

Maryland

UNIFORM APPLICATION
FY2010

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

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

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

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 470 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.

Form 1

State: Maryland
DUNS Number: 134104855-

Uniform Application for FY 2010 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 Zip Code: 21228

Telephone: (410) 402-8600 FAX: (410) 402-8601

Email Address: tcargiulo@dhmh.state.md.us

3. State Expenditure Period:

From: 7/1/2007 To: 6/30/2008

4. Date Submitted:

Date: Original: Revision:

5. Contact Person Responsible for Application Submission:

Name: Steve Bocian Telephone: (410) 402-8570
Email Address: bocians@dhmh.state.md.us FAX: (410) 402-8607

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FORM 3: UNIFORM APPLICATION FOR FY 2010 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX of the Public Health Service (PHS) Act

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

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

I. Formula Grants to States, Section 1921

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.

II. Certain Allocations, Section 1922

- Allocations Regarding Primary Prevention Programs, Section 1922(a)
- Allocations Regarding Women, Section 1922(b)

III. Intravenous Drug Abuse, Section 1923

- 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

Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

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.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- 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

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.”

VIII. Additional Agreements, Section 1928

- 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)

FORM 3: UNIFORM APPLICATION FOR FY 2010 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Funding Agreements/Certifications

As required by Title XIX 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: John M. Colmers

Signature of CEO or Designee:

Title: Secretary, Maryland Department of Health and Mental Hygiene
Date Signed:

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's 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 –
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (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 CFR Part 93).

The undersigned (authorized official signing for the his or her knowledge, and that he or she is aware

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 his or her knowledge, and that he or she is aware that

By signing the certification, the undersigned certifies

that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, 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.

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.

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

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

The Public Health 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.

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

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

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.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

FY 2007 SAPT Block Grant

Your annual SAPT Block Grant Award for FY 2007 is reflected on line 8 of the Notice of Block Grant Award.

\$31,868,920

Maryland**Goal #1: Continuum of Substance Abuse Treatment Services**

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

The Administration provided SAPT funding to 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 included outpatient, intensive outpatient, residential including halfway house, therapeutic community, extended care, intermediate care, medication assistance and detoxification services within various levels.

These services met patient needs identified by Local Drug and Alcohol Abuse Councils found in every Maryland jurisdiction (Jurisdictions are defined as the 23 counties of Maryland and Baltimore City). Local councils provide the ADAA and the Governor's State Drug and Alcohol Abuse Council with 2 year local plans identifying need and future goals for their jurisdiction. 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 established 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 court system; and patients with co-occurring mental health and substance abuse disorders.

In fiscal year 2007, 64,381 ADAA-funded treatment episodes were provided within these modalities. Sixty-six percent of these service episodes were provided to male patients and 34% to female patients.

The Administration's Substance Abuse Management Information System (SAMIS) gathered demographic, as well as capacity and utilization data, in monitoring the treatment delivery system throughout the State of Maryland.

Fiscal year 2007 ADAA treatment grant measurements are as follows:

1. Fifty-eight percent (58%) of patients in ADAA funded outpatient programs were retained in treatment at least 90 days. Fifty-seven percent (57%) of patients in ADAA funded halfway house programs were retained in treatment at least 90 days.
2. Forty-two percent (42%) of the patients completing ADAA funded intensive outpatient programs enter another level of treatment within thirty days of discharge.
3. Seventy-three percent (73%) of patients completing ADAA funded detoxification programs enter another level of treatment within thirty days of discharge.
4. The number of patients using substances at completion of treatment was reduced by 75% from the number of patients who were using substances at admission to treatment.
5. The number of employed patients at completion of treatment increased by 30% from the number of patients who were employed at admission to treatment.

The Administration continues to provide SAPT level funding to 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 included outpatient, intensive outpatient, residential including halfway house, therapeutic community, extended care, intermediate care, medication assistance and detoxification services within various levels.

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

ADAA continues to fund 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 court system; and patients with co-occurring mental health and substance abuse disorders.

In fiscal year 2009, as a condition of grant award, ADAA introduced performance measures for all jurisdictions.

The following performance measures apply to FY09 ADAA treatment grants:

1. Sixty-two percent (62%) of patients in ADAA funded outpatient programs are retained in treatment at least 90 days.
2. Sixty percent (60%) of patients in ADAA funded halfway house programs are retained in treatment at least 90 days.
3. Forty percent (40%) of adolescent patients and 50% of adult patients completing/ transferred/ referred from ADAA funded intensive outpatient programs enter another level of treatment within 30 days of discharge.
4. Seventy-five percent (75%) of patients completing/transferred/referred from ADAA funded detoxification programs enter another level of treatment within 30 days of discharge.
5. The number of patients using substances at completion/transfer/referral from treatment will be reduced by 70% among adolescents and 75% among adults from the number of patients who were using substances at admission to treatment.
6. The number of employed patients at completion/transfer/referral from treatment will increase by at least 29% from the number of patients who were employed at admission to treatment.
7. The number 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.

During FY 2009, 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.

Goal: The Administration intends to provide SAPT level funding in maintaining a continuum of substance abuse treatment services that meet the need for the services identified by the State of Maryland.

Objective: Treatment service providers will attain the following performance measures in FY10:

1. Sixty-two percent (62%) of patients in ADAA funded outpatient programs are retained in treatment at least 90 days.
2. Sixty percent (60%) of patients in ADAA funded halfway house programs are retained in treatment at least 90 days.
3. Forty percent (40%) of adolescent patients and 50% of adult patients completing/ transferred/ referred from ADAA funded intensive outpatient programs enter another level of treatment within 30 days of discharge.
4. Seventy-five percent (75%) of patients completing/transferred/referred from ADAA funded detoxification programs enter another level of treatment within 30 days of discharge.
5. The number of patients using substances at completion/transfer/referral from treatment will be reduced by 70% among adolescents and 75% among adults from the number of patients who were using substances at admission to treatment.
6. The number of employed patients at completion/transfer/referral from treatment will increase by at least 29% from the number of patients who were employed at admission to treatment.
7. The number 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.

Actions:

1. Convey performance measures as conditions of award that are sent to all Maryland jurisdictions.
2. Jurisdictions affirmatively accept the conditions of grant award including the requirement to submit performance data.
3. Jurisdictions submit data monthly.
4. ADAA performs data validation and makes recommendations for technical assistance and corrective action where necessary.

Goal: The Administration intends to provide level funding to maintain the three contracts for statewide long term residential treatment services. 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 FY10:

1. Sixty-five percent (65%) of patient discharges will be retained in treatment at least 60 days.
2. Ninety percent (90%) of patient discharges with SAMIS discharge codes 2 or 3 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 SMAART system within 30 days of admission and discharge.

Action:

1. Convey performance measures as conditions of contract award to all contract recipients.
2. Contract recipients agree to accept the conditions of contract award including the requirement to submit

performance data using ADAA's electronic patient record.

3. Contract providers submit data monthly using ADAA's electronic patient record.

4. ADAA performs data and attendance validation monthly and makes recommendations for technical assistance and corrective action where necessary.

Maryland

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying 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)).

Institute of Medicine Classification: Universal, Selective and Indicated:

- **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.

- **Selective:** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

- **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*)

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

Primary prevention services on a statewide basis were supported by \$6,373,784 of FY 2007 SAPT Block Grant funds. This amount represents 20% of the total SAPT allocation. A total of 229,845 residents throughout the State of Maryland participated in prevention activities in fiscal year 2007 and over 107,750 youth were reached through prevention projects. SAPT Block Grant funds enabled the Administration to support the Prevention Coordinators network. This statewide network utilized a community development model as its primary method of planning and implementing prevention services and for involving the residents within the State of Maryland in prevention goals and strategies. Through this community development model, 27 community-based prevention programs were developed, 14 of which focus on youth and other at risk groups.

The Administration maintained 436 community programs statewide. Additionally, SAPT funds were awarded to six subdivisions to target high-risk youth. A total of 3,145 children and families were served at 15 sites throughout these subdivisions. The Homeless Demonstration Grant provided a continuum of ATOD prevention activities for 313 participants in Baltimore City. Activities include an after-school program, a health education program for adolescents and pregnant teens, a pre-school program, respite care for children whose mothers are in treatment for substance abuse, parenting groups and a mentoring program for school-aged children.

In FY 2007, the Administration continued to fund four strategically located ATOD Prevention Centers in the central, eastern, southern and western regions of the State. These Centers are located at Towson University, the University of Maryland Eastern Shore, Bowie State University, and Frostburg State University respectively. A total of 349 events/activities that reached 27,952 individuals were sponsored by the ATOD Prevention Centers. Utilizing SAPT Block Grant funds, the Administration's FY 2007 prevention effort reached 229,845 individuals and represented a comprehensive approach in which a variety of strategies were employed to prevent alcohol, tobacco and other drug use. Strategies employed and individuals served included information dissemination (104,703), education (16,371), use alternatives (61,257), problem identification and referral (12,535), community-based process (19,163) and environmental improvements (15,816).

The Alcohol and Drug Abuse Administration funded several CSAP Model Programs throughout the state during FY2007. These programs included Across Ages, All Stars, Communities Mobilizing for Change on Alcohol, Creating Lasting Family Connections, Dare To Be You, Guiding Good Choices, Life Skills Training, Positive Action, Project Alert, Second Step and Strengthening Families Program.

Evidenced-based Program and Numbers Served:

Across Ages - 370
 All Stars - 505
 CMCA - 1026
 CLFC - 461
 DTBY - 1783
 GGC - 842
 Life Skills - 713
 Positive Action - 12
 Project Alert - 1863
 Second Step - 5839
 Strengthening Families - 2266
 Total - 15,680

These programs provided services and activities within the six CSAP strategies. Strategies and activities included but were not limited to ATOD-Free Activities, Community Service Activities, Youth Leadership Activities, Community Team Activities, Training Services Activities, Technical Service Activities, COSA Activities, Classroom Educational Services Activities, Educational Services for Youth, Parent and Family Management Activities, Peer Leader Activities, Small Group Activities, Health Fair Activities, Speaking Engagements, Health Promotion Activities Employee Assistance Activities, Student Assistance Activities Preventing Underage Alcohol Sales, Establishing ATOD-Free Policies.

Prevention services provided within the Institute of Medicine Classification were as follows:

Numbers served by IOM Category:

Universal Direct - 31,225

Universal Indirect - 176,939

Selected - 19,574

Indicated - 2,107

Total - 229,845

A minimum of 20% of the SAPT Block Grant funds supports primary prevention activities. An estimated 215,000 Maryland residents have or will participate in these activities. SAPT Block Grant funds enabled the Administration to support the Prevention Coordinators Network. This statewide network provides the infrastructure for the provision of technical assistance support and funding to community groups and /or organizations to plan and implement prevention services thru out the state of Maryland.

The statewide network utilizes a community development model with a focus on community and agency collaboration to address alcohol tobacco and other drug issues. Through this process, 419 community-based prevention programs are maintained. These programs expect to provide in excess of 2,800 prevention activities. Additionally, as a result of collaboration with Head Start agencies, SAPT Block Grant funds support six high-risk youth programs. Approximately 2,600 participants are expected to be served regionally throughout the State of Maryland. Each of the Pre-school programs use evidence based programs targeted for the age group. Family management skills and child development education are central to the curriculum

Four university campuses, regionally placed throughout the State of Maryland, continue to maintain ATOD Prevention Centers. At a cost of \$457,263 these centers expect to reach an estimated 33,000 participants. College students, faculty and staff actively participate in the program development, social norming, mentoring, classroom instruction, and campus-wide events.

Utilizing SAPT Block Grant funds, the Administration's FY 2009 prevention efforts represent a comprehensive approach in which a variety of strategies and activities are employed to prevent ATOD use. College students were served through strategies that included information dissemination, education, use alternatives, problem identification and referral, community-based process, and environmental improvements.

The Alcohol and Drug Abuse Administration funded several evidence based programs throughout the state during FY2009. These programs included Across Ages, All Stars, Communities Mobilizing for Change on Alcohol, Creating Lasting Family Connections, Dare To Be You, Guiding Good Choices, Life Skills Training, Positive Action, Project Alert, Project Towards No Drugs, Second Step and Strengthening Families Program.

These programs provided services and activities within the six CSAP strategies. Strategies and activities included but were not limited to ATOD-Free Activities, Community Service Activities, Youth Leadership Activities, Community Team Activities, Training Services Activities, Technical Service Activities, COSA Activities, Classroom Educational Services Activities, Educational Services for Youth, Parent and Family Management Activities, Peer Leader Activities, Small Group Activities, Health Fair Activities, Speaking Engagements, Health Promotion Activities, Employee Assistance Activities, Student Assistance Activities, Preventing Underage Alcohol Sales, Establishing ATOD-Free Policies.

The Administration's prevention goal will be to utilize not less than 20% of the SAPT Block Grant funds to develop, implement, and oversee ATOD prevention programs and strategies. Direction and technical assistance will be provided to the Prevention Network through communication, education, program development, coordination, cooperation, funding and advocacy. A community development process will be used as one of the mechanisms for the Maryland prevention system. The ADAA will continue to enhance its prevention system structure so that it incorporates the components of the SAMHSA Strategic Prevention Framework.

The Alcohol and Drug Abuse Administration will fund several evidence based programs throughout the state during FY2010. These programs will include Across Ages, All Stars, Communities Mobilizing for Change on Alcohol, Creating Lasting Family Connections, Dare To Be You, Guiding Good Choices, Life Skills Training, Positive Action, Project Alert, Project Towards No Drugs, Second Step and Strengthening Families Program.

These programs will provide services and activities within the six CSAP strategies. Strategies and activities will include ATOD-Free Activities, Community Service Activities, Youth Leadership Activities, Community Team Activities, Training Services Activities, Technical Service Activities, COSA Activities, Classroom Educational Services Activities, Educational Services for Youth, Parent and Family Management Activities, Peer Leader Activities, Small Group Activities, Health Fair Activities, Speaking Engagements, Health Promotion Activities, Employee Assistance Activities, Student Assistance Activities, Preventing Underage Alcohol Sales, Establishing ATOD-Free Policies.

All ADAA providers funded with SAPT Block Grant funds use the Minimum Data Set (MDS) as the data collection system to report prevention services and activities. Legislation in 2004 created a State Drug and Alcohol Council as well as Local Drug and Alcohol Councils located in every jurisdiction. The Administration has been identified as the technical assistance support entity for the local councils. These Councils will enhance and provide direction to the current system and create an environment of agency and community interaction in the process. The Administration has and will continue to utilize the concepts of the Strategic Prevention Framework (SPF) to educate council members and the Prevention Network on a planning process that uses epidemiological data to make informed decisions regarding prevention programming needs. Objective: To identify a framework for the development of a state ATOD Prevention plan.

Action: Establish a workgroup of key policy makers, prevention professionals, community and agency representatives, legislators, local council members etc, to initiate the planning process.

Objective: To develop, implement, maintain and evaluate community-based prevention programs that address ATOD issues utilizing the SPF model.

Action: Maintain a statewide network to support evidence based prevention programs and activities with fiscal and non-fiscal resources, technical assistance/data support and capacity development.

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 the data. Coordinators will work with county addiction coordinators and the Local Drug and Alcohol Councils to help them understand and utilize the SPF 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. Training and technical assistance on needs assessment, assessment, capacity building, planning, evidence based programming

and evaluation will be provided to the Prevention Coordinators and Administration staff by the CSAP CAPT.

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 the 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 develop and implement appropriate legislative strategies to address ATOD issues.

Attachment A: 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? 0.08

Motor vehicle drivers under age 21? 0.02

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

Communities: 28

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

Maryland**Goal #3: Pregnant Women Services**

GOAL # 3. An agreement 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; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FY 2007, the Administration expended \$4,121,210 to provide treatment services designed for pregnant women and women with dependent children. These expenditures included support for fourteen (14) gender-specific programs. Please refer to Attachment B for details. Services provided by these gender-specific programs included 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 State of Maryland provided services to this population with residential treatment slots for women as identified under Maryland Senate Bill 512 (Drug Affected Newborns) and Maryland House Bill 1160 (Welfare Innovation Act of 2000). Addictions specialists hired in local jurisdictions, as a result of these legislative initiatives, provided identification and referral of women in need of substance abuse treatment.

To further expand residential treatment capacity for pregnant women and women with dependent children, in FY 2007, 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 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 (State Fiscal Year) 2007 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, and neglect.
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 2009, 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. Likewise,

ADAA Conditions of Award for SFY2009 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, and neglect.
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 Administration collaborated with the Department of Human Resources on the development of cross training for local Departments of Social Services personnel and substance abuse professionals. To ensure that local health departments and funded providers were able to access residential services for pregnant women and women with dependent children, the ADAA women's services coordinator and contracts coordinator provided 12 in-service trainings in all four (4) regions of the state. The regional stakeholder trainings included information about the women's residential treatment services, as well as medical, mental health and childcare services for their children that accompany them to treatment.

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

Goal: To ensure that pregnant women continue to receive priority admission to substance abuse treatment programs.

Objective: To continue the development of specialized gender-specific treatment services for women, pregnant women, and women with dependent children.

Action: Include this language in the conditions of grant award to local health departments and sub-contractors ensuring priority admission.

Action: Review SAMIS generated utilization reports to measure compliance

Action: Provide ongoing funding for gender-specific programs designed to meet the needs of this population.

Objective: To continue the development of ancillary services/activities that support gender-specific treatment.

Action: Collaborate with the Department of Human Resources on the provision of cross-training for Department of Social Services personnel and substance abuse professionals.

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, and neglect.
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.

Goal: To align state and federal resources to improve the quality of life and reduce infant mortality in Maryland.

Objective: Collaborate with DHMH Family Health Services to ensure timely access for pregnant women and women with dependent children by implementing enhanced medical services in two jurisdictions in the state.

Maryland**Attachment B: Programs for Women**

Attachment B: Programs for Pregnant Women and Women with Dependent Children (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 2007) to the fiscal year for which the State is applying for funds: Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2007. In a narrative of **up to two pages**, describe these funded projects.

Since 1990, the Administration has maintained a specific policy requiring all programs to give priority admission to pregnant women. Women in need of services are defined as women who are using alcohol or drugs, with priority given to those who are pregnant. Our policy on the admission and retention of pregnant addicts is as follows:

A pregnant addicted female of any age, when pregnancy is confirmed by a valid provider, is to be admitted to and retained in treatment on a priority basis. Such a patient shall not be placed on the waiting list or be subject to involuntary termination. This policy applies to pregnant women who abuse alcohol as well as other drugs.

All programs which serve women incorporate gender-specific groups and activities. Pregnant women may be referred to any program statewide, whether it is a women only or mixed gender program. However, a variety of gender-specific programs have been developed including intensive outpatient, intermediate care, halfway house and therapeutic community services for pregnant women and women with dependent children. These projects are defined as those certified programs, which are designed specifically to treat only women, with or without their children in outpatient or residential settings.

As shown in the following table, the Administration uses federal SAPT funds to support 14 programs that provide gender-specific services to pregnant and post-partum women and their dependent children.

Pregnant Women and Women with Dependent Children Programs FFY 2007

WESTERN REGION

Program	Location	Level of Care
Gale House	Frederick County	Halfway House
Massie Women's Unit	Allegany County	ICF
Safe Harbor	Frederick County	Long Term
Shoemaker Center	Carroll County	ICF
W House	Washington County	Halfway House
Avery House	Montgomery County	Halfway House

SOUTHERN REGION

Program	Location	Level of Care
Prince George's Center	Prince George's County	Intensive Outpatient
Chrysalis House	Anne Arundel County	Halfway House
Marcey House	St. Mary's County	Long Term

CENTRAL REGION

Program	Location	Level of Care
A.W.A.R.E.	Baltimore County	Intensive Outpatient

EASTERN SHORE

Program	Location	Level of Care
Center 4 Clean Start	Worcester County	Intensive Outpatient

BALTIMORE CITY

Program	Location	Level of Care
JHH Women's Center	Baltimore City	Intensive Outpatient
Nilsson House	Baltimore City	Halfway House
Safe House	Baltimore City	Halfway House

Maryland

Attachment B: Programs for Women (contd.)

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 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.
2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2007 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 2007 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 FY2007

Program /Location /NFR-ID /Level of Care /Funds /Slots
Gale House /Frederick /750432 /Halfway House /\$191,123 /12
Massie Unit /Allegany /900227 /ICF /\$167,671 /4
Safe Harbor /Frederick /103362 /Long Term /\$242,250 /5
Shoemaker /Carroll /750564 /Detox, ICF /\$218,429 /8
W House /Washington /101230 /Halfway House /\$215,875 /17
Avery House /Montgomery /103392 /Halfway House /\$485,635 /9
P.G. Center /Prince George's /300030 /IOP /\$860,812 /47
Marcy House /St. mary's /101123 /Long Term /\$156,875 /6
A.W.A.R.E. /Baltimore Co. /101834 /IOP /\$370,784 /38
Chrysalis House /Anne Arundel /903759 /Halfway House /\$188,121 /8
Center 4 Clean /Worcester /901845 /IOP /\$273,686 /32
JHH Women's /Baltimore /902355 /IOP /\$501,204 /34
Nilsson House /Baltimore /902140 /Halfway House /\$125,531 /9
Safe House /Baltimore /902389 /Halfway House /\$123,214 /7
\$4,121,210

During April, 2007, the Administration submitted a revision to the SAPT application to clarify the calculation method and to document compliance with the federal requirements. In consultation with SAMHSA, the Administration has revised its calculation method for documenting compliance with 42 U.S.C. 300x-22(b)(1)(C). this calculation established \$5,032,564 as the base for Pregnant Women and Women with Dependent Children.

In FY 2007 Maryland provided services to pregnant women and women with dependent children in 14 locations on a local basis, as well as provided long term residential care on a statewide basis by establishing a pay for performance project for the above population.

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.

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

The State of Maryland expended \$4,121,210 in SAPT federal funds for 14 gender-specific programs in FY 2007 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.

Maryland

Goal #4: IVDU Services

GOAL # 4. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, the Administration used its online data collection systems HATS (HIDTA Automated Tracking System) and SMART (State of Maryland Automated Record Tracking) to track slots and admissions data for capacity management. The Administration 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.

The Administration required, through its 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.

Interim Methadone: Interim methadone maintenance (IM) was developed in response to a shortage of treatment slots during the AIDS epidemic. Its purpose was to permit rapid entry into a low-cost, low threshold treatment as a stopgap alternative to a wait list. Interim methadone maintenance provides medical intake and daily methadone administration under direct observation. It is not intended to replace regular methadone treatment that includes ongoing counseling and other rehabilitative services. Under current regulations, interim methadone treatment is approved by CSAT for a limited duration (up to 120 days), after which patients must be transferred to a traditional opioid treatment program (OTP).

Baltimore Substance Abuse Systems, Inc. (BSAS) has supported interim methadone maintenance since 2005. At that time, six providers participated in a CSAT-funded research project. The study, which ended in 2006, yielded many positive results which supported the continuation of this intervention.

In FY 2007, BSAS funded interim methadone maintenance at two programs for 59 individuals. Of those 59 patients, 10 (17%) were successfully transferred to a traditional OTP, 9 (15%) were discharged unsuccessfully, and 40 (68%) had not yet completed 120 days and were carried over to FY 2008.

In FFY 2009, the Administration used its online data collection systems HATS (HIDTA Automated Tracking System) and SMART (State of Maryland Automated Record Tracking) to track slots and admissions data for capacity management. The Administration 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.

The Administration required, through its 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.

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

Interim methadone: BSAS expects to provide level funding to the 4 interim methadone programs in Baltimore City, while searching for ways to further integrate interim methadone services into its addiction treatment continuum.

ADAA Conditions of Award for SFY 2010 contained 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

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

(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 2007) 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 2007 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 6,586 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 2007.

I-SATS FACILITY

62 Prince George's County Based Substance Abuse Program
 541 Alcohol and Drug Intervention, Inc.
 100018 Addiction and Drug Intervention, Inc.
 100083 University of Maryland Methadone Program
 100091 Baltimore Community Resource Center
 100190 Reflective Treatment Center
 100406 Partners in Recovery
 100981 Hilltop Recovery Center
 101003 Gaudenzia, Inc.
 101123 Marcey House
 101229 Build Fellowship
 101257 I Can We Can Halfway House
 101258 Druid Heights Treatment and Counseling Center
 101292 Turning Point Clinic
 101362 Mountain Manor Treatment Center
 101363 Howard House
 101382 Alcohol and Drug Recovery
 101891 Counseling Plus, Inc.
 102188 Jude House
 102378 Suburban Hospital OP Treatment Program
 102667 Pathways
 102816 The Recovery Resources Group Inc
 103079 Powell Recovery Center
 103533 Ferry Point Assessment and Treatment Services
 103798 Addicts Changing Together Substance Abuse Program
 103889 Family Health Center of Baltimore
 104135 Recovery Network

105983 Alcohol Drug Education Prevention and Treatment
 106619 First Step Recovery Center, Inc.
 300030 Prince Georges CHD
 300329 Second Genesis
 301350 Glenwood Life Counseling Center
 301400 Washington CHD
 750069 Valley/Bridge House
 750283 Mann House, Inc.
 750291 Damascus House
 750382 Caroline CHD Addictions Program
 750424 Frederick CHD
 750473 Charles CHD Substance Abuse Services
 750499 Reality, Inc.
 750523 Second Wind
 750580 Samaritan House
 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
 900326 First Step, Inc.
 900433 Epoch Counseling Center
 900441 Howard CHD
 901720 HARBEL Prevention and Recovery Center
 901779 Walden Sierra, Inc.
 902140 Tuerk House, Inc.
 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
 902967 Montgomery County Office of Addictions Services
 903759 Chrysalis House
 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).

Also see ADAA Conditions of Award listed under Compliance and Intended Use sections of this Goal.

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

Also see ADAA Conditions of Award listed under Compliance and Intended Use sections of this Goal.

Maryland**Attachment D: Program Compliance Monitoring****Attachment D: Program Compliance Monitoring**

(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 2008) 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 data are available to programs staff at all times and provide instant feedback as to capacity status.

ADAA continued development of an automated notification of reaching capacity from its web based clinical record. SMART now 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 new Contract Management module in SMART the Administration is able to track ADAA-funded statewide residential slots. In the future when an opioid maintenance treatment (OMT) program's active client roster reaches 90% of its slot capacity a notification will be sent to the State Opioid Treatment Authority (SOTA). 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.

Maryland**Goal #5: TB Services**

GOAL # 5. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, the Administration 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 also 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 annual/biannual certification process.

In FFY 2009, the Administration 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 also stipulated that programs perform or make available the assessment, and note services or referrals in patient records. This requirement also 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 reviews tuberculosis assessment and referral services for patients during the annual/biannual certification process.

In FFY 2010, the Administration continues 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 will continue to be made available in all levels of care. 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 review tuberculosis assessment and referral services for patients during the annual/biannual certification process.

Maryland

Goal #6: HIV Services

GOAL # 6. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

As a designated state, Maryland expended \$1,593,446 of SAPT Block Grant funds on HIV early intervention services in FFY 2007. 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) 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 the 380 testing sites in Maryland, including two of the three programs supported by the HIV set-aside funds that the ADAA awards to the MAA.

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.

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Objective: To assess and maintain categorical projects in geographic areas having the greatest need.

Action: Identify funding and program support for the continuation and enhancement of categorical projects.

Action: Coordinate funding commitments with the Maryland Infectious Disease and Environmental Health Administration (IDEHA, formerly the "AIDS Administration");

Objective: To ensure the availability of HIV prevention and education services, pre-test counseling, post-test counseling, and risk assessment on-site in all certified treatment programs, with testing and therapeutic services available through referral.

Action: Require, by policy, referral agreements for testing and therapeutic services.

Action: The State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality shall review availability and referral of services for patients during the annual/biannual certification process.

Objective: To collaborate with IDEHA regarding the training and implementation of the HIV rapid testing procedures.

Action: Alcohol and Drug Abuse Administration will identify key staff to collaborate with IDEHA regarding training and implementation of procedures.

Maryland

Attachment E: TB and Early Intervention Svcs for HIV

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV (See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2007) 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 2007 Uniform Application, Section III.4, FY 2007 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. Health Care for the Homeless/PEP	\$107,549	Baltimore City
3. Md. AIDS Administration Program Manager, Program Evaluator and Partial Capacity Building Trainer salary & fringe benefits	\$166,500	Baltimore City
4. Baltimore City Health Dept. and Baltimore Substance Abuse Services (BCHD & BSAS- Project SMART)	\$98,120	Baltimore City
Total ADAA Funds		\$422,637

Summary of Services:

Agency	Activities	# Sessions	# Clients Served
Glenwood Life Counseling Center	Group Sessions	134 Groups	133 clients
Health Care for the Homeless/PEP	Group Sessions	148 Groups	200 group clients
Capacity Building and Training sessions targeted to Substance Abuse providers and HIV Counseling & Testing	Trainings participated in the following trainings: HIV101/Prevention Basics HIV & Substance Abuse	9 Sessions	Over 200 Individuals
Project SMART:			

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

The total amount for HIV/AIDS early intervention and related services totaled \$1,593,466.

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

GOAL # 7. 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.

FY 2007 (Compliance): (Reporting REQUIRED if State chose to participate)

FY 2009 (Progress): (Reporting REQUIRED if State chose to participate)

FY 2010 (Intended Use): (State participation is OPTIONAL)

N/A

N/A

N/A

Maryland

Attachment F: Group Home Entities and Programs

Attachment F: Group Home Entities and Programs

(See 42 U.S.C. 300x-25)

If the State has chosen in FY 2007 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund, then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2007 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.

Maryland
Goal #8: Tobacco Products

GOAL # 8.

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 2010 Annual Synar Report included with the FY 2010 uniform application? (Yes/No)
- If No, please indicate when the State plans to submit the report: (mm/dd/2009)

Note: The statutory due date is December 31, 2009.

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. No changes in the law took place. Enforcement activities took on unique local application of effort and strategy. The State of Maryland strengthened the local activities by providing project funding for the development of a statewide network of control activities.

Through this effort, enforcement activities reduced youth access and the non-compliance inspection rate. Alcohol and Drug Abuse Administration staff conducted random unannounced inspections and found a non-compliance rate of 5.1. This is Maryland's lowest non-compliance rate since the inception of Synar.

The State's 2010 Synar report will be submitted by December 31, 2009.

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

GOAL # 9. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, 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.

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 2007, 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.

In FFY 2009, 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.

The ADAA continued to support residential treatment beds for pregnant women and women with dependent children. To ensure that local health departments and funded providers were able to access the residential services for pregnant women and women with dependent children, the ADAA women's services coordinator and contracts coordinator provided 12 in-service trainings in all four (4) regions of the state. The regional stakeholder trainings included information about the women's residential treatment services, as well as medical, mental health and childcare services for their children that accompany them to treatment.

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

Goal: To approve and implement state-specific standards for preferential admission to substance abuse treatment services for pregnant and women with dependent children.

Objective: Incorporate requirements for preferential admission to women's services into Conditions of Award for all ADAA funded treatment providers that meet or exceed national standards.

Action: 2010 Conditions of Award will require that all funded programs admit pregnant women within 24 hours of request.

Objective: The ADAA will collaborate with other state and local agencies which have a mandate to provide services for pregnant women and women with children.

Action: The ADAA women's treatment coordinator and the women's treatment team will work with the local jurisdictions and programs to provide technical assistance to implement the standards to promote timely access to treatment for pregnant women and women with dependent children.

Goal: To align 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.

Objective: Collaborate with DHMH Family Health Services to ensure timely access for pregnant women and women with dependent children by implementing enhanced medical services in two jurisdictions in the state.

Maryland

Attachment G: Capacity Management and Waiting List Systems

Attachment G: Capacity Management and Waiting List Systems

(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2008) 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:

- 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 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 are met. The Administration has issued and implemented a waiting list policy requiring 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.

Baltimore City has the highest incidence of IVDUs and opioid users in Maryland. Most OMT programs are at capacity and maintaining wait lists for this population is undesirable. In FFY 2005 Baltimore City ran a SAMHSA funded pilot program for Opioid Maintenance Therapy programs to begin using an Interim Maintenance protocol. When these programs reach capacity, they can offer patients the option of entering an Interim Maintenance (IM) protocol. 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.

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 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. All 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 ADAA-QA compliance visit.

Maryland

Goal #10: Process for Referring

GOAL # 10. 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)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, all substance abuse treatment programs were required under the Code of Maryland Regulations (COMAR) to utilize Administration approved assessment tools, which for adults, was the Addictions Severity Index (ASI) and for adolescents, the Problem Oriented Screening Instrument for Teenagers (POSIT). The instruments are provided through the Administration's online clinical record and training in their application is provided to the field through the Administrations Office of Education and Training for Addiction Services (OETAS).

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.

COMAR §10.47.01.04 requires that programs have detailed descriptions of patient placement criteria for admission to the programs, including eligibility criteria "such as the American Society of Addiction [ASAM] Medicine Patient Placement Criteria [PPC] or other guidelines approved by the Administration". COMAR regulations (§10.47.01.04) also prohibit admission to programs unless individuals meet ASAM PPC "or other guidelines approved by the ADAA".

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 FY2 2009.

The Office on Education and Training for Addiction Services (OETAS) provided trainings and technical assistance in best practice and specific application of screening, assessment and placement instruments. As part of the curriculum, the Administration provided additional training on how to use the instruments in computer aided interviewing using SMART.

In August 2008, the ADAA submitted formal requests for amendments to COMAR that would change §10.47.01.04 to remove the words "or other guidelines approved by the ADAA" and 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. The ADAA also planned to make other amendments to COMAR which would eliminate the requirement that programs utilize the ASI, and instead require all funded programs to utilize the TAP. As the ADAA transitions to a full electronic medical record (EMR), modifications are being made which will enable clinicians to use individual client level data from the TAP to make eligibility and level-of-care determinations for adults.

As a member of the Web Infrastructure for Treatment Services (WITS) Collaborative, Maryland has benefited from the efforts of the State of Hawaii to program and make available the Adolescent Drug and Alcohol Diagnosis (ADAD) assessment instrument. In 2009, the ADAA made the decision to incorporate the ADAD into its electronic medical record (EMR) and began piloting it in late FY 2009.

The Office on Education and Training for Addiction Services (OETAS) continued to provide trainings and technical assistance in best practice and specific application of screening, assessment and placement instruments, as well as trainings on how to use the instruments in computer aided interviewing modules of SMART.

Goal: To continue to improve the process for referring individuals to the most appropriate level-of-care according to ASAM placement criteria.

Objective: To provide enhancements in SMART which would include additional screening, assessment and placement instruments.

Objective: To provide Administration sponsored trainings and technical assistance in best practice and specific application of screening, assessment and placement instruments.

Objective: To draft the SFY 2011 Conditions-of-Award to specifically require the TAP and the ADAD for making level-of-care determinations consistent with ASAM placement criteria.

Action: The ADAA will modify COMAR regulations to require that all publicly-funded programs to report all patient data in SMART.

Action: The Office on Education and Training for Addiction Services (OETAS) will routinely offer training on assessment and placement criteria in its catalogue of courses.

Maryland

Goal #11: Continuing Education

GOAL # 11. 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)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, the Administration offered continuing education for the employees of facilities that provided prevention activities and treatment services. The Office of Education and Training (OETAS) within the Administration's Information Division was responsible for ensuring that continuing education courses were provided that met the needs of individuals providing addiction services.

The OETAS in collaboration with the Central East Addiction (CEATTC) and the National Center for Applied Prevention Technology (CAPT) provided year round training to meet the needs identified by the addiction workforce. Programs purchased training to meet the specific workforce needs of their agencies.

In July and August of 2006 and June of 2007, OETAS provided statewide trainings at Salisbury University on the eastern shore of Maryland. During these three months, OETAS provided 24 twenty hour courses to over 500 students. From September 2006 through May 2007 in cooperation with its federal partners offered 27 commuter courses and workshops at our central training location. In addition, OETAS designed and provided customized continuing education activities to meet the specific workforce needs of various agencies' requesting this service. Instruction was provided at the work site to the staff at those addiction programs.

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, advanced pharmacology, the strategic prevention framework and co-occurring disorders.

In October 2006 the ADAA hosted its annual statewide management conference. In attendance were over 200 funded addiction program managers and prevention coordinators. The "Business of Addiction" theme featured nationally recognized keynote speakers who shared their knowledge and expertise on the study, structure and dynamics of the addiction services industry.

During FFY 2009, OETAS provided continuing education for employees of facilities that provide prevention, intervention and treatment services, and provided 21 training opportunities through commuter classes and customized trainings. Approximately 500 participants attended the 21 twenty hour (3 ½ day) programs at Salisbury University (July and August 2008 and June 2009).

The continuing education courses offered by OETAS emphasized advanced addiction counseling and prevention content that integrated evidence based research into daily clinical processes and prevention activities. Trainings on topics such as the implementation of medication services in traditionally abstinence-based programs and treatment of disorders resulting from trauma and brain injury with co-morbid conditions such as co-occurring substance abuse issues among our veteran population are ongoing to address the specialized needs of our workforce.

During FY 2009, 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 to work more collaboratively, and the three administrations began addressing topics and trainings to meet the workforce needs of all three administrations. Planning began for regional workshops to bring the local management and clinical staffs of the three administrations together to develop a more integrated system of care for the patients we share. In addition, we initiated planning for a clinical supervisor's academy to address the three administrations' needs for training on clinical supervision.

In FY 2009, the ADAA initiated an annual lecture series, the C.Wayne Kempske Lecture Series which focused on disseminating and promoting innovative research practice(s) in the treatment of substance abuse disorders within the criminal justice population. Approximately 200 administrators and managers of criminal justice and treatment systems and agencies attended each of the two first lectures in the series.

The ADAA annual management conference focused on building a recovery oriented system of care in Maryland. The conference invitees include funded program managers, prevention coordinators and central administrators. Recognized leaders in the development and administration of recovery oriented systems of care share their knowledge and experience with participants. The conference provides an opportunity for providers and administrators throughout the entire state to network and share resources.

Goal: to provide continuing education for the employees of facilities which provide prevention activities and/or treatment services (See 42 U.S.C. 300x- 28(b) and 45 C.F.R. 96.132(b)).

Objective: Through training and other educational activities expand the scope, functionality and competencies of current and future practitioners who comprise our prevention and treatment systems of care in Maryland.

Action Plan: The Office of Education for Addiction Service (OETAS), in collaboration with the Central East Technology Transfer Center and the National Center for Applied Prevention Technologies, will develop and deliver continuing education courses that support and enhance the identified needs of the workforce. In addition OETAS will assist higher education institutions in Maryland to develop addiction curriculum that prepares students to meet the challenges of the profession.

Objective: To identify, develop and disseminate customized continuing education activities to meet the specific and evolving needs of the workforce.

Maryland

Goal #12: Coordinate Services

GOAL # 12. 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)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, 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 2009, 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.
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- 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): In November 2008, the ADAA submitted a competitive proposal for CSAP funding to support Maryland's SPF project. The application represented a strong collaboration between the Administration, the Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park, the Statewide Epidemiological Workgroup (SEOW), the Maryland State Drug and Alcohol Abuse Council (DAAC) and the local drug and alcohol abuse councils (LDAACs) in 24 jurisdictions. The Administration was notified in July 2009 (FY 2010) that it was the recipient of a \$2,135,724 award to implement MSPF.

The primary purpose of the proposed 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. Implementation of MSPF (to commence in FY 2010) will lead to improved linkages, more effective planning, more strategic targeting and better utilization of prevention resources, and expansion of prevention services capacity.

Goal: Continue efforts in FY 2010 to support a statewide continuum of prevention and treatment services and coordination with other appropriate services through active involvement with other State agencies, local health departments and healthcare professionals.

Objective: Continue to support representation and active involvement of ADAA staff on existing and newly identified committees, task forces and work groups.

Goal: Continue partnerships with other state agencies in FY 2010 to provide and enhance treatment services for substance-using populations in Maryland:

Objective: Continue collaboration with CESAR to coordinate ongoing prevention and treatment needs assessment activities and to support the Maryland Community Services Locator (MDCSL).

Objective: Continue collaboration with the 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.

Objective: Continue collaboration with the Maryland Department of Juvenile Services (DJS) to coordinate referrals to treatment resources for adolescents.

Objective: Continue collaboration with the Maryland Infectious Disease and Environment Health Administration (IDEHA, formerly the "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.

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

Objective: Continue 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).

Objective: Continue 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).

Objective: 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.

Objective: Continue 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.

Goal: Continue partnerships with other state agencies to provide and enhance prevention services in Maryland.

Objective: Effectively and efficiently implement proposed MSPF activities in accordance with the SPF proposal's approved Year 1 work plan.

Objective: Establish the SPF Advisory Council (SPFAC) as a subcommittee of the State Drug and Alcohol Abuse Council (DAAC).

Objective: Develop a comprehensive, cross-system statewide strategic plan for prevention services in Maryland and have it approved by CSAP within 9 months of receiving SPF funding, as per CSAP conditions of award.

Objective: Continue collaboration with CESAR and the SEOW to coordinate ongoing prevention and treatment needs assessment activities, and use the needs assessment data to target resources throughout Maryland communities.

Objective: Continue 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.

Maryland

Goal #13: Assessment of Need

GOAL # 13. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

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 public and private certified treatment programs in Maryland are required to report utilization and performance measure (NOMS) data to SMART, so the data represent the full spectrum of treatment in Maryland. The Administration's Outlook and Outcomes FY 2007 Annual Report 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 2007 Compliance period.

CESAR 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 2006 and 2007 NSDUH surveys provided state level estimates of the need for treatment for alcohol and illicit drug use.

The study determined that an estimated 121,000 Maryland citizens over age 12 needed but did not receive treatment for illicit drug use in the past year and 339,000 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 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 FFY 2010.

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 FFY 2009, 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.).

Objective: To continue existing needs assessment analyses as conducted by the Administration.

Action: 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.

Action: 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.

Action: Partner with the Institute of Governmental Services and Research (IGSR), the Center for Substance Abuse Research (CESAR) to enhance performance measurement and develop resource allocation methodologies.

Action: Continue 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.

Objective: To create and support a 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.

Action: Establish a Maryland SPF Advisory Council (SPFAC) within the State Drug and Alcohol Abuse Council (DAAC).

Objective: To utilize SAMHSA/CSAP funds to continue SEOW activities to collect and analyze relevant epidemiological data to document substance abuse related consequences and consumption patterns.

Action: Continue to partner with the Center for Substance Abuse Research (CESAR) to maintain the SEOW and its SEOW membership as a part of the SPF project.

Maryland

Goal #14: Hypodermic Needle Program

GOAL # 14. 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)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, ADAA conditions of grant award prohibited all funded programs from utilizing SAPT Block Grant funds to support needle exchange. No funds were utilized for that purpose.

In FFY 2009, ADAA conditions of grant award prohibited all funded programs from utilizing SAPT Block Grant funds to support needle exchange.

Objective: To ensure continued compliance of SAPT Block Grant fund restriction on use relating to provision of hypodermic needles or syringes.

Action: Continue prohibiting use of SAPT Block Grant funds for needle exchange as a condition of grant award.

Maryland

Goal #15: Independent Peer Review

GOAL # 15. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007, a total of five (5) Independent Peer Reviews of treatment programs were conducted in the State of Maryland to assess and improve the quality and appropriateness of treatment services delivered by funded providers. These included:

Baltimore City – Penn North Substance Abuse Center (8/3/06 and 8/4/06);
Baltimore City – Glass Counseling Center (8/30/06 and 9/1/06);
Prince Georges County HD – Renaissance Treatment Center in Capital Heights, MD (3/5/07 and 3/9/07);
Montgomery County HD – Counseling Plus, Inc. in Silver Spring, MD (5/4/07 and 5/7/07);
Baltimore City – Echo House Multi-Service Center (6/1/07 and 6/4/07).

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

Baltimore County HD – First Step, Inc., in Reisterstown, MD (10/16/08 and 10/17/08);

Baltimore City – Youth Services, Inc. (10/24/08 and 10/27/08);

Montgomery County HD – Journeys for Adolescents Program in Rockville, MD (11/6/08 and 11/7/08);

Baltimore City – Treatment Resources for Youth (11/7/08 and 11/10/08);

Baltimore County HD – Epoch Counseling Center Adolescent Program in Reisterstown, MD (11/20/08 and 11/21/08).

Objective: To provide 5% of SAPT Block Grant funded programs with Independent Peer Reviews that are helpful to the programs.

Action: Conduct independent peer reviews and distribute findings to programs for use in ongoing program improvement.

Action: Provide peer review findings to Administration Regional Team Managers if technical assistance is needed or requested by the programs.

Action: Request feedback from programs that have participated in Peer Review to provide feedback about the experience and make any suggestions for changes in the process.

Maryland

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (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 2008 (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 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 included those providing outpatient and medication assisted treatment in city, suburbs and rural areas of the State. The Administration 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 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 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 2007, 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 three (3) programs providing services in Baltimore City, one (1) in Montgomery County and one (1) in Prince Georges 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.

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

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

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

Maryland

Goal #16: Disclosure of Patient Records

GOAL # 16. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

In FFY 2007 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).

Also in FFY 2007, OETAS collaborated with SAMHSA-CSAT and Macro International, Inc. to plan and design two 2-day Confidentiality and Ethics Trainings which were delivered early in FFY 2008.

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 annual/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. 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) also monitored patient records for appropriate and accurate consent forms and patient rights statements that include these protections.

The security architecture for the State of Maryland Automated Record Tracking—SMART (web-based data management system) and the ADAA's SAMIS data server were designed to ensure the confidentiality and security of patient data. The ADAA restricted access to the rooms in which primary and back-up servers were located, and maintained procedures for investigating and reporting potential security incidents. Patient information was protected from inappropriate disclosures through personnel security procedures, authentication procedures, firewalls, encryption, and consent processes. The ADAA, its IT vendors and SMART system users adhered to policies, procedures and contractual requirements that addressed several layers of application security. 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 2009 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 annual/bi-annual certification process and other compliance review site visits.

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Goal: To provide a system to ensure patient record confidentiality and prevent inappropriate disclosure of information

Objective: Monitor programs to make sure they are consistently applying Federal/State Confidentiality Regulations.

Action: Conduct regularly scheduled compliance reviews and complaint investigations to evaluate compliance with Federal/State confidentiality rules.

Action: Maintain systems that respond to reported breaches in Federal/State confidentiality rules.

Action: Continue to provide technical assistance and problem resolution to substance abuse treatment programs that are deficient in this area.

Objective: To maintain existing confidentiality training activities through OETAS.

Action: Continue to provide counselor training that includes education regarding State and Federal confidentiality regulations.

Objective: To support the system architecture and personnel security policies/procedures necessary to maintain the security and privacy requirements for client records.

Action: Continue to support and maintain the Statewide electronic web-based data management system (SMART application) security architecture to protect client information from inappropriate disclosure.

Maryland**Goal #17: Charitable Choice**

GOAL # 17. 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).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

N/A

During FY2009, 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.

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.

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.

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.

Attachment I: Charitable Choice

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 Attachment I is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2009) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

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

Referrals to Alternative Services -Check all that Apply

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

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

During FY2007 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.

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.

Maryland

Attachment J: Waivers

Attachment J: Waivers

If the 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 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 2010.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State: Maryland

Dates of State Expenditure Period: From: 7/1/2007 To: 6/30/2008

Activity	Source of Funds					
	A. SAPT Block Grant FY 2007 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	\$ 22,308,244	\$ 990,403	\$	\$ 72,541,140	\$ 6,374,414	\$ 7,699,464
Primary Prevention	\$ 6,373,784		\$	\$	\$	\$
Tuberculosis Services	\$	\$	\$	\$	\$	\$
HIV Early Intervention Services	\$ 1,593,446	\$	\$	\$	\$	\$
Administration: Excluding Program/Provider	\$ 1,593,446		\$	\$ 4,417,195	\$	\$ 84,366
Column Total	\$31,868,920	\$990,403	\$0	\$76,958,335	\$6,374,414	\$7,783,830

*Prevention other than Primary Prevention

Form 4ab

State: Maryland

Form 4a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2007	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 2,230,824	\$	\$	\$	\$
Education	\$ 446,164	\$	\$	\$	\$
Alternatives	\$ 2,167,086	\$	\$	\$	\$
Problem Identification & Referral	\$ 318,692	\$	\$	\$	\$
Community Based Process	\$ 701,116	\$	\$	\$	\$
Environmental	\$ 509,902	\$	\$	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
Column Total	\$6,373,784	\$0	\$0	\$0	\$0

Form 4b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2007	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$ 2,613,251	\$	\$	\$	\$
Universal Indirect	\$ 2,868,202	\$	\$	\$	\$
Selective	\$ 764,854	\$	\$	\$	\$
Indicated	\$ 127,477	\$	\$	\$	\$
Column Total	\$6,373,784	\$0	\$0	\$0	\$0

Resource Development Expenditure Checklist

State: Maryland

Did your State fund resource development activities from the FY 2007 SAPT Block Grant?

Yes No

Expenditures on Resource Development Activities are:
 Actual 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

SUBSTANCE ABUSE ENTITY INVENTORY

State: Maryland

				FISCAL YEAR 2007			
1. Entity Number	2. I-SATS ID [X] if no I-SATS ID	3. Area Served	4. State Funds (Spent during State expenditure period)	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 (if applicable)
101001	900227	Allegany County	\$3,827,271	\$1,055,214	\$167,671	\$375,275	\$27,904
102001	100182	Anne Arundel County	\$1,724,335	\$1,679,709	\$188,121	\$246,099	\$117,238
103001	750614	Baltimore County	\$3,987,967	\$1,810,960	\$370,784	\$561,320	\$140,561
104001	902512	Calvert County	\$531,693	\$275,132	\$0	\$81,827	\$8,330
105001	750382	Caroline County	\$380,386	\$130,717	\$0	\$76,195	\$1,041
106001	750564	Carroll County	\$2,400,952	\$1,163,616	\$218,429	\$93,246	\$57,474
107001	900375	Cecil County	\$923,490	\$256,773	\$0	\$71,132	\$16,243
108001	750473	Charles County	\$1,287,095	\$290,139	\$0	\$133,634	\$13,744
109001	902199	Dorchester County	\$777,996	\$219,658	\$0	\$112,159	\$53,101
110001	750424	Frederick County	\$1,324,413	\$498,390	\$433,373	\$371,051	\$63,513
111001	901209	Garrett County	\$534,677	\$145,490	\$0	\$249,658	\$4,581
112001	903817	Harford County	\$1,118,173	\$344,048	\$0	\$106,021	\$31,861
113001	900441	Howard County	\$1,085,550	\$186,268	\$0	\$85,752	\$9,371
114001	301293	Kent County	\$1,544,871	\$168,533	\$0	\$102,152	\$35,192
115001	902967	Montgomery County	\$2,769,740	\$773,324	\$485,635	\$497,689	\$55,392
116001	300030	Prince George's County	\$5,478,256	\$1,587,826	\$860,812	\$643,656	\$21,032
117001	750325	Queen Anne's County	\$584,668	\$151,676	\$0	\$87,004	\$7,080
118001	901779	St Mary's County	\$1,871,937	\$501,439	\$156,875	\$97,501	\$15,410
119001	103608	Somerset County	\$596,622	\$95,189	\$0	\$236,177	\$4,165
120001	750390	Talbot County	\$570,712	\$173,855	\$0	\$102,479	\$4,373
121001	301400	Washington County	\$2,256,907	\$805,351	\$215,875	\$244,869	\$23,323
122001	900300	Wicomico County	\$1,143,957	\$397,367	\$0	\$354,959	\$16,659
123001	901845	Worcester County	\$1,892,516	\$775,717	\$273,686	\$106,981	\$44,980
130001	100091	Baltimore City	\$26,581,960	\$8,684,590	\$749,949	\$1,023,439	\$735,292
135001	X	Statewide Contracts	\$7,344,996	\$137,263	\$0	\$313,509	\$85,586
Totals:			\$72,541,140	\$22,308,244	\$4,121,210	\$6,373,784	\$1,593,446

PROVIDER ADDRESS TABLE

State: Maryland

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

Form 6a

State: Maryland

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Brochures [4]	39
	Speaking engagements [6]	34
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	33
	Parenting and family management [11]	24
	Peer leader/helper programs [13]	14
	Education programs for youth groups [14]	26
	Mentors [15]	11
	Preschool ATOD prevention programs [16]	6
	Drug free dances and parties [21]	16
	Youth/adult leadership activities [22]	33
	Community service activities [24]	15
	Recreation activities [26]	35
	Student Assistance Programs [32]	7
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	9
	Community team-building [44]	6
Pregnant Women/Teens [2]	Brochures [4]	14
	Speaking engagements [6]	19
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	2
	Parenting and family management [11]	22
	Community service activities [24]	5
Violent and Delinquent Behavior [4]	Brochures [4]	17
	Speaking engagements [6]	21
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	8
	Peer leader/helper programs [13]	6
	Education programs for youth groups [14]	13
	Community team-building [44]	2
Mental Health Problems [5]	Brochures [4]	16
	Speaking engagements [6]	11
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	17
Economically Disadvantaged [6]	Brochures [4]	19
	Speaking engagements [6]	21
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	12
	Parenting and family management [11]	17
	Education programs for youth groups [14]	7
	Mentors [15]	4
	Youth/adult leadership activities [22]	16
	Community service activities [24]	1
	Recreation activities [26]	19
Physically Disabled [7]	Speaking engagements [6]	9
	Ongoing classroom and/or small group sessions [12]	1
	Youth/adult leadership activities [22]	4
	Recreation activities [26]	10
Already Using Substances [9]	Brochures [4]	32
	Speaking engagements [6]	30
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	21
	Education programs for youth groups [14]	10
Parents [11]	Brochures [4]	35
	Speaking engagements [6]	24
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	13
	Parenting and family management [11]	31

	Peer leader/helper programs [13]	18
	Youth/adult leadership activities [22]	16
	Community service activities [24]	17
Preschool [12]	Brochures [4]	6
	Speaking engagements [6]	6
	Parenting and family management [11]	6
	Preschool ATOD prevention programs [16]	6

TREATMENT UTILIZATION MATRIX

State: Maryland

Dates of State Expenditure Period: From: 7/1/2007 To: 6/30/2008

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	4275	3907	\$ 979.79	\$	\$
Rehabilitation / Residential					
Hospital Inpatient			\$	\$	\$
Short-term (up to 30 days)	7491	6980	\$ 2287.16	\$	\$
Long-term (over 30 days)	3250	2949	\$ 9263.32	\$	\$
Ambulatory (Outpatient)					
Outpatient	21272	19750	\$ 1634.32	\$	\$
Intensive Outpatient	8293	7454	\$ 1714.83	\$	\$
Detoxification	559	529	\$ 723.49	\$	\$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	2271	2138	\$ 10854.95	\$	\$

Form 7b

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

State: Maryland

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	3541	1371	610	1089	217			19	2	5	0	22	9	155	42	2499	831	157	47
2. 18-24	6527	2920	1308	1453	455			47	15	12	8	24	9	239	37	4448	1774	241	56
3. 25-44	16855	5232	2998	5173	2614			57	16	35	36	66	28	512	88	10499	5642	556	133
4. 45-64	8160	2227	978	3318	1441			13	7	10	8	12	1	123	22	5544	2421	140	36
5. 65 and over	171	72	22	58	12			2	0	0	0	1	0	3	1	133	34	3	1
6. Total	35254	11822	5916	11091	4739	0	0	138	40	62	52	125	47	1032	190	23123	10702	1097	273
7. Pregnant Women	492		295		183				1		1		3		9		480		14

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

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 17900

The Unknown Race category is actually an ";Other"; category that consists largely of Hispanics who select neither the white nor the African American option.

Maryland

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 \$13,294,821 in 2004, \$13,294,821 in 2005 and \$13,294,821 projected in 2006.

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 TABLE I)

State: Maryland

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

PERIOD	EXPENDITURES	B1(2007) + B2(2008)
(A)	(B)	----- 2 (C)
SFY 2007 (1)	\$71,133,248	\$71,832,805
SFY 2008 (2)	\$72,532,362	
SFY 2009 (3)	\$ 77,626,960	

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

- FY 2007 Yes No
- FY 2008 Yes No
- FY 2009 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) 2009 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

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

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

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

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

- Yes No

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

TB (MOE TABLE II)

State: Maryland

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 A X 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 A X B (C)
SFY 2009 (3)	\$ 752,816	1 %	\$ 7,528

HIV (MOE TABLE III)

State: Maryland

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 2009 (3)	\$ 3,516,155

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

Womens (MOE TABLE IV)

State: Maryland

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	
2007		\$13,294,821
2008		\$13,294,821
2009		\$ 11,812,774

Enter the amount the State plans to expend in FY 2010 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}): \$ 11,000,000

Maryland

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the 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.

In a narrative of **up to three 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. 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. Describe the State's Epidemiological Outcomes Workgroup's 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 efforts, such as programs, policies and practices, and how this data is used for planning. For the prevention assessment, States should focus on the SEOW process. Provide a summary of how data/data indicators were chosen, as well as, key data construct and indicators for understanding State-level substance use patterns and related consequences and mechanisms for tracking data and reporting significant changes should be outlined.

- 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 2010 application for SAPT Block Grant funds.

Local 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 (23 counties and Baltimore City) in Maryland develop local Drug and Alcohol Advisory Councils (LDAACs). The law required that certain agency representatives be appointed to each local advisory council. All twenty-four jurisdictions have maintained active LDAACs, with the required membership and structure. The ADAA provided technical assistance to the LDAACs by providing data to assist in needs assessments and outcome evaluations, and by helping the jurisdictions conduct surveys of local resources and develop their local plans.

The LDAACs' comprehensive plans included the vision, mission, priorities, goals and objectives for each jurisdiction. They incorporated the jurisdictions' strategies and priorities for meeting identified needs of the general public as well as the criminal justice system for alcohol and other drug evaluation, prevention, intervention and treatment services. They addressed priority and target populations, in accordance with state and federal block grant requirements, including pregnant women and women with dependent children, injection drug users, and individuals with or at risk of HIV infection. Each LDAAC assessed the ability of the local treatment system to identify and treat persons with co-occurring mental health and substance abuse disorders. Each LDAAC met the initial mandate to submit a comprehensive plan for prevention, intervention and treatment services in their jurisdictions to the Governor or his designee by July 1, 2005. The LDAACs have continued to submit plans as required every two years thereafter, and have consistently reported every six months to the ADAA on progress toward implementation of the plans.

State Council: In July 2008, Governor Martin O'Malley signed an Executive Order re-authorizing the Maryland State Drug and Alcohol Abuse Council (the Council, or DAAC). The Council is composed of 27 members, including key state cabinet secretaries, judges, legislators, providers, consumers and citizens. The chair of the Council is the Secretary of the Department of Health and Mental Hygiene. As outlined in the Executive Order, the purpose of the Council is:

- to develop a comprehensive, coordinated and strategic approach to the use of State and local resources for substance abuse prevention and treatment services;
- to promote a collaborative effort:
 - a) by State executive agencies who have resources dedicated to substance abuse services;
 - b) by local drug and alcohol abuse councils and local state agencies to ensure an effective and efficient use of State resources for the delivery of a full-continuum of substance abuse services to citizens within their jurisdictions;
 - c) by State and local agencies to allocate adequate resources to address substance abuse services needs of the criminal justice system;
 - d) by State and local agencies to allocate adequate resources to address the substance abuse services needs of individuals with co-occurring problems, including mental health disorders, homelessness, somatic health problems, physical and cognitive abilities and child welfare involvement.

A central purpose of the Council, therefore, is to foster collaboration among departments and serve as a forum to facilitate meaningful conversations among the top executives of the administration concerning:

- the effective and efficient use of all of the available resources in Maryland;
- the development of accessible and quality services for all citizens in need; and
- the advancement of coordinated, innovative and unified public policies.

The primary mechanism by which the Council will accomplish this is through the development of a Strategic Plan (Plan) for the organization and delivery of substance abuse services in Maryland. Various work groups of the Council will review and discuss available information, and present recommendations for improvement of substance abuse services. By Executive Order, a two-year plan is to be submitted to the Governor in August 2009, and annual updates will be required.

Data Collection and Monitoring: To determine areas of high incidence and prevalence, Maryland employs a multi-faceted data gathering process and monitors numerous indicators. The ADAA utilizes data from the State of Maryland Automated Record Tracking (SMART) system to obtain, process, analyze, report and monitor demographic, utilization, categorical (e.g. pregnancy, adolescent, prevention, certification, and capacity/waiting list) and other statistical data generated from the state's alcohol and drug abuse treatment services network and other state and federal resources.

As an adjunct to this data gathering effort, the Administration has partnered with the Substance Abuse and Mental

Health Services Administration (SAMHSA) regarding data reporting requirements for the Treatment Episode Data Set (TEDS), the National Survey of Substance Abuse Services (N-SSATS), and the Inventory of Substance Abuse Treatment Services (I-SATS). Information from the Drug Abuse Warning Network (DAWN), the Maryland Adolescent Survey (MAS) and the Uniform Crime Reporting System (UCRS) have supplemented SMART data to support the ADAA's assessment capabilities and to assist the ADAA in designating areas of greatest need.

Statewide Epidemiologic Outcomes Workgroup (SEOW): The Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park has managed SEOWs for Maryland and DC since 2006, as well as numerous other epidemiologic work groups, including Maryland's Drug Early Warning System (DEWS). In 1992, CESAR launched Maryland's first Statewide Epidemiologic Work Group (SEWG), modeled after the National Institute on Drug Abuse (NIDA) Community Epidemiologic Work Group (CEWG). The purpose of the SEOW and other epidemiologic studies is to track, monitor and analyze trends and patterns for legal and illegal substances throughout Maryland, with detailed focus on SEWG member counties and Baltimore City. These efforts have enabled Maryland officials to quickly identify new drug trends, such as the use of club drugs by youth; have ensured that data were promptly distributed to people at the state, county and community levels; and have assisted the ADAA and other state agencies in the development of action plans to address those trends.

NSDUH: The ADAA obtains state and sub-state estimates of alcohol and drug dependence and abuse and unmet treatment need from SAMHSA's National Survey on Drug Use and Health (NSDUH). ADAA has worked with the SAMHSA Office of Applied Studies (OAS) to plan for sub-state estimates of substance abuse measures for the following regions, dictated somewhat by sample size:

- Anne Arundel County
- Baltimore City
- Baltimore County
- Montgomery County
- North Central Maryland (Carroll and Howard counties)
- Northeast Maryland (Caroline, Cecil, Harford, Kent, Queen Anne's and Talbot counties)
- Prince George's County
- South Maryland (Calvert, Charles, Dorchester, St. Mary's, Somerset, Wicomico, and Worcester counties)
- Western Maryland – (Allegany, Frederick Garrett, and Washington counties)

HB 850—Substance Abuse Needs Assessment: During the 2007 legislative session, Maryland Delegate Peter A. Hammen, Chair of the Health and Government Operations Committee, and 22 of his colleagues sponsored HB 850, which required the ADAA to conduct a needs assessment "for prevention, diagnosis, and treatment of drug misuse and alcohol misuse in the State". The assessment was expected to "identify the financial and treatment needs of each jurisdiction and of each drug treatment program operated by the State".

The ADAA subcontracted with CESAR to conduct the needs assessment, which updated needs assessments performed by CESAR in 1998 and 2002, as a part of SAMHSA's national program for assessing state treatment needs. CESAR engaged Dr. William McAuliffe (of the Department of Psychiatry at Harvard Medical School and director of the SAMHSA-funded National Technical Center) to collaborate with and direct Maryland's treatment needs assessment. ADAA staff, members of the Maryland DAAC, representatives from the SAMHSA Office of Applied Studies and staff of the following State agencies provided the research team with data and assistance which made the needs assessment study possible:

- Maryland Department of State Police
- Maryland Vital Statistics Administration
- Center for Surveillance and Epidemiology, Maryland AIDS Administration
- Maryland Health Services Cost Review Commission
- Maryland State Highway Administration
- Comptroller of Maryland

The Need for Substance Abuse Treatment in Maryland Final Report is scheduled for release in FY 2009.

To summarize, Maryland collects and maintains massive amounts of data that contribute to formulation of local and

state alcohol and drug abuse plans. Additionally, public comment is generated through the state legislative process and the House of Delegates Committee on Alcohol and Drugs.

Planning Checklist

State: Maryland

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2010 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.

4 Population levels, Specify formula:

1 Incidence and prevalence levels

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

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

Problem levels as estimated by social indicator data

3 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)

Other (specify method)

Form 8

State: Maryland

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: 2008			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	72238	4595	3157	741	513	1666	1138	579	560	0	0	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: 2008			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	512790	19634	13565	4240	2843	5933	4003	2152	2063	0	2.93	7.61	3.51

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: 2008			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	785618	37273	28409	8654	6446	11065	8190	1944	4958	0	2.93	12.86	2.55

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: 2008			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	88698	4612	3167	247	157	1180	800	979	728	0	2.25	7.89	1.13

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: 2008 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	33138	2127	1562	97	61	578	426	283	234	0	0	9.05	3.02

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: 2008 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	169353	7154	5231	1311	866	2165	1540	678	823	0	0	1.18	2.95

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: 2008 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	99926	6097	4514	927	621	1863	1332	1065	685	0	2	4	1

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: 2008 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	140764	7729	5958	293	204	1965	1488	1066	1477	0	1.42	14.21	2.84

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: 2008 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

		services	seek	services	seek	services	seek	arrests	related	0	/100,000		
Dorchester County	31998	2241	1502	142	91	582	381	290	299	0	0	9.38	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: 2008 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
Frederick County	225721	8159	5745	1036	744	2444	1707	1095	1341	0	0.44	1.77	5.32

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: 2008 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
Garrett County	29698	1471	1046	121	85	344	228	261	143	0	3.37	0	3.37

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: 2008 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
Harford County	240351	11925	9146	1469	1003	3285	2412	994	1057	0	2.91	9.15	1.25

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: 2008 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
Howard County	274995	5105	3796	821	607	1442	1044	1357	1370	0	0	4.73	4

1. Substate Planning Area	2. Total Population	3. Total Population		4. Number of IVDUs		5. Number of		Calendar Year: 2008 6. Prevalence of			7. Incidence of		
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Area		in need		in need		women in need		substance-related criminal activity			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
Kent County	20151	1867	1326	91	58	457	305	116	272	0	0	4.96	4.96

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
Montgomery County	950680	15350	9951	1321	860	3232	2016	3854	2868	0	0.21	14.20	9.26

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
Prince George's County	820852	18301	13873	1303	978	4353	3138	1831	4211	0	2.31	31.31	8.28

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
Queen Anne's County	47091	2021	1301	197	122	613	389	407	354	0	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		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	101578	4854	3421	217	164	1283	868	699	603	0	0	4.92	1.97
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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
										0			
Somerset County	26119	2367	1816	223	187	569	417	232	195	0	3.83	7.66	3.83

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
										0			
Talbot County	36215	1930	1308	121	77	518	348	464	342	0	0	2.76	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
										0			
Washington County	145384	9980	7778	1300	1002	2434	1674	785	1184	0	0	5.50	0.69

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
										0			
Wicomico County	94046	5554	3792	458	306	1674	1105	677	971	0	5.32	4.25	6.38

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		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

		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	49274	3832	2651	172	109	967	639	861	1236	0	4.06	8.12	2.03

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: 2008			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 City	636919	67235	45006	24429	16957	25057	16370	319	27847	0	1.57	74.58	5.02

Form 9

State: Maryland

Substate Planning Area [95]: State Total

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	27,442	8,382	3,783	10,993	2,260			113	6	24	1	86	121	1,205	468	18,695	5,708	1,385	539
18 - 24 Years Old	48,743	22,393	9,812	9,831	2,639			469	113	100	43	176	43	2,704	420	32,311	12,182	3,092	633
25 - 44 Years Old	121,064	42,516	20,991	30,382	15,643			858	295	371	279	314	108	8,600	707	73,517	36,431	8,759	1,293
45 - 64 Years Old	57,655	18,644	8,063	19,797	8,933			356	59	149	67	54	24	1,299	210	37,968	16,862	1,897	412
65 and Over	2,034	1,110	266	488	137			8						21	4	1,563	393	36	6
Total	256,938	93,045	42,915	71,491	29,612	0	0	1,804	473	644	390	630	296	13,829	1,809	164,054	71,576	15,169	2,883

Maryland

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for 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 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 8.

The estimates of treatment need presented in Forms 08 and 09 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. Adjustments were made for cases missing part of the unique identifier, which comprised less than 5 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. The estimates of those who would seek treatment were derived by taking 25 percent of this latter group.

Form 11**State: Maryland****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 2010 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	\$ 22,386,001	\$ 3,754,765	\$	\$ 155,733,684	\$ 13,156,233	\$ 12,055,564
Primary Prevention	\$ 6,396,000		\$	\$	\$	\$
Tuberculosis Services	\$	\$	\$	\$	\$	\$
HIV Early Intervention Services	\$ 1,599,000	\$	\$	\$	\$	\$
Administration: (Excluding Program/Provider Lvl)	\$ 1,599,000		\$	\$ 9,633,945	\$	\$ 231,392
Column Total	\$31,980,001	\$3,754,765	\$0	\$165,367,629	\$13,156,233	\$12,286,956

Form 11ab**State: Maryland****Form 11a. Primary Prevention Planned Expenditures Checklist**

Activity	Block Grant FY 2010	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 2,622,360	\$	\$	\$	\$
Education	\$ 447,720	\$	\$	\$	\$
Alternatives	\$ 2,110,680	\$	\$	\$	\$
Problem Identification & Referral	\$ 63,960	\$	\$	\$	\$
Community Based Process	\$ 511,680	\$	\$	\$	\$
Environmental	\$ 639,600	\$	\$	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
Column Total	\$6,396,000	\$0	\$0	\$0	\$0

Form 11b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2010	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$ 1,726,920	\$	\$	\$	\$
Universal Indirect	\$ 2,622,360	\$	\$	\$	\$
Selective	\$ 1,279,200	\$	\$	\$	\$
Indicated	\$ 767,520	\$	\$	\$	\$
Column Total	\$6,396,000	\$0	\$0	\$0	\$0

Resource Development Planned Expenditure Checklist

State: Maryland

Did your State plan to fund resource development activities with FY 2010 funds?

 Yes No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	\$	\$	\$	\$ 0
Quality Assurance	\$	\$	\$	\$ 0
Training (post-employment)	\$ 43,000	\$ 25,000	\$	\$ 68,000
Education (pre-employment)	\$ 42,000	\$ 30,000	\$	\$ 72,000
Program Development	\$	\$	\$	\$ 0
Research and Evaluation	\$	\$	\$	\$ 0
Information Systems	\$	\$	\$	\$ 0
Column Total	\$85,000	\$55,000	\$0	\$140,000

Form 12**State: Maryland****TREATMENT CAPACITY MATRIX**

This form contains data covering a 24- month projection for the period during which your principal agency of the State is permitted to spend the FY 2010 block grant award.

Level of Care	A.Number of Admissions	B.Number of Persons
Detoxification (24-Hour Care)		
Hospital Inpatient (Detox)		
Free-standing Residential	4,275	3,907
Rehabilitation / Residential		
Hospital Inpatient (Rehabilitation)		
Short-term (up to 30 days)	7,491	6,980
Long-term (over 30 days)	3,250	2,949
Ambulatory (Outpatient)		
Outpatient	21,272	19,750
Intensive Outpatient	8,293	7,454
Detoxification	559	529
Opioid Replacement Therapy (ORT)		
Opioid Replacement Therapy	2,271	2,138

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 2010 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: 49 %
 - 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:

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

Level of Care		
Short-term Residential (SR)		
Employment Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients employed or student(full-time and part-time) [numerator]	1708	1650
Total number of clients with non-missing values on employment\student status [denominator]	6685	6685
Percent of clients employed or student (full-time and part-time)	25.55%	24.68%
Long-term Residential (LR)		
Employment Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients employed or student(full-time and part-time) [numerator]	190	1151
Total number of clients with non-missing values on employment\student status [denominator]	2927	2927
Percent of clients employed or student (full-time and part-time)	6.49%	39.32%
Intensive Outpatient (IO)		
Employment Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients employed or student(full-time and part-time) [numerator]	1398	1742
Total number of clients with non-missing values on employment\student status [denominator]	6362	6362
Percent of clients employed or student (full-time and part-time)	21.97%	27.38%
Outpatient (OP)		
Employment Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients employed or student(full-time and part-time) [numerator]	9264	10735
Total number of clients with non-missing values on employment\student status [denominator]	18093	18093
Percent of clients employed or student (full-time and part-time)	51.20%	59.33%

State Description of Employment\Education Status Data Collection (Form T1)

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>Data pertain to primary patients in treatment programs receiving block-grant funds. Detoxification and ORT are excluded. Reasons for discharge of incarceration, transfer or death are excluded.</p>
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DATA SOURCE	<p>What is the source of data for table T1? (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> <p><input type="text"/></p>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T1? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input checked="" type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p> <p><input type="text"/></p>
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DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T1? (Select all that apply)</p> <p><input type="text"/></p>
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COLLECTION	<input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge Specify: <input type="radio"/> In-Treatment data <input type="text"/> days post admission <input type="radio"/> Follow-up data <input type="text"/> months post <input type="text"/> admission <input type="button" value="v"/> <input type="radio"/> Other, Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment <input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment <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 <input type="checkbox"/> Discharge records are not collected for approximately <input type="text"/> % of clients who were admitted for treatment

RECORD LINKING	<p>Was the admission and discharge data linked for table T1? (Select all that apply)</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: <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 <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 <input type="checkbox"/> No, admission and discharge records were matched using probabilistic record matching
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IF DATA IS UNAVAILABLE	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <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.
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DATA PLANS IF DATA IS NOT AVAILABLE	<p>State must provide time-framed plans for capturing employment\student status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <input type="text"/>
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Most recent year for which data are available ?

From: 1/1/2008 To: 12/31/2008

Level of Care		
Short-term Residential (SR)		
Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients in a stable living situation [numerator]	5648	6332
Total number of clients with non-missing values on living arrangements [denominator]	6685	6685
Percent of clients in stable living situation	84.49%	94.72%
Long-term Residential (LR)		
Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients in a stable living situation [numerator]	2554	2591
Total number of clients with non-missing values on living arrangements [denominator]	2927	2927
Percent of clients in stable living situation	87.26%	88.52%
Intensive Outpatient (IO)		
Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients in a stable living situation [numerator]	5964	5958
Total number of clients with non-missing values on living arrangements [denominator]	6362	6362
Percent of clients in stable living situation	93.74%	93.65%
Outpatient (OP)		
Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients in a stable living situation [numerator]	17273	17827
Total number of clients with non-missing values on living arrangements [denominator]	18093	18093
Percent of clients in stable living situation	95.47%	98.53%

State Description of Stability of Housing (Living Status) Data Collection (Form T2)

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>Data pertain to primary patients in treatment programs receiving block-grant funds. Detoxification and ORT are excluded. Reasons for discharge of incarceration, transfer or death are excluded.</p>
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DATA SOURCE	<p>What is the source of data for table T2? (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>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T2? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input checked="" type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p>
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DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T2? (Select all that apply)</p>
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COLLECTION	<input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge Specify: <input type="radio"/> In-Treatment data <input type="text"/> days post admission <input type="radio"/> Follow-up data <input type="text"/> months post <input type="text" value="admission"/> admission <input type="radio"/> Other, Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment <input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment <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 <input type="checkbox"/> Discharge records are not collected for approximately <input type="text"/> % of clients who were admitted for treatment

RECORD LINKING	<p>Was the admission and discharge data linked for table T2? (Select all that apply)</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: <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
	<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 <input type="checkbox"/> No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <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.
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DATA PLANS IF DATA IS NOT AVAILABLE	<p>State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <input type="text"/>
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Most recent year for which data are available ?

From: 1/1/2008 To: 12/31/2008

Level of Care		
Short-term Residential (SR)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients without arrests [numerator]	6049	6606
Total number of clients with non-missing values on arrests [denominator]	6685	6681
Percent of clients without arrests	90.49%	98.88%
Long-term Residential (LR)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients without arrests [numerator]	2787	2910
Total number of clients with non-missing values on arrests [denominator]	2927	2920
Percent of clients without arrests	95.22%	99.66%
Intensive Outpatient (IO)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients without arrests [numerator]	5829	6175
Total number of clients with non-missing values on arrests [denominator]	6360	6253
Percent of clients without arrests	91.65%	98.75%
Outpatient (OP)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients without arrests [numerator]	16564	17694
Total number of clients with non-missing values on arrests [denominator]	18073	18060
Percent of clients without arrests	91.65%	97.97%

State Description of Criminal Involvement Data Collection (Form T3)

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>Data pertain to primary patients in treatment programs receiving block-grant funds. Detoxification and ORT are excluded. Reasons for discharge of incarceration, transfer or death are excluded.</p>
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DATA SOURCE	<p>What is the source of data for table T3? (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>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T3? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input checked="" type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p>
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DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T3? (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 [] days post admission</p> <p><input type="radio"/> Follow-up data [] months post [admission]</p>
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	<input type="radio"/> Other, Specify: <input style="width: 580px; height: 15px;" type="text"/>
	<input checked="" type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment <input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment <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 <input type="checkbox"/> Discharge records are not collected for approximately <input style="width: 60px; height: 15px;" type="text"/> % of clients who were admitted for treatment

RECORD LINKING	<p>Was the admission and discharge data linked for table T3? (Select all that apply)</p> <div style="border: 1px solid black; padding: 5px;"> <input checked="" type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: <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 </div> <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 <input type="checkbox"/> No, admission and discharge records were matched using probabilistic record matching
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IF DATA IS UNAVAILABLE	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <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.
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DATA PLANS IF DATA IS NOT AVAILABLE	<p>State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <input style="width: 600px; height: 15px;" type="text"/>
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Most recent year for which data are available ?

From: 1/1/2008 To: 12/31/2008

Level of Care		
Short-term Residential (SR)		
Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients abstinent from alcohol [numerator]	3189	6129
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	6685	6685
Percent of clients abstinent from alcohol	47.70%	91.68%
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)		
Long-term Residential (LR)		
Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients abstinent from alcohol [numerator]	2292	2554
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	2927	2927
Percent of clients abstinent from alcohol	78.31%	87.26%
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)		
Intensive Outpatient (IO)		
Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients abstinent from alcohol [numerator]	3907	5262
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	6362	6362
Percent of clients abstinent from alcohol	61.41%	82.71%
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)		
Outpatient (OP)		
Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients abstinent from alcohol [numerator]	11348	15667
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	18093	18093
Percent of clients abstinent from alcohol	62.72%	86.59%
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)		

State Description of Alcohol Use Data Collection (Form T4)

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>Data pertain to primary patients in treatment programs receiving block-grant funds. Detoxification and ORT are excluded. Reasons for discharge of incarceration, death or transfer are excluded.</p>
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DATA SOURCE	<p>What is the source of data for table T4? (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 checked="" type="checkbox"/> urinalysis, blood test or other biological assay</p> <p><input type="checkbox"/> Collateral source</p> <p><input type="checkbox"/> Administrative data source</p> <p><input type="checkbox"/> Other: Specify</p>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T4? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the</p>
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	<p>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 T4? (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>

RECORD LINKING	<p>Was the admission and discharge data linked for table T4? (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)</p> <p>Select type of UCID:</p> <p><input type="radio"/> Master Client Index or Master Patient Index, centrally assigned</p> <p><input type="radio"/> Social Security Number (SSN)</p> <p><input checked="" type="radio"/> Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)</p> <p><input type="radio"/> Some other Statewide unique ID</p> <p><input type="radio"/> Provider-entity-specific unique ID</p> <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>
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IF DATA IS UNAVAILABLE	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <p><input type="checkbox"/> Information is not collected at admission</p> <p><input type="checkbox"/> Information is not collected at discharge</p> <p><input type="checkbox"/> Information is not collected by the categories requested</p> <p><input type="checkbox"/> State collects information on the indicator area but utilizes a different measure.</p>
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DATA PLANS IF DATA IS NOT AVAILABLE	<p>State must provide time-framed plans for capturing alcohol abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <input type="text"/>
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Most recent year for which data are available ?

From: 1/1/2008 To: 12/31/2008

Level of Care		
Short-term Residential (SR)		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients abstinent from illegal drugs [numerator]	1513	5708
Total number of clients with non-missing values on "used any drug" variable [denominator]	6685	6685
Percent of clients abstinent from drugs	22.63%	85.39%
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		
Long-term Residential (LR)		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients abstinent from illegal drugs [numerator]	1690	2151
Total number of clients with non-missing values on "used any drug" variable [denominator]	2927	2927
Percent of clients abstinent from drugs	57.74%	73.49%
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		
Intensive Outpatient (IO)		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients abstinent from illegal drugs [numerator]	2016	4078
Total number of clients with non-missing values on "used any drug" variable [denominator]	6362	6362
Percent of clients abstinent from drugs	31.69%	64.10%
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		
Outpatient (OP)		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients abstinent from illegal drugs [numerator]	10244	13688
Total number of clients with non-missing values on "used any drug" variable [denominator]	18093	18093
Percent of clients abstinent from drugs	56.62%	75.65%
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		

State Description of Other Drug Use Data Collection (Form T5)

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>Data pertain to primary patients in treatment programs receiving block-grant funds. Detoxification and ORT are excluded. Reasons for discharge of incarceration, death or transfer are excluded.</p>
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DATA SOURCE	<p>What is the source of data for table T5? (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 checked="" type="checkbox"/> urinalysis, blood test or other biological assay</p> <p><input type="checkbox"/> Collateral source</p> <p><input type="checkbox"/> Administrative data source</p> <p><input type="checkbox"/> Other: Specify</p> <p>_____</p>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T5? (Select one)</p>
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	<input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days <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 <input type="radio"/> Other, Specify: <input type="text"/>
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DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T5? (Select all that apply)</p> <div style="border: 1px solid black; padding: 5px;"> <input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge Specify: <input type="radio"/> In-Treatment data <input type="text"/> days post admission <input type="radio"/> Follow-up data <input type="text"/> months post <input type="text" value="admission"/> admission <input type="radio"/> Other, Specify: <input type="text"/> </div> <input checked="" type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment <input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment <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 <input type="checkbox"/> Discharge records are not collected for approximately <input type="text"/> % of clients who were admitted for treatment
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RECORD LINKING	<p>Was the admission and discharge data linked for table T5? (Select all that apply)</p> <div style="border: 1px solid black; padding: 5px;"> <input checked="" type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: <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 </div> <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 <input type="checkbox"/> No, admission and discharge records were matched using probabilistic record matching
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IF DATA IS UNAVAILABLE	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <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.
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DATA PLANS IF DATA IS NOT AVAILABLE	<p>State must provide time-framed plans for capturing drug abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <input type="text"/>
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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"/>	<input type="text"/>
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	<input type="text"/>	<input type="text"/>
Percent of clients participating in social support activities		

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> <input type="text"/>
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DATA SOURCE	<p>What is the source of data for table T6? (Select all that apply)</p> <p><input 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 <input type="text"/></p>
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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 been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input 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: <input type="text"/></p>
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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: <input type="text"/></p> <p><input 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>
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RECORD LINKING	<p>Was the admission and discharge data linked for table T6? (Select all that apply)</p> <p><input type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)</p> <p>Select type of UCID:</p> <p><input type="radio"/> Master Client Index or Master Patient Index, centrally assigned</p> <p><input type="radio"/> Social Security Number (SSN)</p> <p><input type="radio"/> Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)</p> <p><input type="radio"/> Some other Statewide unique ID</p> <p><input type="radio"/> Provider-entity-specific unique ID</p> <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>
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<p>IF DATA IS UNAVAILABLE</p>	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <p><input type="checkbox"/> Information is not collected at admission</p> <p><input type="checkbox"/> Information is not collected at discharge</p> <p><input type="checkbox"/> Information is not collected by the categories requested</p> <p><input type="checkbox"/> State collects information on the indicator area but utilizes a different measure.</p>
<p>DATA PLANS IF DATA IS NOT AVAILABLE</p>	<p>State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <div data-bbox="397 380 1386 403" style="border: 1px solid black; height: 11px; width: 609px;"></div>

The Alcohol and Drug Abuse Administration (ADAA) currently collects data on clients participating in self-help groups and support groups (e.g., AA, NA, etc.) at admission via the State of Maryland Automated Record Tracking (SMART) system. In March 2009, ADAA added the required fields to the discharge screen in SMART and made them mandatory.

All funded providers will be required to enter the Social Support of Recovery (SSR) data or the record will be marked as incomplete and the agency will not receive credit for the patient.

A programming request was submitted in June 2008. Upon further examination it was determined that testing would begin October 1, 2008. Communication to the providers regarding the new required fields will be sent by October 1, 2008. All funded providers will be responsible for data entry in these fields beginning March 1, 2009. The ADAA will be reporting NOMs data for Form T-6 (admission and discharge) in the 2010 SAPT Block Grant Application.

ADAA will monitor compliance on a monthly basis. ADAA Management Information Systems (MIS) analysts will be responsible for program monitoring and subsequently communicate to the appropriate agency staff if an agency is not in compliance. MIS analysts will also be responsible for providing technical assistance to agency staff as needed.

Form T7

State: Maryland

Length of Stay (in Days) of All Discharges

Most recent year for which data are available From: 1/1/2008 To: 12/31/2008

Length of Stay			
Level of Care	Average	Median	Interquartile Range
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential	6	5	3 - 8
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	18	16	8 - 27
5. Long-term (over 30 days)	112	100	37 - 179
Ambulatory (Outpatient)			
6. Outpatient	137	113	50 - 190
7. Intensive Outpatient	57	43	13 - 78
8. Detoxification	7	4	4 - 4
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	900	436	129 - 1103

Maryland**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 utilized 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 obtained data on a monthly basis by virtue of a data download procedure; however, SMART provided on-demand reports and raw data as an Excel export. These data were then available for any secondary analysis needed.

Training for providers on how to use the treatment applications remained ongoing. The Administration employed two full-time trainers who provided 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, provided four trainers for SMART. ADAA has an established computer training lab where training occurred on both a regular and ad hoc basis.

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

The Information Services Division provided semi-annual reports on the performance measures for local planners at both the jurisdictional (county or Baltimore City) and the individual provider levels. These reports were also reviewed by the ADAA regional teams. When a jurisdiction or individual provider was found to be falling short of the projected performance targets, the team worked with the jurisdiction to identify problems and recommend resolutions based on best practices.

ADAA administered, for the third time, a "pay for performance" incentive program designed to reward local jurisdictions for proactively managing their local system of care. An incentive was paid to jurisdictions if their Level I (outpatient) programs achieved a successful discharge rate of 50% or better and/or had 65% patients stay in treatment 90 days or more. These incentives were given to jurisdictions to use in any way they felt would enhance their service network. Several jurisdictions used the monies to reward the Level I programs, and others chose to use the dollars to help close treatment gaps.

FY 2007 was the first full year of the pay for performance for Statewide Residential Contracts. These contracts for long term residential care were made available to agencies that satisfied the Code of Maryland (COMAR) program requirements for Level III.3 and Level III.5 with demonstrated ability to provide specialty services to pregnant and post-partum women and women with dependent children, individuals with co-occurring disorders and those referred through the criminal justice system. At the end of the contract year, agencies were evaluated against two goals. Contracted programs were to achieve 1) a successful discharge rate of 50% or better; and/or 2) a length-of-stay equal to or greater than 210 days for 50% or more of their discharges. Agencies that achieved either goal were paid 2.5% of their per-diem rate for each patient that achieved one of the goals. If both goals were met, a bonus was paid that equaled 5% of the per-diem rate.

Maryland
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.

Form T6:

The Alcohol and Drug Abuse Administration (ADAA) currently collects data on clients participating in self-help groups and support groups (e.g., AA, NA, etc.) at admission via the State of Maryland Automated Record Tracking (SMART) system. In March 2009, ADAA added the required fields to the discharge screen in SMART and made them mandatory.

All funded providers will be required to enter the Social Support of Recovery (SSR) data or the record will be marked as incomplete and the agency will not receive credit for the patient.

A programming request was submitted in June 2008. Upon further examination it was determined that testing would begin October 1, 2008. Communication to the providers regarding the new required fields will be sent by October 1, 2008. All funded providers will be responsible for data entry in these fields beginning March 1, 2009. The ADAA will be reporting NOMs data for Form T-6 (admission and discharge) in the 2010 SAPT Block Grant Application.

ADAA will monitor compliance on a monthly basis. ADAA Management Information Systems (MIS) analysts will be responsible for program monitoring and subsequently communicate to the appropriate agency staff if an agency is not in compliance. MIS analysts will also be responsible for providing technical assistance to agency staff as needed.

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 12-20 - FFY 2007	<input type="text"/>
		Ages 21+ - FFY 2007	<input type="text"/>
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 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 12-17 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>

((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 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>

((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 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 12-17 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 12-17 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>
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 12-17 - FFY 2007	<input type="text"/>
		Ages 18+ - FFY 2007	<input type="text"/>

((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]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12-17 - FFY 2007	<input type="text"/>
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]</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>	Ages 12-17 - FFY 2007	<input type="text"/>
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]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12-17 - FFY 2007	<input type="text"/>
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]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12-17 - FFY 2007	<input type="text"/>
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]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12-17 - FFY 2007	<input type="text"/>

((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	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]	Ages 15-17 - FFY 2007	<input type="text"/>
	Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 18+ - FFY 2007	<input type="text"/>

((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 2007	<input type="text"/> <input type="text"/>

((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>	FFY 2007	<input data-bbox="974 352 1039 388" type="text"/> <input data-bbox="1063 352 1128 388" type="text"/>

((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	<p>Source: Federal Bureau of Investigation Uniform Crime Reports</p> <p>Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.</p>	FFY 2007	<input data-bbox="974 352 1050 388" type="text"/> <input data-bbox="1066 352 1143 388" type="text"/>

((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 - FFY 2007 <input type="text"/>	<input type="text"/>
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+ - FFY 2007 <input type="text"/>	<input type="text"/>

((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 - FFY 2007 <input type="text"/>	<input type="text"/>

(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.

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	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	
	10. Age Not Known	
B. Gender	Male	
	Female	
	Gender Unknown	
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	
D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	

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	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7. 25-44	
	8. 45-64	
	9. 65 And Over	
	10. Age Not Known	
B. Gender	Male	
	Female	
	Gender Unknown	
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	
D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	

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		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total		

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 solid theory or theoretical perspective that has validated research, and
 - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
 - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). “Informed experts” may include key community prevention leaders, and elders or other respected leaders 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						
2. Total number of Programs and Strategies Funded						
3. Percent of Evidence-Based Programs and Strategies	74.99%	73.18%	74.16%	85.98%	91.67%	79.50%

Form P15 - FY 2007 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2007 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2007 Total SAPT Block Grant \$Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct		\$
2. Universal Indirect		\$
3. Selective		\$
4. Indicated		\$
5. Totals	10108	\$6,373,784.00

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

Maryland
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.

Server Error in '/' Application.

Compilation Error

Description: An error occurred during the compilation of a resource required to service this request. Please review the following specific error details and modify your source code appropriately.

Compiler Error Message: BC30456: 'lblstate' is not a member of 'ASP_2010_print_print_fomp_attachments_source_aspx'.

Source Error:

```
Line 77:         If dt1.Rows.Count > 0 Then
Line 78:             row1 = dt1.Rows(0)
Line 79:             Me.lblstate.Text = row1.STATE_NAME
Line 80:         End If
Line 81:     End If
```

Source File: D:\WEBPUB\BGAS_V\WWW2010\print\print_FormP_Attachments_source.aspx **Line:** 79

[Show Detailed Compiler Output:](#)

[Show Complete Compilation Source:](#)

Version Information: Microsoft .NET Framework Version:2.0.50727.4016; ASP.NET Version:2.0.50727.4016

Prevention Attachment D

FFY 2007 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2007 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 2007 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 FFY2007 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY2007 Program/Strategy Name Universal Direct	FFY2007 Total Number of Evidence-based Programs and Strategies by Intervention	FFY2007 Total Costs of Evidence based Programs and Strategies for each IOM Category	FFY2007 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 FFY2007 SAPT Block Grant Dollars \$ Spent on Evidence-Based Programs and Strategies			\$

Maryland

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.

Maryland**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.