during FY 2009.

### **Goal #14: Hypodermic Needle Program**

An agreement to ensure that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. §300x-31(a)(1)(F) and 45 C.F.R. §96.135(a)(6)).

*Note:* In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY2009 (Annual Report/Compliance):

**GOAL #14: Hypodermic Needle Exchange**

In FFY 2009, ADAA Conditions of Grant Award prohibited any funded program from utilizing SAPT Block Grant funds to support needle exchange.

### **Goal #15: Independent Peer Review**

An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. §300x-53(a) and 45 C.F.R. §96.136).

*Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/etc) accreditation.*

FY2009 (Annual Report/Compliance):

**Goal #15: Independent Peer Review**

**WHO:** A five percent (5%) representative sample of State-funded treatment programs in Maryland.

**WHAT:** Independent peer review of the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant, as required by 45 C.F.R §96.136.

**WHEN:** FY 2009.

**WHERE:** Baltimore City, Baltimore County, and Montgomery County.

**HOW:** The ADAA continued to contract with independent peer reviewers to ensure that the reviews were conducted and that findings were distributed to programs for use in ongoing program improvement. ADAA Quality Assurance staff managed the contracts, scheduled the reviews, and solicited feedback from programs that participated in the reviews to obtain their input about how the Independent Peer Review process can be improved.

In FFY 2009, a total of five (5) Independent Peer Reviews of treatment programs were conducted in the State of Maryland to assess and improve the quality and appropriateness of treatment services delivered by funded providers. These included:

- § Baltimore County HD – First Step, Inc., in Reisterstown, MD (10/16/08 and 10/17/08);
- § Baltimore City – Youth Services, Inc. (10/24/08 and 10/27/08);
- § Montgomery County HD – Journeys for Adolescents Program in Rockville, MD (11/6/08 and 11/7/08);
- § Baltimore City – Treatment Resources for Youth (11/7/08 and 11/10/08);
- § Baltimore County HD – Epoch Counseling Center Adolescent Program in Reisterstown, MD (11/20/08 and 11/21/08).

## **Independent Peer Review (formerly Attachment H)**

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2010 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

Examples of **procedures** may include, but not be limited to:

- the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year ;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

## **Attachment H: Independent Peer Review**

### **Role of the Administration (SSA) – IPR Process Environment, Approach and Activities**

The Administration has tailored its Independent Peer Review process to be comprehensive and to highlight specific levels of treatment identified as priorities based on internal data and CSAT. Reviews of programs have included those providing outpatient and medication assisted treatment in city, suburbs and rural areas of the State. The Administration has designed its Independent Peer Review process to be an educational experience intended to provide feedback to addiction treatment programs for the enhancement of the quality of their services to patients.

The Administration has continued to assess its reviews by including the provision of a follow-up questionnaire to each program that completed a review and received a final report from the reviewer. This has allowed the Administration to increase the overall effectiveness of the independent review process. In addition, the Administration provides information about the Independent Peer Review process to the field of addiction service providers. The areas of review include quality of services, appropriateness of services, efficacy of services and appropriateness of placement.

During FFY 2010, a total of five (5) independent peer reviews of treatment programs were conducted in the State of Maryland. The peer review process was performed in two programs providing services for adolescents in Baltimore City, two programs providing services for adolescents in Baltimore County, and one program providing services for adolescents in Montgomery County. We anticipate maintaining ongoing full compliance with the peer review requirement.

### **Role of the Treatment Program Peer Reviewers – IPR Credentialing and Procedures**

Treatment program peer reviewers are selected from a pool of treatment professionals experienced in the field of addictions. The Administration's Quality Assurance Director reviews all applications and verifies applicants' credentials. Reviewers demonstrate experience as treatment providers and have knowledge and experience with a variety of target groups; i.e., alcohol abuse, other drug abuse, co-occurring disorders, medication assisted treatment, youth, women, inner city/urban, rural, and criminal justice. The reviewer must have knowledge and experience with more than one of the following levels of care; residential, outpatient, intensive outpatient, and culturally specific programs. Experience as a treatment program Clinical Supervisor or Program Director is desired. The reviewer must be a member of one of the following disciplines: Licensed Clinical Alcohol and Drug Counselor, Social Worker, Psychologist, Registered Nurse, Psychiatrist, or possess a Masters Degree in a Human Service discipline. The reviewer must have at least five (5) years of experience in the AOD field.

Since May 2009, the ADAA has required that reviewers sign an *Affidavit of Peer Reviewer Independence*, affirming that the reviewers are not reviewing their own programs, and that they have no conflict of interest with, any administrative oversight of, nor any funding decision responsibility for, any of the programs that they are reviewing.

The Administration requires programs that receive federal funds to be available for Independent Peer Review if selected. The ADAA Peer Review Coordinator selects the programs and schedules dates for the site review. During the site review, interviews are conducted with the Program Director, QA/QI Manager, Clinical Supervisor, and program staff. Personnel records and CQI/QA documentation are reviewed. A random sample of recently discharged patient records is examined for the following:

- Quality of the intake process and appropriateness of the admission;
- Quality of the assessment;
- Quality and appropriateness of the treatment plan, including referrals;
- Quality of the implementation of treatment services; and
- Quality and appropriateness of patient discharge.

Subsequently, reviewers and program staff participate in an oral exit interview to discuss the site visit results. It is stated at that time that the Administration will supply any technical assistance requested to improve identified program needs. The Peer Reviewer prepares a written summary of the peer review visit and submits it to the Administration within three weeks. The Administration maintains a copy in the master file and sends the final report to the treatment program's director. In addition, the Program Director is sent a follow-up questionnaire asking for feedback concerning the experience.

## **Goal #16: Disclosure of Patient Records**

An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. §300x-53(b), 45 C.F.R. §96.132(e), and 42 C.F.R. Part 2).

*Note:* In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY2009 (Annual Report/Compliance):

## **Goal #16: Disclosure of Patient Records**

**WHO:** Jurisdictions, programs and treatment providers in Maryland.

**WHAT:** Protection of patient records from inappropriate disclosure, per §96.132-e.

**WHEN:** Ongoing during FY 2009.

**WHERE:** All Maryland jurisdictions (23 counties in MD and Baltimore City).

**HOW:** Code of Maryland Regulations (COMAR) 10.47.01.03 requires programs to include information about ethics and confidentiality procedures in staff orientation, supervision, training, and education; and COMAR 10.47.01.08 requires that medical records be maintained, transferred, and destroyed in a manner consistent with medical records confidentiality and disclosure requirements. These regulations specifically cross-reference the following State and Federal confidentiality regulations: 1) Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland; 2) Health-General Article, §4-403, Annotated Code of Maryland; 3) 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records); 4) 45 CFR Parts 160 and 164 (Security and Privacy); 5) The Health Insurance Portability Assurance and Accountability Act (HIPAA). Each substance abuse treatment program is also required by regulation to provide each patient with a statement of patient's rights upon admission.

In FFY 2009, the ADAA Quality Assurance staff and the MD Department of Health and Mental Hygiene Office of Health Care Quality (OHCQ) continued to assess for adherence to State and Federal confidentiality regulations, and continued to monitor patient records for evidence of patient rights statements and appropriate/accurate consent forms that included these protections, during the annual/bi-annual certification process and other compliance review site visits. The ADAA Community Services Division routinely incorporated information about confidentiality regulations into technical assistance functions performed with jurisdictions, programs and providers. The ADAA Office of Education and Training for Addictions Services (OETAS) staff continued to incorporate information regarding State and Federal confidentiality regulations into all addiction counselor/provider trainings delivered through OETAS.

The security architecture for Maryland's web-based data management system (SMART) and the ADAA's SAMIS data server were designed to ensure the confidentiality and security of patient data. The ADAA restricted access to the rooms in which primary and back-up servers were located, and maintained procedures for investigating and reporting potential security incidents. Patient information was protected from inappropriate disclosures through personnel security procedures, authentication procedures, firewalls, encryption, and consent processes. The ADAA, its IT vendors and SMART system users adhered to policies, procedures and contractual requirements that addressed several layers of application security. These included checks of usernames against Agency and Unit lists, application security levels that defined screens to which users have access, requirements that all users to have a unique usernames and passwords, and disconnection if more than 3 non-valid logins occurred.

### **Goal #17: Charitable Choice**

An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. §300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. §54.8(b) and §54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

*Note: In addressing this narrative please specify if this provision was not applicable because State did not fund religious providers. If the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.*

FY2009 (Annual Report/Compliance):

## **Goal #17: Charitable Choice**

**WHO:** Jurisdictions, programs and treatment providers in Maryland.

**WHAT:** Charitable Choice Provisions, per 42 C.F.R. §54.8(b) and §54.8(c)(4).

**WHEN:** Ongoing during FY 2009.

**WHERE:** All Maryland jurisdictions (23 counties in MD and Baltimore City).

**HOW:** In Maryland, the Alcohol and Drug Abuse Administration (ADAA) awards funds (including SAPT) for substance abuse prevention and treatment services to local health departments or other designated entities of local government. These recipients in turn provide or fund services via sub-grants or sub-contracts with direct service providers. The providers must be certified by the Department of Health and Mental Hygiene to provide services consistent with the specific level(s) of care for which they receive funds.

Under the Code of Maryland Regulations (COMAR), providers must be certified to provide Levels of Care that are consistent with the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. A “religious organization” meeting that standard would certainly be eligible for funding; however, to date none have applied for funding. ADAA Regional Technical Assistance Team Leaders have surveyed their respective regions to verify this information. The ADAA also reported on the FY 2009 Compliance Report Attachment I that no individuals were referred to alternative providers due to religious objections; that item was “Not Applicable” because, to the best of our knowledge, Maryland has not funded any religious organizations.

Under Charitable Choice, States, local governments, and religious organizations, must, as SAMHSA grant recipients: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

To ensure that Maryland complies with all aspects of SAMHSA’s Charitable Choice regulations and statutes, the ADAA has prepared a Memorandum, dated 5/23/12, which is being sent to all jurisdictional Treatment and Prevention Coordinators, all Access to Recovery (ATR) providers, and directors of all treatment programs which are directly funded by the ADAA (e.g. services for pregnant women, incarcerated individuals, and individuals that are deaf and hard of hearing). The Memorandum provided excerpts from the Charitable Choice regulations, with a link to the Federal Register with the Final Rule (<http://www.gpo.gov/fdsys/pkg/FR-2003-09-30/html/03-24289.htm>). Additionally, the Memorandum included a flier entitled “*Notice to Individuals Receiving Substance Abuse Services*”, which contains the required model notice language and provides the ADAA phone number for individuals to call with questions or complaints. The Memorandum instructed providers to post the flier in a prominent location that is readily observable by all actual or potential program beneficiaries (services recipients).

## Charitable Choice (formerly Attachment I)

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Charitable Choice is to document how your State is complying with these provisions.

**For the fiscal year prior (FY 2011) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.**

### Notice to Program Beneficiaries -Check all that Apply

- Used model notice provided in final regulations
- Used notice developed by State (Please attach a copy in Appendix A)
- State has disseminated notice to religious organizations that are providers
- State requires these religious organizations to give notice to all potential beneficiaries

### Referrals to Alternative Services -Check all that Apply

- State has developed specific referral system for this requirement
- State has incorporated this requirement into existing referral system(s)
- SAMHSA's Treatment Facility Locator is used to help identify providers
- Other networks and information systems are used to help identify providers
- State maintains record of referrals made by religious organizations that are providers
- 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

**Brief description (one paragraph)** of any training for local governments and faith-based and community organizations on these requirements.



The State of Maryland did not award SAPT Block Grant funds to recipients or sub-recipients (“program participants”) that would be considered a “religious organization” under the Final Rule. In Maryland, the Alcohol and Drug Abuse Administration (ADAA) awards funds (including SAPT) for substance abuse prevention and treatment services to local health departments or other designated entities of local government. These recipients in turn make awards to or contract for services with local programs or vendors (sub-recipients).

Under the Code of Maryland Regulations (COMAR), providers must be certified to provide Levels of Care that are consistent with the American Society of Addiction Medicine (ASM) Patient Placement Criteria. A “religious organization” meeting that standard would certainly be eligible for funding; however, to date none have applied for funding. ADAA Regional Technical Assistance Team Leaders have surveyed their respective regions to verify this information.

To ensure that Maryland complies with all aspects of SAMHSA’s Charitable Choice regulations and statutes, the ADAA has prepared a Memorandum, dated 5/23/12, which is being sent to all jurisdictional Treatment and Prevention Coordinators, all Access to Recovery (ATR) providers, and directors of all treatment programs which are directly funded by the ADAA (e.g. services for pregnant women, incarcerated individuals, and individuals that are deaf and hard of hearing). The Memorandum provided excerpts from the Charitable Choice regulations, with a link to the Federal Register with the Final Rule (<http://www.gpo.gov/fdsys/pkg/FR-2003-09-30/html/03-24289.htm>). Additionally, the Memorandum included a flier entitled “Notice to Individuals Receiving Substance Abuse Services”, which contains the required model notice language and provides the ADAA phone number for individuals to call with questions or complaints. The Memorandum instructed providers to post the flier in a prominent location that is readily observable by all actual or potential program beneficiaries (services recipients).

## Waivers (formerly Attachment J)

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

## **Waivers**

### **Waivers**

If the State proposes to request a waiver at this time for one or more of the provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. §96.124(d), §96.128(d), §96.132(d), §96.134(b), and §96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

## **Waivers**

The State of Maryland plans to apply for a waiver for the Statewide Maintenance of Effort (MOE) expenditures. The State MOE waiver will be sent to SAMHSA in a separate attachment not included in the 2012 SAPT Block Grant application.

## Form 8 (formerly Form 4)

## SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

<b>Dates of State Expenditure Period:</b> From: 7/1/2009 To: 6/30/2010
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Activity	Source of Funds					
	A.SAPT Block Grant FY 2009 Award (Spent)	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 22,687,019	\$ 2,389,789		\$ 73,022,123	\$ 7,382,630	\$ 8,011,710
Primary Prevention	\$ 6,396,000			\$	\$	\$
Tuberculosis Services	\$	\$		\$ 9,978	\$	\$
HIV Early Intervention Services	\$ 1,599,000	\$		\$ 1,530,290	\$	\$
Administration: Excluding Program/Provider	\$ 1,297,982			\$ 4,881,888	\$	\$
<b>Column Total</b>	<b>\$31,980,001</b>	<b>\$2,389,789</b>		<b>\$0</b>	<b>\$7,382,630</b>	<b>\$8,011,710</b>

\*Prevention other than Primary Prevention

**Form 8ab (formerly Form 4ab)****Form 8a. Primary Prevention Expenditures Checklist**

<b>Activity</b>	<b>SAPT Block Grant FY 2009</b>	<b>Other Federal</b>	<b>State Funds</b>	<b>Local Funds</b>	<b>Other</b>
Information Dissemination	\$ 2,622,360	\$	\$	\$	\$
Education	\$ 447,720	\$	\$	\$	\$
Alternatives	\$ 2,110,680	\$	\$	\$	\$
Problem Identification & Referral	\$ 63,690	\$	\$	\$	\$
Community Based Process	\$ 639,610	\$	\$	\$	\$
Environmental	\$ 511,940	\$	\$	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
<b>Column Total</b>	<b>\$6,396,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Form 8b. Primary Prevention Expenditures Checklist**

<b>Activity</b>	<b>SAPT Block Grant FY 2009</b>	<b>Other Federal</b>	<b>State Funds</b>	<b>Local Funds</b>	<b>Other</b>
Universal Direct	\$ 1,918,801	\$	\$	\$	\$
Universal Indirect	\$ 3,645,720	\$	\$	\$	\$
Selective	\$ 767,520	\$	\$	\$	\$
Indicated	\$ 63,959	\$	\$	\$	\$
<b>Column Total</b>	<b>\$6,396,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Form 8c (formerly Form 4c)****Resource Development Expenditure Checklist**

Did your State fund resource development activities from the FY 2009 SAPT Block Grant?

 Yes  No

<b>Expenditures on Resource Development Activities are:</b>				
<input type="radio"/> Actual <input type="radio"/> Estimated				
<b>Activity</b>	<b>Column 1 Treatment</b>	<b>Column 2 Prevention</b>	<b>Column 3 Additional Combined</b>	<b>Total</b>
Planning, Coordination and Needs Assessment	\$	\$	\$	\$ 0
Quality Assurance	\$ 28,434	\$	\$	\$ 28,434
Training (post-employment)	\$	\$	\$	\$ 0
Education (pre-employment)	\$	\$	\$	\$ 0
Program Development	\$ 162,431	\$ 33,992	\$	\$ 196,423
Research and Evaluation	\$	\$	\$	\$ 0
Information Systems	\$ 223,057	\$	\$	\$ 223,057
<b>Column Total</b>	<b>\$413,922</b>	<b>\$33,992</b>	<b>\$0</b>	<b>\$447,914</b>

## Form 9 (formerly Form 6)

## SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2009			
1. Entity Number	2. I-SATS ID <small>[X] if no I-SATS ID</small>	3. Area Served	4. State Funds <small>(Spent during State expenditure period)</small>	5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV <small>(if applicable)</small>
101001	MD900227	Allegany County	\$3,608,870	\$1,039,137	\$215,719	\$370,674	\$26,531
102001	MD100182	Anne Arundel County	\$1,553,680	\$1,655,577	\$159,810	\$395,998	\$199,263
103001	MD750614	Baltimore County	\$4,693,295	\$1,783,018	\$141,224	\$553,416	\$142,439
104001	MD902512	Calvert County	\$521,609	\$270,560	\$0	\$85,904	\$25,966
105001	MD750382	Caroline County	\$224,450	\$127,873	\$0	\$75,487	\$941
106001	MD750564	Carroll County	\$1,870,390	\$1,148,832	\$461,744	\$92,381	\$51,180
107001	MD900375	Cecil County	\$704,711	\$252,601	\$0	\$70,472	\$13,924
108001	MD750473	Charles County	\$1,210,503	\$284,463	\$0	\$132,395	\$9,596
109001	MD902199	Dorchester County	\$751,441	\$215,163	\$0	\$111,666	\$61,717
110001	MD750424	Frederick County	\$1,135,943	\$486,090	\$0	\$356,372	\$51,180
111001	MD901209	Garrett County	\$539,196	\$139,354	\$0	\$247,340	\$5,269
112001	MD903817	Harford County	\$1,070,167	\$338,263	\$0	\$104,528	\$21,262
113001	MD900444	Howard	\$1,013,388	\$182,625	\$0	\$84,957	\$9,220

## Maryland / SAPT FY2012 / Form 9 (formerly Form 6)

115001	MD900441	County					
114001	MD301293	Kent County	\$1,522,484	\$164,794	\$0	\$101,204	\$26,719
115001	MD902967	Montgomery County	\$2,642,950	\$755,648	\$411,468	\$493,069	\$67,926
116001	MD300030	Prince George's County	\$5,686,956	\$1,560,915	\$1,209,017	\$637,682	\$20,886
117001	MD750325	Queen Anne's County	\$519,106	\$148,400	\$0	\$86,197	\$7,903
118001	MD901779	St Mary's County	\$1,870,825	\$494,017	\$116,197	\$96,597	\$23,897
119001	MD103608	Somerset County	\$626,976	\$92,429	\$0	\$233,986	\$4,516
120001	MD750390	Talbot County	\$568,615	\$170,051	\$0	\$101,528	\$1,317
121001	MD301400	Washington County	\$1,877,374	\$791,869	\$222,951	\$241,420	\$21,450
122001	MD900300	Wicomico County	\$927,487	\$386,495	\$239,439	\$602,802	\$19,004
123001	MD901845	Worcester County	\$1,761,370	\$765,053	\$346,400	\$105,988	\$44,030
130001	MD100091	Baltimore City	\$25,719,745	\$9,218,782	\$749,949	\$1,013,937	\$742,864
135001	X	Statewide Contracts	\$10,400,592	\$215,010	\$0	\$0	\$0
<b>Totals:</b>			<b>\$73,022,123</b>	<b>\$22,687,019</b>	<b>\$4,273,918</b>	<b>\$6,396,000</b>	<b>\$1,599,000</b>

## PROVIDER ADDRESS TABLE

<b>Provider ID</b>	<b>Description</b>	<b>Provider Address</b>
135001	Provider 135001	55 Wade Avenue Catonsville, MD 21228 410-402-8600

## Form 9a (formerly Form 6a)

## Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Brochures [ 4 ]	29
	Speaking engagements [ 6 ]	28
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	30
	Parenting and family management [ 11 ]	20
	Peer leader/helper programs [ 13 ]	10
	Education programs for youth groups [ 14 ]	20
	Mentors [ 15 ]	9
	Preschool ATOD prevention programs [ 16 ]	6
	Drug free dances and parties [ 21 ]	9
	Youth/adult leadership activities [ 22 ]	29
	Community service activities [ 24 ]	15
	Recreation activities [ 26 ]	33
	Student Assistance Programs [ 32 ]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [ 41 ]	7
Community team-building [ 44 ]	7	
Pregnant Women/Teens [2]	Brochures [ 4 ]	6
	Speaking engagements [ 6 ]	11
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	3
	Parenting and family	15

	management [ 11 ]	10
	Community service activities [ 24 ]	3
Violent and Delinquent Behavior [4]	Brochures [ 4 ]	11
	Speaking engagements [ 6 ]	20
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	9
	Peer leader/helper programs [ 13 ]	2
	Education programs for youth groups [ 14 ]	11
	Community team-building [ 44 ]	2
Mental Health Problems [5]	Brochures [ 4 ]	19
	Speaking engagements [ 6 ]	15
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	20
Economically Disadvantaged [6]	Brochures [ 4 ]	9
	Speaking engagements [ 6 ]	18
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	11
	Parenting and family management [ 11 ]	13
	Education programs for youth groups [ 14 ]	8
	Mentors [ 15 ]	2
	Youth/adult leadership activities [ 22 ]	11
	Community service activities [ 24 ]	1
	Recreation activities [ 26 ]	13
Physically Disabled [7]	Speaking engagements [ 6 ]	2
	Ongoing classroom and/or small group sessions [ 12 ]	1
	Youth/adult leadership activities [ 22 ]	3
	Recreation activities [ 26 ]	5
Already Using Substances [9]	Brochures [ 4 ]	30

Maryland / SAPT FY2012 / Form 9a (formerly Form 6a)

	Speaking engagements [ 6 ]	29
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	25
	Parenting and family management [ 11 ]	20
	Education programs for youth groups [ 14 ]	6
Parents [11]	Brochures [ 4 ]	30
	Speaking engagements [ 6 ]	29
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	16
	Parenting and family management [ 11 ]	30
	Peer leader/helper programs [ 13 ]	11
	Youth/adult leadership activities [ 22 ]	19
	Community service activities [ 24 ]	11
Preschool [12]	Brochures [ 4 ]	6
	Speaking engagements [ 6 ]	6
	Parenting and family management [ 11 ]	6
	Preschool ATOD prevention programs [ 16 ]	6

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 7/1/2009 To: 6/30/2010

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services	D.Median Cost of Services	E.Standard Deviation of Cost
<b>Detoxification (24-Hour Care)</b>					
Hospital Inpatient			\$	\$	\$
Free-standing Residential	5077	4650	\$ 652.79	\$	\$
<b>Rehabilitation / Residential</b>					
Hospital Inpatient			\$	\$	\$
Short-term (up to 30 days)	6775	6220	\$ 2356.39	\$	\$
Long-term (over 30 days)	4029	3598	\$ 7544.32	\$	\$
<b>Ambulatory (Outpatient)</b>					
Outpatient	21382	19617	\$ 1553.94	\$	\$
Intensive Outpatient	9151	8168	\$ 1279.61	\$	\$
Detoxification	374	359	\$ 678.81	\$	\$
<b>Opioid Replacement Therapy (ORT)</b>					
Opioid Replacement Therapy	2793	2593	\$ 8800.93	\$	\$

Form 10b (formerly Form 7b)

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	3,458	1,217	449	1,343	233			15	2	5	0	25	1	126	42	2,574	674	157	53
2. 18-24	7,293	3,260	1,592	1,572	485			41	15	15	6	43	12	192	60	4,877	2,088	248	80
3. 25-44	15,703	5,305	3,009	4,637	2,137			64	18	39	21	46	26	332	69	10,010	5,140	409	144
4. 45-64	8,487	2,366	1,131	3,444	1,393			16	4	17	6	13	4	75	18	5,823	2,513	110	41
5. 65 and over	214	81	22	96	8			0	0	2	0	0	0	4	1	178	29	5	2
6. Total	35,155	12,229	6,203	11,092	4,256	0	0	136	39	78	33	127	43	729	190	23,462	10,444	929	320
7. Pregnant Women	342		193		132					1	1		4	11			328		14

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers?  Yes  No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 18,322

Numbers of Persons Served outside of the levels of care described in Form 10a. 0

## Description of Calculations

### Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d) (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

## Description of Calculations

### 96.124 - Pregnant Woman and Women with Dependent Children

The State of Maryland Alcohol and Drug Abuse Administration (ADAA) reviewed data for addictions services provided to pregnant women and women with dependent children in Maryland's publicly funded treatment system (e.g. grant awards, statewide contracts, number of pregnant women and women with dependent children served). It was estimated that for Fiscal Year 1994 expenditures for treatment services for Pregnant Women and Women With Dependent Children established a total Women's Base of \$5,032,564 (Refer to MOE Table IV). As demonstrated in subsequent years, service resources for this target group have continued to grow. Historical trends reflect total expenditures of \$12,264,437 in 2010, \$11,832,231 in 2011 and \$11,800,000 projected in 2012.

### 96.127 - Tuberculosis Services

The State of Maryland Alcohol and Drug Abuse Administration (ADAA) reviewed epidemiological data and disease control programming specifically targeted for tuberculosis services within the State. This activity falls under the Department of Health and Mental Hygiene (DHMH) Community Health Administration (CHA), which is charged with the control of communicable diseases in the State of Maryland. Services provided include treatment and preventive measures related to controlling tuberculosis infection. Based on information provided by CHA, the Fiscal Year 1991 and 1992 totals for all State funds spent on tuberculosis services were \$596,143 and \$649,086 respectively. State substance abuse treatment program directors were polled by the Administration as to incidence and prevalence of tuberculosis within their modalities. The program directors estimated that 2% of the substance abuse treatment population received tuberculosis services.

### 96.128 - HIV Early Intervention Services

The State of Maryland, under Section 1924 (b)(2), is a designated state. Using the definition of early intervention services for HIV, the Administration reviewed its substance abuse treatment sites and estimated 1992 base expenditures of \$1,272,808 for calculating the MOE level.

#### SSA MOE Description of Calculations:

The State of Maryland's SSA MOE data are calculated annually and are based on actual expenditures reported in the ADAA's yearly Budget Request. These expenditures include the State's General Funds, Reimbursable Funds, Special Funds and House Bill 7 funds. This methodology has been applied for fiscal years 2004 through 2011.

**SSA (MOE TABLE I)**

**Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)**

PERIOD	EXPENDITURES	B1(2007) + B2(2008)
(A)	(B)	----- 2 (C)
SFY 2009 (1)	<b>\$79,949,324</b>	<b>\$77,646,871</b>
SFY 2010 (2)	<b>\$75,344,417</b>	
SFY 2011 (3)	\$ 72,027,363	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

- FY 2009  Yes  No
- FY 2010  Yes  No
- FY 2011  Yes  No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2011 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

- Yes  No If yes, specify the amount and the State fiscal year: \$ , (SFY)

Did the State include these funds in previous year MOE calculations?

- Yes  No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations?  
(Date)

**TB (MOE TABLE II)**

**Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)**

**(BASE TABLE)**

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)	Average of Columns C1 and C2 C1 + C2 ----- 2 (D)
SFY 1991 (1)	<b>\$ 596,143</b>	<b>1 %</b>	<b>\$ 5,961</b>	<b>\$ 6,226</b>
SFY 1992 (2)	<b>\$ 649,086</b>	<b>1 %</b>	<b>\$ 6,491</b>	

**(MAINTENANCE TABLE)**

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)
SFY 2011 (3)	<b>\$ 997,764</b>	<b>1 %</b>	<b>\$ 9,978</b>

**HIV (MOE TABLE III)**

**Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)**

**(BASE TABLE)**

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 ----- 2 (B)
SFY 1991 (1)	\$ 989,864	\$ 1,272,809
SFY 1992 (2)	\$ 1,555,753	

**(MAINTENANCE TABLE)**

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2011 (3)	\$ 1,530,290

\* Provided to substance abusers at the site at which they receive substance abuse treatment

**Womens (MOE TABLE IV)**

**Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)**

**(MAINTENANCE TABLE)**

Period	Total Women's Base (A)	Total Expenditures (B)
1994	<b>\$5,032,564</b>	
2009		<b>\$11,812,774</b>
2010		<b>\$12,264,437</b>
2011		\$ 11,832,231

Enter the amount the State plans to expend in FY 2012 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$ 11,800,000

## Form T1

Form T1 was pre-populated with the following Data Source: Discharges in CY 2010

### EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

<b>Short-term Residential(SR)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	1,881	1,873
Total number of clients with non-missing values on employment\student status [denominator]	7,464	7,464
Percent of clients employed (full-time and part-time) or student	25.2%	25.1%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	7,907
Number of CY 2010 discharges submitted:	7,640
Number of CY 2010 discharges linked to an admission:	7,474
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,464
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,464
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	269	1,076
Total number of clients with non-missing values on employment\student status [denominator]	3,669	3,669
Percent of clients employed (full-time and part-time) or student	7.3%	29.3%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	5,453
Number of CY 2010 discharges submitted:	4,964
Number of CY 2010 discharges linked to an admission:	3,736
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3,669
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	3,669
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	1,453	1,827
Total number of clients with non-missing values on employment\student status [denominator]	7,471	7,471
Percent of clients employed (full-time and part-time) or student	19.4%	24.5%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	11,728
Number of CY 2010 discharges submitted:	9,153
Number of CY 2010 discharges linked to an admission:	7,665
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,471
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,471
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Outpatient (OP)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	8,335	9,671
Total number of clients with non-missing values on employment\student status [denominator]	17,492	17,492
Percent of clients employed (full-time and part-time) or student	47.7%	55.3%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	30,052
Number of CY 2010 discharges submitted:	24,306
Number of CY 2010 discharges linked to an admission:	20,031
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	17,493
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	17,492
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

## Form T2

Form T2 was pre-populated with the following Data Source: Discharges in CY 2010

### STABLE HOUSING SITUATION (From Admission to Discharge)

<b>Short-term Residential(SR)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	6,643	7,193
Total number of clients with non-missing values on living arrangements [denominator]	7,464	7,464
Percent of clients with stable housing	89.0%	96.4%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	7,907
Number of CY 2010 discharges submitted:	7,640
Number of CY 2010 discharges linked to an admission:	7,474
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,464
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,464
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	3,282	3,294
Total number of clients with non-missing values on living arrangements [denominator]	3,669	3,669
Percent of clients with stable housing	89.5%	89.8%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	5,453
Number of CY 2010 discharges submitted:	4,964
Number of CY 2010 discharges linked to an admission:	3,736
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3,669
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	3,669
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	7,112	7,207
Total number of clients with non-missing values on living arrangements [denominator]	7,471	7,471
Percent of clients with stable housing	95.2%	96.5%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	11,728
Number of CY 2010 discharges submitted:	9,153
Number of CY 2010 discharges linked to an admission:	7,665
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,471
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,471
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Outpatient (OP)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	17,153	17,291
Total number of clients with non-missing values on living arrangements [denominator]	17,493	17,493
Percent of clients with stable housing	98.1%	98.8%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	30,052
Number of CY 2010 discharges submitted:	24,306
Number of CY 2010 discharges linked to an admission:	20,031
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	17,493
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	17,493
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

## Form T3

Form T3 was pre-populated with the following Data Source: Discharges in CY 2010

### CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

<b>Short-term Residential(SR)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	6,818	7,438
Total number of clients with non-missing values on arrests [denominator]	7,472	7,472
Percent of clients with no arrests	91.2%	99.5%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	7,907
Number of CY 2010 discharges submitted:	7,640
Number of CY 2010 discharges linked to an admission:	7,474
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,472
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,472
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	3,519	3,681
Total number of clients with non-missing values on arrests [denominator]	3,733	3,733
Percent of clients with no arrests	94.3%	98.6%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	5,453
Number of CY 2010 discharges submitted:	4,964
Number of CY 2010 discharges linked to an admission:	3,736
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	3,735
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	3,733
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	6,930	7,391
Total number of clients with non-missing values on arrests [denominator]	7,653	7,653
Percent of clients with no arrests	90.6%	96.6%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	11,728
Number of CY 2010 discharges submitted:	9,153
Number of CY 2010 discharges linked to an admission:	7,665
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,653
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,653
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Outpatient (OP)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	16,574	17,508
Total number of clients with non-missing values on arrests [denominator]	18,054	18,054
Percent of clients with no arrests	91.8%	97.0%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	30,052
Number of CY 2010 discharges submitted:	24,306
Number of CY 2010 discharges linked to an admission:	20,031
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	18,054
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	18,054
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

## Form T4

Form T4 was pre-populated with the following Data Source: Discharges in CY 2010

### ALCOHOL ABSTINENCE

<b>Short-term Residential(SR)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	3,629	6,762
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,466	7,466
Percent of clients abstinent from alcohol	48.6%	90.6%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,164
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,837	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		82.5%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3,598
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,629	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		99.1%

#### Notes (for this level of care):

Number of CY 2010 admissions submitted:	7,907
Number of CY 2010 discharges submitted:	7,640
Number of CY 2010 discharges linked to an admission:	7,474

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,472
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,466
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b> [Records received through 5/4/2011]	

<b>Long-term Residential(LR)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
Denominator = All clients		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	2,650	3,290
All clients with non-missing values on at least one substance/frequency of use [denominator]	3,699	3,699
Percent of clients abstinent from alcohol	71.6%	88.9%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
Denominator = Clients using at admission		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		755
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,049	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		72.0%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
Denominator = Clients abstinent at admission		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		2,535
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,650	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		95.7%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	5,453
Number of CY 2010 discharges submitted:	4,964

Number of CY 2010 discharges linked to an admission:	3,736
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	3,735
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	3,699
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
Denominator = All clients		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	4,606	6,154
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,609	7,609
Percent of clients abstinent from alcohol	60.5%	80.9%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
Denominator = Clients using at admission		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,747
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,003	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		58.2%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
Denominator = Clients abstinent at admission		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,407
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,606	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		95.7%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	11,728

Number of CY 2010 discharges submitted:	9,153
Number of CY 2010 discharges linked to an admission:	7,665
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,653
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	7,609
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Outpatient (OP)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge (T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	11,765	15,944
All clients with non-missing values on at least one substance/frequency of use [denominator]	18,025	18,025
Percent of clients abstinent from alcohol	65.3%	88.5%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge (T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		4,647
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,260	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		74.2%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge (T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		11,297
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	11,765	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		96.0%

**Notes (for this level of care):**

Number of CY 2010 admissions submitted:	<b>30,052</b>
Number of CY 2010 discharges submitted:	<b>24,306</b>
Number of CY 2010 discharges linked to an admission:	<b>20,031</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>18,054</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>18,025</b>
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

**Form T5**Form T5 was pre-populated with the following Data Source: Discharges in CY 2010**DRUG ABSTINENCE**

<b>Short-term Residential(SR)</b>		
<b>A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs [numerator]	1,644	6,219
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,586	7,586
Percent of clients abstinent from drugs	21.7%	82.0%
<b>B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,615
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,942	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		77.7%
<b>C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,604
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,644	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		97.6%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>8,034</b>
Number of CY 2010 discharges submitted:	<b>7,765</b>
Number of CY 2010 discharges linked to an admission:	<b>7,595</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>7,593</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>7,586</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>	

<b>Long-term Residential(LR)</b>		
<b>A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs [numerator]	1,804	2,920
All clients with non-missing values on at least one substance/frequency of use [denominator]	3,902	3,902
Percent of clients abstinent from drugs	46.2%	74.8%
<b>B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1,396
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,098	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		66.5%
<b>C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,524

Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	1,804	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		84.5%

**Notes (for this level of care):**

Number of CY 2010 admissions submitted:	5,604
Number of CY 2010 discharges submitted:	5,277
Number of CY 2010 discharges linked to an admission:	3,940
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	3,939
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	3,902
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs [numerator]	2,816	5,462
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,775	8,775
Percent of clients abstinent from drugs	32.1%	62.2%
<b>B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		3,027
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	5,959	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		50.8%
<b>C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION</b>		

**Denominator = Clients abstinent at admission**

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,435
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,816	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		86.5%

**Notes (for this level of care):**

Number of CY 2010 admissions submitted:	12,352
Number of CY 2010 discharges submitted:	10,783
Number of CY 2010 discharges linked to an admission:	8,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	8,825
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	8,775
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>	

**Outpatient (OP)**

**A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)**

**Denominator = All clients**

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs [numerator]	11,210	15,305
All clients with non-missing values on at least one substance/frequency of use [denominator]	20,194	20,194
Percent of clients abstinent from drugs	55.5%	75.8%

**B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION**

**Denominator = Clients using at admission**

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		5,026

Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	<b>8,984</b>	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		<b>55.9%</b>

**C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION**

**Denominator = Clients abstinent at admission**

<b>Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		<b>10,279</b>
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	<b>11,210</b>	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		<b>91.7%</b>

**Notes (for this level of care):**

Number of CY 2010 admissions submitted:	<b>32,025</b>
Number of CY 2010 discharges submitted:	<b>27,674</b>
Number of CY 2010 discharges linked to an admission:	<b>22,476</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>20,238</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>20,194</b>

**Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]**

# Form T6

Most recent year for which data are available ? From:  To:

Level of Care		
Short-term Residential (SR)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T <sub>1</sub> )	Discharge Clients (T <sub>2</sub> )
Number of clients attending self-help programs [numerator]	873	2928
Total number of clients with non-missing values on self-help attendance [denominator]	3205	3205
Percent of clients attending self-help programs	27.24%	91.36%
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]	64.12%	
Long-term Residential (LR)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T <sub>1</sub> )	Discharge Clients (T <sub>2</sub> )
Number of clients attending self-help programs [numerator]	647	1059
Total number of clients with non-missing values on self-help attendance [denominator]	1163	1163
Percent of clients attending self-help programs	55.63%	91.06%
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]	35.43%	
Intensive Outpatient (IO)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T <sub>1</sub> )	Discharge Clients (T <sub>2</sub> )
Number of clients attending self-help programs [numerator]	819	1289
Total number of clients with non-missing values on self-help attendance [denominator]	3109	3109
Percent of clients attending self-help programs	26.34%	41.46%
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]	15.12%	
Outpatient (OP)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T <sub>1</sub> )	Discharge Clients (T <sub>2</sub> )
Number of clients attending self-help programs [numerator]	682	985

Total number of clients with non-missing values on self-help attendance [denominator]	4716	4716
Percent of clients attending self-help programs	14.46%	20.89%
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	6.43%	

## State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	<p><b>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</b></p> <p>TEDS categories and definitions are used for all admissions and discharges.</p>
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DATA SOURCE	<p><b>What is the source of data for table T6? (Select all that apply)</b></p> <p><input checked="" type="checkbox"/> Client Self Report</p> <p>Client self-report confirmed by another source:</p> <p><input type="checkbox"/> Collateral source</p> <p><input type="checkbox"/> Administrative data source</p> <p><input type="checkbox"/> Other: Specify</p> <p></p>
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EPISODE OF CARE	<p><b>How is the admission/discharge basis defined for table T6? (Select one)</b></p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input checked="" type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p> <p></p>
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DISCHARGE DATA COLLECTION	<p><b>How was discharge data collected for table T6? (Select all that apply)</b></p> <p><input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge</p> <p>Specify:</p> <p><input type="radio"/> In-Treatment data [ ] days post admission</p> <p><input type="radio"/> Follow-up data [ ] months post [admission]</p> <p><input type="radio"/> Other, Specify:</p> <p></p> <p><input checked="" type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are not collected for approximately [ ] % of clients who were admitted for treatment</p>
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RECORD LINKING	<p><b>Was the admission and discharge data linked for table T6? (Select all that apply)</b></p> <p><input checked="" type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)</p> <p>Select type of UCID:</p> <p><input type="radio"/> Master Client Index or Master Patient Index, centrally assigned</p> <p><input type="radio"/> Social Security Number (SSN)</p> <p><input type="radio"/> Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN,</p>
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etc.)

- Some other Statewide unique ID
- Provider-entity-specific unique ID

No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data

No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE

**If data is not reported, why is State unable to report? (Select all that apply)**

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE

**State must provide time-framed plans for capturing self-help participation status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

**Form T7**

Form T7 was pre-populated with the following Data Source: Discharges in CY 2010

**Length of Stay (in Days) of All Discharges**

Level of Care	Length of Stay (in Days)			
	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
<b>Detoxification (24-Hour Care)</b>				
1. Hospital Inpatient				
2. Free-standing Residential	4	6	5	7
<b>Rehabilitation / Residential</b>				
3. Hospital Inpatient				
4. Short-term (up to 30 days)	9	18	15	24
5. Long-term (over 30 days)	31	103	90	163
<b>Ambulatory (Outpatient)</b>				
6. Outpatient	51	131	108	185
7. Intensive Outpatient	15	63	45	86
8. Detoxification	5	46	5	20
<b>Opioid Replacement Therapy (ORT)</b>				
9. Opioid Replacement therapy	23	252	37	75
10. ORT Outpatient	65	311	173	416

<b>Notes:</b>		
Level of Care	2010 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Total count, all levels of care	57,384	47,979
1. Hospital Inpatient-Detoxification (24-Hour Care)	278	
2. Free-standing Residential-Detoxification (24-Hour Care)	5,112	4,941
3. Hospital Inpatient-Rehabilitation / Residential		
4. Short-term (up to 30 days)-Rehabilitation / Residential	7,765	7,595
5. Long-term (over 30 days)-Rehabilitation / Residential	5,277	3,940

6. Outpatient-Ambulatory (Outpatient)	27,674	20,276
7. Intensive Outpatient-Ambulatory (Outpatient)	10,783	8,838
8. Detoxification-Ambulatory (Outpatient)	495	180
9. Opioid Replacement therapy-Opioid Replacement Therapy (ORT)		9
10. ORT Outpatient-Opioid Replacement Therapy (ORT)		2,200

Source: **SAMHSA/CBHSQ TEDS CY 2010 linked discharge file**  
 [Records received through **02/07/2012** ]

## **INSERT OVERALL NARRATIVE:**

### **INSERT OVERALL NARRATIVE:**

*The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.*

### **State Performance Management and Leadership**

*Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.*

*Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.*

*If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?*

*What actions does the State take as a result of analyzing performance management data?*

*If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.*

*Do workforce development plans address NOMs implementation and performance-based management practices?*

*Does the State require providers to supply information about the intensity or number of services received?*

## **Treatment Performance Measures (Overall Narrative)**

The Maryland Alcohol and Drug Abuse Administration utilizes its web-based clinical record (State of Maryland Automated Record Tracking—SMART) application to provide real time data about the intensity and number of services received. The Administration obtains data on a monthly basis via data download procedures. SMART also provides on-demand reports and raw data exports for any needed secondary data analysis. Training for providers on how to use the treatment applications remains ongoing. The Administration employs two full-time trainers who provide training on SMART. In addition to the in-house trainers, the University of Maryland Institute for Governmental Services and Research, ADAA's partner in the development of SMART, provides four SMART trainers. ADAA has an established computer training lab where training occurs on both a regular and ad hoc basis.

The ADAA has established benchmarks for performance measures for the local jurisdictions based on TOPPS II research findings and National Outcome Measures (NOMs). These performance targets are established in each jurisdiction's yearly grant application.

Governor Martin O'Malley has instituted StateStat – a system of performance-based management to improve accountability and efficiency (<http://www.statestat.maryland.gov/>). The Governor's Delivery Units (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. The O'Malley Administration set a goal and implemented a plan to expand access to SA services in Maryland by 25% by the end of 2012.

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. JurisStat measures parallel SAMHSA's National Outcome Measures (NOMs), as do the Managing for Results (MFRs) measures that the ADAA generates twice yearly for funded providers.

FY 2007 was the first full year of the pay for performance for Statewide Residential Contracts. These were still in effect during FY 2009. These contracts for long term residential care were made available to agencies that satisfy Code of Maryland (COMAR) program requirements for Level III.3 and Level III.5 and that demonstrated ability to provide specialty services to pregnant and post-partum women and women with dependent children, individuals with co-occurring disorders and those referred through the criminal justice system. Contracted programs were to achieve the following required performance measures: 1) At least 65% of patient discharges retained in treatment at least 60 days; 2) At least 90% of patient discharges referred to a lower level of treatment; and 3) At least 90% of all patient admission and discharge records accurately and completely entered into SMART within 30 days of admission and discharge.

Additional incentive performance measures include: 1) Contractor discharges for "Completed Treatment" 55% in Year 1, 60% in Year 2 and 65% of Year 3 of the contract; and 2) At least 50% of contractor discharges engaged in the next level of care within 30 days.

A team comprised of the ADAA's Information Services, Community Services, and Quality Assurance Divisions reviewed performance data, and when a jurisdiction or individual provider was found to be falling short of projected performance targets, the team worked with them to identify problems and recommend resolutions based on best practices.

## **Treatment Corrective Action Plan (submit upon request)**

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.
2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.
3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

**Form P1**

**NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use**

**Measure: 30-Day Use**

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	<p><b>Source Survey Item:</b> NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.]</p> <p><b>Outcome Reported:</b> Percent who reported having used alcohol during the past 30 days.</p>	Ages 18+ - CY 2009	58.60
		Ages 12–17 - CY 2009	13.80
2. 30-day Cigarette Use	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]</p> <p><b>Outcome Reported:</b> Percent who reported having smoked a cigarette during the past 30 days.</p>	Ages 12–17 - CY 2009	7.70
		Ages 18+ - CY 2009	22.70
3. 30-day Use of Other Tobacco Products	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.]</p> <p><b>Outcome Reported:</b> Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).</p>	Ages 18+ - CY 2009	5.70
		Ages 12–17 - CY 2009	3.30
4. 30-day Use of Marijuana	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.]</p> <p><b>Outcome Reported:</b> Percent who reported having used marijuana or hashish during the past 30 days.</p>	Ages 12–17 - CY 2009	6.60
		Ages 18+ - CY 2009	4.60
5. 30-day Use of Illegal Drugs Other Than Marijuana	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?"</p> <p><b>Outcome Reported:</b> Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).</p>	Ages 12–17 - CY 2009	3.60
		Ages 18+ - CY 2009	3.30

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

**Form P2**

**NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use**

**Measure: Perception of Risk/Harm of Use**

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data	
1. Perception of Risk From Alcohol	<b>Source Survey Item:</b> NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] <b>Outcome Reported:</b> Percent reporting moderate or great risk.	Ages 18+ - CY 2009	79.80	
		Ages 12–17 - CY 2009	78.40	
2. Perception of Risk From Cigarettes	<b>Source Survey Item:</b> NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] <b>Outcome Reported:</b> Percent reporting moderate or great risk.	Ages 12–17 - CY 2009	94.40	
		Ages 18+ - CY 2009	93.20	
3. Perception of Risk From Marijuana	<b>Source Survey Item:</b> NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] <b>Outcome Reported:</b> Percent reporting moderate or great risk.	Ages 18+ - CY 2009	74.20	
		Ages 12–17 - CY 2009	82	

((s)) Suppressed due to insufficient or non-comparable data

**Form P3**

**NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use**

**Measure: Age of First Use**

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	<b>Source Survey Item:</b> NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of alcohol.	Ages 12–17 - CY 2009 13.10	
		Ages 18+ - CY 2009 17	
2. Age at First Use of Cigarettes	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of cigarettes.	Ages 18+ - CY 2009 16	
		Ages 12–17 - CY 2009 13.30	
3. Age at First Use of Tobacco Products Other Than Cigarettes	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of tobacco products other than cigarettes.	Ages 18+ - CY 2009 19.70	
		Ages 12–17 - CY 2009 14.20	
4. Age at First Use of Marijuana or Hashish	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of marijuana or hashish.	Ages 12–17 - CY 2009 14.20	
		Ages 18+ - CY 2009 18.40	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of other illegal drugs.	Ages 18+ - CY 2009 20.60	
		Ages 12–17 - CY 2009 12.20	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

**Form P4**

**NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use  
Measure: Perception of Disapproval/Attitudes**

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 88.90	
2. Perception of Peer Disapproval of Cigarettes	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent reporting that their friends would somewhat or strongly disapprove.</p>	Ages 12–17 - CY 2009 91	
3. Disapproval of Using Marijuana Experimentally	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age trying marijuana or hashish once or twice?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 82.20	
4. Disapproval of Using Marijuana Regularly	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age using marijuana once a month or more?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 82.20	
5. Disapproval of Alcohol	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 86.40	

((s)) Suppressed due to insufficient or non-comparable data

**Form P5**  
**NOMs Domain: Employment/Education**  
**Measure: Perception of Workplace Policy**

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	<b>Source Survey Item:</b> NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] <b>Outcome Reported:</b> Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 18+ - CY 2009	33.70
		Ages 15-17 - CY 2009	((s))

((s)) Suppressed due to insufficient or non-comparable data

**Form P7**  
**NOMs Domain: Employment/Education**  
**Measure: Average Daily School Attendance Rate**

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	<p><b>Source:</b> National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at <a href="http://nces.ed.gov/ccd/stfis.asp">http://nces.ed.gov/ccd/stfis.asp</a></p> <p><b>Measure calculation:</b> Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>	CY 2009	93.40	

((s)) Suppressed due to insufficient or non-comparable data

**Form P8**  
**NOMs Domain: Crime and Criminal Justice**  
**Measure: Alcohol-Related Traffic Fatalities**

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	<p><b>Source:</b> National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p><b>Measure calculation:</b> The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>	CY 2009	31.50	

((s)) Suppressed due to insufficient or non-comparable data

**Form P9**  
**NOMs Domain: Crime and Criminal Justice**  
**Measure: Alcohol- and Drug-Related Arrests**

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	<b>Source:</b> Federal Bureau of Investigation Uniform Crime Reports <b>Measure calculation:</b> The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	CY 2009	29	

((s)) Suppressed due to insufficient or non-comparable data

**Form P10**

**NOMs Domain: Social Connectedness**

**Measure: Family Communications Around Drug and Alcohol Use**

A. Measure	B. Question/Response		C. Pre- Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No]</p> <p><b>Outcome Reported:</b> Percent reporting having talked with a parent.</p>		Ages 12–17 - CY 2009  60.70	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times]</p> <p><b>Outcome Reported:</b> Percent of parents reporting that they have talked to their child.</p>		Ages 18+ - CY 2009  ((s))	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

**Form P11**

**NOMs Domain: Retention**

**Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message**

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	<b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" <b>Outcome Reported:</b> Percent reporting having been exposed to prevention message.	Ages 12–17 - CY 2009 93.40	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

**P-Forms 12a- P-15 – Reporting Period**

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

<b>Forms</b>	<b>A. Reporting Period Start Date</b>	<b>B. Reporting Period End Date</b>
Form P12a Individual-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2010	12/31/2010
Form P12b Population-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2010	12/31/2010
Form P13 (Optional) Number of Persons Served by Type of Intervention	1/1/2010	12/31/2010
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	1/1/2010	12/31/2010
Form P15 FY 2009 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	1/1/2010	12/31/2010

**Form P12a**

**Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity**

**Question 1:** Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The State of Maryland uses the Minimum Data Set (MDS) to collect the NOMs data.

**Question 2:** Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

For those individuals receiving prevention services who indicated they are multi-racial, the state identifies each participant in one of the racial categories and then identifies the individual in the "More Than One Race" Category.

Category	Description	Total Served
A. Age	1. 0-4	1938
	2. 5-11	2133
	3. 12-14	2917
	4. 15-17	1118
	5. 18-20	397
	6. 21-24	550
	7. 25-44	3340
	8. 45-64	1734
	9. 65 And Over	185
	10. Age Not Known	0
B. Gender	Male	6007
	Female	8305
	Gender Unknown	0
C. Race	White	6537
	Black or African American	7601
	Native Hawaiian/Other Pacific Islander	48
	Asian	94
	American indian/Alaska Native	32
	More Than One Race (not OMB required)	0
Race Not Known or Other (not OMB required)	0	
D. Ethnicity	Hispanic or Latino	948
	Not Hispanic or Latino	13364
	Ethnicity Unknown	0

**Form 12b****Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity**

Category	Description	Total Served
A. Age	1. 0-4	2675
	2. 5-11	13407
	3. 12-14	13035
	4. 15-17	28766
	5. 18-20	46894
	6. 21-24	19949
	7. 25-44	36534
	8. 45-64	27744
	9. 65 And Over	5256
	10. Age Not Known	0
B. Gender	Male	83718
	Female	110542
	Gender Unknown	0
C. Race	White	128216
	Black or African American	61585
	Native Hawaiian/Other Pacific Islander	775
	Asian	3303
	American indian/Alaska Native	381
	More Than One Race (not OMB required)	0
	Race Not Known or Other (not OMB required)	0
D. Ethnicity	Hispanic or Latino	11550
	Not Hispanic or Latino	182710
	Ethnicity Unknown	0

**Form P13 (Optional)**  
**Number of Persons Served by Type of Intervention**

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	10018	N/A
2. Universal Indirect	N/A	194260
3. Selective	3864	N/A
4. Indicated	430	N/A
5. Total	14312	194260

**Form P14**

**Number of Evidence-Based Programs and Strategies by Type of Intervention**

**NOMs Domain: Retention**

**NOMs Domain: Evidence-Based Programs and Strategies**

**Measure: Number of Evidence-Based Programs and Strategies**

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
  - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
  - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition. As a condition of grant award, all SAPT Block Grant funded recipients must implement at least one evidence-based program.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?  
 The State of Maryland collects data on prevention programs and strategies using CSAP's Minimum Data Set (MDS) data collection system.

**Number of Evidence-Based Programs and Strategies by Type of Intervention**

	<b>A. Universal Direct</b>	<b>B. Universal Indirect</b>	<b>C. Universal Total</b>	<b>D. Selected</b>	<b>E. Indicated</b>	<b>F. Total</b>
1. Number of Evidence-Based Programs and Strategies Funded	60	37	94	52	17	163
2. Total number of Programs and Strategies Funded	77	45	122	60	17	199
3. Percent of Evidence-Based Programs and Strategies	77.92%	82.22%	77.05%	86.67%	100.00%	81.91%

**Form P15 - FY 2009 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies**

IOM Categories	FY 2009 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2009 Total SAPT Block Grant \$Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	60	\$ 2366520
2. Universal Indirect	34	\$ 1407120
3. Selective	52	\$ 2046720
4. Indicated	17	\$ 575640
5. Totals	163	\$6,396,000.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

## **Prevention Corrective Action Plan (submit upon request)**

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.
2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.
3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

## Prevention Attachment D

**FFY 2009 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2009 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.**

**Note:**The Sub-totals for each IOM category and the Total FFY 2009 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

**See:**The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

**Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2009 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.**

1	2	3	4
FFY2009 Program/Strategy Name Universal Direct	FFY2009 Total Number of Evidence-based Programs and Strategies by Intervention	FFY2009 Total Costs of Evidence based Programs and Strategies for each IOM Category	FFY2009 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies
1.			
2.			
3.			
4.			
<b>Subtotal</b>			
<b>Universal Indirect Programs and Strategies</b>			
1.			
2.			
3.			
4.			
<b>Subtotal</b>			
<b>Selective Programs and Strategies</b>			
1.			
2.			
3.			
4.			
<b>Subtotal</b>			
<b>Indicated Programs and Strategies</b>			

1.			
2.			
3.			
4.			
<b>Subtotal</b>			
<b>Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies</b>	#	\$	
<b>Total FFY 2009 SAPT Block Grant Dollars \$ Spent on Evidence-Based Programs and Strategies</b>			\$

### **Description of Supplemental Data**

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

## Attachment A, Goal 2: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (<http://www.healthypeople.gov/>) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

Yes  No  Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

Yes  No  Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT  
Block  
Grant

Yes  
 No  
 Unknown

Other  
State  
Funds

Yes  
 No  
 Unknown

Drug Free  
Schools

Yes  
 No  
 Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

Yes  No  Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?  Yes  No  Unknown

Dissemination of materials?  Yes  No  Unknown

Media campaigns?  Yes  No  Unknown

Product pricing strategies?  Yes  No  Unknown

Policy to limit access?  Yes  No  Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

Yes  No  Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

- Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:  Yes  No  Unknown
- New product pricing:  Yes  No  Unknown
- New taxes on alcoholic beverages:  Yes  No  Unknown
- New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:  Yes  No  Unknown
- Parental responsibility laws for a child's possession and use of alcoholic beverages:  Yes  No  Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

Yes  No  Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	<u>Age 0 - 5</u>	<u>Age 6 - 11</u>	<u>Age 12 - 14</u>	<u>Age 15 - 18</u>
Cigarettes	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? 8

Motor vehicle drivers under age 21? 8

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 24

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

Yes  No  Unknown

## **Appendix A - Additional Supporting Documents (Optional)**

### **Appendix A - Additional Supporting Documents (Optional)**

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

This narrative response not included because it does not exist or has not yet been submitted.