

Maryland

UNIFORM APPLICATION
FY2011

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

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

OMB - Approved 07/20/2010 - Expires 07/31/2013

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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-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-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>.

DUNS Number: 134104855-

Uniform Application for FY 2011-13 Substance Abuse Prevention and Treatment Block Grant

1. State Agency to be the Grantee for the Block Grant:

Agency Name: Department of Health and Mental Hygiene
Organizational Unit: Alcohol and Drug Abuse Administration
Mailing Address: 55 Wade Avenue
City: Catonsville Zip Code: 21228

2. Contact Person for the Grantee of the Block Grant:

Name: Thomas Cargiulo, Director
Agency Name: Alcohol and Drug Abuse Administration
Mailing Address: 55 Wade Avenue
City: Catonsville Code: 21228
Telephone: (410) 402-8600 FAX: (410) 402-8601
Email Address: tcargiulo@dhmh.state.md.us

3. State Expenditure Period:

From: 7/1/2008 To: 6/30/2009

4. Date Submitted:

Date: 10/1/2009 1:12:53 PM Original: ● Revision: ●

5. Contact Person Responsible for Application Submission:

Name: Fran Givens Telephone: (410) 402-8570
Email Address: fgivens@dhmh.state.md.us FAX: (410) 402-8607

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FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act	
<p><i>Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.</i></p> <p>SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.</p>	
I.	Formula Grants to States, Section 1921
<p>Grant funds will be expended “only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities” as authorized.</p>	
II.	Certain Allocations, Section 1922
<ul style="list-style-type: none"> • Allocations Regarding Primary Prevention Programs, Section 1922(a) • Allocations Regarding Women, Section 1922(b) 	
III.	Intravenous Drug Abuse, Section 1923
<ul style="list-style-type: none"> • Capacity of Treatment Programs, Section 1923(a) • Outreach Regarding Intravenous Substance Abuse, Section 1923(b) 	
IV.	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924
V.	Group Homes for Recovering Substance Abusers, Section 1925
<p>Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.</p> <p>The State “has established, and is providing for the ongoing operation of a revolving fund” in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.</p>	
VI.	State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
<ul style="list-style-type: none"> • The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1). • The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1). • The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2). 	
VII.	Treatment Services for Pregnant Women, Section 1927
<p>The State “...will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant.”</p>	
VIII.	Additional Agreements, Section 1928
<ul style="list-style-type: none"> • Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a) • Continuing Education, Section 1928(b) • Coordination of Various Activities and Services, Section 1928(c) • Waiver of Requirement, Section 1928(d) 	

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FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications As required by Title XIX , Part B, Subpart II and Subpart III of the PHS Act (continued)	
IX.	Submission to Secretary of Statewide Assessment of Needs, Section 1929
X.	Maintenance of Effort Regarding State Expenditures, Section 1930
	With respect to the principal agency of a State, the State “will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.”
XI.	Restrictions on Expenditure of Grant, Section 1931
XII.	Application for Grant; Approval of State Plan, Section 1932
XIII.	Opportunity for Public Comment on State Plans, Section 1941
	The plan required under Section 1932 will be made “public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.”
XIV.	Requirement of Reports and Audits by States, Section 1942
XV.	Additional Requirements, Section 1943
XVI.	Prohibitions Regarding Receipt of Funds, Section 1946
XVII.	Nondiscrimination, Section 1947
XVIII.	Services Provided By Nongovernmental Organizations, Section 1955
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
	State: Maryland
	Name of Chief Executive Officer or Designee: Thomas P. Cargiulo, Pharm.D.
	Signature of CEO or Designee:
Title:	Date Signed:
Director, Alcohol and Drug Abuse Administration	
If signed by a designee, a copy of the designation must be attached	

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<p>1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION</p> <p>The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 C.F.R. Part 76, and its principals:</p> <ul style="list-style-type: none"> (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency; (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default. <p>Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.</p> <p>The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 C.F.R. Part 76.</p>	<p>2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS</p> <p>The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 C.F.R. Part 76 by:</p> <ul style="list-style-type: none"> (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition; (b) Establishing an ongoing drug-free awareness program to inform employees about – <ul style="list-style-type: none"> (1) The dangers of drug abuse in the workplace; (2) The grantee’s policy of maintaining a drug-free workplace; (3) Any available drug counseling, rehabilitation, and employee assistance programs; and (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above; (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will – <ul style="list-style-type: none"> (1) Abide by the terms of the statement; and (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction; (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
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- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

The undersigned (authorized official signing for the

applicant organization) certifies, to the best of his or her knowledge and belief, that:

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

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

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of

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<p>his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.</p> <p>5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE</p> <p>Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.</p> <p>Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.</p>	<p>By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.</p> <p>The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.</p> <p>The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.</p>
<p>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p>	<p>TITLE Director, ADA A</p>
<p>APPLICANT ORGANIZATION ADA A, Maryland Department of Health and Mental Hygiene</p>	<p>DATE SUBMITTED</p>

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**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

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of

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INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

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ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

Approval Expires 07/31/2013

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, ADAA	
APPLICANT ORGANIZATION ADAA, Maryland Department of Health and Mental Hygiene		DATE SUBMITTED

Approval Expires 07/31/2013

1. Planning

THREE YEAR PLAN, ANNUAL REPORT, and PROGRESS REPORT: PLAN FOR FY 2011-FY 2013 PROGRAM ACTIVITIES

This section documents the States plan to use the FY 2011 through FY 2013 Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. For each SAPT Block Grant award, the funds are available for obligation and expenditure for a 2-year period beginning on October 1 of the Federal Fiscal Year (FY) for which an award is made. States are encouraged to incorporate information on needs assessment, resource availability and States priorities in their plan to use these funds over the next three fiscal years. In the interim years (FY 2012 and FY 2013), updates to this 3-year plan are required; however, if the plan remains unchanged, additional narrative is not necessary. This section requires completion of needs assessment forms, services utilization forms and a narrative description of the States planning processes.

1. Planning

This section provides an opportunity to describe the State's planning processes and requires completion of needs assessment data forms, utilization information and a description of the State's priorities. In addition, this section provides the State the opportunity to complete a three year intended use plan for the periods of FY 2011-FY 2013. Finally this section requires completion of planning narratives and a checklist. These items address compliance with the following statutory requirements:

- 42 U.S.C. §300x-29, 45 C.F. R. §96.133 and 45 C.F.R. §96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

The State is to develop a 3-year plan which covers the three (3) fiscal years from FFY 2011-FY 2013. In a narrative of **up to five pages**, describe:

- How your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need.
- Include a definition of your State's sub-State planning areas (SPA).
- Identify what data is collected, how it is collected and how it is used in making these decisions.
- If there is a State, regional or local advisory council, describe their composition and their role in the planning process.
- Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.
- Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

Describe how your State evaluates activities related to ongoing substance abuse prevention and treatment efforts, such as performance data, programs, policies and practices, and how this data is produced, synthesized and used for planning. A general narrative describing the States planned approach to using State and Federal resources should be included. For the prevention assessment, States should focus on the SEOW process. Describe State priorities and activities as they relate to addressing State and Federal priorities and requirements.

- 42 U.S.C. §300x-51 and 45 C.F. R. §96.123(a)(13) require the State to make the State plan public in

such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2011-FY 2013 application for SAPT Block Grant funds.

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

The Prevention component of your Three Year Plan Should Include the Following:

Problem Assessment (Epidemiological Profile)

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. **Describe the criteria and rationale for establishing primary prevention priorities.**

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)

Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Prevention System Capacity Development

Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels—processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Implementation of a Data-Driven Prevention System

Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether sub-recipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

Evaluation of Primary Prevention Outcomes

Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

Introduction: The Alcohol and Drug Abuse Administration (ADAA) of the Maryland Department of Health and Mental Hygiene (DHMH) is the Single State Authority (SSA) responsible for the provision, coordination, and regulation of the statewide network of substance abuse prevention, intervention and treatment services. The ADAA serves as the initial point of contact for technical assistance and regulatory interpretation for all Maryland prevention and certified treatment programs. In SFY 2010, the ADAA served approximately 223,000 individuals in prevention programs and approximately 51,133 individuals in ADAA-funded treatment programs. This three-year plan was developed in response to specific questions of Substance Abuse and Mental Health Services Administration (SAMHSA) regarding Maryland's plans for the 2011-2013 Intended Use of the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG), and it accompanies Maryland's FFY 2011 SAPT-BG Application as a stand-alone document.

Sub-State Planning and the Role of the State and Local Advisory Councils: Legislation proposed by Governor Robert L. Ehrlich and signed into law on May 11, 2004 established a mandate that all twenty-four political subdivisions in Maryland (23 counties and Baltimore City) develop, and appoint certain agency representatives to Local Drug and Alcohol Advisory Councils (LDAACs). Each LDAAC prepares a biennial plan and consistently reports every six months to the ADAA on progress toward implementation of the plan.

The composition of each LDAAC must, per the Annotated Code of Maryland § 8-1001, consist of the following agency representatives or their designees:

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

The following individuals appointed by the county executive, the Mayor of Baltimore City, or the county commissioner:

- At least one recipient of addictions treatment services;
- Two substance abuse providers, at least one with experience with services to individuals with co-occurring substance abuse and mental health disorders;
- At least one substance abuse prevention provider;
- At least one individual who is knowledgeable and active on substance abuse issues that affect the county;
- The superintendent, warden or director of the local correctional facility located in the county or in Baltimore

City, the warden of the Baltimore City Detention Center; and

--At least one other individual who is knowledgeable about treatment of substance abuse in the county, including members of civic organizations, the chamber of commerce, health care professional organizations, or the clergy.

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

Data Collection, Utilization, and Data-driven Decision-Making: Maryland collects and utilizes data from numerous sources to assess gaps and needs, to measure and report on performance, and to inform stakeholders. Extensive sub-state level data is collected through the State of Maryland Automated Record Tracking (SMART) system, and an array of ancillary sub-state level data is used to determine areas of highest incidence, prevalence and need. SMART data and data from other State and Federal resources are used for utilization and categorical analysis and monitoring (e.g. pregnancy, adolescent, prevention, certification, and capacity/waiting list). The ADAA periodically employs probability models to estimate treatment needs by subdivision, and routinely shares, through its JurisStat program, regional- and sub-state level performance data with local coordinators for analysis and feedback. Sub-state level analyses are conducted throughout the year to examine trends in demographics, patient profiles, substances used and provider service delivery and performance. For example, the ADAA utilizes incidence-of-first-use analyses to track sub-state changes in Maryland's extensive heroin problem; and performed a "high-end services user analysis" which examined characteristics of patients with multiple residential treatment episodes over the past three years.

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

Maryland has facilitated the Statewide Epidemiologic Outcomes Workgroup (SEOW) since 2006. The

SEOW tracks, monitors and analyzes trends and patterns for legal and illegal substances throughout Maryland, with detailed focus on the 23 counties and Baltimore City. Throughout 2009 and 2010, the ADAA worked with its local prevention coordinators to generate input into the implementation of Maryland's Strategic Prevention Framework (MSPF). In FY 2011, Assessment/Planning grants will be made to all Maryland jurisdictions to enable them to carry out jurisdiction-wide prevention needs assessment activities, resulting in the selection of their jurisdictional priorities as well as target communities for MSPF resources. Following a competitive application and selection process, 10-15 local communities of greatest need will be selected to receive MSPF Implementation grants. The MSPF planning model and allocation approach will result in approximately 50% of Maryland's 24 jurisdictions receiving funding and technical assistance devoted specifically toward reducing the State's priority substance use and consequence indicators in highest need communities.

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

Monitoring to Assure that Funded Programs Serve Areas with Greatest Need: The ADAA is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention and treatment services. In addition to developing, establishing, promoting, regulating and monitoring these services, the ADAA conducts substance abuse-related education, training, data collection and research. The ADAA awards State and Federal funds to the 24 jurisdictions for substance abuse prevention and treatment grants that support the services infrastructure for Maryland's uninsured or under-insured patient population. Public funding through the ADAA is therefore the safety net for individuals in need of services who would otherwise lack the ability to pay, which is a particularly important consideration in view of the number of court commitments and other justice system referrals. The conditions of award for these grants provide contractual parameters for the sub-recipient jurisdictions (23 counties and Baltimore City) to ensure that SAPT-BG and other Federal and State requirements are met.

Maryland utilizes a two-tiered level of monitoring compliance with conditions of award. First, the ADAA's Division of Quality Assurance regulatory compliance staff review and audit the jurisdictional health departments and the Baltimore Substance Abuse Services (BSAS) regarding the services that they directly provide. Local jurisdictions are responsible for monitoring programs from which they subcontract for additional services, and they submit program monitoring data to the ADAA on a quarterly basis. ADAA staff members perform second tier audit functions as they continually monitor jurisdictional-level program data reports to ensure that services are provided in communities with highest need. Compliance review teams audit those reports during routine compliance or problem investigation review visits.

Statewide Epidemiological Outcomes Workgroup: The Maryland Strategic Prevention Framework Advisory Committee (SPFAC) is one of the subcommittees of the Governor's State Drug and Alcohol Advisory Committee (DAAC). The SPFAC consists of three subcommittees: the Statewide Epidemiologic Outcomes Workgroup (SEOW), and the Evidence-Based Practices and the Cultural Competence Workgroups. The structure of the Maryland SEOW includes the full SEOW Workgroup, and the Outcomes and Indicators and MSPF Recommendations sub-committees. In its second year, Maryland's SEOW was expanded to include the needs of local jurisdictions as well as the State. Maryland SEOW oversees the collection, interpretation and dissemination of statewide and local data that quantify substance use and its consequences for the State. MSPF utilizes SEOW data to focus on strategic planning to address identified needs and will enable Maryland to develop and implement a data-driven prevention network.

How Maryland Evaluates Ongoing SA Prevention and Treatment Efforts: The ADAA has developed a number of systems for evaluation of prevention and treatment efforts, and these are included in the conditions of award for any jurisdictional grant or other funded program. Compliance with policies and practices for performance measurement are evaluated by the Quality Assurance Division during annual compliance reviews, and by the Community Services Division whose regional coordinators provide technical assistance on an as needed basis. Governor Martin O'Malley has instituted StateStat – a system of performance-based management to improve accountability and efficiency. The Governor's Delivery Unit (GDU) is an extension of StateStat that works with state agencies to align State and Federal resources around 15 strategic and visionary goals to improve the quality of life in Maryland. The O'Malley Administration has set a goal and is implementing 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. The ADAA directly funds residential treatment services to expand access to certain high risk populations, including: pregnant women, women with dependent children, individuals with co-occurring mental and substance use disorders, and corrections, for which the ADAA has established three required performance measures and two incentive measures. JurisStat measures mimic SAMHSA's National Outcome Measures (NOMs), as do the Managing for Results (MFRs) measures that the ADAA generates twice yearly for funded providers.

Maryland utilizes both the NSDUH and CSAP's Prevention Minimum Data Set (MDS) to report prevention NOM's data (PNOMs) for the SAPT Block Grant. Evaluation of the MSPF initiative will utilize qualitative interviews with key informants, observations, surveys, archival data (i.e. education and arrest/crime data), and objective, standardized tools such as the MDS, the Youth Risk Behavior Survey (YRBS), and the NSDUH. The Maryland Adolescent Survey was recently eliminated due to State budget reductions, but the ADAA is researching alternative methods for capturing some of those data elements. The ADAA will continue to report on community- and program-level prevention measures (PNOMs) relevant to priority programs, policies, and practices implemented through MSPF.

Prevention Plan: Maryland’s MSPF Project submitted its draft Strategic Plan to CSAP in July 2010 and is currently awaiting final approval of the plan, which included:

- Problem Assessment/Epidemiological Profile: The Maryland SEOW examined use and consequence data, developed an Epidemiological Profile, and conducted a prioritization process which determined that underage drinking, binge drinking by young adults and alcohol-related crashes were its top three MSPF priorities.
- Prevention System Capacity and Infrastructure: MSPF conducted a resource assessment which determined that Maryland’s current prevention system capacity and infrastructure need significant strengthening in order to effectively address the MSPF priorities. Identified needs include intensive prevention training at the State, county and community levels; technical assistance for county and community level prevention planning teams; and additional resources at the community level for evidence-based prevention strategies that specifically address the State’s use and consequences priorities.
- Prevention System Capacity Development: The MSPF Strategic Plan describes a number of prevention system capacity development activities intended to address the gaps identified in the resource assessment. These activities include the creation of a Prevention Academy to provide intensive training for state, county and community prevention planners and providers; the provision of MSPF planning and assessment grants, training and technical assistance to all Maryland jurisdictions; and the provision of competitive implementation funding and technical assistance to local communities of greatest need.
- Implementation of Data Driven Prevention System: As the MSPF plan details, Maryland will continue to use data to drive its prevention decision making processes. The SEOW will continue to provide prevention planners with updated substance use and consequences data at both the State and jurisdictional levels. County planning groups will be required to use epidemiological data to support their priorities and target communities; and local communities will be required to use data to determine the contributing factors that their programs will be addressing. Only data-supported evidence-based strategies and programs will be selected for implementation funding.
- Evaluation of Primary Prevention Outcomes: The MSPF Evaluation includes outcome evaluation at the State, community and program levels. The State and community level evaluations will measure changes in the three MSPF priority indicators across the duration of the project. The program level evaluation will establish and measure outcomes directly related to reducing risk factors and strengthening protective factors related to youth and young adult drinking, binge drinking, and drinking and driving.

Criteria for Allocating Funds: Use following checklist; mark all criteria that apply and indicate priorities

- Population levels (Specify formula: _____)
- Incidence & prevalence levels (Priority #1)
- Problem levels as est. by alcohol/drug-related crime statistics
- Problem levels as est. by alcohol/drug-related health statistics
- Problem levels as est. by social indicator data
- Problem levels as est. by expert opinion
- Resource levels as determined by (Specify method: _____)

[] Size of gaps b/w resources (as measured by) and needs (as estimated by).

[X] Other (Specify): (Priority #2) The Maryland General Assembly's 2003 Joint Chairmen's Report required the ADAA to report on the distribution of substance abuse treatment and prevention funds by jurisdiction. Four methods of allocating funds were determined, including:

- Historic Allocation—percentage distribution implied by the prior year's allocation;
- Legislative Awards—method used by the General Assembly to direct the ADAA to provide funding for specific purposes or to specific jurisdictions;
- Competitive Awards—awards distributed through Requests-for-Proposal (RFP);
- Formula Awards—distribution of grant funds by certain agreed upon criteria, a process explicitly delineating a need.

Facilitation of Public Comment in Developing the State's Plan and the FY 2011-2013 Application for SAPT BG Funds: The ADAA solicited public comment regarding the prevention and treatment elements of the State's Plan and the FY 2011-2013 Application for SAPT Block Grant funds (the "Application"), through the Administration's involvement with the Governor's Drug and Alcohol Abuse Council (DAAC), and the 24 Local Drug and Alcohol Abuse Councils—LDAACs (Baltimore City and the 23 county jurisdictions). Additionally, feedback about the prevention elements of the Plan and Application were developed through the work of the Maryland Strategic Prevention Framework (MSPF) Advisory Committee (SPFAC), which is a subcommittee of the DAAC. The SPFAC and its three work groups have representatives from numerous agencies external to the ADAA, and they provided public comment regarding prevention elements of the Plan and Application. The three SPFAC work groups include: the Statewide Epidemiological Outcomes Workgroup, the Cultural Competence Workgroup, and the Evidence-Based Practices (EBP) Workgroup. The Cultural Competence Workgroup evaluated the prevention elements of the plan for cultural competence and inclusion of widely diverse populations. The EBP Workgroup contributed to the MSPF State Prevention Plan by selecting and prioritizing practices and strategies, and by developing Maryland's plan for allocation of MSPF funds. Finally, the prevention aspects of the Plan and Application were presented to the Prevention Coordinators in the 24 jurisdictions for their feedback. The ADAA also held numerous meetings with prevention and treatment stakeholders to solicit input into needs assessment, planning and the development of standards for recovery support services and Maryland's transition to a Recovery-Oriented Systems of Care (ROSC).

The Maryland State legislature has had input into the development of the Plan and Application through its development of the Maryland StateStat performance measurement system, the ADAA's performance measures and the Governor's Deliverable Units (GDU). The ADAA obtained public input into its plans for local jurisdictional treatment performance measurement through numerous presentations to, and meetings with, local treatment coordinators. The ADAA routinely posts solicitations for public comment on the ADAA website regarding issues such as revisions to the Code of Maryland Regulations (COMAR). Additionally, in FY 2009, the ADAA held two meetings (in Hagerstown and Eastern Shore) to solicit feedback regarding proposed changes to COMAR. Other recent efforts to solicit public feedback for the ADAA's Plan, Application and operations have included web-based surveys regarding stakeholder input regarding Medicaid/Primary

Adult Care expansion and the integration of treatment for problem gambling in addiction treatment programs.

State Priorities and Activities for FY 2011-2013: The ADAA has incorporated Federal, State and local priorities and activities into this list of Maryland's top ten priorities. These are unranked and are not in priority order, but they represent, and were developed in concert with, the partners described previously in the "Facilitation of Public Comment" section.

Form 7: STATE PRIORITIES

1. Healthcare Reform—(Including infrastructure enhancements; reengineering of finance mechanisms; Medicaid/PAC expansion; certification; monitoring; etc.)
2. Expanded Access to Substance Abuse Services
3. Recovery-Oriented System Of Care (ROSC)—(Including continuing care, recovery support services, Access to Recovery-ATR)
4. Strategic Prevention Framework (SPF)—SA Prevention (Including underage drinking)
5. Quality Improvement – National Quality Forum (NQF) Standards—
(Including implementation of evidence-based practices (EBPs); pharmacotherapy i.e., buprenorphine; improving quality in criminal justice/juvenile justice services; early identification and intervention—SBIRT, etc.)
6. Integration Of Behavioral Health And Medical/Somatic Care—(Including primary care integration—SBIRT, office-based treatment/buprenorphine, and improving quality of services for co-occurring disorders (COD)
7. Youth Access To Tobacco—(Including Synar and FDA regulatory authority)
8. Veterans
9. Workforce Development
10. Information Technology—(Including electronic medical record-EMR; enhanced capabilities for data collection/analysis, monitoring, performance measurement, billing/reimbursement; telephonic recovery support services; technology-enhanced treatment & prevention services, etc.

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

- SAMHSA's 8 Strategic Initiatives (<http://www.samhsa.gov/about/strategy.aspx>);
- SAPT-Block Grant requirements and regulations (<http://tie.samhsa.gov/SAPT2011.html>);
- U.S. Dept. of Health and Human Services (DHHS) Healthy People 2010 (<http://www.healthypeople.gov/>);
- Office of National Drug Control Policy (ONDCP) National Drug Control Strategy (<http://www.whitehousedrugpolicy.gov/strategy/>);
- Maryland Dept. of Health and Mental Hygiene (DHMH) Plan To Expand Access To Substance Abuse

Services In Maryland By 25% By 2012; and
(<http://www.statestat.maryland.gov/GDU/15SubstanceAbuseDeliveryPlan.pdf>)

- Partnerships with other Maryland DHMH Offices and Administrations (i.e. Office on Infant Mortality for FASD and other substance exposed infant initiatives, Infectious Disease and Environmental Health Administration for HIV and TB initiatives, etc.).

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

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2011-2013 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

Population levels, Specify formula:

1 Incidence and prevalence levels

Problem levels as estimated by alcohol/drug-related crime statistics

Problem levels as estimated by alcohol/drug-related health statistics

Problem levels as estimated by social indicator data

Problem levels as estimated by expert opinion

Resource levels as determined by (specify method)

Size of gaps between resources (as measured by)

and needs (as estimated by)

2 Other (specify method)

Historical Allocation, Legislative Awards, Competitive Awards, Formula Awards Distribution

Form 4 (formerly Form 8)

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Allegany County	72,532	4,528	3,157	890	616	1,666	1,160	549	540		2.76	5.51	1.38

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Anne Arundel County	521,209	17,684	12,330	4,225	2,854	5,247	3,550	2,054	2,326		3.12	20.87	0.78

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Baltimore County	789,814	35,141	26,706	8,463	6,148	10,058	7,303	2,119	4,989		1.53	27.49	3.18

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Calvert County	89,212	4,281	2,730	378	244	1,006	619	889	698		2.25	10.15	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of		
								6. Prevalence of					

Planning Area		in need		in need		women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Caroline County	33,367	2,199	1,610	159	113	462	312	3,979	265		0	9.05	6.04

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Carroll County	170,089	6,114	4,242	1,413	928	1,765	1,199	640	604		1.77	4.72	0.59

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Cecil County	100,796	6,506	4,918	1,040	727	2,206	1,631	954	552		6	6	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Charles County	142,226	5,979	4,236	290	181	1,343	906	820	1,354		0.71	22.73	1.42

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Dorchester County	32,043	2,254	1,496	257	170	636	416	213	225		0	6.25	9.38

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Frederick County	227,980	7,301	5,038	1,014	679	1,985	1,290	1,146	1,310		0.44	16.83	0.44

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Garrett County	29,555	1,252	831	179	116	314	194	206	105		0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Harford County	242,514	10,412	7,879	1,622	1,094	2,875	2,028	873	855		0.83	16.23	2.91

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Howard County	281,884	5,591	4,195	699	480	1,563	1,161	1,547	1,352		1.45	11.27	2.91

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests				
Kent County	20,247	1,888	1,394	127	88	557	403	103	197		0	9.93	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVUDs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Montgomery County	971,600	14,791	9,632	1,307	814	3,316	2,074	4,323	2,948		0.42	38.81	7.36

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVUDs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Prince George's County	834,560	17,912	13,567	1,230	934	3,507	2,431	1,879	3,677		1.10	77.72	7.92

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVUDs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Queen Anne's County	47,958	1,964	1,219	264	173	658	404	392	286		2.12	6.37	2.12

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVUDs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
St Mary's County	102,999	3,545	2,385	289	214	988	641	685	511		0	8.86	1.97

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Somerset County	25,959	1,678	1,185	120	76	499	369	208	169		0	7.66	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Talbot County	36,262	2,174	1,547	107	77	491	330	443	327		0	16.57	5.52

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Washington County	145,910	9,930	7,641	1,144	871	2,476	1,809	646	1,163		1.38	28.89	2.06

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Wicomico County	94,222	5,449	3,600	511	321	1,545	964	520	807		7.44	22.33	4.25

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Worcester													

County	49,122	3,430	23,984	259	164	1,025	715	822	1,188		0	14.21	2.03
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1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDPs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity			A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:			
Baltimore City	637,418	63,550	42,520	23,328	16,180	23,073	14,958	251	23,929		1.73	146.33	2.67

Form 5 (formerly Form 9)

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	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
17 Years Old and Under	22,544	6,192	2,529	9,864	1,412			368	3	147	0	527	189	932	381	16,503	4,435	1,136	470
18 - 24 Years Old	44,120	18,757	8,745	10,066	2,198			776	132	69	38	175	77	2,419	668	28,901	11,250	3,223	746
25 - 44 Years Old	107,696	37,081	18,975	27,991	13,857			1,125	135	411	147	269	99	6,900	706	65,446	32,897	8,130	1,223
45 - 64 Years Old	51,130	15,986	6,803	18,539	8,048			283	26	139	58	47	43	996	162	34,457	14,802	1,538	333
65 and Over	1,500	722	144	499	79			0	0	21	0	0	0	30	5	1,216	227	50	7
Total	226,990	78,738	37,196	66,959	25,594	0	0	2,552	296	787	243	1,018	408	11,277	1,922	146,523	63,611	14,077	2,779

Native Hawaiians and Pacific Islanders are included in the Asian category.

The Unknown category is in fact the "Other" race, which is an alternative selected primarily by Hispanics.

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

Under 42 U.S.C. §300x-29 and 45 C.F.R. §96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 4 and 5. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of State service needs and informs the planning process to address such needs. The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

The estimates of treatment need presented in Forms 4 and 5 were generated from treatment data available through the State of Maryland Automated Record Tracking (SMART) system using the truncated Poisson Probability Model. This is an inexpensive method that uses the numbers of episodes individual patients have experienced during the year to estimate the truncated portion of the prevalence pool - those in need of treatment who had no treatment episodes during the year. A drawback to using the Poisson model is that it requires some difficult assumptions about the treatment data:

- 1) the probability of treatment admission is the same for the substance users and at all times;
- 2) treatment admissions are randomly distributed over time; and,
- 3) the treatment population is homogenous with respect to factors associated with the likelihood of entering treatment.

However, given its ease of use, the nature of the population and the difficulty in obtaining data on injecting drug users anywhere but in treatment, we believe the estimates are reasonable.

Use of the Poisson Model to estimate treatment need requires availability of a unique identifier in the treatment data. ADAA bases its unique identifier on the last four digits of Social Security Number (SSN) combined with the full date of birth and gender. Adjustments were made for cases missing part of the unique identifier, which comprised less than 3 percent of the cases. Two figures were generated for each selected sub-population - the actual counts of unduplicated individuals receiving treatment during the year, and the estimated untreated portion of the need pool, which is reflected in the numbers of those who would seek treatment but were not currently being served.

Form 6 (formerly Form 11)

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

Activity	(24 Month Projections)					
	A.SAPT Block Grant FY 2011 Award	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	\$ 22,467,667	\$ 6,489,733		\$ 142,243,234	\$ 14,029,306	\$ 16,783,812
Primary Prevention	\$ 6,418,044			\$	\$	\$
Tuberculosis Services	\$	\$	\$	\$ 9,978	\$	\$
HIV Early Intervention Services	\$ 1,604,511	\$	\$	\$ 1,688,635	\$	\$
Administration: (Excluding Program/Provider Lvl)	\$ 1,600,000		\$	\$ 12,861,827	\$	\$ 754,863
Column Total	\$32,090,222	\$6,489,733	\$0	\$156,803,674	\$14,029,306	\$17,538,675

*Prevention other than Primary Prevention

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 1,835,000	\$	\$	\$	\$
Education	\$ 855,320	\$	\$	\$	\$
Alternatives	\$ 1,720,000	\$	\$	\$	\$
Problem Identification & Referral	\$ 101,924	\$	\$	\$	\$
Community Based Process	\$ 895,300	\$	\$	\$	\$
Environmental	\$ 1,010,500	\$	\$	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
Column Total	\$6,418,044	\$0	\$0	\$0	\$0

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$ 1,925,413	\$	\$	\$	\$
Universal Indirect	\$ 1,925,413	\$	\$	\$	\$
Selective	\$ 1,604,511	\$	\$	\$	\$
Indicated	\$ 962,707	\$	\$	\$	\$
Column Total	\$6,418,044	\$0	\$0	\$0	\$0

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2011 funds?

Yes No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	\$	\$	\$	\$ 0
Quality Assurance	\$	\$	\$	\$ 0
Training (post-employment)	\$ 43,000	\$ 28,000	\$	\$ 71,000
Education (pre-employment)	\$ 42,000	\$ 30,000	\$	\$ 72,000
Program Development	\$	\$	\$	\$ 0
Research and Evaluation	\$	\$	\$	\$ 0
Information Systems	\$	\$	\$	\$ 0
Column Total	\$85,000	\$58,000	\$0	\$143,000

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2011 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

- Competitive grants Percent of Expense: %
 - Competitive contracts Percent of Expense: 6 %
 - Non-competitive grants Percent of Expense: 75 %
 - Non-competitive contracts Percent of Expense: 19 %
 - Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services Percent of Expense: %
 - Other Percent of Expense: %
- (The total for the above categories should equal 100 percent.)**
- According to county or regional priorities Percent of Expense: 26 %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

- Line item program budget Percent of Clients Served: %
Percent of Expenditures: %

- Price per slot Percent of Clients Served: %
Percent of Expenditures: %
 - Rate: \$ Type of slot:
 - Rate: \$ Type of slot:
 - Rate: \$ Type of slot:

- Price per unit of service Percent of Clients Served: %
Percent of Expenditures: %
 - Unit: Rate: \$
 - Unit: Rate: \$
 - Unit: Rate: \$

- Per capita allocation (Formula:) Percent of Clients Served: %
Percent of Expenditures: %

- Price per episode of care Percent of Clients Served: %
Percent of Expenditures: %
 - Rate: \$ Diagnostic Group:
 - Rate: \$ Diagnostic Group:
 - Rate: \$ Diagnostic Group:

Program Performance Monitoring

On-site inspections

Frequency for treatment: QUARTERLY

Frequency for prevention: QUARTERLY

Activity Reports

Frequency for treatment: QUARTERLY

Frequency for prevention: QUARTERLY

Management Information System

Patient/participant data reporting system

Frequency for treatment: MONTHLY

Frequency for prevention: MONTHLY

Performance Contracts

Cost reports

Independent Peer Review

Licensure standards - programs and facilities

Frequency for treatment: ANNUALLY

Frequency for prevention: NOT APPLICABLE

Licensure standards - personnel

Frequency for treatment: ANNUALLY

Frequency for prevention: NOT APPLICABLE

Other:

Specify:

Form 7

State Priorities

State Priorities	
1	Health Care Reform - (Including infrastructure enhancements; re-engineering of finance mechanisms; Medicaid/Primary Adult Care - PAC; certification; monitoring etc.)
2	Expand Access To Substance Abuse Services
3	Recovery Oriented Systems of Care (ROSC) - Including Continuing Care, Recovery Support Services, Access to Recovery - ATR
4	Strategic Prevention Framework (SPF) Substance Abuse Prevention - Including Underage Drinking
5	Quality Improvement (NQF Standards) - Including Implementation of Evidence-Based Practices (EBP's); pharmacotherapy services (including Buprenorphine); improving quality in criminal justice/juvenile justice services; early identification and intervention - SBIRT; etc.)
6	Integration of Behavioral Health and Medical/Somatic Care - Including primary care integration - SBIRT; office-based treatment/buprenorphine; and improving quality of services for co-occurring disorders (COD)
7	Youth Access to Tobacco - Including SYNAR and FDA regulatory authority.
8	Services for Veterans
9	Workforce Development
10	Information Technology - Including Electronic Medical Record (EMR); enhanced capabilities for data collection/data analysis, monitoring, performance measurement, billing/reimbursement; technology-enhanced treatment and prevention services; etc.)

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.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

The ADAA services continuum is intended to meet patient needs as identified by Local Drug and Alcohol Abuse Councils (LDAACs) located within every local jurisdiction in Maryland (local jurisdictions are defined as the 23 counties in Maryland and Baltimore City). Local councils provide the ADAA and the Governor's State Drug and Alcohol Abuse Council with 2 year local plans identifying needs and future goals for their jurisdictions. Local plans are consolidated to produce the State plan for substance abuse treatment services.

The ADAA utilizes the following approaches to maintain a statewide continuum of services:

Comprehensive Continuum of Care: During FY 2011-2013, the ADAA will provide SAPT funding to serve approximately 42,000 individuals admitted into treatment annually within the 24 jurisdictions in Maryland. These individuals will receive treatment within a continuum of substance abuse services spanning all levels of care. Treatment episodes associated with these admissions will be supported with a combination of federal, state and Medicaid dollars and may be supplemented with local funding. State-controlled (non-local) funding is provided via grant awards to the local jurisdictions, who administer the services either directly or via sub-contractual agreements with state-certified programs.

ADAA-supported levels of care are based on the American Society of Addiction Medicine-Patient Placement Criteria, II or II-Revised (ASAM PPC II or II-R) and include:

- ~Outpatient (Level I – Outpatient Treatment);
- ~Intensive outpatient (Level II.1 - Intensive Outpatient Treatment);
- ~Residential including halfway house (Level III.1 – Clinically Managed Low-Intensity Residential Treatment);
- ~Extended care Level III.3 – Clinically Managed Medium-Intensity Residential Treatment);
- ~Therapeutic community (Level III.5 – Clinically Managed High-Intensity Residential Treatment);
- ~Intermediate care (Level III.7 – Medically Monitored Intensive Inpatient Services);
- ~Medication assistance and detoxification services within various levels.

Recovery Oriented Systems of Care: As a means to improve the quality of services, the ADAA will implement a statewide Recovery Oriented System of Care (ROSC) model during FY 2011-2013. Additionally, the ADAA intends to implement the Access to Recovery (ATR) program in compliance with CSAT conditions of award.

The ADAA added Continuing Care as a level of care offered by ADAA funded outpatient programs, effective October 2010. Each of the ADAA-funded counties has developed a plan for delivering comprehensive recovery support services for patients and their families, per the ADAA FY 2011 Conditions of Award. Key components of this program include phone-based risk assessment and counseling, face-to-face sessions as needed and case management services.

Initially, in FY 2011, Continuing Care services intended to support the positive gains of treatment will be

delivered to individuals who have completed or who are making adequate progress in their outpatient treatment programs. In FY 2012 and 2013, the ADAA will explore the feasibility of expanding its recovery-oriented support services to target individuals in need of re-engagement because they have dropped out or are at risk of dropping out of treatment services.

The program is flexibly designed to provide recovery support in variable frequencies and amounts within each jurisdiction, depending on identified patient need and/or upon request. These are new services for which to date, Maryland has not been able to establish a baseline. Therefore, the ADAA intends to monitor patient utilization of these services, and expects to be able to make reasonable projections for 2013 and beyond based on actual utilization patterns measured during FY 2011- 2012, the first years for which data will be available.

Medicaid Expansion: One of Maryland Governor Martin O'Malley's Strategic Goals is to expand access to substance abuse services in Maryland by 25% by 2012, both by focusing on service system capacity expansion and by improving the quality and efficiency of the current system. Capacity expansion will be accomplished by increasing provider capability to obtain Medicaid reimbursement for outpatient and intensive outpatient treatment, and by drawing down federal matching funds, which will enable the use of grant funded treatment slots to treat new patients. Improving the quality and efficiency of the current system will open treatment slots to new patients by reducing patient relapse and subsequent re-admission, and by increasing treatment slot turnover rates. During 2011-2013, the Administration will continue its technical assistance activities to assist treatment programs to develop Medicaid billing and collections expertise, and to increase capacity through improved business management practices.

Other ADAA 2011-2013 goals are to:

- Continue to fund contracts for statewide long-term residential treatment services which serve pregnant women and post-partum women with dependent children (see also Goals 3 and 9);
- Continue to fund services for patients referred by the court system that require a therapeutic community milieu;
- Continue to fund residential treatment services for patients with co-occurring mental health and substance use disorders;
- Increase access to and utilization of pharmacotherapy;
- Improve linkages between primary care (federally-qualified health centers-FQHCs) and the behavioral health services system;
- Integrate administrative and clinical practices utilized by the ADAA and the DHMH Mental Health Administration (MHA);
- Implement a comprehensive electronic health record (EHR);
- Expand workforce capacity (licensure; cross-training between disciplines);
- Implement services for individuals with problem and/or pathological gambling;

Treatment service providers will attain the following performance measures in FY11-13:

1. Fifty-five percent (55%) of patients in ADAA-funded halfway house programs will be retained in treatment at least 90 days.
2. Forty percent (40%) of adolescent patients and 58% of adult patients completing/ transferred/ referred from ADAA-Funded intensive outpatient programs will enter another level of treatment within 30 days of discharge.
3. Eighty-five percent (85%) of patients at completion/transfer/referral from ADAA-funded residential detoxification programs will enter another level of treatment within 30 days of discharge.
4. The number of patients using substances at completion/transfer/referral from treatment will be reduced by 75% among adolescents and adults from the number of patients who were using substances at admission to treatment.
5. The number of adult patients employed at completion/transfer/referral from treatment will increase by at least 32% from the number of patients who were employed at admission to treatment.
6. The number arrested during the 30 days before discharge will decrease by 65% for adolescents and 72% for adults from the number arrested during the 30 days before admission.
7. Fifty percent (50%) of patients dis-enrolled from a Level III.7 will enter another level of care within 30 days.
8. Fifty percent (50%) of patients dis-enrolled from a Level III.5 will enter another level of care within 30 days.
9. Fifty percent (50%) of patients dis-enrolled from a Level III.3 will enter another level of care within 30 days.

Actions:

1. The ADAA will continue to include performance measures in the Conditions of Award for services grants to each Maryland jurisdiction.
2. The jurisdictions will comply with the conditions of grant award and will submit data monthly.
3. The ADAA will perform data validation and make recommendations for technical assistance and corrective action when necessary.

Goal: The Administration intends to provide continued funding to maintain the three contracts for statewide long term residential treatment services through FY 2012. These contracts will continue to serve pregnant women and post partum women with dependent children, patients requiring a therapeutic community milieu referred by the court system, and patients with co-occurring mental health and substance abuse disorders.

Objective: Statewide treatment service providers will attain the following performance measures in FY11-13:

1. Sixty-five percent (65%) of patient discharges will be retained in treatment at least 60 days.
2. Ninety percent (90%) of patient discharges will be referred to a lower level of treatment.
3. Ninety percent (90%) of all patient admission and discharge records will be accurately and completely entered into the SMART system within 30 days of admission and discharge.

Action:

1. The ADAA will continue to include performance measures in the Conditions of Award for all contract sub-recipients.
2. Contract sub-recipients will comply with the conditions of grant award and will submit data monthly.
3. The ADAA will perform data validation and make recommendations for technical assistance and corrective action when necessary.

During FY 2008, the ADAA provided SAPT funding for a continuum of substance abuse treatment services spanning all levels of care. The levels of treatment care were based on the American Society of Addiction Medicine-Patient Placement Criteria, II or II-Revised (ASAM PPC II or II-R) and will include outpatient (Level I – Outpatient Treatment), intensive outpatient (Level II.1 - Intensive Outpatient Treatment), residential including halfway house (Level III.1 – Clinically Managed Low-Intensity Residential Treatment) , extended care Level III.3 – Clinically Managed Medium-Intensity Residential Treatment), therapeutic community (Level III.5 – Clinically Managed High-Intensity Residential Treatment), intermediate care (Level III.7 – Medically Monitored Intensive Inpatient Services), and medication assistance and detoxification services within various levels. In Fiscal Year 2008, 29,775 individual males (69%) and 13,362 individual females (31%) received treatment in ADAA-funded programs.

These services met patient needs identified by Local Drug and Alcohol Abuse Councils (LDAACs) located in every Maryland jurisdiction (jurisdictions are defined as the 23 counties of Maryland and Baltimore City). Local councils provide the ADAA and the Governor's State Drug and Alcohol Abuse Council with 2 year local plans identifying needs and future goals for their jurisdictions. Local plans are consolidated to produce the State plan for substance abuse treatment services.

In an effort to bridge continuum service gaps in the jurisdictions in the four Maryland regions, ADAA-Funded three contracts for statewide long-term residential treatment services. These contracts served pregnant women and post partum women with dependent children; patients requiring a therapeutic community milieu referred by the judicial system and patients with co-occurring mental health and substance use disorders.

Fiscal year 2008 ADAA treatment grant performance targets were as follows:

1. Sixty-two percent (62%) of patients in ADAA-Funded outpatient programs were to be retained in treatment at least 90 days. Actual statewide attainment was 59%. Ten of the 24 grant-funded subdivisions achieved this objective.
2. Sixty percent (60%) of patients in ADAA-Funded halfway house programs were to be retained in treatment at least 90 days. Actual statewide attainment was 56%. Four of 14 subdivisions with halfway-house treatment achieved this objective.
3. Fifty percent (50%) of the patients completing ADAA-Funded intensive-outpatient programs enter another level of treatment within thirty days of discharge. Actual statewide attainment was 49%. Twelve of 20 subdivisions with intensive-outpatient treatment achieved this objective.
4. Seventy-five percent (75%) of patients completing ADAA-funded residential detoxification programs enter another level of treatment within thirty days of discharge. Actual statewide attainment was 78%. Seven of 10 subdivisions with residential detoxification achieved this objective.

5. The number of patients using substances at completion of treatment will be reduced by 85% among adolescents and 68% among adults from the number of patients who were using substances at admission to treatment. Actual statewide attainment was 76% among adolescents and 61% among adults. Eight of the 24 subdivisions achieved this objective for adolescents and 19 of 24 achieved it for adults.

6. The number of employed adult patients at completion of treatment will increase by 29% from the number of patients who were employed at admission to treatment. Actual statewide attainment was 34% with ten of 24 subdivisions achieving this objective.

7. The average arrest rate per patient during treatment will decrease by 65% among adolescents and 75% among adults. Because the item capturing numbers of arrests during treatment was removed from the reporting system, this measure could not be calculated.

During FY 2010, the ADAA provided SAPT funding for a continuum of substance abuse treatment services spanning all levels of care. The levels of treatment care were based on the American Society of Addiction Medicine-Patient Placement Criteria, II or II-Revised (ASAM PPC II or II-R) and will include outpatient (Level I – Outpatient Treatment), intensive outpatient (Level II.1 - Intensive Outpatient Treatment), residential including halfway house (Level III.1 – Clinically Managed Low-Intensity Residential Treatment) , extended care Level III.3 – Clinically Managed Medium-Intensity Residential Treatment), therapeutic community (Level III.5 – Clinically Managed High-Intensity Residential Treatment), intermediate care (Level III.7 – Medically Monitored Intensive Inpatient Services), and medication assistance and detoxification services within various levels.

These services met patient needs identified by Local Drug and Alcohol Abuse Councils (LDAACs) located in every Maryland jurisdiction (jurisdictions are defined as the 23 counties of Maryland and Baltimore City). Local councils provide the ADAA and the Governor's State Drug and Alcohol Abuse Council with 2 year local plans identifying needs and future goals for their jurisdictions. Local plans are consolidated to produce the State plan for substance abuse treatment services.

In an effort to bridge continuum service gaps in the jurisdictions in the four Maryland regions, ADAA-Funded three contracts for statewide long-term residential treatment services. These contracts served pregnant women and post partum women with dependent children; patients requiring a therapeutic community milieu referred by the judicial system and patients with co-occurring mental health and substance use disorders.

During FY 2010 the Maryland Alcohol and Drug Abuse Administration (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 Maryland Department of Health and Mental Hygiene. This provided an opportunity for the three administrations to work more collaboratively to develop a more integrated system of care for the patients we share. One of the main FY 2010 accomplishments of the Deputy Secretary for BHDD was the implementation of regional trainings and workgroups for staff and clinical service providers to build on the process of integrating cross system collaboration for serving patients with addictions, mental health disorders and developmental disabilities.

In FY 2010, a major DHMH initiative was launched to expand Medicaid coverage for outpatient and intensive outpatient addictions treatment services and primary adult care (PAC) for somatic care. The ADAA and the DHMH Health Care Financing, Office of Health Services formed a partnership to coordinate the drafting of standards and policies for implementation of the State's revised Medical Assistance requirements for patients with substance use disorders.

In FY 2010, the Administration established a Recovery Oriented System of Care (ROSC) Steering Committee to guide the process of ROSC implementation in Maryland. The Committee was charged with

developing standards, policies and practices for treatment and recovery support services. The ADAA has submitted an application for an Access to Recovery (ATR) grant to provide recovery services for patients following residential care episodes. Upon receipt of notification, the ADAA intends to implement the ATR program in compliance with CSAT conditions of award.

In FY 2010, the ADAA continued to collaborate with MedChi, the Maryland State Medical Society, to increase the capacity of certified physicians to provide buprenorphine treatment services. The initiative provided four regional certification trainings for nearly 200 physicians, as well as additional trainings regarding clinical and office management practices.

In fiscal year 2010, as a condition of grant award, the ADAA required that all jurisdictions measure performance as follows.

1. Sixty-two percent (62%) of patients in ADAA-funded outpatient programs will be retained in treatment at least 90 days. This measure remains at 59% statewide. At this time 12 of 24 subdivisions have attained the objective.
2. Sixty percent (60%) of patients in ADAA-funded halfway house programs will be retained in treatment at least 90 days. This measure is at 55% statewide, still short of attainment. Only four of 14 subdivisions with halfway-house treatment have reached the sixty-percent level.
3. Forty-five percent (45%) of adolescent patients and 55% of adult patients completing/ transferred/ referred from ADAA-funded intensive outpatient programs will enter another level of treatment within 30 days of discharge. Statewide the measure was attained for adults (55%) but only 38% of statewide adolescents entered another level of treatment, although 6 of 9 applicable subdivisions achieved the objective. One subdivision with 42 percent of the statewide cases had only 13% of adolescents enter another level of treatment. Twelve of 21 subdivisions with adult IOP achieved the 55-percent level.
4. Seventy-eight percent (78%) of patients completing/transferred/referred from ADAA-funded residential detoxification programs will enter another level of treatment within 30 days of discharge. This objective was attained at the statewide level – 83 percent entered another level of care. Seven of nine subdivisions with residential detoxification achieved the objective.
5. The number of patients using substances at completion/transfer/referral from treatment will be reduced by 70% among adolescents and 78% among adults from the number of patients who were using substances at admission to treatment. Statewide the objective was attained for adolescents (73%) but fell short for adults (74%). Fifteen of 24 subdivisions achieved the objective for adolescents and 15 achieved the adult objective.
6. The number of adult patients employed at completion/transfer/referral from treatment will increase by at

least 24% from the number of patients who were employed at admission to treatment. This objective was attained on a statewide basis - employed adult patients increased by 32% during treatment. Thirteen of the 24 subdivisions had at least a 24% increase in patients employed.

7. The number of patients arrested during the 30 days before discharge will decrease by 70% for adolescents and 75% for adults from the number arrested during the 30 days before admission. The reduction in patients arrested stands at 64% for adolescents and 72% for adults. Thirteen of 24 subdivisions attained this objective among adolescents and 11 of 24 among adults.

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*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013, the Alcohol and Drug Abuse Administration (ADAA) will continue to utilize no less than 20% of its SAPT Block Grant funds to develop, implement and oversee ATOD prevention programs and strategies. The ADAA will continue to provide direction and technical assistance to its Prevention Network via communication, education, program development, coordination, cooperation, funding and advocacy. The ADAA intends to continue to use the SAMHSA Strategic Prevention Framework (SPF) model as its vehicle for developing and implementing an effective prevention system.. SAPT funded counties will be required as a condition of grant award to implement the five components of the SPF SIG-need assessment, capacity building, planning, evidence based programming/strategies, and evaluation

The ADAA has received funding to implement a SPF SIG in Maryland (MSPF). The ADAA submitted its Prevention Plan to CSAP for review and approval in July 2010. The Statewide Epidemiological Outcomes Workgroup (SEOW), the MSPF Advisory Committee (SPFAC), the members of the SPFAC Evidence Based Practices and Cultural Competency Workgroups will continue to work with ADAA staff to provide guidance and oversight of this system-changing process.

The MSPF theory of action proposes that by providing data driven, culturally competent, evidence based prevention strategies and programs at the community level, Maryland will impact a number of key contributing factors for underage drinking, binge drinking, alcohol and drug-related crashes and alcohol and/or drug dependence and as a result reducing the incidence of these problems.

In an effort to move the MSPF process forward, the ADAA is providing \$10,000 of SAPT funds to each of the 24 jurisdictions (\$240,000 total) to help them initiate the SPF needs assessment and capacity building process at the local level. Local Prevention offices will be required to provide the results of the needs assessment and corresponding plans to the ADAA by early 2011. With support from the ADAA Office for Education and Addiction Training (OETAS), the Northeast CAPT, and other contractors, ADAA MSPF staff will provide training and technical assistance at the county and community levels. This activity will be initiated in October, 2010.

To determine Maryland's Prevention Workforce capacity and training needs, the ADAA, OETAS and the Maryland Association of Prevention Professionals and Advocates (MAPPA) will analyze the data and report the results from the Prevention Workforce Development Survey that was distributed to prevention professionals and advocates during the Summer of 2010.

The Administration will fund several evidence based programs throughout the state during FY 2011. These programs will include Across Ages, All Stars, CMCA, CLFC, Dare to Be You, Guiding Good Choices, Life Skills Training, Positive Action, Project Alert, Project Towards No Drug Use, Second Step and Strengthening Families Program.

These programs will provide services and activities within the six CSAP strategies. Strategies and activities

will include ATOD-Free Activities, Community Service Activities, Youth Leadership Activities, Training Services Activities, Technical Services Activities, COSA Activities, Classroom Educational Activities, Educational Services for Youth, Parent and Family Management Activities, Peer Leader Activities, Small Group Activities, Health Promotion Activities, Preventing Underage Alcohol Sales, Establishing ATOD –Free Policies.

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

CSAP Strategies:

Information Dissemination: Funds will be provided to County Prevention Coordinators to establish mini-resource centers. They will coordinate and provide speaker bureaus and develop and implement media campaigns.

Community-Based Process: Administration staff will maintain interaction with program developers to remain current with evidence-based programs. Training and technical assistance will be provided to Prevention Coordinators, their staff and those community representatives implementing evidence based programs.

Community-Based Process: County Prevention Coordinators will provide resources to community-based groups and organizations to assist in the development of evidence based programs and activities based on data. Coordinators will work with county addiction coordinators and the Local Drug and Alcohol Abuse Councils (LDAACs) to help them understand and utilize MSPF to meet the AOD Prevention needs in their counties.

Education: Each of the County Prevention Coordinators will work with community coalitions, groups and/or agencies to identify and institute AOD prevention training courses/seminars in order to implement evidence based programs. Staff of the Northeast CAPT will provide training and technical assistance on needs assessment, capacity building, planning, evidence-based programming and evaluation to local Prevention Coordinators and Administration staff.

Alternative Activities: County Prevention Coordinators will assist in the development and funding of activities to reduce underage drinking and eliminate tobacco use. They will provide resources to community-based organizations to implement before- and after-school ATOD prevention programs.

Problem Identification and Referral: Administration staff will continue to work collaboratively with local health departments to provide student assistance programs and education programs that address substance use issues.

Environmental: Technical assistance will be provided to community groups and organizations on how to

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develop and implement appropriate legislative strategies to address ATOD issues.

A minimum of 20% of the SAPT Block Grant funds were utilized to support primary prevention activities. A total of 235,622 Maryland residents received prevention services. These funds enabled the Administration to support the Prevention Coordinator's Network. This statewide network provided the infrastructure for the provision of technical assistance support and funding to community group/organizations to plan and implement prevention services throughout the State. The Administration maintained a total of 27 community based programs. Additionally, SAPT funds were provided to six counties to provide services to high risk youth. A total of 3,276 children and their families were served at 15 sites throughout these counties.

These programs provided services and activities within the six CSAP strategies. Strategies and activities included ATOD-Free Activities, Community Service Activities, Youth Leadership Activities, Training Services Activities, Technical Services Activities, COSA Activities, Classroom Educational Activities, Educational Services for Youth, Parent and Family Management Activities, Peer Leader Activities, Small Group Activities, Health Promotion Activities, Preventing Underage Alcohol Sales, Establishing ATOD-Free Policies.

The Administration continued to fund four strategically located ATOD Prevention Centers in the central, eastern, southern and western areas of the state. These Centers are at Towson University, the University of Maryland Eastern Shore, Bowie State University and Frostburg State University. The ATOD Prevention Centers sponsored a total of 386 events/activities that reached 35,464 individuals.

During FY 2008, the ADAA funded several CSAP evidence-based programs throughout the state. These programs included Across Ages, All Stars, Creating Lasting Family Connections, Communities Mobilizing for Change on Alcohol, Dare to be You, Guiding Good Choices, Life Skills, Positive Action, Project Alert, Project TND, Second Step, and Strengthening Families

Evidence-based Programs and Numbers Served:

Across Ages - 203
 All Stars - 572
 CLFC - 363
 CMCA - 16,963
 DTBY - 1801
 GGC - 828
 Life Skills - 630
 Positive Action - 18
 Project Alert - 1608
 Project TND - 28
 Second Step - 5702
 Strengthening Families - 2035
 Total - 20,429

Prevention services provided within the Institute of Medicine (IOM) Classification were as follows (numbers served by IOM Category):

Universal Direct - 38,501

Universal Indirect - 164,132

Selected - 28,566

Indicated - 4,423

Total - 235,622

In 2010, the Administration was awarded funding from SAMHSA to develop and implement the Maryland Strategic Prevention Framework (MSPF). The MSPF Advisory Committee, a committee of the Governor's State Drug and Alcohol Abuse Council (DAAC) was convened and tasked with guiding and overseeing the development, implementation and success of the MSPF initiative. The MSPF Advisory Committee has three active workgroups: the Statewide Epidemiological Work Group(SEOW), the Cultural Competence Work Group and the Evidence Based Practices Work Group. These work groups met regularly during FY 2010 to develop recommendations for MSPF priorities, activities, policies and guiding principles. These recommendations were then presented to the MSPF Advisory Committee for further discussion and approval. The priorities to be addressed are:

- Reduce the number of youth; age 12-20, reporting past month alcohol use
 - Reduce the number of young persons; age 18-25, reporting past month binge drinking
 - Reduce the number of alcohol and/or drug related crashes
- Reduce the number of Marylanders across the lifespan that report past year alcohol and/or drug dependence or abuse

The MSPF Plan was submitted to CSAP for review and approval in July 2010.

The ADAA has required, as a condition of award for FY2011 funding, that each of the 23 counties, Baltimore City and the University ATOD Prevention Centers describe how they are implementing the five steps of the Strategic Prevention Framework.

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.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013 ADAA plans to provide gender-specific services to approximately 750 pregnant women and women with dependent children annually. These women will be served in up to 11 programs that deliver a variety of types of services (intermediate care-ICF, long-term residential, halfway house, and intensive outpatient-IOP). These 11 programs serve women in Baltimore City and ten counties (Allegany, Anne Arundel, Baltimore [County], Carroll, Frederick, Montgomery, Prince Georges, St. Mary's, Washington, and Worcester), but also accept statewide referrals from the other 12 counties in the state based on need. If current trends continue, nearly 60% of these women will receive IOP services, another 30% will be served in halfway houses, nearly 7% will be served in ICF and 2-3% will be served in long-term residential. We intend to continue to fund these services in eligible programs via contractual agreements directly with the programs, or via purchase of service agreements between the programs and local jurisdictions. We intend to maintain this level of support in FY 2012 and FY 2013.

During FY 2011-2013, the ADAA will continue to ensure that pregnant women will receive priority admission to substance abuse treatment programs by supporting the development and maintenance of specialized gender-specific treatment services for women, pregnant women, and women with dependent children. This will be accomplished by continuing the development of ancillary services/activities that support, and by providing ongoing funding for, gender-specific programs and gender-specific treatment services.

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

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

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

7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above”.

The ADAA also strives to attain its goal of aligning State and federal resources to improve the quality of life of pregnant and parenting women, and to reduce infant mortality in Maryland. To this end, the ADAA will continue to collaborate with the Department of Human Resources (DHR) for the provision of cross-training for Department of Social Services (DSS) personnel and substance abuse professionals. The ADAA will continue to collaborate with DHMH Family Health Services (FHS) implement enhanced medical services in two jurisdictions in the state. The ADAA will continue to collaborate with the DHMH FASD office to present FASD training to providers at the individual and population levels.

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

In FY 2008, the Administration expended \$4,121,210 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 Maryland 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 2008, the ADAA solicited bids from providers in the state, and awarded contracts to five (5) gender-specific residential programs. These five (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 Alcohol and Drug Abuse Administration Compliance Unit.

ADAA Conditions of Award for all treatment awards for SFY 2008 contained the following requirements:

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

1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.
3. The program provides or arranges for child care while the women are receiving services.
4. The program provides or arranges for primary pediatric care for the women’s children, including immunizations.
5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
6. The program provides or arranges for therapeutic interventions for children in custody of women in

treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, neglect and FASD.

7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above”.

To ensure continued growth and awareness of service availability, the Administration updates and posts on its website the Directory of Drug and Alcohol Treatment Services for Women, Infants and Children in Maryland, a comprehensive reference guide detailing type of patients served and 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.

In FY 2010, the ADAA continued to support gender-specific residential treatment beds for women, pregnant women and women with dependent children by providing categorical funds to support the continuum of treatment services for those populations. Service provision included but was not limited to 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. The Administration continued funding for the development of ancillary services/activities that supported gender-specific treatment.

To ensure that pregnant women and women with children continued to receive priority admission to treatment programs, the Administration included this requirement in the conditions of grant award to local health departments and sub-contractors. The ADAA Conditions of Award for SFY 2010 contained the following requirements:

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

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

The ADAA women services coordinator was the Region III representative on the NASADAD Women’s Services Network (WSN) workgroup throughout FY 2009. With assistance from the WSN, a guidance document was developed and distributed to programs during FY 2010, to assist them with implementing best practices in gender specific programming. The guidance document was also utilized in the ADAA solicitation request for gender specific residential services. ADAA staff continued to utilize the guidance document during FY 2010 when providing technical assistance to programs and providers.

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 2008; 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 2008. 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 2008 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 2008 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?

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 FY2008

PROGRAM	LOCATION	NFR-ID	LEVEL OF CARE	Funds	Slots
Massie Unit	Allegany	900227	ICF	\$167,671	4
Chrysalis H	Anne Arundel	903759	Halfway House	\$188,121	8
JHH Women's	Baltimore City	902355	IOP	\$749,949	34
A.W.A.R.E.	Baltimore Co.	101834	IOP	\$370,784	38
Shoemaker	Carroll	750564	Detox, ICF	\$218,429	8
Gale House	Frederick	750432	Halfway House	\$433,373	12
Avery House	Montgomery	103392	Halfway House	\$485,635	9
P.G. Center	P.G. Co.	300030	IOP	\$860,812	56
Marcy House	St. Mary's	101123	Long Term	\$156,875	6
W House	Washington	101230	Halfway House	\$215,875	17
Center 4 Clean	Worcester Co	901845	IOP	\$273,686	32
				\$4,121,210	

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2008 block grant and/or State funds?

In FY 2008, 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 2008 and beyond.

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 2008 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 \$4,121,210 in SAPT federal funds for 11 gender-specific programs in FY 2008 focused on categorically maintaining and enhancing prevention activities and treatment services for pregnant women and women with dependent children. Programs are itemized in the following matrix.

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.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Requirements for Sub-recipients: During FY 2011-2013, the ADAA will continue to require that the Conditions of Award for sub-recipients will contain the following requirements:

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

8. Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State that 90 percent of the capacity has been reached.
9. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:
 - (a.) 14 days after making the request or
 - (b.) 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program
10. When applicable, the program offers interim services that include, at a minimum , the following:
 - (a.) Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission do not occur
 - (b.) Referral for HIV or TB treatment services, if necessary
 - (c.) Counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women
11. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.
12. The program has a mechanism that enables it to:
 - (a.) Maintain contact with individuals awaiting admission
 - (b.) Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area
13. The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when one of the following conditions exists:
 - (a.) Such persons cannot be located for admission into treatment or
 - (b.) Such persons refuse treatment
14. The program carries out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:
 - (a.) The standard intervention model as described in The NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)

- (b.) The health education model as described in Rhodes, F. Humfleet, G.L. et al., AIDS Intervention Program for Injection Drug Users: Intervention Manual, (Feb. 1992)
 - (c.) The indigenous leader model as described in Wiebel, W., Levin, L.B., The Indigenous Leader Model: Intervention Manual, (Feb. 1992)
15. The program ensures that outreach efforts (have procedures for):
- (a.) Selecting, training, and supervising outreach workers
 - (b.) Contacting, communicating, and following up with high-risk substance abusers, their associates and neighborhood residents within the constraints of Federal and State confidentiality requirements
 - (c.) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV
 - (d.) Recommending steps that can be taken to ensure that HIV transmission does not occur”.

Interim methadone: During FY 2011-2013, the ADAA intends to continue its support of Interim Methadone services when indicated, particularly in Baltimore City, which has the highest incidence of IVDUs and opioid users in Maryland, and where most OMT programs are at or near capacity. When demand for services requires is such that patients cannot be admitted to treatment in a timely manner, patients can be admitted to Interim Methadone (IM) services instead of being placed on waiting lists. Under the IM standard protocol, patients can receive daily doses of opioid maintenance medication for a period of time not to exceed 120 days, at which time they must be placed into a permanent treatment slot.

Baltimore Substance Abuse Services (BSAS) initiated Interim Methadone (IM) services in FY 2005. The IM pilot project was converted to a standard protocol for opioid-addicted individuals in Baltimore City, and the ADAA has supported the IM standard protocol in Baltimore City through Baltimore Substance Abuse Services (BSAS) since FY 2006 and in Anne Arundel County through the County Dept. of Health since FY 2007. BSAS expanded IM services to Johns Hopkins BPRU and the University of Maryland Methadone Program in FY 2010. In FY 2011, the ADAA will continue to support IM slots at BPRU, University of Maryland, IBR Reach, Sinai – Sharp and Anne Arundel County. The ADAA will also continue efforts to expand capacity for Methadone treatment by improving treatment efficiencies and by increasing treatment capacity, i.e. counselor /patient ratios in funded programs.

Tracking Capacity: The ADAA will continue to use its online data collection system, SMART (State of Maryland Automated Record Tracking) to track slots and admissions data for capacity management during FY 2011-2013. The ADAA utilizes SMART data to identify patient census levels for all IVDU programs. All programs, including IVDU programs receiving state and/or federal funds, submit monthly Census and Waiting List data to the ADAA MIS Section. The ADAA MIS reconciles individual programs' active patient lists against the monthly census and waiting list reports and the ADAA centralized database. This allows an ongoing count of slot availability and, in concert with Compliance Services Section program visits, ensures that programs serving IV drug users (IVDU) provide notification to the State when they reach 90% capacity. The Community Services Division will continue to provide technical assistance to help local programs with their plans for addressing utilization issues.

In FFY 2008, the ADAA used its online data collection system SMART (State of Maryland Automated Record Tracking) to track slots and admissions data for capacity management. The ADAA utilized SMART data to identify patient census levels for all IVDU programs. All programs, including IVDU programs receiving state and/or federal funds, submitted monthly Census and Waiting List data to the ADAA MIS Section. The ADAA MIS reconciled individual programs' active patient lists against the monthly census and waiting list reports and the ADAA centralized database. This allowed an ongoing count of slot availability and, in concert with Compliance Services Section program visits, ensured that programs serving IV drug users (IVDU) provided notification to the State when they reached 90% capacity. The Community Services Division provided technical assistance to help local programs develop plans for addressing utilization issues.

In addition, 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 Services (BSAS) initiated Interim Methadone (IM) services in FY 2005. The IM pilot project was converted to a standard protocol for opioid-addicted individuals in Baltimore City, and the ADAA has supported the IM standard protocol in Baltimore City through Baltimore Substance Abuse Services (BSAS) since FY 2006 and in Anne Arundel County through the County Dept. of Health since FY 2007. In FY 2008, the ADAA supported jurisdictions (Baltimore City and Anne Arundel County) whose sub-vendors were approved by CSAT to provide Interim Methadone services.

The ADAA required, through its FY 2008 Conditions of Award, that any entity that received federal funding for treatment services for IVDUs utilize effective outreach models to recruit and retain persons in need of treatment.

In FFY 2010, the ADAA used its online data collection system, SMART (State of Maryland Automated Record Tracking) to track slots and admissions data for capacity management. The ADAA utilized SMART data to identify patient census levels for all IVDU programs. All programs, including IVDU programs receiving state and/or federal funds, submitted monthly Census and Waiting List data to the ADAA MIS Section. The ADAA MIS reconciled individual programs' active patient lists against the monthly census and Waiting list reports and the ADAA centralized database. This allowed an ongoing count of slot availability and, in concert with Compliance Services Section jurisdictional visits, ensured that programs serving IV drug users (IVDU) provided notification to the State when they reached 90% capacity. The Community Services Division provided technical assistance to help County Treatment Directors establish monitoring protocols for addressing utilization issues.

In addition, 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 Services (BSAS) initiated Interim Methadone (IM) services in FY 2005. The IM pilot project was converted to a standard protocol for opioid-addicted individuals in Baltimore City, and the ADAA has supported the IM standard protocol in Baltimore City through Baltimore Substance Abuse Services (BSAS) since FY 2006 and in Anne Arundel County through the County Dept. of Health since FY 2007. BSAS expanded IM services to Johns Hopkins BPRU and the University of Maryland Methadone Program in FY 2010.

The ADAA required, through its FY 2010 Conditions of Award, that any entity that received federal funding for treatment services for IVDUs utilize effective outreach models to recruit and retain persons in need of treatment.

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 2008; 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 2008 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)).

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 of our addictions treatment programs are mandated to provide HIV risk-reduction counseling to all patients as an integral part of the intake admission process.

The treatment service continuum in Maryland has been not only maintained but expanded by the use of SAPT Block Grant funds. The Administration supported 7,319 slots dedicated to opioid maintenance therapy (OMT) services. These services were provided in nine (9) of the jurisdictions: Allegany County, Anne Arundel County, Baltimore City, Baltimore County, Frederick County, Harford County, Montgomery County, Prince George's County and Wicomico County. The treatment continuum in Maryland incorporates the ASAM PPC II-R levels of care. All treatment programs, including programs treating IVDU patients, uses the ADAA sponsored web enabled treatment episode reporting system. To specifically ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act the Administration requires each program to report monthly on admission and discharge activities. This information is collected and maintained on the Administration's centralized database and 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 provides reports to the programs for self-monitoring and quality improvement. Reports on program data are available to program staff at all times and provide instant feedback as to capacity status. In addition, all programs are required to submit a monthly Census and Waiting List (CWL) along with their monthly report on admissions and discharges. MIS staff monitor the CWL submissions and when anomalies appear they notify both Community Services Division and the Compliance Section of the Quality Assurance Division. Programs are called or visited to provide technical assistance to remedy the situation.

The following is a list of programs treating IVDUs and reported a 90% capacity during FFY 2008.

I-SATS FACILITY

- 62 Prince George's County Based Substance Abuse Program
- 143 Baltimore Crisis Response Inc.
- 541 Alcohol and Drug Intervention, Inc.
- 621 Recovery in Community
- 100018 Addiction Treatment Services
- 100059 Echo House
- 100083 University of Maryland Methadone Program
- 100091 Baltimore Community Resource Center
- 100182 Anne Arundel County Mental Health and Addictions
- 100190 Reflective Treatment Center
- 100981 Hilltop Recovery Center

101002 Journeys Treatment Program
 101003 Gaudenzia, Inc.
 101123 Marcey House
 101229 Build Fellowship
 101230 W House
 101288 Avery Road Combined Care
 101292 Turning Point Clinic
 101311 Park West Medical Systems Inc.
 101327 Comprehensive Treatment Services
 101360 Right Turn of Maryland
 101362 Mountain Manor Treatment Center
 101363 Howard House
 101468 Transitioning Lives
 101735 Universal Counseling Services
 101834 AWARE A Womens Active Recovery Center
 101891 Counseling Plus, Inc.
 101983 Deale One-Step Recovery Program
 102147 IBR Reach Mobile Health Services
 102188 Jude House
 102378 Suburban Hospital OP Treatment Program
 102428 Calvert County Treatment Facility
 102667 Pathways
 102972 University of Maryland – Walter P Carter Center
 103079 Powell Recovery Center
 103392 Avery Halfway House for Women & Children
 103608 Somerset County Health Department
 103798 Addicts Changing Together Substance Abuse Program
 103889 Family Health Center of Baltimore
 103962 Health Care for the Homeless
 104135 Recovery Network
 104150 U of Md Harambee Treatment Center
 104804 Renaissance Treatment Center
 105983 Alcohol Drug Education Prevention and Treatment
 106502 Warwick Manor Behavioral Health Inc
 106619 First Step Recovery Center, Inc.
 106825 Partners in Recovery
 300014 Junction Inc
 300030 Prince Georges CHD
 300329 Second Genesis
 301293 Kent CHD – Publik House

301350 Glenwood Life Counseling Center
301400 Washington CHD
750283 Mann House, Inc.
750291 Damascus House
750382 Caroline CHD Addictions Program
750390 Talbot County Drug and Alcohol Program
750408 Haven House Halfway House
750424 Frederick CHD
750432 Gale Houses Inc
750473 Charles CHD Substance Abuse Services
750499 Reality, Inc.
750523 Second Wind
750564 Carroll CHD Bureau of Addiction Treatment Services
750580 Samaritan House
750614 Baltimore County Bureau of Substance Abuse
900102 Daybreak Rehab Treatment Center
900128 Man Alive, Inc.
900151 ADAPT Cares
900169 Sinai Hospital Addictions Recovery Program
900185 New Hope Treatment Center
900227 Allegany County Addictions Services
900300 Wicomico Behavioral Health
900326 First Step, Inc.
900375 Cecil CHD Alcohol and Drug Center
900433 Epoch Counseling Center
900441 Howard CHD
901209 Garrett CHD
901720 HARBEL Prevention and Recovery Center
901779 Walden Sierra, Inc.
901811 Next Passage
901845 Worcester CHD
901902 JHU Behavioral Pharmacology Research Unit
902140 Tuerk House, Inc.
902165 Bridge & Valley House
902199 Dorchester CHD
902314 Avery Road Treatment Center
902355 JHH Programs for Alcoholism
902389 Friendship House/Safe House
902512 Calvert CHD
902546 Hudson Health Services

902710 Hope House
902801 Total Health Care
902934 Wells House
902959 Lawrence Court Halfway House
902967 Montgomery County Office of Addictions Services
903759 Chrysalis House
903817 Harford CHD
903874 New Life Addictions Counseling Services, Inc.

Also see ADAA Conditions of Award listed under Compliance and Intended Use sections of this Goal. ADAA regulations and Conditions of Grant Award state that all patients must be seen within 10 working days from the date of first contact and a long standing policy that pregnant women, IV Drug Users, and HIV Positive patients are given priority status for admission to all funded programs.

The Quality Assurance Division, Compliance Section, conducts random compliance reviews with programs receiving federal funds to assure patients are seen for admission within 10 working days from date of first contact as required by Code of Maryland Regulations 10.47.01.04 A (1) (a).

ADAA directs local jurisdictions to provide outreach activities toward all drug users including IDUs to increase awareness of treatment services available in their communities.

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 2009) 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)).

Notification of program census throughout the State is accomplished through the use of the ADAA online data collection application and the submission of a Census and Waiting List (CWL). Programs use the application to submit a monthly report on admission and discharge activity. The online application also provides reports to the programs for self-monitoring and quality improvement. Reports on program capacity status are available to program staff at all times.

ADAA continued development of an automated notification of reaching capacity from its web based clinical record. SMART has the ability to record an agency's slot capacity and as patients are admitted, SMART counts capacity in use. With the use of the Contract Management module in SMART, the Administration is able to track ADAA-funded statewide residential slots. We are developing an alert to notify the State Opioid Treatment Authority (SOTA) when an opioid maintenance treatment (OMT) program's active client roster reaches 90% of its slot capacity.

The Regional Managers and ADAA MIS analysts provide technical assistance to the programs to help them manage their capacity.

All addictions treatment programs must, by State regulations, be certified and report to the Administration's online data collection application. The Administration has implemented regulation to ensure that any individual who requests and is in need of treatment be seen in the appropriate treatment within 10 days or be referred to another certified program.

Administration policy mandates a screening for tuberculosis and referral to appropriate health services for substance abuse patients. All addiction treatment programs funded by the State shall directly or through arrangements with other public or non-profit entities routinely make available tuberculosis services to the admitted patients. Programs have implemented assessment, education and testing activities. Case management ensures that individuals needing TB services receive them, and treatment requirements are maintained and follow-up evaluations are performed. The Department of Health and Mental Hygiene, Office of Health Care Quality performs program compliance monitoring functions biannually.

In addition ADAA's web-based clinical record tracks whether the patient received a TB Risk assessment and whether the patient was referred for testing.

The 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.

Since 1990, the Administration has maintained a specific policy requiring all programs to give priority admission to pregnant women. The ADAA required that addicted females with confirmed pregnancies be admitted to and retained in treatment on a priority basis and not be waiting lists or be subjected to involuntary discharge. A variety of women's programs were implemented over the past decade. These programs provided a full continuum of addiction treatment services as well as 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 other community resources were also utilized.

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

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FFY 2010 - 2013, the ADAA will continue to require that a tuberculosis risk assessment be performed on all patients receiving services. The ADAA will continue to require that individuals in all levels of care that are identified to be at risk receive further testing to be made available either on-site and/or by referral. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and the Administration's Compliance Section will continue to review tuberculosis assessments and referral services for patients during the biannual certification process.

In FFY 2008, the ADAA required that a tuberculosis risk assessment be performed on all patients receiving services. For individuals at risk, further testing provided on-site and/or by referral was required to be made available in all levels of care. This requirement stipulated that programs perform or make available the assessment, and note services or referrals in patient records. These requirements are included in the Conditions of Award for sub-recipients. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and the Administration's Compliance Section reviewed tuberculosis assessment and referral services for patients during the biannual certification process.

In FFY 2010, the ADAA continued to require that a tuberculosis risk assessment be performed on all patients receiving services. For individuals at risk, further testing provided on-site and/or by referral was required to be made available in all levels of care. This requirement stipulated that programs perform or make available the assessment, and note services or referrals in patient records. These requirements are included in the Conditions of Award for sub-recipients. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and the Administration's Compliance Section reviewed tuberculosis assessment and referral services for patients during the 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

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013, the ADAA will continue to ensure that all individuals admitted to treatment in Maryland's certified treatment programs receive risk assessment, risk reduction and referral for counseling and testing if appropriate, within the first 30 days of treatment.

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

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

As a designated State, all jurisdictions must, as a Condition of Award, make available HIV Early Intervention Services (HIV-EIS) for individuals in treatment for substance use disorders. In accordance with 45 CFR §96.128, Maryland's Treatment Conditions of Award state that as a condition of acceptance of ADAA funding, the 24 jurisdictions (Baltimore City and 23 counties) must ensure that programs which they directly administer and/or sub-contract with must:

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

Funding to support these services is provided to the local jurisdictions through the 5% HIV Early Intervention Set Aside. A portion of the 5% Set Aside (approximately \$405,000) will be awarded annually via an MOU with the Maryland Infectious Disease and Environmental Health Administration (IDEHA, formerly the “AIDS Administration”). IDEHA will provide HIV testing services (pre-test counseling, testing and post-test

counseling) to individuals within the areas of the State with greatest need, at the locations at which they are receiving treatment.

The remaining portion of the 5% Set Aside will be allocated to the 24 jurisdictions to support risk assessment, risk reduction and coordination of referrals for HIV testing if appropriate. This may include referrals for testing in local health departments, community health centers, primary care providers, or AIDS Services Organizations (ASOs).

We will maintain this level of support during FY 2011-2013. We intend to continue to fund these services via contractual agreements directly with the jurisdictions, or via purchase of service agreements between the jurisdictions and their sub-recipient programs.

For some time, the ADAA experienced difficulty in tracking the HIV Set Aside funding expenditures. Starting in FY 2012, the ADAA will require that all jurisdictions and sub-recipient programs provide evidence of how the HIV Set Aside funding was expended.

Since HIV risk assessment, risk reduction and coordination of referrals for HIV testing is required for all treatment admissions, the ADAA estimates that these services will be provided to approximately 42,000 individuals to be admitted annually during FY 2011-2013. However, pre-test counseling, HIV testing and post-test counseling will occur at variable frequencies within each jurisdiction, depending on identified patient need, and a utilization baseline has not yet been established.

The ADAA will continue to identify key staff responsible for linkages with IDEHA regarding training and implementation of procedures, and will continue to collaborate with IDEHA regarding the training and implementation of the HIV rapid testing procedures.

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

As a designated state, Maryland expended \$1,593,484 of SAPT Block Grant funds on HIV early intervention services in FFY 2008. Activities included education, assessment and counseling services. Each of the 24 jurisdictions in Maryland received HIV set-aside funds as part of their total SAPT Block Grant allocation. As a condition of award, the jurisdictions agreed to comply with 45 C.F.R 96.128, to ensure that counseling, testing and post test counseling are provided at the sites at which the individuals were receiving treatment.

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.

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.

The Alcohol & Drug Abuse Administration continued to contract annually with the Maryland AIDS Administration (MAA, now the Maryland Infectious Disease and Environmental Health Administration-IDEHA) 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. The trainings included HIV 101/Prevention Basics, HIV & Substance Abuse and HIV Counseling and Testing. As part of this statewide effort, three programs from Baltimore City were categorically funded to provide outreach, case management, assessment and referral services. These programs targeted the areas in Baltimore City that had the greatest need.

In addition, the Maryland AIDS Administration began implementation of rapid HIV testing in October 2003, and it became fully operational by February 2004. The OraQuick HIV-1 Rapid Testing device, a new 20-minute testing technology, was 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.

As a designated state, Maryland continued to expend SAPT Block Grant funds on HIV early intervention services. Activities included education, assessment and counseling services.

Each of the 24 jurisdictions in Maryland received HIV set-aside funds as part of their total SAPT Block Grant allocation. As a condition of award, the jurisdictions agreed to comply with 96.128, by insuring that counseling, testing and post test counseling are provided at the sites at which the individuals are receiving treatment. Further, Maryland COMAR 10.47.01.04 (D) required every certified (licensed) substance abuse treatment program in the State 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.

The Alcohol & Drug Abuse Administration continued to contract annually with the Maryland Infectious Disease and Environmental Health Administration (IDEHA) 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. The trainings included HIV 101/Prevention Basics, HIV & Substance Abuse and HIV Counseling and Testing. As part of this statewide effort, the Baltimore Substance Abuse Services, Inc.(BSAS) HIV Prevention Integration Initiative was categorically funded to provide outreach, case management, assessment and referral services. This initiative targeted the areas in Baltimore City that had the greatest need.

In addition, IDEHA continued rapid HIV testing using the OraQuick HIV-1 Rapid Testing device. These services were made available for free and confidential or anonymous testing in 42 of 350 testing sites in Maryland (12%), including those supported by the HIV set-aside funds that the ADAA awarded to IDEHA. This amounts to a 23.5% increase since 2008 in the number of sites in Maryland that provide rapid HIV testing.

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 2008; 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 2008 Uniform Application, Section III.4, FY 2008 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.

Tuberculosis (TB)

Administration 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. In addition, 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.

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

Programs shall provide the following services to employees:

NOTE: ("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.)

Employee TB Training: All employees shall receive TB infection control training within one month of employment and annually. 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.

Early Intervention Services for HIV

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 Administration has required all funded providers to provide HIV/AIDS education, assessment and counseling services to their patients.

Additionally and in support of this process, the following targeted projects detailed by region provide categorical early intervention services for HIV.

Agency	Amount	Location
1. Glenwood Life Counseling Center	\$ 50,468	Baltimore City
2. Md. AIDS Administration Program Manager, Program Evaluator and Partial Capacity Building Trainer salary & fringe benefits	\$177,169	Baltimore City
3. Baltimore SA Services (BSAS) HIV Prevention Integration Initiative	\$195,000	Baltimore City
Total ADAA Funds		\$422,637

The remaining balance of the 5% HIV Set Aside is 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.

Summary of Services:

Training & Capacity Building:

In FY 2010, staff of the Infectious Disease and Environmental Health Administration (IDEHA) 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.

The HIV Prevention Integration Initiative at Baltimore Substance Abuse Systems, Inc., which was established by IDEHA in FY 09, continued into FY 10. IDEHA staff members provided HIV prevention training and capacity building to staff of BSAS and its grantees. As part of this initiative, 178 staff were trained to incorporate HIV prevention programming—including Extra Steps and Pharaoh, two behavioral interventions, and HIV Counseling, Testing, and Referral (CTR)—in their delivery of substance abuse treatment services in Baltimore City.

Training Recipients	Curricula	# Staff Trained
Parole & Probation Staff	HIV 101/Prevention Basics Graying of HIV SA and HIV HIV/TB and Hepatitis Daily Challenges of Living with HIV	824 staff

BSAS Substance Abuse Treatment Grantees	Extra Steps	55 staff
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BSAS Substance Abuse	Pharaoh	10 staff
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Agency	Interventions Completed	# Cycles/Tests	# Clients Served
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Glenwood Life Counseling Center	Intensive Group Level HIV Prevention Intervention Utilizing the Project SMART Curriculum	21	173
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BSAS Substance Abuse Treatment Grantees	Intensive Group Level HIV Prevention Intervention Utilizing the Extra Steps Curriculum	84	511
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BSAS Substance	Intensive Group Level	15	74
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Abuse Treatment HIV Prevention Intervention
 Grantees Utilizing the Pharaoh
 Curriculum

BSAS Substance Abuse Treatment Grantees	HIV Counseling, Testing, and Referral (CTR)	424	424
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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 IDUs 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.

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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

N/a

N/A

N/A

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 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 2008 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.

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 2011 Annual Synar Report included with the FY 2011 uniform application? (Yes/No)
- If No, please indicate when the State plans to submit the report: (mm/dd/2010)

Note: The statutory due date is December 31, 2010.

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.

Maryland will continue to maintain a non-compliance rate equal to or below the required target of twenty percent (20%), as mandated by the Synar Amendment. In August 2010, Maryland was awarded a contract from the Food and Drug Abuse Administration (FDA) to strengthen Maryland's Youth Access to Tobacco Program by providing consistent statewide enforcement activities. The integration of the Synar program and the FDA's enforcement efforts will help Maryland achieve its goals for reducing the sale of tobacco products to minors, resulting in the maintenance of a non-compliance rate of less than 20%.

In FFY 2011, Maryland will conduct its second List Coverage Study with a required coverage rate of at least 80 percent, with a 90 percent coverage rate recommended. Maryland's target rate is below 90%. A coverage rate of 90% or below and compelling evidence that the list is comprehensive and stable for the second List Coverage Study could result in Maryland being allowed to implement the Coverage Study at five year intervals.

The State's 2011 Synar report will be submitted by December 31, 2010.

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*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FY 2011-2013, the ADAA will continue to ensure that pregnant women are given preference in admission to treatment through its conditions-of-award for these programs, which include the requirements found in 45 CFR §96.131.

Compliance with these regulations will benefit 365-400 pregnant women per year, or 2.5% to 3% of the total number of females admitted annually to ADAA-funded substance abuse treatment services in Maryland's 24 local jurisdictions (Baltimore City and 23 counties).

First, the ADAA has implemented the following policy and Conditions of Award which hold local jurisdictions and other sub-recipient programs to a standard that goes well-beyond 45 CFR §96.131: "All grantees and all sub-grantees shall admit pregnant women within 24 hours of request."

This overarching policy has had the effect of eliminating any issues related to insufficient capacity for pregnant women. Pregnant women are not placed on waiting lists or provided only "interim services". Programs in Maryland must provide certified addictions treatment services within 24 hours of request, even if only at a lower level of care (e.g., outpatient or intensive outpatient treatment services), until the preferred level of care (e.g. residential treatment services) is available.

Also in accordance with CFR §96.131, the ADAA Conditions of Award for its jurisdictional grants specify that program preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services must give preference in the following order:

- (a.) To pregnant injecting drug users first
- (b.) To other pregnant substance abusers second
- (c.) To other injecting drug users third
- (d.) To all other individuals fourth

Compliance with these and other requirements will continue to be maintained through the bi-annual certification process and through annual site visits conducted by the ADAA Compliance Unit.

Additionally, the ADAA will also continue to ensure that its funded treatment programs provide, at a minimum, prenatal care, access to medical services, parenting skills, life skills education and vocational skills to pregnant women in need of services either directly or through referral. The ADAA women's treatment coordinator and the ADAA Statewide Projects Division also will continue to work with the 24 local jurisdictions and programs to provide technical assistance to implement the NASADAD Treatment Standards for Women with Substance Use Disorders (Mandell and Werner, 2008) and to promote gender specific best practices within treatment services that serve pregnant women and women with dependent children.

Further, the ADAA will continue to collaborate with other state and local agencies which have a mandate to

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provide services for pregnant women and women with dependent children. The ADAA will promote the alignment of state and federal resources to improve the quality of life and reduce infant mortality in Maryland through the Governor's Delivery Unit performance management system. The ADAA women's treatment coordinator will continue to work in collaboration with DHMH Child and Maternal Health to ensure that factors that have lead to high infant mortality rates are eliminated. This partnership will result in enhanced prenatal care for pregnant women in residential addictions treatment programs.

In FFY 2008, the State of Maryland continued to ensure pregnant women were given preference in admission to treatment. conditions-of-award for these programs included the requirements found in CFR §96.131 regarding preference in admission to pregnant injecting drug users and other pregnant women in need of treatment, and other requirements found in that section.

All ADAA funded treatment programs provided at a minimum prenatal care, access to medical services, parenting skills, life skills education and vocational skills to pregnant women in need of services. Compliance was maintained through the bi-annual certification process and through annual site visits conducted by the Alcohol and Drug Abuse Administration Compliance Unit.

To expand residential treatment capacity for pregnant women and women with dependent children, in FY 2008 the ADAA solicited bids from providers in the state, and awarded contracts to five (5) gender-specific residential programs. These five (5) programs were located in the central, southern and western regions of the state.

In FFY 2010, the State of Maryland continued to ensure pregnant women be given preference in admission to treatment. Conditions-of-award for these programs included the requirements found in CFR §96.131 regarding preference in admission to pregnant injecting drug users and other pregnant women in need of treatment, and other requirements found in that section.

Additionally, the ADAA issued its revised “Infant Mortality Reduction Initiative” policy, which became effective on October 2, 2009. Previous policy required that programs admit pregnant women into treatment within 48 hours, but the revised policy required that treatment programs admit pregnant women within 24 hours of the request for service.

All ADAA funded treatment programs provided at a minimum prenatal care, access to medical services, parenting skills, life skills education and vocational skills to pregnant women in need of services. Compliance was maintained through the bi-annual certification process and through annual site visits conducted by the Alcohol and Drug Abuse Administration Compliance Unit.

To expand residential treatment capacity for pregnant women and women with dependent children, in FY 2010 the ADAA solicited bids from providers in the state, and awarded contracts to five (5) gender-specific residential programs. These five (5) programs were located in the central, southern and western regions of the state.

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 2009) 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.

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

programs' policies for priority admission of addicted pregnant women is reviewed onsite at every routine OHCQ certification or ADAQ-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 four SFY, 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 ADAQ 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.

For SFY 2011, funding changes have necessitated reducing Interim Methadone slots at BPRU, University of Maryland and IBR because Medicaid Primary Adult Care (PAC) now funds methadone maintenance treatment. This funding shift opened block grant slots within methadone programs, thereby reducing the need for Interim Methadone. However, Sinai is in a Health Services Cost Review Commission's (HSCRC)

regulated space. Because of the HSCRC designation, Sinai is unable to bill Medicaid or PAC. Sinai's Methadone Maintenance slots are full, and it continues to experience demand for Interim Methadone. The patients treated at Sinai's Methadone Maintenance program are served with block grant dollars. For SFY 2011, BSAS expects to fund 15 Interim Methadone slots at BPRU, University of Maryland and IBR, and 45 slots at Sinai – Sharp.

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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

The State of Maryland Automated Record Tracking (SMART) application is a web based full clinical record based on the WITS platform. In the application two assessments are provided for clinicians: the ASI and the Treatment Assignment Protocol (TAP). The TAP has been required of evaluators that perform assessments for court-ordered defendants for several years. The TAP provides questions based on the ASAM PPC II or II-R criteria and is very useful for determining the appropriate patient level-of-care placement. Once the appropriate level-of-care is determined, programs use the SMART application to electronically refer the patient to the appropriate treatment provider. SMART enhancements have also included additional programming to provide instruments such as the Simple Screening Interview – Substance Abuse (SSI-SA) from the SAMHSA TAP 49.

During FY 2011-2013, the ADAA will continue to improve the process for referring individuals to the most appropriate level-of-care according to ASAM placement criteria. The ADAA will continue to require, via COMAR regulations, that all publicly-funded programs report all patient data in SMART. The ADAA will provide, as needed, additional enhancements in SMART which may include additional screening, assessment and placement instruments.

The ADAA will continue to require in its Conditions-of-Award the use of the TAP and the ADAD for making level-of-care determinations consistent with ASAM placement criteria.

Additionally, the ADAA will continue to provide training and technical assistance in best practices and the specific applications of screening, assessment and placement instruments, and the Office on Education and Training for Addiction Services (OETAS) will routinely offer training on assessment and placement criteria in its catalogue of courses.

Further, in light of federal health care reform efforts, the DHMH Office of Behavioral Health and Disabilities (OBHD) is currently exploring the integration of the Alcohol and Drug Abuse Administration (ADAA) and the Mental Health Administration (MHA). This exploration includes administrative, medical records (SMART), data management, clinical, fiscal, training and monitoring functions. These OBHD decisions will affect our approach to establishing an integrated electronic record, data gathering system and outcomes/performance measurement. The ADAA will continue collaboration with the MHA to coordinate, fund and promote treatment capacity expansion for individuals with co-occurring mental health disorders (COD).

In 2008, the ADAA began to require that programs utilize only the American Society of Addiction Medicine [ASAM] Patient Placement Criteria [PPC] for establishing eligibility and making level-of-care determinations. COMAR §10.47.01.04 required that programs have detailed descriptions of eligibility and patient placement criteria for admission to the programs. COMAR regulations (§10.47.01.04) also prohibit admission to programs unless individuals meet ASAM PPC “or other guidelines approved by the ADAA”.

In 2008, the ADAA also planned to make amendments to COMAR which would eliminate the requirement that programs utilize the ASI, and would instead require all funded programs to utilize the TAP. As the ADAA began to transition to a full electronic medical record (EMR), modifications were made which enabled clinicians to use individual client level data from the TAP to make eligibility and level-of-care determinations for adults. The instruments were provided through the State of Maryland Automated Record Tracking-SMART system. The ADAA procured programming to add the SSI-SA to its inventory of screening instruments and continued to require that specific court evaluations use the TAP. The ADAA provided training in their application through the Administrations Office of Education and Training for Addiction Services (OETAS).

In planning for incorporation of the POSIT adolescent assessment tool into SMART, the ADAA went to the National Institute on Drug Addiction (NIDA) for updated scoring protocols. At that time, the ADAA was informed that the POSIT is no longer endorsed by NIDA. The ADAA began searching for a new public-domain adolescent assessment tool to program into SMART, and this search continued through FY 2008 and FY 2009.

In order to improve the process of referring individuals to the most appropriate level-of-care, ADAA continued to organize all treatment program regulations and require that all treatment programs become certified according to ASAM Patient Placement Criteria [PPC].

In SFY 2010 the Administration made significant progress revising the Alcohol and Drug Abuse Administration section of the State of Maryland Code of Maryland Regulations (COMAR) for the second time. Revisions to the 2008 Code will be submitted for review and publication in SFY 2011. These regulations further define and clarify ASAM criteria listed in the current Maryland requirements governing all substance abuse treatment programs and the protocols for referring patients.

The ADAA continued to require that all Maryland treatment providers use the State's electronic record, SMART, in order to better screen, assess and provide the most appropriate treatment placements. The ADAA made three additional screening instruments and eight assessment instruments available within SMART. The screening tools included the SA/MH, the South Oaks Gambling Screen (SOGS), and the CSAT approved SSI/SA. The eight assessment instruments included:

- Treatment Assignment Protocol
- Behavioral Health Assessment
- Juvenile Risk Assessment
- Dens ASI
- ASI Lite
- Cage Assessment
- E Court Drug and Alcohol Assessment
- Adolescent Drug and Alcohol Diagnosis Assessment

The Administration has the following Condition of Award included in their grant application instructions for SFY 2011:

A. Screening, Assessment and Patient Placement Criteria

1. The grantee and all sub-grantees shall use the Treatment Assignment Protocol (TAP) to assist in determining the level of care.

The Administration mandated the TAP for all grant funded agencies to assist clinicians in assessing the various ASAM domains and making treatment determinations.

Once evaluated, if the appropriate level of care is not available, clinicians may refer patients to an appropriately certified program (according to ASAM-PPC), through the referral module in the SMART application. With the proper consents in place, SMART will electronically send the referral (patient

demographic and assessment information) to the receiving agency. The receiving program, in real time, will have the treatment recommendations and an assessment of the patient's level of care requirements according to ASAM.

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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

The mission of the Office of Education and Training for Addiction Services (OETAS) is to improve addiction treatment and prevention services by strengthening the knowledge, skills and attitudes of those providing these services in Maryland. To achieve this mission, OETAS works collaboratively with a variety of other state administrations such as the Mental Hygiene Administration, Developmental Disabilities Administration, the AIDS Administration, the Juvenile Services Administration and other state agencies. OETAS has formed close working relationships with our counterparts at the federal level, the Central East Technology Transfer Center (CEATTC), the Northeast Center for the Application of Prevention Technologies (N-CAPT) and the Mid-Atlantic Clinical Trials Network (CTN). We also partner with our two addiction associations: the Maryland Addiction Directors Consortium (MADC) and the Maryland Addiction Prevention Professional Association (MAPPA). We will continue to work in collaboration with these entities to provide the necessary training and support for Maryland's addictions workforce.

To further our mission, specific goals for FY 2011-2013 are:

1. To conduct a workforce survey to inform our addictions workforce development plans. The ADAA conducted a survey of Maryland's addiction workforce in 2006, in collaboration with the Central East Addiction Technology Transfer Center (CEATTC). The information obtained from the 2006 workforce survey was instrumental in our understanding workforce needs and how we could address them. In order to obtain a more current assessment of the field's needs the ADAA is currently conducting a prevention services workforce survey, and is currently designing a treatment workforce survey instrument to be distributed to the field shortly.
2. To continue to provide evidence-based and best practices courses and training opportunities. OETAS will continue to provide courses and training on such topics as motivational interviewing, cognitive behavioral therapy, and the use of motivational incentives. OETAS will also continue to provide professional development courses on ethics, management, cultural competency as well as a variety of courses targeted to the many diverse ethnic and cultural populations which are served by the addictions field in Maryland. The workforce survey will provide guidance concerning specific topics and training formats to help tailor the trainings to the needs of the workforce.
3. To prepare the workforce for transformation to a Recovery-Oriented System of Care (ROSC). The ADAA is moving forward to transform its addiction services system from an acute care model to one which reflects the chronic nature of addiction. The ADAA is in the early stages of implementing ROSC which is lead by a ROSC Steering Committee comprised of identified leaders in the addiction field that bring a myriad of experience. The Steering Committee provides guidance and direction to several critical subcommittees, including the ROSC Technology Transfer Subcommittee. This group provides leadership, resources and planning to support Maryland's ROSC Learning Collaborative, comprised of change agents from each of the 24 jurisdictions. The ROSC Learning Collaborative meets quarterly to discuss pertinent training and planning issues and to energize the State during the transition to ROSC. To effectively disseminate ROSC

principles throughout the State, the ADAA has developed and conducted a twenty-four hour (24-hour) training of trainers (TOT) provided to a select group of 20 individuals. These individuals will continue to learn and to teach the Administration's ROSC curriculum. This cadre of ROSC trainers will enable the Administration to respond to a variety of ROSC training requests and to quickly expand the field's knowledge base and skills concerning ROSC. Additional trainers will receive the TOT in FY 2011. In addition, the ADAA will begin providing technical assistance to support telephonic continuing care services; these technology transfer activities will continue throughout 2012 and 2013.

4. To prepare the capabilities of the workforce to treat problem and pathological gambling.

The ADAA expects that, during FY 2011-2013, there will be increased numbers of individuals presenting themselves to addictions programs for the treatment of gambling disorders, due to new and expanded access to gambling casinos with slot machines throughout the State. In anticipation of the increase, the ADAA will provide two gambling addiction TOT courses in FY 2011, and will provide additional training and support to our providers as treatment programs identify additional need throughout FY 2012-2013.

5. To continue to infuse technology into professional and clinical practice. During FY 2011-2013, OETAS will continue to offer courses on clinical issues such as assessment and treatment planning that integrates the use of our web based data reporting system. This goal is intended to foster the use of technology in clinical settings and to enhance the skills of clinicians.

6. To support MSPF and enhance the skills of Maryland's prevention services workforce.

During FY 2011-2013, OETAS will coordinate with MSPF and local prevention services staff to plan, implement and evaluate prevention technology training necessary for full realization of the goals of MSPF.

The Office of Education and Training (OETAS) within the Administration's Information Division is responsible for ensuring that continuing education courses meet the needs of individuals that provide addiction prevention and treatment services. In FY 2008, OETAS provided year round training to meet the needs identified by the addiction workforce, including commuter and residential (overnight) continuing education courses and trainings delivered in collaboration with the Central East Addiction (CEATTC), the National Center for Applied Prevention Technology (CAPT), the Mid-Atlantic Clinical Trials Network, and other State and local agencies. Further, OETAS provided certain customized on-site trainings, which agencies and programs purchased to meet the specific needs of their workforce. Training and courses offered by OETAS focused on the acquisition of advanced and specialized knowledge and skills on treatment and prevention topics, such as motivational interviewing, cognitive behavior therapy, clinical supervision, the Strategic Prevention Framework and co-occurring disorders.

In July and August of 2007 and June of 2008, OETAS provided statewide trainings at Salisbury University on the eastern shore of Maryland. During these three months, OETAS provided 21 twenty hour courses to approximately 500 students. From September 2007 through May 2008, in collaboration with federal and other partners, OETAS offered 26 commuter courses and workshops at the ADAA's central training location in Catonsville, MD.

In October 2007 the ADAA hosted its annual Statewide Management Conference. In attendance were over 200 funded addiction program managers and prevention coordinators. The "Recovery Oriented System of Care" theme featured nationally recognized keynote speakers who shared their knowledge and expertise on the study, structure and dynamics of the addiction services industry.

During FY 2010, OETAS provided continuing education for employees of facilities that provide prevention, intervention and treatment services. Twenty-nine (29) training opportunities were provided through commuter classes and customized trainings. Approximately 400 participants attended the 18 twenty hour (3 ½ day) programs at Salisbury University (July and August 2008 and June 2009). OETAS offered continuing education courses that emphasized advanced addiction counseling and prevention content and that integrated research evidence into information about clinical processes and prevention activities. Trainings addressed the specialized needs of our workforce, and included topics such as the treatment of co-occurring disorders, substance-related disorders resulting from trauma and brain injury, and clinical supervision.

During FY 2010, the ADAA worked closely with the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) to provide regional workshops that brought the local management and clinical staffs of the three administrations together to develop a more integrated system of care for the patients we share. In addition, the three administrations developed a clinical supervisors' academy to address the need for integrated training on clinical supervision.

In FY 2010, the ADAA collaborated with the Office of Problem Solving Courts (OPSC) to continue the annual C.Wayne Kempke Lecture Series, which focuses on disseminating and promoting innovative research practices in the treatment of substance abuse disorders for criminal justice populations. Approximately 200 administrators and managers of criminal justice and addiction treatment systems and agencies attended the third lectures in the series.

In FY 2010, the ADAA's annual Statewide Management Conference provided an opportunity for providers and administrators throughout the state to network and share resources and to examine several work processes. Invitees include program managers, prevention coordinators and central office administrators. The conference focused on Maryland's transformation to a Recovery-Oriented System of Care (ROSC), Medical Assistance/Primary Adult Care expansion, the MSPF grant award and other structural changes within our addiction prevention and treatment system.

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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013, the Alcohol and Drug Abuse Administration will continue its efforts to support a statewide continuum of prevention; treatment and recovery oriented services as well as coordination with other appropriate services through active involvement with other State agencies, local health departments and healthcare professionals. This goal will be accomplished through the ADAA's continued participation with collaborative activities involving other appropriate State and local agencies, and through continued support, representation and active involvement of ADAA staff on serving on existing and newly identified committees, task forces and work groups.

The following partnerships will enhance the quality of treatment services for substance-using populations in Maryland:

- The ADAA plans to continue its collaborations with the Maryland Drug Treatment Court Commission and the Maryland Office of Problem-Solving Courts to support local jurisdictions in planning, implementing and operating drug courts, and to encourage a collaborative, comprehensive, multi-disciplinary approach to reducing drug-related crime.
- The ADAA will continue collaboration with the Maryland Department of Juvenile Services (DJS) to coordinate referrals to treatment resources for adolescents, and with the Maryland Infectious Disease and Environment Health Administration (IDEHA, formerly the "AIDS Administration") to coordinate HIV Set Aside-funded HIV risk assessment, testing, and referral for individuals undergoing treatment within high incidence areas of the State.
- In light of federal health care reform efforts, the DHMH Office of Behavioral Health and Disabilities (OBHD) is currently exploring the integration of the Alcohol and Drug Abuse Administration (ADAA) and the Mental Health Administration (MHA). This exploration includes administrative, data management, clinical, fiscal, training and monitoring functions. These OBHD decisions will affect our approach to establishing an integrated electronic record, data gathering system and outcomes/performance measurement. The ADAA will continue collaboration with the MHA to coordinate, fund and promote treatment capacity expansion for individuals with co-occurring mental health disorders (COD).
- During FY 2011-2013, the ADAA anticipates continued collaboration with the Maryland Department of Human Resources Family Investment Administration (DHR/FIA) to coordinate interagency funding for screening, assessment and referral services for Temporary Cash Assistance (TCA) and certain Food Supplement Program (FSP, formerly Food Stamps) applicants and recipients (per Maryland's Welfare Innovation Act of 2000/House Bill 1160). The ADAA also anticipates continued collaboration with the Maryland Department of Human Resources Social Services Administration (DHR/SSA) to coordinate and provide substance abuse treatment services for pregnant and 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).

- The ADAA plans to continue collaboration with the Center for Health Promotion, Education and Tobacco Use Prevention of the Maryland Department of Health and Mental Hygiene-Family Health Administration (FHA) 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.
- The Administration also plans continued collaboration with the Maryland Department of Health and Mental Hygiene Office of TB Control to coordinate cross-training of addictions treatment personnel and TB Control public health nurses, and to implement current protocols for TB screening, testing and referral within Maryland's addiction treatment programs.

During FY 2011-2013, the ADAA plans to maintain and expand partnerships with other state, county and community agencies to enhance the quality of prevention services in Maryland. The ADAA plans to effectively and efficiently implement Maryland Strategic Prevention Framework (MSPF) activities in accordance with the CSAPT-approved Strategic Plan. The ADAA plans to sustain the activities of the Statewide Epidemiological Outcomes Workgroup (SEOW). The ADAA also anticipates ongoing collaboration with the University of Maryland Eastern Shore (UMES) ATOD Prevention Center and Eastern Shore prevention coordinators to maintain and/or expand the underage drinking media campaign, and collect data to evaluate its impact.

During FY 2011-2013, the ADAA plans to continue to expand its partnerships with other State and local agencies to provide and enhance recovery oriented services in Maryland. The ADAA is implementing Continuing Care as a level of care offered by ADAA funded outpatient programs, beginning in the Fall of 2010. Key components of this program include phone-based risk assessment and counseling, face-to-face sessions as needed and case management services. The program is flexibly designed to provide recovery support in variable frequencies and amounts, depending on patient need and request. Further, the ADAA is poised to implement the Access to Recovery (ATR) Initiative in Maryland, upon CSAT notification of grant award.

In FFY 2008, the Administration 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. Examples of this 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 Maryland Annual Suicide Prevention Conference Planning Committee (with the Maryland Mental Hygiene Administration [MHA], the ADAA's Office of Education and Training for Addiction Services [OETAS] and other agencies);
- Maryland Department of Health and Mental Hygiene-Infectious Disease and Environmental Health Administration's Partnership for Prevention ("Supporting Partner") to promote immunization of healthcare workers against influenza.

Additionally, the ADAA Medical Director served on the following committees, task forces and work groups:

- Hepatitis Task Force
- Traumatic Brain Injury Task Force
- Advisory Council on Prescription Drug Monitoring
- 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 Coordination of Care Meetings
- Medical Assistance MCO Medical Directors Roundtable Meetings
- Maryland Advisory Council on Mental Hygiene
- Physician Clinical Support System National Steering Committee (SAMHSA)
- Transitional Youth Policy Academy
- Buprenorphine Task Force of the Center for a Healthy Maryland (MED-CHI)
- MHA/ADAA/DDA Clinical Case Collaborative Meetings
- Child Mental Health Blueprint Task Force

Further, the ADAA partnered with the following other state agencies to provide and further enhance the services for substance-using populations in Maryland:

- Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park to coordinate prevention and treatment needs assessment and planning activities, and to support the Maryland

Community Services Locator (MDCSL).

- Maryland Drug Treatment Court Commission and the Maryland Office of Problem-Solving Courts to support jurisdictions in planning, implementing and operating drug courts and to encourage a collaborative, comprehensive, multi-disciplinary approach to reducing drug-related crime.
- Maryland AIDS Administration to coordinate HIV Set Aside-funded HIV risk assessment, testing, referral, and prevention education for individuals undergoing treatment within Baltimore City's treatment programs.
- Maryland Mental Hygiene Administration (MHA) to coordinate, fund and promote treatment capacity expansion for individuals with co-occurring mental health disorders (COD).
- Maryland Department of Human Resources Family Investment Administration (DHR/FIA) to coordinate interagency funding for screening, assessment and referral services for Temporary Cash Assistance (TCA) and certain Food Supplement Program (FSP, formerly Food Stamps) applicants and recipients (per Maryland's Welfare Innovation Act of 2000/House Bill 1160).
- Maryland Department of Human Resources Social Services Administration (DHR/SSA) to coordinate and provide substance abuse treatment services for pregnant and 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).
- Center for Health Promotion, Education and Tobacco Use Prevention of the Maryland Department of Health and Mental Hygiene-Family Health Administration (FHA) 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.

In FFY 2010, the Administration 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. Examples of this interagency collaboration included 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;
- Maryland Annual Suicide Prevention Conference Planning Committee (with the Maryland Mental Hygiene Administration [MHA], the ADAA's Office of Education and Training for Addiction Services [OETAS] and other agencies);
- Maryland Department of Health and Mental Hygiene-Infectious Disease and Environmental Health Administration's Partnership for Prevention ("Supporting Partner") to expand promotional activities to include immunization of healthcare workers against influenza as well as other vaccine-preventable diseases.

Additionally, the ADAA Medical Director served on the following committees, task forces and work groups:

- Hepatitis Task Force
- Traumatic Brain Injury Task Force
- Advisory Council on Prescription Drug Monitoring
- 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 Coordination of Care Meetings
- Medical Assistance MCO Medical Directors Roundtable Meetings
- Maryland Advisory Council on Mental Hygiene
- Physician Clinical Support System National Steering Committee (SAMHSA)
- Transitional Youth Policy Academy
- Buprenorphine Task Force of the Center for a Healthy Maryland (MED-CHI)
- MHA/ADAA/DDA Clinical Case Collaborative Meetings
- Child Mental Health Blueprint Task Force

Further, the ADAA partnered with the following other state agencies to provide and further enhance the services for substance-using populations in Maryland:

- Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park to coordinate prevention and treatment needs assessment and planning activities, and to support the Maryland

Community Services Locator (MDCSL).

-Maryland Department of Juvenile Services (DJS) to coordinate referrals to treatment resources for adolescents.

-Maryland Drug Treatment Court Commission and the Maryland Office of Problem-Solving Courts to support jurisdictions in planning, implementing and operating drug courts and to encourage a collaborative, comprehensive, multi-disciplinary approach to reducing drug-related crime.

-Maryland AIDS Administration to coordinate HIV Set Aside-funded HIV risk assessment, testing, referral, and prevention education for individuals undergoing treatment within Baltimore City's treatment programs.

-Maryland Mental Hygiene Administration (MHA) to coordinate, fund and promote treatment capacity expansion for individuals with co-occurring mental health disorders (COD).

-Maryland Department of Human Resources Family Investment Administration (DHR/FIA) to coordinate interagency funding for screening, assessment and referral services for Temporary Cash Assistance (TCA) and certain Food Supplement Program (FSP, formerly Food Stamps) applicants and recipients (per Maryland's Welfare Innovation Act of 2000/House Bill 1160).

-Maryland Department of Human Resources Social Services Administration (DHR/SSA) to coordinate and provide substance abuse treatment services for pregnant and 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).

-Center for Health Promotion, Education and Tobacco Use Prevention of the Maryland Department of Health and Mental Hygiene-Family Health Administration (FHA) 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.

-Maryland Department of Health and Mental Hygiene Office of TB Control to coordinate cross-training of addictions treatment personnel and TB Control public health nurses, and to update protocols for TB screening, testing and referral within Maryland's addiction treatment programs.

-University of Maryland Eastern Shore (UMES) ATOD Prevention Center, prevention coordinators in nine (9) Eastern Shore Counties and Comcast Cable to implement an underage drinking media campaign that utilized materials created by FACE, a national non-profit alcohol information dissemination organization.

Strategic Prevention Framework (SPF): The Administration was notified in July 2009 that it was the recipient of a \$2,135,724 award to implement SAMHSA's Strategic Prevention Framework.

The primary purpose of the MSPF project is to create and support a statewide, cross-system prevention infrastructure that will help communities across Maryland implement the five-step SPF planning process at the State- and community-level. The implementation of the MSPF has improved linkages with

agencies/organizations at the State, county and community levels. It has instituted effective planning and more strategic targeting of limited prevention resources.

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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013, the ADAA plans to continue its existing needs assessment analyses and to provide technical assistance to the local councils to utilize data to identify gaps in the county/regional prevention/treatment system and to assess performance.

The ADAA will continue to compile and generate Outlook and Outcomes reports, treatment utilization reports, team grant review reports, subdivision–level performance reports and other patient-based analyses of the treatment network. The ADAA will implement conversion of the treatment network to web-based reporting and promote greater use of data by providers for program improvement, needs assessment and effective outreach.

Plans for enhancing performance measurement and developing resource allocation methodologies include continuation of a long-standing partnership with the Institute of Governmental Services and Research (IGSR), and the forging of a new partnership with the University of Maryland School of Pharmacy Department of Pharmaceutical Health Services Research (PHSR)

During FY 2011-2103, the Administration plans to expand and support its statewide, cross-system prevention infrastructure that will help communities across Maryland to implement the five-step Strategic Prevention Framework (SPF) planning process at the State- and community-level. The ADAA plans to continue its support of the Maryland SPF Advisory Council (SPFAC) within the State Drug and Alcohol Abuse Council (DAAC) and the Local Drug and Alcohol Abuse Councils (LDAACs) in the 24 local jurisdictions. The backbone of these efforts is the 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. The ADAA plans to transition SEOW functions to the University of Maryland School of Pharmacy Department of Pharmaceutical Health Services Research (PHSR) during FY 2011.

The Administration 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. The State of Maryland Automated Record Tracking (SMART) system was rolled out in FY 2006, and funded programs were transitioned from the State's previous data set (Substance Abuse Management Information System-SAMIS) to SMART in FY 2007. All publicly-funded treatment programs in Maryland are required to report utilization and performance measure (NOMs) data to SMART, so the data represent 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 Statewide Epidemiologic Outcomes Workgroup (SEOW), which was established in FY 2006, completed its Charter (mission, goals, membership roles and responsibilities, meeting schedules and data work plan) during FY 2007. The ADAA and the Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park continued to support the SEOW during the FY 2008 Compliance period.

NEEDS ASSESSMENT

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 CESAR 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.

Baltimore City's drug and alcohol problems ranked among the highest in the state. Although current treatment allocations fit the variations in need statewide, admission rates in some counties were lower than their substance abuse treatment need scores predicted.

NSDUH

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.

The study determined that an estimated 115,000 Maryland citizens over age 12 needed but did not receive treatment for illicit drug use in the past year and 326,000 needed but did not receive treatment for alcohol use.

The ADAA used the above-mentioned data sources, along with SMART data, to estimate need for each of

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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.

The Maryland Alcohol and Drug Abuse Administration (ADAA) successfully applied for the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) in November 2008 (FY 2009), and was notified in June 2009 that Maryland had been awarded \$2,135,724, to commence in FY2010.

The Administration has utilized concepts of the Strategic Prevention Framework (SPF) to educate members of the legislatively mandated Local Drug and Alcohol Councils in each of Maryland's 24 jurisdictions. The ADAA supported ongoing operation of the MD State Epidemiological Outcomes Workgroup (SEOW), in part with funding that the Administration applied for and received in FY 2008.

Local council members and county prevention coordinators were provided regional trainings that focused on implementing a strategic planning process that used epidemiological data to make informed decisions regarding treatment, intervention and prevention programming needs. Like their state-level counterparts, local program personnel were being trained in analyzing data for use in planning and resource allocation.

During FY2010, work continued on an internet reporting initiative in SMART that facilitated patient-based data collection throughout the State, allowed for enhanced needs assessment analyses, and promoted the development of program performance standards.

The ADAA Research Section focused on developing new data analysis strategies, developing strategic planning and local needs assessment capabilities, and performance measurement. Reports were developed that examined retention, progression from one level of care to another, reduction in substance use and arrests and improvement in employment and living situation by subdivision and for individual treatment programs. The Administration also examined these data in relation to individuals in treatment who were deemed to be "high end users" of treatment services (multiple detoxification episodes, above average utilization of high intensity services, repeated treatment "failures", etc.).

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.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013, ADAA conditions of grant award will continue to prohibit any funded program from utilizing SAPT Block Grant funds to support needle exchange. No funds will be utilized for this purpose.

In FY2008, ADAA conditions of grant award prohibited any funded program from utilizing SAPT Block Grant funds to support needle exchange.

In FY2010, to ensure continued compliance with SAPT Block Grant funding restrictions regarding hypodermic needles or syringes, the ADAA prohibited, as a condition of grant award, the use of 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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Objective: To ensure that helpful Independent Peer Reviews are provided each year to a 5% representative sample of all SAPT Block Grant funded programs in the State.

During FY 2011-2013, the ADAA will continue to contract with independent providers to ensure that independent peer reviews are conducted and that findings are distributed to programs for use in ongoing program improvement. Further, if technical assistance is needed or requested by the programs, the ADAA will continue to facilitate such technical assistance through its Administration Regional Team Managers. The ADAA will continue to solicit feedback from programs that have participated in the reviews to obtain their input about how the Independent Peer Review process can be improved.

In FFY 2008, 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:

Calvert County – Calvert County Health Department-Chesapeake Beach Office, in Prince Frederick, MD (4/17/08 and 4/18/08);

Frederick County – Adolescent Outpatient Program in Frederick, MD (5/7/08 and 5/8/08);

Baltimore City – Partners in Recovery (5/16/08 and 5/19/08).

Carroll County – Carroll County Health Department in Westminster, MD (9/14/07 and 9/17/07);

Prince Georges County – Clinton Outpatient Program in Clinton, MD (11/14/07 and 11/15/07);

In FFY 2010, a total of six (6) 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:

Frederick County – Frederick County Olson House in Frederick, MD (7/8/10 and 7/9/10);

Kent County – Kent County Publick House in Chestertown, MD (7/12/10 and 7/14/10);

Baltimore City – Baltimore City Valley House (7/22/10 and 7/23/10);

Wicomico County – Wicomico County Second Wind in Salisbury, MD (8/11/10 and 8/12/10);

Anne Arundel County – Anne Arundel County Damascus House (8/12/10 and 8/13/10);

Washington County – Washington County Wells House in Hagerstown, MD (8/16/10 and 8/17/10).

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 2009 (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.

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 2009, 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 09, 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 ADA 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.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During 2011-2013, the ADAA will continue to support a messaging engine that will soon be able to exchange data with legacy systems as well as the Health Information Exchange (HIE). In 2010 and 2011, the ADAA will make enhancements to bring this new messaging engine into compliance with HL7, in preparation with requirements for the HIE. The ADAA will continue to develop modules within the State of Maryland Automated Record Tracking—SMART application to expand our current electronic record building capabilities and facilitate transition to a full electronic medical record (EMR). All such described development will continue to adhere to the strictest standards of confidentiality (HIPAA, 42 CFR Part 2, Code of Maryland Regulations – COMAR, Maryland State Privacy Act, etc.).

During FY 2011-2013, the ADAA will continue to support and maintain its statewide electronic web-based data management system (SMART application) security architecture to maintain a data system that ensures patient record confidentiality, prevents inappropriate disclosure of information and that responds to any identified breaches in Federal/State confidentiality rules.

The ADAA will continue to support and maintain personnel security policies/procedures necessary to ensure the security and privacy requirements for client records. ADAA staff will continue to monitor programs to make sure they are consistently applying Federal/State confidentiality regulations, and to conduct regularly scheduled compliance reviews and complaint investigations.

Further, in FY 2011-2013, the ADAA will continue to maintain existing confidentiality training activities through its Office of Education and Training for Addictions Services (OETAS), including counselor training that includes education regarding State and Federal confidentiality regulations. Staff of the ADAA Community Services Division will also continue to routinely incorporate information about confidentiality regulations into technical assistance functions performed with jurisdictions, programs and providers, both proactively, and in terms of problem resolution to address any identified deficiencies.

In FFY 2008 staff of the ADAA Community Services Division routinely incorporated information about confidentiality regulations into technical assistance functions performed with jurisdictions, programs and providers. The Administration continued to incorporate information regarding State and Federal confidentiality regulations into all of the addiction counselor/provider trainings delivered through the Office of Education and Training for Addictions Services (OETAS).

The ADAA Quality Assurance Division and the Maryland Department of Health and Mental Hygiene Office of Health Care Quality (OHCQ) assessed for adherence to State and Federal confidentiality regulations during the bi-annual certification process and other compliance review site visits.

Code of Maryland Regulations (COMAR) 10.47.01.03 requires programs to include information about ethics and confidentiality in procedures for 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:

- Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland;
- Health-General Article, §4-403, Annotated Code of Maryland;
- 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records);
- 45 CFR Parts 160 and 164 (Security and Privacy);
- The Health Insurance Portability Assurance and Accountability Act (HIPAA);

Each substance abuse treatment program is required by regulation to have a statement of patient's rights and to provide a copy to each patient upon admission. During FY 2008, the ADAA Quality Assurance Division Treatment Compliance Section (QA-TC) and the Maryland Department of Health and Mental Hygiene Office of Health Care Quality (OHCQ) continued to monitor patient records for appropriate and accurate consent forms and patient rights statements that include these protections.

During FY 2008, the ADAA continued to protect patient information from inappropriate disclosures through personnel security procedures, authentication procedures, firewalls, encryption, and consent processes. The security architecture for the State of Maryland Automated Record Tracking—SMART (web-based data management system) and the ADAA's SAMIS data server continued to ensure the confidentiality and security of patient data.

The ADAA continued to restrict access to the rooms in which primary and back-up servers were located, and maintained procedures for investigating and reporting potential security incidents. The ADAA, its IT vendors and SMART system users adhered to policies, procedures and contractual requirements that addressed several layers of application security. Usernames were checked against Agency and Unit lists, and application security defined screens to which users had access. All logins required each user to have a unique username and password. If more than 3 non-valid logins occur, the user was disconnected.

In FFY 2010, staff of the ADAA Community Services Division routinely incorporated information about confidentiality regulations into technical assistance functions performed with jurisdictions, programs and providers. The Administration continued to incorporate information regarding State and Federal confidentiality regulations into all of the addiction counselor/provider trainings delivered through the Office of Education and Training for Addictions Services (OETAS). The ADAA Quality Assurance Division Treatment Compliance Section (QA-TC) and the Maryland Department of Health and Mental Hygiene Office of Health Care Quality (OHCQ) assessed for adherence to State and Federal confidentiality regulations during the bi-annual certification process and other compliance review site visits.

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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.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-2013, ADAA may or may not award SAPT Block Grant funds to recipients or sub-recipients (“program participants”) that would be 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 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.

During FY 2008, Maryland did not award SAPT Block Grant funds to recipients or sub-recipients (“program participants”) that would be 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 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.

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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.

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 2010) 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
- 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.

During FY 2009 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.

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.

The State of Maryland does not intend to file any waiver applications for FFY 2011.

Form 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

Activity	Source of Funds					
	A.SAPT Block Grant FY 2008 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	\$ 22,308,777	\$ 2,090,464		\$ 77,626,960	\$ 6,982,453	\$ 7,479,349
Primary Prevention	\$ 6,373,936			\$	\$	\$
Tuberculosis Services	\$	\$	\$	\$ 9,978	\$	\$
HIV Early Intervention Services	\$ 1,593,484	\$	\$	\$ 1,688,635	\$	\$
Administration: Excluding Program/Provider	\$ 1,593,484		\$	\$ 4,624,616	\$	\$ 80,884
Column Total	\$31,869,681	\$2,090,464	\$0	\$83,950,189	\$6,982,453	\$7,560,233

*Prevention other than Primary Prevention

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 1,848,441	\$	\$	\$	\$
Education	\$ 828,612	\$	\$	\$	\$
Alternatives	\$ 1,657,223	\$	\$	\$	\$
Problem Identification & Referral	\$ 191,219	\$	\$	\$	\$
Community Based Process	\$ 892,351	\$	\$	\$	\$
Environmental	\$ 956,090	\$	\$	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
Column Total	\$6,373,936	\$0	\$0	\$0	\$0

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$ 1,720,962	\$	\$	\$	\$
Universal Indirect	\$ 2,039,660	\$	\$	\$	\$
Selective	\$ 1,784,702	\$	\$	\$	\$
Indicated	\$ 828,612	\$	\$	\$	\$
Column Total	\$6,373,936	\$0	\$0	\$0	\$0

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2008 SAPT Block Grant?

Yes No

Expenditures on Resource Development Activities are:				
<input type="radio"/> Actual <input type="radio"/> Estimated				
Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	\$	\$	\$	\$ 0
Quality Assurance	\$	\$	\$	\$ 0
Training (post-employment)	\$ 41,250	\$ 26,450	\$	\$ 67,700
Education (pre-employment)	\$ 40,100	\$ 29,250	\$	\$ 69,350
Program Development	\$	\$	\$	\$ 0
Research and Evaluation	\$	\$	\$	\$ 0
Information Systems	\$	\$	\$	\$ 0
Column Total	\$81,350	\$55,700	\$0	\$137,050

Form 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2008			
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	\$3,941,470	\$1,025,395	\$167,671	\$364,523	\$42,224
102001	MD100182	Anne Arundel County	\$1,904,496	\$1,633,685	\$188,121	\$389,426	\$107,874
103001	MD750614	Baltimore County	\$4,234,071	\$1,759,441	\$370,784	\$544,232	\$94,192
104001	MD902512	Calvert County	\$532,805	\$266,982	\$0	\$84,478	\$28,571
105001	MD750382	Caroline County	\$441,422	\$126,182	\$0	\$74,234	\$7,301
106001	MD750564	Carroll County	\$2,069,571	\$1,133,640	\$218,429	\$90,848	\$30,094
107001	MD900375	Cecil County	\$989,905	\$249,260	\$0	\$69,302	\$16,987
108001	MD750473	Charles County	\$1,352,536	\$280,702	\$0	\$130,198	\$31,330
109001	MD902199	Dorchester County	\$878,093	\$212,317	\$0	\$109,813	\$62,229
110001	MD750424	Frederick County	\$1,391,611	\$479,663	\$433,373	\$350,458	\$41,936
111001	MD901209	Garrett County	\$601,490	\$137,511	\$0	\$243,235	\$10,118
112001	MD903817	Harford County	\$1,227,720	\$333,790	\$0	\$102,793	\$21,299
113001	MD900444	Howard	\$1,144,049	\$180,211	\$0	\$83,547	\$16,441

Maryland / SAPT FY2011 / Form 9 (formerly Form 6)

115001	MD900441	County					
114001	MD301293	Kent County	\$1,629,390	\$162,615	\$0	\$99,525	\$18,309
115001	MD902967	Montgomery County	\$2,992,857	\$745,657	\$485,635	\$484,886	\$74,071
116001	MD300030	Prince George's County	\$6,430,920	\$1,540,274	\$860,812	\$627,099	\$78,613
117001	MD750325	Queen Anne's County	\$638,927	\$146,437	\$0	\$84,767	\$11,469
118001	MD901779	St Mary's County	\$1,714,970	\$487,484	\$156,875	\$94,994	\$39,062
119001	MD103608	Somerset County	\$686,005	\$91,206	\$0	\$230,103	\$10,836
120001	MD750390	Talbot County	\$640,368	\$167,802	\$0	\$99,845	\$12,705
121001	MD301400	Washington County	\$2,221,628	\$781,398	\$215,875	\$237,414	\$37,970
122001	MD900300	Wicomico County	\$1,234,410	\$381,385	\$0	\$592,799	\$21,328
123001	MD901845	Worcester County	\$1,951,522	\$754,938	\$273,686	\$104,229	\$41,735
130001	MD100091	Baltimore City	\$28,400,708	\$9,096,880	\$749,949	\$997,111	\$718,509
135001	X	Statewide Contracts	\$8,376,016	\$133,922	\$0	\$84,077	\$18,281
Totals:			\$77,626,960	\$22,308,777	\$4,121,210	\$6,373,936	\$1,593,484

PROVIDER ADDRESS TABLE

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

Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Brochures [4]	31
	Speaking engagements [6]	29
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	32
	Parenting and family management [11]	22
	Peer leader/helper programs [13]	12
	Education programs for youth groups [14]	23
	Mentors [15]	8
	Preschool ATOD prevention programs [16]	6
	Drug free dances and parties [21]	15
	Youth/adult leadership activities [22]	32
	Community service activities [24]	13
	Recreation activities [26]	34
	Student Assistance Programs [32]	4
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	9
Community team-building [44]	7	
Pregnant Women/Teens [2]	Brochures [4]	9
	Speaking engagements [6]	16
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	5
	Parenting and family management [11]	18
	Community service activities [24]	4
Violent and Delinquent Behavior [4]	Brochures [4]	13
	Speaking engagements [6]	23
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	12

	Peer leader/helper programs [13]	4
	Education programs for youth groups [14]	16
	Community team-building [44]	2
Mental Health Problems [5]	Brochures [4]	18
	Speaking engagements [6]	13
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	19
Economically Disadvantaged [6]	Brochures [4]	17
	Speaking engagements [6]	20
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	14
	Parenting and family management [11]	13
	Education programs for youth groups [14]	8
	Mentors [15]	4
	Youth/adult leadership activities [22]	12
	Community service activities [24]	1
	Recreation activities [26]	16
Physically Disabled [7]	Speaking engagements [6]	6
	Ongoing classroom and/or small group sessions [12]	1
	Youth/adult leadership activities [22]	3
	Recreation activities [26]	8
Already Using Substances [9]	Brochures [4]	29
	Speaking engagements [6]	26
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	24
	Parenting and family management [11]	19
	Education programs for youth groups [14]	7
Parents [11]	Brochures [4]	31
	Speaking engagements [6]	25
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	17

	Parenting and family management [11]	28
	Peer leader/helper programs [13]	15
	Youth/adult leadership activities [22]	17
	Community service activities [24]	13
Preschool [12]	Brochures [4]	6
	Speaking engagements [6]	6
	Parenting and family management [11]	6
	Preschool ATOD prevention programs [16]	6

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

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
Detoxification (24-Hour Care)					
Hospital Inpatient			\$	\$	\$
Free-standing Residential	4588	4205	\$ 907.28	\$	\$
Rehabilitation / Residential					
Hospital Inpatient			\$	\$	\$
Short-term (up to 30 days)	5895	5454	\$ 3032.44	\$	\$
Long-term (over 30 days)	3944	3587	\$ 8070.97	\$	\$
Ambulatory (Outpatient)					
Outpatient	21679	20014	\$ 1681.74	\$	\$
Intensive Outpatient	9069	8001	\$ 1714.83	\$	\$
Detoxification	526	475	\$ 1133.88	\$	\$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	2751	2536	\$ 10854.95	\$	\$

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	3,115	1,105	413	1,223	183			16	0	6	0	16	2	105	46	2,327	597	144	47
2. 18-24	7,035	3,120	1,491	1,582	475			40	19	14	8	31	14	197	44	4,724	1,970	260	81
3. 25-44	15,447	5,100	2,867	4,701	2,118			53	15	31	20	55	25	388	74	9,855	4,978	470	144
4. 45-64	8,021	2,227	1,045	3,224	1,352			18	4	15	9	11	5	94	17	5,463	2,389	130	39
5. 65 and over	192	70	21	89	8			0	0	0	0	0	0	3	1	158	28	4	2
6. Total	33,810	11,622	5,837	10,819	4,136	0	0	127	38	66	37	113	46	787	182	22,527	9,962	1,008	313
7. Pregnant Women	285		172		99				1		2		4	7			274		11

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. ⁰

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)).

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 \$11,812,774 in 2008, \$12,264,437 in 2009 and \$11,500,000 projected in 2010.

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 2002 through 2010.

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 2008 (1)	\$72,532,362	\$75,079,661
SFY 2009 (2)	\$77,626,960	
SFY 2010 (3)	\$ 75,344,417	

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

FY 2008 Yes No

FY 2009 Yes No

FY 2010 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) 2010 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)

The State of Maryland incurred significant budget cuts in fiscal year 2010 which resulted in the state not meeting its MOE requirement.

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)	\$ 596,143	1 %	\$ 5,961	\$ 6,226
SFY 1992 (2)	\$ 649,086	1 %	\$ 6,491	

(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 2010 (3)	\$ 997,764	1 %	\$ 9,978

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 2010 (3)	\$ 1,688,635

* 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	\$5,032,564	
2008		\$13,294,821
2009		\$11,812,774
2010		\$ 12,264,437

Enter the amount the State plans to expend in FY 2011 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}): \$ 11,500,000

Form T1

Form T1 was pre-populated with the following Data Source: Discharges in CY 2009

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	1,220	1,189
Total number of clients with non-missing values on employment\student status [denominator]	6,461	6,461
Percent of clients employed (full-time and part-time) or student	18.9%	18.4%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	7,325
Number of CY 2009 discharges submitted:	7,289
Number of CY 2009 discharges linked to an admission:	6,472
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,461
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	6,461
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	151	931
Total number of clients with non-missing values on employment\student status [denominator]	3,185	3,185
Percent of clients employed (full-time and part-time) or student	4.7%	29.2%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,398
Number of CY 2009 discharges submitted:	4,890
Number of CY 2009 discharges linked to an admission:	3,247
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3,187
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	3,185
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	1,477	1,968
Total number of clients with non-missing values on employment\student status [denominator]	7,372	7,372
Percent of clients employed (full-time and part-time) or student	20.0%	26.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	12,036
Number of CY 2009 discharges submitted:	10,467
Number of CY 2009 discharges linked to an admission:	7,531
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,374
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	7,372
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	9,130	10,413
Total number of clients with non-missing values on employment\student status [denominator]	18,906	18,906
Percent of clients employed (full-time and part-time) or student	48.3%	55.1%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	30,343
Number of CY 2009 discharges submitted:	28,213
Number of CY 2009 discharges linked to an admission:	21,478
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	18,908
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	18,906
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T2

Form T2 was pre-populated with the following Data Source: Discharges in CY 2009

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	5,571	6,190
Total number of clients with non-missing values on living arrangements [denominator]	6,461	6,461
Percent of clients with stable housing	86.2%	95.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	7,325
Number of CY 2009 discharges submitted:	7,289
Number of CY 2009 discharges linked to an admission:	6,472
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,461
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	6,461
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	2,847	2,847
Total number of clients with non-missing values on living arrangements [denominator]	3,187	3,187
Percent of clients with stable housing	89.3%	89.3%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,398
Number of CY 2009 discharges submitted:	4,890
Number of CY 2009 discharges linked to an admission:	3,247
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3,187
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	3,187
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	6,953	7,059
Total number of clients with non-missing values on living arrangements [denominator]	7,374	7,374
Percent of clients with stable housing	94.3%	95.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	12,036
Number of CY 2009 discharges submitted:	10,467
Number of CY 2009 discharges linked to an admission:	7,531
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,374
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	7,374
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	18,500	18,718
Total number of clients with non-missing values on living arrangements [denominator]	18,908	18,908
Percent of clients with stable housing	97.8%	99.0%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	30,343
Number of CY 2009 discharges submitted:	28,213
Number of CY 2009 discharges linked to an admission:	21,478
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	18,908
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	18,908
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T3

Form T3 was pre-populated with the following Data Source: Discharges in CY 2009

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

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	5,851	6,448
Total number of clients with non-missing values on arrests [denominator]	6,471	6,471
Percent of clients with no arrests	90.4%	99.6%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	7,325
Number of CY 2009 discharges submitted:	7,289
Number of CY 2009 discharges linked to an admission:	6,472
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	6,472
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	6,471
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	3,107	3,206
Total number of clients with non-missing values on arrests [denominator]	3,235	3,235
Percent of clients with no arrests	96.0%	99.1%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,398
Number of CY 2009 discharges submitted:	4,890
Number of CY 2009 discharges linked to an admission:	3,247
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	3,244
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	3,235
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	6,813	7,337
Total number of clients with non-missing values on arrests [denominator]	7,514	7,514
Percent of clients with no arrests	90.7%	97.6%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	12,036
Number of CY 2009 discharges submitted:	10,467
Number of CY 2009 discharges linked to an admission:	7,531
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,522
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	7,514
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	17,767	18,836
Total number of clients with non-missing values on arrests [denominator]	19,438	19,438
Percent of clients with no arrests	91.4%	96.9%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	30,343
Number of CY 2009 discharges submitted:	28,213
Number of CY 2009 discharges linked to an admission:	21,478
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	19,455
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	19,438
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T4

Form T4 was pre-populated with the following Data Source: Discharges in CY 2009

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	3,164	5,826
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,472	6,472
Percent of clients abstinent from alcohol	48.9%	90.0%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,702
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,308	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		81.7%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3,124
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,164	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		98.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	7,325
Number of CY 2009 discharges submitted:	7,289
Number of CY 2009 discharges linked to an admission:	6,472
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	6,472
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	6,472

Long-term Residential(LR)		
A ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	2,511	2,869
All clients with non-missing values on at least one substance/frequency of use [denominator]	3,242	3,242
Percent of clients abstinent from alcohol	77.5%	88.5%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		485
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	731	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		66.3%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		2,384
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,511	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		94.9%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,398
Number of CY 2009 discharges submitted:	4,890
Number of CY 2009 discharges linked to an admission:	3,247
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	3,244
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	3,242
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	

Intensive Outpatient (IO)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	4,639	6,215
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,508	7,508
Percent of clients abstinent from alcohol	61.8%	82.8%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,796
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,869	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		62.6%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,419
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,639	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		95.3%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	12,036
Number of CY 2009 discharges submitted:	10,467
Number of CY 2009 discharges linked to an admission:	7,531
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,522
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	7,508
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	

Outpatient (OP)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	12,577	17,014
All clients with non-missing values on at least one substance/frequency of use [denominator]	19,444	19,444
Percent of clients abstinent from alcohol	64.7%	87.5%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		5,051
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,867	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		73.6%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		11,963
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	12,577	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		95.1%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	30,343
Number of CY 2009 discharges submitted:	28,213
Number of CY 2009 discharges linked to an admission:	21,478
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	19,455
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	19,444
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	
[Records received through 5/6/0010]	

Form T5

Form T5 was pre-populated with the following Data Source: Discharges in CY 2009

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> 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 ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	1,453	5,309
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,472	6,472
Percent of clients abstinent from drugs	22.5%	82.0%
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> 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 ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		3,896
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,019	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		77.6%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
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 ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,413
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,453	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		97.2%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	7,325
Number of CY 2009 discharges submitted:	7,289
Number of CY 2009 discharges linked to an admission:	6,472
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	6,472

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	6,472
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> 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 (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs [numerator]	1,590	2,263
All clients with non-missing values on at least one substance/frequency of use [denominator]	3,242	3,242
Percent of clients abstinent from drugs	49.0%	69.8%
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> 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 (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		989
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,652	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		59.9%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,274
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,590	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		80.1%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,398
Number of CY 2009 discharges submitted:	4,890
Number of CY 2009 discharges linked to an admission:	3,247
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	3,244

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	3,242
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
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 (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs [numerator]	2,552	4,800
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,508	7,508
Percent of clients abstinent from drugs	34.0%	63.9%
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 (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,617
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,956	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		52.8%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,183
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,552	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		85.5%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	12,036
Number of CY 2009 discharges submitted:	10,467
Number of CY 2009 discharges linked to an admission:	7,531
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	7,522

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	7,508
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

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 ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	11,046	14,805
All clients with non-missing values on at least one substance/frequency of use [denominator]	19,444	19,444
Percent of clients abstinent from drugs	56.8%	76.1%

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 ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,685
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	8,398	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		55.8%

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

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 ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		10,120
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	11,046	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		91.6%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	30,343
Number of CY 2009 discharges submitted:	28,213
Number of CY 2009 discharges linked to an admission:	21,478
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	19,455

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	19,444
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Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]

Form T6

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

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	<input type="text" value="5241"/>	<input type="text" value="10671"/>
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	<input type="text" value="26200"/>	<input type="text" value="26200"/>
Percent of clients participating in social support activities	20.00%	40.73%

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

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>At admission the existing item asks for the actual number of days in the past 30 the patient attended AA/NA or other self-help meetings. This was recoded 0 = NO/1 thru 30 = YES. At discharge the Maryland item has the exact TEDS categories except ther is no category for attendance with unknown frequency.</p>
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DATA SOURCE	<p>What is the source of data for table T6? (Select all that apply)</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> <input type="text"/>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T6? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has bee 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> <input type="text"/>
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DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T6? (Select all that apply)</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 <input type="text"/> days post admission</p> <p><input type="radio"/> Follow-up data <input type="text"/> months post <input type="text" value="admission"/></p> <p><input type="radio"/> Other, Specify:</p> <input type="text"/>
	<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 <input type="text"/> % of clients who were admitted for treatment</p>

<p>RECORD LINKING</p>	<p>Was the admission and discharge data linked for table T6? (Select all that apply)</p> <p><input checked="" type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID:</p> <ul style="list-style-type: none"> <input type="radio"/> Master Client Index or Master Patient Index, centrally assigned <input type="radio"/> Social Security Number (SSN) <input checked="" type="radio"/> Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) <input type="radio"/> Some other Statewide unique ID <input type="radio"/> Provider-entity-specific unique ID <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> No, admission and discharge records were matched using probabilistic record matching</p>
<p>IF DATA IS UNAVAILABLE</p>	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Information is not collected at admission <input type="checkbox"/> Information is not collected at discharge <input type="checkbox"/> Information is not collected by the categories requested <input type="checkbox"/> State collects information on the indicator area but utilizes a different measure.
<p>DATA PLANS IF DATA IS NOT AVAILABLE</p>	<p>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.</p> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>

Form T7

Form T7 was pre-populated with the following Data Source: Discharges in CY 2009

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
Detoxification (24-Hour Care)				
1. Hospital Inpatient				
2. Free-standing Residential	6	4	5	7
Rehabilitation / Residential				
3. Hospital Inpatient				
4. Short-term (up to 30 days)	19	9	18	28
5. Long-term (over 30 days)	107	32	91	174
Ambulatory (Outpatient)				
6. Outpatient	138	58	120	190
7. Intensive Outpatient	70	20	46	89
8. Detoxification	28	5	5	6
Opioid Replacement Therapy (ORT)				
9. Opioid Replacement therapy	309	49	162	335
10. ORT Outpatient	594	94	247	774

Notes:		
Level of Care	2009 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Total count, all levels of care	57,079	44,215
1. Hospital Inpatient-Detoxification (24-Hour Care)	244	
2. Free-standing Residential-Detoxification (24-Hour Care)	5,382	5,165
3. Hospital Inpatient-Rehabilitation / Residential	5	
4. Short-term (up to 30 days)-Rehabilitation / Residential	7,289	6,472
5. Long-term (over 30 days)-Rehabilitation / Residential	4,890	3,247
6. Outpatient-Ambulatory (Outpatient)	28,213	19,496
7. Intensive Outpatient-Ambulatory (Outpatient)	10,467	7,531
8. Detoxification-Ambulatory (Outpatient)	589	212
9. Opioid Replacement therapy-Opioid Replacement Therapy (ORT)		110

10. ORT Outpatient-Opioid Replacement Therapy (ORT)		1,982
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Source: **SAMHSA/OAS TEDS CY 2009 linked discharge file**
[Records received through **05/06/2010**]

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?

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. The Governor's Delivery Unit (GDU) is an extension of StateStat that works with state agencies to align State and Federal resources around 15 strategic and visionary goals to improve the quality of life in Maryland. The O'Malley Administration has set a goal and is implementing 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 mimic SAMHSA's National Outcome Measures (NOMs), as do the Managing for Results (MFRs) measures that the ADAA generates twice yearly for funded providers.

FY 2007 was the first full year of the pay for performance for Statewide Residential Contracts. These contracts for long term residential care are made available to agencies that satisfy Code of Maryland (COMAR) program requirements for Level III.3 and Level III.5 and that demonstrate 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. Currently, contracted programs must 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 review performance data, and when a jurisdiction or individual provider is found to be falling short of projected performance targets, the team works 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.

Maryland has completed all of the required programming and updates to the discharge screen for the self help and support groups portion of the State of Maryland Automated Record Tracking system (SMART). Maryland is now reporting Social Support of Recovery data in Form T6 as required in the FY2011 SAPT Block Grant Application.

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>Source Survey Item: 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>Outcome Reported: Percent who reported having used alcohol during the past 30 days.</p>	Ages 18+ - FFY 2008 58.60	
		Ages 12–17 - FFY 2008 13.80	
2. 30-day Cigarette Use	<p>Source Survey Item: 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>Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.</p>	Ages 12–17 - FFY 2008 7.70	
		Ages 18+ - FFY 2008 22.70	
3. 30-day Use of Other Tobacco Products	<p>Source Survey Item: 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>Outcome Reported: 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+ - FFY 2008 5.70	
		Ages 12–17 - FFY 2008 3.30	
4. 30-day Use of Marijuana	<p>Source Survey Item: 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>Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.</p>	Ages 12–17 - FFY 2008 6.60	
		Ages 18+ - FFY 2008 4.60	
5. 30-day Use of Illegal Drugs Other Than Marijuana	<p>Source Survey Item: 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>Outcome Reported: 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 - FFY 2008 3.60	
		Ages 18+ - FFY 2008 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	Source Survey Item: 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] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - CY 2008 78.40	
		Ages 18+ - CY 2008 79.80	
2. Perception of Risk From Cigarettes	Source Survey Item: 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] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - CY 2008 94.40	
		Ages 18+ - CY 2008 93.20	
3. Perception of Risk From Marijuana	Source Survey Item: 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] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - CY 2008 82	
		Ages 18+ - CY 2008 74.20	

((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	Source Survey Item: 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.] Outcome Reported: Average age at first use of alcohol.	Ages 12–17 - FFY 2008 13.10	
		Ages 18+ - FFY 2008 17	
2. Age at First Use of Cigarettes	Source Survey Item: 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.] Outcome Reported: Average age at first use of cigarettes.	Ages 18+ - FFY 2008 16	
		Ages 12–17 - FFY 2008 13.30	
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you used [any other tobacco product] † ?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.	Ages 18+ - FFY 2008 19.70	
		Ages 12–17 - FFY 2008 14.20	
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you used marijuana or hashish?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2008 14.20	
		Ages 18+ - FFY 2008 18.40	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you used [other illegal drugs] ‡ ?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.	Ages 18+ - FFY 2008 20.60	
		Ages 12–17 - FFY 2008 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>Source Survey Item: 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] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 88.90	
2. Perception of Peer Disapproval of Cigarettes	<p>Source Survey Item: 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] Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>	Ages 12–17 - FFY 2008 91	
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: 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] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 82.20	
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: 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] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 82.20	
5. Disapproval of Alcohol	<p>Source Survey Item: 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] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 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	<p>Source Survey Item: 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]</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>	Ages 18+ - FFY 2008 33.70	
		Ages 15-17 - FFY 2008 ((s))	

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

Form P6
NOMs Domain: Employment/Education
Measure: ATOD-Related Suspensions and Expulsions

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
In Development	In Progress	In Progress	((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>Source:National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>		FFY 2008	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>Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p>Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>	CY 2008	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	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	CY 2008	134.50

((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>Source Survey Item: 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>Outcome Reported: Percent reporting having talked with a parent.</p>	Ages 12–17 - CY 2008	60.70
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	<p>Source Survey Item: 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>Outcome Reported: Percent of parents reporting that they have talked to their child.</p>	Ages 18+ - CY 2008	((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	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?"</p> <p>Outcome Reported: Percent reporting having been exposed to prevention message.</p>		Ages 12-17 - CY 2008 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

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2009	12/31/2009
Form P12b Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2009	12/31/2009
Form P13 (Optional) Number of Persons Served by Type of Intervention	1/1/2009	12/31/2009
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	1/1/2009	12/31/2009
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	1/1/2009	12/31/2009

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. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

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	3088
	2. 5-11	2532
	3. 12-14	2385
	4. 15-17	2042
	5. 18-20	369
	6. 21-24	780
	7. 25-44	3355
	8. 45-64	1536
	9. 65 And Over	107
	10. Age Not Known	0
B. Gender	Male	6807
	Female	9387
	Gender Unknown	0
C. Race	White	8330
	Black or African American	7727
	Native Hawaiian/Other Pacific Islander	61
	Asian	69
	American indian/Alaska Native	7
	More Than One Race (not OMB required)	0
	Race Not Known or Other (not OMB required)	0
D. Ethnicity	Hispanic or Latino	939
	Not Hispanic or Latino	15255
	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	3075
	2. 5-11	12304
	3. 12-14	15802
	4. 15-17	26250
	5. 18-20	52914
	6. 21-24	20589
	7.25-44	47490
	8. 45-64	25685
	9. 65 And Over	5487
	10. Age Not Known	0
B. Gender	Male	92271
	Female	117325
	Gender Unknown	0
C. Race	White	122455
	Black or African American	79750
	Native Hawaiian/Other Pacific Islander	2738
	Asian	3728
	American indian/Alaska Native	925
	More Than One Race (not OMB required)	0
	Race Not Known or Other (not OMB required)	0
D. Ethnicity	Hispanic or Latino	11480
	Not Hispanic or Latino	198116
	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	10526	N/A
2. Universal Indirect	N/A	209596
3. Selective	5182	N/A
4. Indicated	486	N/A
5. Total	16194	209596

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 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

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	45	61	106	48	13	167
2. Total number of Programs and Strategies Funded	57	78	135	54	15	204
3. Percent of Evidence-Based Programs and Strategies	78.95%	78.21%	78.52%	88.89%	86.67%	81.86%

Form P15 - FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant \$Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	45	\$ 1720962
2. Universal Indirect	61	\$ 2358356
3. Selective	48	\$ 1848441
4. Indicated	13	\$ 446177
5. Totals	167	\$6,373,936.00

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 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 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 2008 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 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY2008 Program/Strategy Name Universal Direct	FFY2008 Total Number of Evidence-based Programs and Strategies by Intervention	FFY2008 Total Costs of Evidence based Programs and Strategies for each IOM Category	FFY2008 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			

1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	\$	
Total FFY 2008 SAPT Block Grant Dollars \$ Spent on Evidence-Based Programs and Strategies			\$

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)

Age 0 - 5 Age 6 - 11 Age 12 - 14 Age 15 - 18

Cigarettes

Alcohol

Marijuana

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? 2

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

Communities: 26

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.