

**Idaho**

**UNIFORM APPLICATION  
FY2012**

**SUBSTANCE ABUSE PREVENTION AND TREATMENT  
BLOCK GRANT**

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

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

(generated on 7/15/2013 12:36:35 PM)

**Substance Abuse and Mental Health Services Administration**

**Center for Substance Abuse Treatment**

**Center for Substance Abuse Prevention**

## **Introduction:**

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

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

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

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

DUNS Number: 08-816-56-18-

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

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III. State Expenditure Period:

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

IV. Date Submitted:

Date: 11/30/2011 5:33:04 PM Original: ● Revision: ●

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

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

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

FY2009 (Annual Report/Compliance):

## Idaho / SAPT FY2012 / Goal \_1:Improving access to prevention and treatment services

## Goal 1 Revised Report - 2009 Data

## Treatment Services

As in past years, the 2009 SAPT block grant funds to treat adolescents, adults, pregnant women and women with dependent children in each of the seven regions of the Idaho. In order to qualify for block grant-funded substance abuse treatment, clients had to be financially eligible, below 175% of the federal poverty rate, and clinically eligible, diagnosed as substance dependent indicating the need for at least outpatient (ASAM PPC 2R Level I) substance use disorders treatment. Treatment services included assessment, individual and group counseling, education, social setting detoxification and residential and case management in outpatient or residential settings. Recovery support services were also funded by State and Block Grant funds and included child care, transportation, drug testing, marriage and family life skills education and safe and sober housing for adults.

The Idaho Interagency Committee on Substance Abuse Prevention and Treatment collaborated to support state-wide comprehensive and coordinated substance abuse treatment and prevention funding, programs, and services to Idaho citizens. This was the body that determines State priorities for treatment funding within each State agency including Health and Welfare.

To operationalize the delivery of Block Grant funded services, the Division of Behavioral Health released an RFP in FY 2008 for a new contract with an entity for statewide management of the substance use disorder treatment and recovery support system of care. This contract was awarded to Business Psychology Associates (BPA) in November 2009. Management services include administration, approved provider network management, client intake and service coordination, data management, fiscal management, reporting and quality assurance. Within this contract, BPA is responsible for contracting with State approved providers. BPA pays claims to the providers when services are rendered and then bills the state for these services. BPA is responsible, per the H&W contract, to monitor providers for block grant requirements. This includes maintaining a State wide PWWC specialty network. Providers in this network agree to follow and are audited to, block grant requirements.

To assure block grant requirements, the Department has assigned one person to audit and monitor the BPA contract. Monitoring happens quarterly utilizing standard monitoring tools that were created several years ago for the express purpose of monitoring for block grant requirements. The Department then generates a letter to BPA that identifies any findings along with penalties for not adhering to the requirements.

In FY 2009 the Division provided treatment services to:

- ¿ 2,087 adolescents
- ¿ 12,840 total adults

Of those 12,840 adults:

Idaho / SAPT FY2012 / Goal \_1:Improving access to prevention and treatment services

- ¿ 200 where pregnant women
- ¿ 1,610 where women with dependent children
- ¿ 909 where involved in the child protection system

In 2009 the State anticipated serving 365 families within the child protection system. The increase from the projection, 909 vs. 365, is due to a more coordinated effort between the Division of Behavioral Health and Idaho's Child Protection program. In addition, Child Protection cases grew in 2009, and the State continued to implement fully 3 new Child Protection Drug Courts.

Adolescent Prevention Intervention Services

In 2009, Adolescent Prevention Intervention Services were funded with Block Grant prevention funds not included in the primary prevention set-aside. These services were piloted in 2008 and full implementation began in 2009. Prevention Intervention services had three components - ongoing assessment, an education program and support group. The program ran two hours, two times per week and combines the education program and support group. The goal was to build positive attitudes and decision-making skills, coping and social skills to lead to health-promoting behaviors. All services were delivered by community-based providers located in the communities to be served. The education program was Project Toward No Drug Abuse, an evidence-based program. The support group provided each participant with the opportunity to discuss issues in their lives and apply the knowledge gained in the education program. Youth completed the program by developing a graduation plan which included support for gains achieved, includes names to contacts in case of an emergency and recognized gains achieved. The program concluded with a graduation ceremony. In 2009, 323 youth participated in this program.

Prevention

As in past years, prevention services were made available to the residents of Idaho using 3 delivery methods - recurring services, single services and clearinghouse resources. In 2009, there were 15,974 participants in Idaho's recurring education programs – a significant increase in participation/outreach from 2003's participation of approximately 9,000 with no additional funds. During the same period an additional 8,629 participated in single programs such as community education evenings, prevention events and health fairs. In addition, over 175,000 individuals received information and materials from the Idaho alcohol/drug clearinghouse.

Information about available prevention services is located on the preventionidaho.net website under "Find Prevention Near You." All services are based on the needs assessment and are designed to address needs identified for the priority populations. As with treatment services, prevention services are managed for the state by a private contractor. This contractor is responsible for conducting an annual needs assessment, funding and monitoring prevention services and providing technical services to prevention programs and community groups throughout Idaho. Also, similar to treatment services, all prevention services are delivered by community-based providers. In order to qualify for funding community-based providers must meet the requirements of the Division of Behavioral Health, Bureau of Substance Use Disorders, Substance Abuse

Idaho / SAPT FY2012 / Goal \_1:Improving access to prevention and treatment services  
Prevention Program, Substance Abuse Prevention Standards.

Idaho uses the SAMHSA prevention strategies to define the types of programming funded. All strategies are available in each of Idaho's 7 regions. Information dissemination is offered directly by the Idaho alcohol/drug clearinghouse. To make materials easily accessible to all Idaho residents, the clearinghouse has a large reading room, a 1-800 number and hosts a website (<http://radar.boisestate.edu/>). Idaho also supports an underage drinking prevention media campaign. As stated above the media campaign reached 55% of Idaho adults with repeated messages. The information dissemination strategy is also offered in conjunction with prevention education, community-based and environmental strategies. All education programs are offered in more than one session. Youth substance abuse prevention education classes are most often offered in school districts and all students in the priority population within the school district have the opportunity to participate in the program. By offering services within the school day more youth have the opportunity to participate because they do not need transportation. Parenting education classes are offered in all 7 regions and are available to anyone willing to attend. For all recurring education strategies only those programs that have valid research documenting their ability to address the identified risk factor within the prioritized population are funded.

Community-based and environmental strategies are implemented by coalitions. Coalitions can access support for these strategies through three options. Coalitions wishing to assess community readiness to change can ask the prevention services contractor for technical assistance in assessing readiness, creating plans to increase readiness and initiating community-wide conversations. Coalitions, who are more organized, are able to apply for SAPT Block Grant funding to implement their community plan including the initiation of environmental strategies. Finally, community groups and organized coalitions can request assistance from the Division of Behavioral Health, Prevention Specialist. These requests include specialized training, conference call support, specialized training and request for mentoring from another coalition. Support for these strategies is available to any community in Idaho, regardless of risk factors.

The vast majority of alternative strategies funded by Idaho are after school programs. A high percentage of these programs also include a substance abuse prevention education class as part of the services offered to youth. Any youth within the communities where alternative strategies are funded have the opportunity to access these services. Problem identification and referral strategies were only offered to youth with multiple risk factors that made them more likely to participate in a variety of negative behaviors including substance abuse. Services included in this strategy included brief screening to determine appropriateness for prevention services, referral to treatment services if not appropriate for prevention, support groups and prevention education programming.

The following shows the Number of Participants per CSAP Strategy. Please note that a single person can count as more than one participant if they participate in more than one program in a fiscal year, and some programs have employed more than one strategy.

Idaho / SAPT FY2012 / Goal \_1:Improving access to prevention and treatment services

Strategy	Number Served
Information Dissemination	19,010
Prevention Education	20,980
Alternative Activities	813
Community-based Processes	6,017
Environmental Strategies	6,838
Problem Identification	2,668

## Goal #2: Providing Primary Prevention services

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

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

Primary Prevention: Six (6) Strategies

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

Institute of Medicine Classification: Universal, Selective and Indicated:

o **Universal:** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

o **Universal Direct. Row 1**—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

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

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

FY2009 (Annual Report/Compliance):

## Idaho / SAPT FY2012 / Goal \_2: Providing Primary Prevention services

1. In the reviewing of Goal#2 it was observed that (1) the state did not included a narrative description of the State's agreement to spend not less than 20 percent of the SAPT Block Grant on primary prevention strategies directed to individuals not identified to be in need of treatment

Since the current SAPT Block Grant legislation was passed in the early 1990's, the State of Idaho has certified that not less than 20% of the annual SAPT Block Grant Application will be spent on primary prevention activities. In order to comply with this requirement, the State established a budgeting protocol which ensured that not less than 20% of the annual Idaho SAPT Block Grant appropriation was set-aside for primary prevention. Compliance with this protocol is reviewed quarterly during budget reviews.

and (2) the narrative relevant to the comprehensive primary prevention programs, activities and services provided were discussed using data from 2010 by mistake. For this BG report purposes, the compliance year to be reported is FY 2009. Please correct and incorporate the information required above considering FY 2009 as the compliance reporting period.

In FY 2009, Idaho served 24,603 individuals in substance abuse prevention single and recurring program services funded by the SAPT block grant. Of those served, 8,629 participated in single programs and 15,974 in recurring programs. As in past years, Idaho had two target populations for services in 2009. The first was primary prevention programs were children and adolescents aged 0 – 18 years. In FY 2009, 14,690 youth, 17 and younger were served in recurring programs at the universal, selective and indicated levels of care. Additionally, 374 individuals aged 18 - 24 also participated in recurring programs. Parents and community members working with you were the second target population in 2009. During this period, 910 adults were served in recurring. Finally, over 185,000 Idaho residents were able to access prevention materials, professional resources and videos through the Idaho alcohol/tobacco/drug clearinghouse.

As was Idaho's practice in previous years, all primary prevention services were provided by community-based providers. In 2009, state level these funds supported the alcohol/tobacco/drug clearinghouse and college courses in substance abuse prevention. Community level services were managed by the statewide Prevention Technical Assistance and Support Contractor, Benchmark Research and Safety, who was responsible to ensure that all substate areas had prevention services and that all services were provided to populations at greatest need or with fewest resources. Under their direction community-based providers in each of the substate areas delivered recurring services to prioritized populations. In 2009, 100% of funded recurring programs were on the National Registry of Effective Programs and Practices. During this year, Idaho initiated a process to review all proposed programs to ensure they had documentation that the program effectively address the prioritized population's targeted behavior. Over half of the single service funding went to coalitions. Standardized and program-specific pre and post-tests were administered to all participants in recurring programs based on the services being provided. Collection of pre/post data enabled the Department to evaluate the outcomes of the funded prevention programs. Finally coalitions were funded to support self-sustaining community efforts to prevent underage drinking, increase community awareness of drug use, increase community readiness to change, implement environmental programs and educate

Idaho / SAPT FY2012 / Goal \_2: Providing Primary Prevention services youth and parents about the negative effects of alcohol on the youth.

#### Information Dissemination

Information Dissemination statewide services are being provided by Idaho's alcohol/tobacco/ drug clearinghouse. The Idaho RADAR Center is managed by Boise State University under a contract with the Department. The RADAR Center provided information and educational materials to Idaho groups and organizations such as schools, prevention, social service providers, health care providers, other professionals and the general public. The RADAR Center is also includes a video lending library and makes the videos available to all Idaho residents. As stated above, over 185,000 persons were served by the RADAR Center in 2009. At the community level, information dissemination activities were delivered by community-based programs and coalitions through subcontracts with the Prevention Technical Assistance and Support Contractor. Community-based providers included information dissemination activities within their recurring programs. In 2009, 4388 Idaho youth and adults received information dissemination services as a part of single programs and an additional 14,662 received information dissemination services as an add-on to participation in a recurring program.

#### Education

Idaho residents in all sub-state planning areas had the opportunity to access education services provided to by community-based providers who held subcontracts with the Prevention Technical Assistance and Support Contractor. Idaho continued to fund a variety of providers to deliver these services. Examples of community-based providers are Boys and Girls Clubs, school districts, youth/family nonprofits, faith-based organizations and community action agencies. The target populations for this activity were parents, youth, and community members working with youth. Services were made available to youth and adults at the universal, selective and indicated levels or care. During this period, Idaho funded Project Alert, All Stars, Project Towards No Drug Abuse, Life Skills Training, Prevent Alcohol Related Crashes, Parents Who Care, Too Good for Drugs, Positive Action and Strengthening Families. In 2009, 20,980 persons were served under this strategy. During this period, 100% of recurring education programs were evidence-based. In 2009, 15,476 youth and adults received education services in recurring programs and 5,504 had participated in one-time education programs.

#### Alternative Activities

As in past years, in 2009, alternative activities focused on youth and include skill-building and academic after school programs, mentoring programs, and community service substance abuse education programs. In these programs children worked with adults modeling and promoting positive behaviors. Alternative activities were also provided by coalitions to provide youth will safe, ATOD-free options. Services were provided at the universal and selective levels of care. During this year, 34 individuals participated in alternative activities as single programs and 779 individuals participated in alternative activities as a part of recurring programs. All recurring activities included evidence-based prevention education. Programs were being delivered in all sub-state planning areas of the state by community-based providers.

## Idaho / SAPT FY2012 / Goal \_2: Providing Primary Prevention services

**Problem Identification and Referral**

Problem Identification and Referral services focused on adolescents with risk factors in multiple domains. All participants were screened for risky behaviors and when appropriate, referred to other community resources. Problem identification and referral services were offered in the school or community setting as a part of a student assistance program. In 2009, 295 youth received problem identification and referral services in single programs. An additional 1,705 youth received problem identification and referral services in recurring programs. These services were provided to participants at the indicated level of care. Programs were delivered in all sub-state planning areas of the state by community-based providers who held contracts with the Prevention Technical Assistance and Support Contractor.

**Community-based Process**

In 2009, Community-based Process focused on the development of community anti-AOD coalitions throughout Idaho. The Prevention Technical Assistance and Support Contractor's regional coordinators provided assistance to community groups wishing to develop a coalition as well as to coalitions interested in addressing AOD-related issues in their communities. The focus of each of the coalitions was based on the assessment of risk factors, resources and needs identified in their community. The coalitions provided a variety of activities based on their community's needs and readiness to change. Examples of funded community-based activities are community awareness campaigns, media events, retailer/server education, parent's nights and presentations at community events. These activities are being delivered at the universal level of care. In 2009, 5,570 individuals participated in single event programs and 447 persons attended recurring program community-based processes.

**Environmental**

Environmental strategies continued to be undertaken by coalitions as a part of their annual plans. Activities were designed to change community norms, law enforcement practices, develop of school night curfews. Some communities also provided retailer/server education. All services were delivered at the universal or selective levels of care. In 2009, over 6,686 persons were served in single programs and 152 individuals participated in recurring programs. All sub-state planning areas were served under this strategy. Activities were implemented using funds managed by the Prevention Technical Assistance and Support Contractor.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

In 2009, the Division of Behavioral Health continued to implement the delivery of specialized services according to the CSAT Blending Perspectives model and the Division's guidelines presented in the Pregnant Women and Women with Children Treatment Service Continuum State of Idaho (Revised August 2007) to support the training and technical assistance provided in the previous 2 years. The Division planned to serve 1,300 women and children in the PWWC category (150 pregnant women and 1,150 women with dependent children) in 2009. The Division actually provided specialized pregnant women and women with dependent children services to 1,334 women with dependent children and 276 being pregnant women in 2009. The goal was to add two additional providers in un- or under-served areas in 2010.

The Division funded five designated PWWC specialized providers to deliver specialized women's services. Riverside Recovery and Sitman Family Services, Inc. provided PWWC services in an outpatient setting, Road to Recovery – Discovery House offered a day treatment program and Bell Counseling and the Women and Children's Alliance delivered the services in a half-way house setting. In addition, Business Psychology Associates conducted the initial qualification for care, placement, and assessment services for the women who were met Idaho PWWC financial and clinical requirements. All women, whether approved for service or not were provided with information on resources for the women and their children. No cuts were made to Pregnant Women and Women with Dependent Children funding in 2009, nor was access restrained in any way. In 2009, the Division worked with MEDICAID to access these funds for women and children currently enrolled in the MEDICAID program. The goal of this initiative was to greatly expand access to services, including to pregnant women, women with dependent children and their children.

Initiated in 2008, the Division continued in the process of rewriting the 'Minimum Standards Governing Alcohol and Substance Use Disorders Treatment Facilities and Programs.' Included in this rule rewrite, are standards specific to the delivery of PWWC services. The 'Guidance to States: Treatment Standards for Women with Substance Use Disorders' was referenced during this rewrite. Division employee, Sherry Johnson, was an active member of the committee that was formed as a part of the Women's Services Network to work on the guidance document.

During 2009, the Division provided treatment, and recovery support services and care management statewide through its contract with a Management Services Contractor (MSC). The MSC conducted the initial care qualification, screening and risk assessments of pregnant women and women with dependent children. If children's needs were also identified during the initial assessment the MSC referred them to appropriate resources. Eligible clients were authorized for a comprehensive assessment and subsequent treatment. The specialized PWWC providers under contract with the MSC conducted comprehensive assessments of the women and their dependent children, identified needed services, made referral to appropriate external resources and delivered substance use disorders treatment and recovery support services, including child care. All other services, including those for the children, were delivered via use of

community resources. The MSC was also responsible for extended stay authorizations. In addition the MSC used a specific audit tool for providers delivering services to the PWWC specialty network to ensure that Federal standards for this population are followed.

In 2009, the Division exceeded the pregnant women and women with dependent children maintenance of effort requirement, spending a total of \$875,896. Expenditures per provider are listed below:

Agency	Amount	Capacity
Riverside Recovery	\$182,054	20 slots
Sitman Family Services	\$ 55,284	30 slots
Women & Children's Alliance	\$226,526	6 slots
Bell Chemical Dependency	\$287,700	
Bell Linden House Half-way House		6 slots
Bell Linden House Outpatient		75 slots
Discovery House, Road to Recovery	\$ 39,402	20 slots
Business Psychology Associates (MSC)	\$ 84,930	based on need - MSC was responsible for authorization of care for all Idaho PWWC clients.

Revision Request:

Please indicate the client capacity for each facility listed in the chart as well as the amount of funds that expended by each program. To simply state there is "No Limit" on the capacity for each program is inappropriate because each facility has a maximum number of occupants that it is able to house. Please provide this detailed information by 2/28/12. • Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

Idaho Response:

The 2009 response to Goal 3 failed to save when entered. The data in the system was the 2010 response. The 2009 response is now saved in the BGAS system and addresses this revision request in the table at the end of the report.

Revision Request

The narrative provided is very vague and needs to be more detailed. For example, what was the target number of clients to be served for the fiscal year? You mention budget cuts to the Department but don't define how much they were and how this impacted your services delivery to this population. How has this impacted your ability to meet the MOE requirement for this group. What types of services were offered to this population? In the PWWDC chart listed on page 15, please specify what amount of funds were expended by each of the providers listed. Based upon the MOE shortfall reported in Table IV, what efforts were made to prevent this shortfall in spending? What specific Best Practices were utilized with this population? Please revise and resubmit by 2/28/12 • Goal #3: Providing specialized services for pregnant women and women with dependent children  
• Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

Idaho Response:

As stated above the correct response is now entered into the BGAS system. In 2009, there were no cuts to PWWC services. Per the narrative, Idaho had 5 providers and anticipated adding 2 more. The target numbers can now be found in the narrative, as well as the actual numbers served and the amounts expended by each provider per Table 9. The types of services offered is also found in the narrative as well as detail on the models used.

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

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

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

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

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

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

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

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.

Program Name	ISATS #	Type of Care	Capacity	Funds Available
Riverside Recovery	ID100448	Outpatient	20 Slots	\$182,054
Sitman Family Services	ID100577	Outpatient	30 Slots	\$ 55,284
Women & Children's Alliance	ID100084	Half-way House	6 Slots	\$226,526
Linden House, Belle Counseling	ID101420			\$287,700
		Half-way House	6 Slots	
		Outpatient	75 Slots	
Road to Recovery, Discovery House	ID100599	Day Treatment	20 Slots	\$ 39,402
Business Psychology Associates	ID100476	Outpatient -MSC was responsible for authorization of care for all Idaho PWWC clients.		\$ 84,930

In FY09 the Treatment Master Services contract with Business Psychology Associates continued to require the support of a specialty network of PWWC providers who agreed to follow all Federal Regulations around treatment of this population.

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

In FY 2009, specialized substance abuse treatment services were provided to Pregnant Women and Women with Dependent Children (PWWC) through a network of approved specialty providers managed by the Division's statewide Master Services Contractor. The specialty providers were required to provide the range of all services established in the Block Grant regulations. These services included, but were not limited to, comprehensive evaluation of pregnant women and women with dependent children including the dependent children. The MSC services included an evaluation that covered an assessment of risk, immediate needs, gender-specific substance use disorder treatment, case management and assistance in accessing other community services including, when appropriate, referral for prenatal care, parenting classes and services for the children. Although the Division was payer of last resort, the provider was also responsible to ensure the children received child care and needed substance use disorder education, medical and developmental services. This was accomplished using the DHW's children's mental health and developmental disabilities program services, Medicaid funding, as well as emergency assistance monies and community indigence funding and networking with other community agencies.

Idaho / SAPT FY2012 / Programs for Pregnant Women and Women with Dependent Children (formerly To ensure compliance, the Division took a variety of actions. In the treatment Master Services contract the Division identified PWWC populations as the high priority and included the federal requirements in the standards for all services to be provided under the contract. Using a specialized tool, the treatment Master Services Contractor regional substance abuse professionals conducted on-site monitoring visits at PWWC treatment facilities. The frequency of these visits was based on the provider's compliance with the standards and need for technical assistance. Length of time between visits ranged from every other week to quarterly depending on where the provider was in their implementation of specialized services.

Performance requirements were incorporated in the contract with the Master Services Contractor that imposed financial penalties for not meeting the PWWC maintenance of effort amount and for failure to refer women and their children to services appropriately.

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

The Division assigned a Substance Use Disorders staff specialist to focus on development and implementation of specialized services for pregnant women and women with dependent children. The specialist worked with Business Psychology Associates, the Master Services Contractor to review and implement services identified in the block grant requirements. A specific audit tool was created through collaboration between Business Psychology Associates and the Division to ensure compliance by providers who were in the PWWC specialty network. Providers in this network were audited every two weeks to quarterly depending on their audit scores. The Division had four performance requirements in its contract with Business Psychology Associates that established service delivery requirement for special needs of pregnant women and women with dependent children and their children. These requirements improved program development and service delivery. These requirements include:

1. PWWC REQUIREMENTS – The Master Services Contractor(MSC) was responsible to evaluate their documentation and data in order submit quarterly reports on their performance for: a) compliance with priority admission including cross-regional admission for pregnant women needing services; and b) PWWC clients' eligibility evaluated using the Division's financial eligibility scale. The MSC also reviewed specialty provider files to determine that client documentation evidenced that Division funds were "funds of last resort" for ancillary services, clients were assisted in applying for Medicaid, there were indicators of community network of treatment for the client and the family and, ancillary services/activities to which a client was referred were monitored for attendance and outcomes of those activities. The Division semi-annually conducted random site audits of PWWC client records for documentation and assessed BPA a \$100 financial penalty for each audit that does not meet expectations.

2. ANCILLARY SERVICE REFERRALS – PWWC providers facilitated referrals, to services that address prevention, developmental issues and issues of sexual and physical abuse/neglect for the dependent child(ren) a indicated by their assessment.. Specialty providers were required to make referrals by the end

Idaho / SAPT FY2012 / Programs for Pregnant Women and Women with Dependent Children (formerly of the second week of services. The Division semi-annually conducted random site audits of client records for documentation and assessed Business Psychology Associates a \$100 financial penalty for each audit that did not meet expectations.

C. USE OF BEST PRACTICE MODELS – The treatment models used in PWWC residential programs were Division approved evidenced-based models for the treatment of pregnant and parenting women. The Division semiannually conducted program audits, review of program materials, client records and assessed Business Psychology Associates a penalty of \$500 for each PWWC residential provider who had not created an action plan or implemented an evidence-based program by June 30, 2006. This requirement was continued through 2009.

D. SUBSTANCE ABUSING PREGNANT WOMEN'S ADMISSION TO TREATMENT – The Master Services Contractor screened pregnant women for financial and clinical eligibility for substance abuse services to enable them to enter treatment within fourteen (14) calendar days of screening. The Division monitored quarterly care management logs and reports for compliance and assessed BPA a financial penalty of \$100 for each pregnant woman not admitted at the required level of expectation. The Division had an established policy stating that if a PWWC specialty provider was not able to immediately admit a pregnant woman, a non-PWWC specialty provider is utilized until such time as a PWWC Specialty provider had capacity. If capacity was reached within the entire treatment system, the MSC made available interim services within 48 hours, including a referral for prenatal care. In 2009, capacity was not reached and no pregnant women had to be referred to a non-PWWC specialty provider nor given interim services.

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

The Master Services Contractor was responsible for managing capacity within the PWWC specialty network. This was done quarterly through a standard capacity tool that identified number of beds/slots in the specialty provider network vs. number of PWWC clients requesting treatment. Capacity of the system vs. need was monitored monthly during the Division's contract monitoring meeting with Business Psychology Associates. In addition, at these meetings the Maintenance of Effort was reviewed to assure compliance. No issues with capacity vs. need were identified in 2009.

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

In 2009, the Division continued its partnership with the Regional Advisory Committees in each region to plan for enhancement of capacity of programs for pregnant women and women with dependent children. During this period, Idaho had PWWC specialty providers in 5 of Idaho's 7 regions. The goal for 2010 was to build a PWWC provider in the 2 remaining regions.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

During 2009, the Department continued to have the Management Services Contractor (MSC) triage IVUDs (intravenous drug abusers) requesting services statewide. Those who did not need emergency care were scheduled for the first available assessment appointment. Those who needed detoxification were referred to a detoxification center or emergency room depending on the drugs involved, level of intoxication and detoxification history. All treatment facilities within the MSC provider network had the capacity to serve IVDU clients.

In 2009, 1,194 clients self-identified as being IV drug users. All were placed within the appropriate level of care within the required 14 day period. BPA was evaluated for compliance during quarterly monitoring visits. A random selection of 10% of the clients who were reported as IVDU was pulled. Division staff compared the services received, including time from screening to admission to treatment, to ensure block grant IVDU requirements were met. As part of the MSC's provider audit, referrals and services provided by the private treatment provider were audited for compliance with block grant requirements.

The Department maintained the protocol for reporting and provision of interim services at the service contractor level. As in past years, data on the rate of growth of the number of IVUDs in Idaho, particularly HIV positive individuals, is so low, that the state had no problems in meeting this federal requirement during 2009. Monitoring of the federal requirements is discussed at monthly Division meeting with the MSC. This includes review of capacity and if any providers have notified the MSC that they have reached 90% capacity. A protocol is in place that BPA will notify the Department within 7 days, through email, if a provider has hit 90% capacity. In 2009, no provider reached 90% capacity.

The Department maintained language in its contract with the MSC to ensure all providers in the networks for all client groups are capable of treating IVUDs and that these clients in each region of the state will be placed in the appropriate treatment level of care within fourteen (14) days of requesting services, and if there is inadequate capacity, interim services will be provided in compliance with SAPT block grant requirements until placed in treatment. This requirement was monitored as part of the overall monitoring of compliance with the terms of the contract four times in 2009. No compliance issues were noted during the 4 compliance monitoring sessions.

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

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

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

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

For the fiscal year three years prior to the fiscal year for which the State is applying for funds:

The most recent Behavior Risk Surveillance survey, Idaho participants were asked if they had used intravenous drugs, been treated for a sexually transmitted or venereal disease, received money or drugs in exchange for sex, or had anal sex without a condom within the past year. Of those surveyed 2.9% of the participants responded yes to this survey question. Only 2.9% of the Idaho residents surveyed indicated they had used IV drugs or been treated for an STD or were paid for sex or had unprotected anal sex in the past year. The actual percentage of Idaho's population who are IDUs is only a portion of that percentage. This is the only data Idaho has related to this behavior. State rates for IV drug use were not found in the NSDUH data.

As reported in past applications, the Division did not fund any programs serving only IV drug users. The Management Services Contractor (MSC), through its network of approved substance use disorder treatment providers, continued to require services be provided to individuals identifying themselves as an IDU. All treatment facilities within the MSC's service network had to be able to serve IDUs in order to qualify for the network. As a part of the screening process, IDUs were identified as priority clients and given the first available treatment appointment. The number of IDUs, particularly HIV positive individuals, in Idaho was so low, there was no problem meeting the federal requirements for admission to treatment. The Division continued to work with the Department of Health and Welfare's Division of Health to provide training resources regarding HIV/AIDS for substance abuse counselors.

1. How did the State define IDUs in need of treatment services?

As reported in past applications, the Division defined IDUs in need of services as those individuals who self-identify IV as their primary or secondary route of administration at intake, have used intravenously in the 30 days prior to requesting services and who applied for treatment and met the financial and clinical eligibility criteria. These criteria consisted of financial need and a DSM-IV diagnosis of substance dependence as established by an initial screening and a comprehensive clinical assessment.

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)).

Compliance with this section was ensured through provisions in the contract with the MSC. State approved alcohol/drug abuse treatment providers in the MSC's network were required to notify the MSC of their capacity and the MSC managed a waiting list on all providers. This allowed the MSC to know when providers were at 90% of capacity. A protocol is in place that if a provider notifies the MSC that they have

reached 90% capacity, the MSC will then notify the Division within 7 days via email. No treatment providers within the MSC network notified the MSC during 2009, that they were at 90% of capacity.

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)).

Provisions established in the Division's contract with BPA, specified the time frame for assessing and placing IVDUs into treatment. BPA tracked in their management information system the date an IVDU was screened, the date when services were authorized and the date of first delivered service to verify that IVDU's were cleared and referred for treatment within fourteen (14) days of screening. The MSC was monitored for compliance during contracting monitoring visits. Division staff would randomly select 10% of the clients who were reported as IVDU and comparing the services received, to include time from screening to admittance to treatment, to assure block grant requirements were followed.

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 to IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

There has never been a recognized district or area where IVDUs were concentrated in Idaho. Even in Idaho's largest city, Boise, IVDUs were distributed throughout the community. Therefore, outreach efforts were concentrated on referral sources. The Division focused on contacting potential referral sources to educate them about IVDU priority status, the services available, the eligibility requirements and methods for accessing services. One referral source that was contacted were HIV/AIDS contractors who were providing medical and support services to the individuals. Another referral source that was contacted was the criminal justice system who had access to individuals who were on probation, incarcerated or participating in drug-court. Activities to ensure that IVDUs were properly served in treatment were evaluated during quarterly contract monitoring visits. The above outreach description has been in effect for over 10 years in Idaho.

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

(See 45 C.F.R. §96.122(f)(3)(vii))

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

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

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

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and

- A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)

(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));

2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)

(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and

3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)

(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

Program Compliance Monitoring (formerly Attachment D)

1. Notification of Reaching Capacity

Per the form instructions, Idaho is reporting on 2010 data for this form. In Idaho, in 2010, 32 cases of HIV and 51 AIDS cases were reported. In FY 2010, treatment of IVDUs was made available within the 14-day period as required by the block grant. As in past years, the Division did not fund programs serving only IVDUs. All treatment providers with the MSC's network had the capacity to provide services to IV drug users. The Division required its treatment Master Services Contractor to provide both drug and alcohol treatment services. Through the screening process IVDUs were self-identified as a priority client and given the first available treatment appointment. The number of IVDUs, particularly HIV positive individuals, in Idaho remained so low that, the state was able to meet the federal requirements for admission to treatment in 2010. (In Idaho, in 2010, 32 cases of HIV and 51 AIDS cases were reported.) The treatment Master Services Contractor maintained a statewide waiting list on all clients for all levels of care and was responsible to report the waiting list to the Division monthly. This procedure enabled the Master Services Contractor to know which treatment providers were at 90% capacity and report that information to the Division. In 2010, no programs reached 90% of capacity. In addition, the treatment Master Services Contractor used their management information system data to determine the date each IVDU was screened, services were authorized and first service were delivered. No client waited more than 14 days to access treatment services. The Division continued the practice of monitoring the Master Services Contractor's records quarterly. Each quarter a sample of IVDU clients was drawn and their records were examined during the quarterly review. Failure to meet this requirement resulted in a penalty impose on the Master Services Contractor. Of the samples reviewed, all met the 14-day requirement and no penalties were imposed.

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

In 2010, the Division of Behavioral Health required that the Master Services Contractor care management unit be responsible for screening clients and ensuring that appropriate services were provided for all treatment clients based on the issues identified during their assessment. To support this effort, the Division's contract with the treatment Master Services Contractor required that they have a substance use disorder professional staff person located in each Idaho region, who was dedicated to the oversight of services provided to clients in that region. At the program level, counselors were responsible to assess all clients for TB risk and refer that clients at risk of having TB or engaging in behaviors that made that made them at risk for TB to Idaho Health Districts for TB screening and treatment.

Collaboration between the Division and the Department of Health and Welfare's Division of Public Health resulted in a formal agreement that the seven Idaho Health Districts, who had the resource to treat individuals with tuberculosis, would provide these services. Since Health District offices were located in several sites in each of the regions, this was a natural partnership. This joint undertaking ensured that Idaho was able to meet the TB requirement without a duplication of effort. Working with the treatment Master

Services Contractor, the Division and the Health Districts continued to use the standard procedures were designed to prevent the transmission of tuberculosis developed in 2004. The procedures are listed below.

1. Screen all treatment clients;
2. Identify individuals who are at high risk of becoming infected;
3. Treat or Refer as appropriate
4. Meet all State and Federal disease reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2.

In 2010 no problems were identified requiring corrective action.

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)).

In 2010, the Division maintained the contract with the treatment Master Services Contractor to establish and manage a network of providers to deliver specialized services to pregnant women and women with dependent children and their children. Women with dependent children included women attempting to regain custody of their children per Federal requirements. The treatment Master Services Contractor's care management unit assessed women for clinical and financial qualifications for care, conducted initial client screenings and risk assessments, made referrals to ancillary services and authorized a comprehensive assessment and treatment services. Network providers conducted the comprehensive assessments which included all the areas identified in the Block Grant requirements. The women's children were also assessed for service needs. All network provider services were monitored by the treatment Master Services Contractor. At the state level, the Division monitored the Master Services Contractor for compliance with the Block Grant requirements. Below are the elements monitored at the Master Services Contractor and local provider levels.

A. PWWC REQUIREMENTS – The Contractor was required to track provider documentation and data and report network provider performance for:

- a) Client admission within 48 hours.
- b) PWWC client eligibility evaluated using the Division's financial eligibility scale policy. (Client documentation indicates the Division funds were "funds of last resort" for ancillary services. Clients were assisted in applying for Medicaid;)
- c) Documentation of assessment and treatment services met the client/children's needs are in the files; and,
- d) Documentation that ancillary services/activities to which a client/child were referred were monitored for attendance and outcomes of those activities.

Per the Division's contract, a penalty of \$100 is assessed to the Master Services Contractor for any audit finding that does not meet established requirements.

B. ANCILLARY SERVICE REFERRALS – Specialty providers were responsible to make referrals for service needs identified in the client and child assessments. The referrals could be made to prevention providers, children's development programs and to agencies to deliver services deal with issues of sexual and physical abuse/neglect for the dependent child(ren). The Master Services Contract required that these referrals be

made no later than the end of the second week of services. The same process was used to refer the women to services that they needed which were not offered by the provider. As stated above, semi-annually random site audits of client records were conducted by Division staff. The audits evaluate documentation of services delivered and referrals made. If specialty PWWC providers in the Master Services Contractor's network fail to meet the established requirements, the Division assesses the Master Services Contractor a \$100 financial penalty for each audit that does not meet expectations.

**C. USE OF BEST PRACTICE MODELS** – The treatment models used by PWWC residential programs were approved Division evidenced-based practices for the treatment of pregnant and parenting women. All models used were approved prior to implementation of the service. Two times each year, Division staff audited specialty providers. As a part of this audit, program materials, client documentation and program improvement plan were evaluated for compliance with the Master Services Contract requirements. Specialty provider failing to meet any of the contract elements were required to draft a corrective action plan and submit it to the Division for approval. If any specialty provider had not drafted an action plan or implemented an evidence-based program within the required time period, a penalty of \$500 was charged to the Master Services Contractor.

**D. SUBSTANCE ABUSING PREGNANT WOMEN'S ADMISSION TO TREATMENT**

Per the terms of the Master Services Contract, pregnant women or women with dependent children were screened to determine need for treatment services and financial eligibility to receive state assistance. The Master Services Contract required that these tasks be completed and eligible pregnant women be entered into treatment within 48 hours of the screening. As with the other requirements, the Division monitored the Master Services Contractor to evaluate compliance. In this case, care management logs and reports were audited for compliance. Failure to comply results in a \$100 fine for each pregnant woman not treated within the established timeline. The treatment Master Services Contractor's regional staff conducted site visits at the specialty providers to determine if they met the standards set for these specialized services. File reviews and interview with specialty provider program managers and counselors were used to evaluate compliance. For this level of care the Master Services Contractor's care management unit was responsible for quality assurance oversight of specialty providers. This was done through the concurrent review process and the preauthorization for specialized services. Compliance was conducted by Division staff during contract monitoring meetings with the Master Services Contractor and network specialized PWWC provider site visits. Division staff provided training and technical assistance upon request. No corrective actions or fines were imposed for this requirement in 2010.

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

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

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

FY2009 (Annual Report/Compliance):

In 2009, the Division continued the services initiated in the contract with a Management Services Contractor (MSC) in July 2003. The provisions of this contract call for multiple avenues or approaches to be required to ensure substance abuse treatment clients were referred to appropriate services including tuberculosis screening and treatment. These include the Care Management component of the MSC, the MSC's regional coordinator in each sub-state planning area and the counselors at the program level.

The Care Management component of the MSC, which includes treatment planning, ensured appropriate, comprehensive services were provided for all treatment needs identified in the comprehensive assessment including referral to TB screening and treatment. The MSC's regional coordinators were responsible for review and oversight of services provided to clients including those relating to TB. As a part of the treatment process, counselors at the program level conducted ongoing provider monitoring to ensure that clients received care for all identified treatment needs including those relating to TB and that they referred clients to ancillary services not provided directly by the program.

At the state level, the Division continued to collaborate with the Department of Health and Welfare's Division of Health to facilitate referrals to TB services provided by district health clinics including TB testing, counseling, medications and medical services. This collaborative effort enabled the state to comply with this requirement without a duplication of effort. To accomplish this collaboration the Division met with each of the seven Health Districts twice during FY2009. No significant issues were raised at any of these meetings.

As stated in the intended use plan for FY2009, the Division did not track and report the number of clients referred to TB services as it is the expectation that all clients will be referred for testing, if they have not already been within reasonable timeframes.

The Division conducted ongoing evaluation of MSC providers TB-related services to clients including documentation of referral to testing and services during each quarterly contract review. In 2009, the MSC monitored all treatment providers within their network to ensure compliance. No compliance issues were identified during the audits.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

Idaho was not a designated state in 2009. Idaho continues to have a very low HIV/AIDS rate. 1,026 HIV and AIDS cases have been diagnosed in Idaho residents. Idaho cases are 0.16 of the total HIV cases and 0.06% of the total AIDS cases reported in the U.S. 1,028 individuals are presumed to be living with HIV or AIDS in Idaho. Improvements in HIV treatment have reduced the number of deaths from 26 per year during 1984–1995 to 15 per year from 1996–2007.

In 2009, the Division continued its work with providers who expressed interest in providing rapid HIV testing. Training on education and intervention on HIV/AIDS was provided through Idaho's Management Services Contractor, Business Psychology Associates once in 2009.

The Division continued to participate on the Idaho Advisory Council on HIV and AIDS (IACHA) to assess prevention and care needs in the State and identify the areas of the State that have the greatest need for HIV services. Through the IAC, the Division collaborated with 25 different community partners throughout the State of Idaho.

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

(See 45 C.F.R. §96.122(f)(1)(x))

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

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

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

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

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

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

## 2009 Data

### Tuberculosis services:

Idaho has an extremely low rate of tuberculosis (TB). In 2009, all publicly funded tuberculosis services in Idaho were financed and coordinated by the Department of Health and Welfare's Division of Public Health. The Division of Behavioral Health did not have the expertise or funds to support additional tuberculosis services. Given the low disease rate, it would have been an unnecessary duplication of effort to initiate new TB programming. In addition, since both public entities were part of the Department of Health and Welfare, a qualified service organization agreement was not necessary.

The Division of Behavioral Health continued to require compliance with this federal requirement through the contracting agreement with the Master Services Contractor. In 2009, the care management unit of the Master Services Contractor, which oversaw all aspects of treatment planning and delivery, was responsible to ensure appropriate, comprehensive services were provided for all treatment needs identified in Idaho's mandated assessment, the GAINI, including referral to TB screening and treatment. The Master Services Contractor's regional coordinators were responsible for the oversight of services provided by network provider to treatment clients, including those relating to TB. Counselors at the provider level were responsible for ensuring that clients receive care for identified treatment needs including those relating to TB and to refer clients to ancillary services not provided directly by the program.

The Master Services Contractor network treatment providers were responsible to address TB issues with clients and refer them for testing and services. The Division monitored compliance with this requirement during each MSC quarterly contract review and randomly selected provider file reviews. In 2009, the treatment MSC conducted a chart audit on a random sample of provider charts for all treatment providers within the publicly funded network to assure compliance. In total the Master Services Contractor audited 712 charts, representing an 11% sample of overall client files. Of the 712 files reviewed, three (00.42%) did not contain documentation that the client was given a referral or information regarding TB testing. Non-compliant providers submitted a Clinical Quality Checklist Action Plan in response. In 2009, the Division did not track and report the number of clients referred to TB services as it is the expectation that all clients will be referred for testing, if they have not already been within reasonable timeframes

With the implementation of the WITS electronic record system, the Division will be able to collect data during admission regarding whether or not a client has had a TB test in the past and what the results of that test were. The target date for entering all new substance use disorder clients into the WITS system is July 1st, 2012.

### HIV services:

Even though Idaho was not a designated HIV Early Intervention State, in 2009, the Division continued proactive endeavors to maintain a low rate of HIV/AIDS among clients receiving substance use disorders

Idaho / SAPT FY2012 / Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E) treatment. Activities incorporated into the Division's efforts included a blood-borne pathogens class in required course work for individuals seeking to be a certified alcohol/drug counselor in Idaho, provision of no-cost educational materials for professionals and clients available through the Idaho RADAR Network Center, continued collaboration with the state entity responsible for HIV/AIDS public services and ongoing technical assistance and support to treatment programs and counselors addressing HIV/AIDS in their programming. Total funds spend are not tracked as Idaho is not designated as a HIV Early Intervention State.

Idaho / SAPT FY2012 / Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

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

The state failed to provide the amount of funds expended for TB services in this section. Please revise by 2/17/12.

The state failed to provide the amount of funds expended for TB services in this section. This revision was due by 2/17/12, but has yet to be completed. Please respond by 3/15/12.

Idaho Response

In FY 2011, Idaho spent \$98,525 on state-funded TB services. The Idaho Department of Health & Welfare's Division of Health reported that there were only 11 active cases of TB during this period. While the substance abuse program referred 75 people to TB testing, when matching this data to those 11 individuals that received TB service, it was found that no substance abusers in treatment were one of the 11 reported TB cases. This resulted in no state TB funds being expended on clients who were substance abusers in treatment.

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

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

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

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

FY2009 (Annual Report/Compliance):

The Group Home Loan program was discontinued in Idaho. No loans were funded in 2009.

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

(See 42 U.S.C. §300x-25)

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

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

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

The Group Home Loan program was discontinued in Idaho. No loans were funded in 2009.

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

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

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

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

Idaho statute Chapter 39, Title 57 establishes a requirement that all tobacco sellers in Idaho be permitted, sets a minimum age for purchasing tobacco products (18), requires compliance inspections be conducted on all permittees based on a formula established in the law, sets penalties for retailers who violate the statute and requires vendor assistance for all tobacco sales except for those in tobacco shops. The full statute can be found online at <http://legislature.idaho.gov/idstat/Title39/T39CH57.htm>.

The 2012 Idaho Synar report was submitted at the same time as the 2012 Idaho Combined Behavioral Health Assessment and Plan.

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

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

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

FY2009 (Annual Report/Compliance):

In 2009, the Department of Health and Welfare's Division of Behavioral Health continued to have pregnant women as the highest priority for placement in substance use disorder treatment system. The Division anticipated serving 150 pregnant women statewide during the grant period and actually served 276 pregnant women. The management of the admission to treatment and management of care while in treatment were a part of the Management Services Contract. In 2009, Business Psychology Associates was the Management Services Contractor.(MSC)

The MSC's Care Management unit was responsible for oversight of utilization to ensure appropriate, timely and appropriate services were provided for all treatment needs identified in the comprehensive assessment for pregnant women. In addition, the MSC continued to have a substance use disorders professional in each of the states 7 regions who was dedicated to the oversight of services provided to pregnant clients. At the network program level, counselors were responsible for ensuring that pregnant clients received care for identified treatment needs and referred clients to ancillary services, which were not provided directly by the program. At the state level, the Division continued to collaborate with the Department of Health and Welfare's Division of Public Health to facilitate referrals to services provided by District Health clinics. This collaborative effort enabled the Division to comply with this requirement without a duplication of effort.

The Division required the MSC to identify pregnant women upon application and refer them to the most appropriate service. The initial screen was conducted when individuals call the 1-800 treatment qualification phone numbers. All callers were screened and if they qualified for publicly funded treatment, the MSC would clarify at that time if they are pregnant. If they were pregnant, the Division's client prioritization protocol established that pregnant women should be placed in treatment within 48 hours, but in no instance over 14 days. The MSC was responsible maintain current capacity data statewide. The Division gave authority to the MSC to place the pregnant client anywhere in the state without first clearing it with Division authorities, thus reducing wait time due to administrative procedures. The MSC was responsible for placing pregnant women into treatment within fourteen days of their request for services, thus negating the need for interim services. The MSC's regional substance use disorders professional staff worked with providers to have them and their counselors ready to deliver services to pregnant clients according to the requirements, which included referral to prenatal care. In 2009, all pregnant women were admitted to treatment within 14 days of qualifying for care.

The MSC regional substance use disorders professionals worked with their pregnant women providers so they are aware of the prenatal care and other resources available through the District Health Agencies, such as, prenatal medical care, immunization, Women Infants and Children services, and TB and STD/AIDS testing and care. Annual chart audits by the MSC and the Division included checking to verify that referrals to appropriate services for pregnant clients were made.

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

See 45 C.F.R. §96.122(f)(3)(vi))

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

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

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

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

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

**Capacity Management/Waiting List Systems (formerly Attachment G) - 2010 Data**  
 (See 45 C.F.R. 96.122(f)(3)(vi))

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

Per instructions, Idaho is reporting on 2010 data in this section. In 2010, the Department of Health and Welfare’s Division of Behavioral Health continued to contract with a statewide Management Services Contractor (MSC), Business Psychology Associates to manage a statewide network of substance use disorder treatment and recovery support services providers. Tasks in the contract included screening new clients via a 1-800 # for financial and clinical eligibility, authorizing placements in accordance with ASAM patient placement criteria for initial assessments and subsequent treatment services and managing client placements based on capacity, census and budgeted funds. In 2010, the MSC continued to use a client prioritization system to determine admission to treatment and recovery support services. In 2010, Pregnant Women and Women with Dependent Children (PWWC) and IV Drug Using (IVDU) individuals remained the highest priority. Provisions in the Division’s management services contract specified the time frames for admitting PWWC and IVDU clients to treatment and included the imposition of financial penalties for not meeting the PWWC maintenance of effort (MOE) amount. The contract clearly stated that IVDUs and pregnant women were not to be put in on a waitlist. Through the screening process PWWC and IVDUs were identified as a priority population and connected to the program closest to them with space available.

The Division established the following client prioritization system for adults and adolescents to determine admission to treatment:

<b>Priority</b>	<b>Target Group</b>	
<b>Rank</b>	<b>Adult</b>	<b>Adolescent</b>
1	01A = Pregnant, injection	01Y = Pregnant, injection
2	02A = Pregnant, alcohol	02Y = Pregnant, alcohol
3	03A = Injection Drug	03Y = Injection Drug
4	04A = Woman, Dep. Child	04Y = Woman, Dep. Child
5	05A = Domestic Violence	05Y = Juvenile Justice
6	06A = General	06Y = Domestic Violence

Through the contract, the MSC was required to ensure that IVDUs and pregnant women in each region of the state were placed in the appropriate level of care within fourteen (14) days of requesting services. Upon completion of the eligibility determination, the MSC immediately transferred IVDU clients and pregnant women to treatment providers. The MSC staff verbally confirmed the selected agency had an appointment available within 14 days of eligibility determination prior to completing the transfer, and with the client and provider on the call simultaneously, introduced the client to the provider. The

MSC then exited the call and the provider and client completed the appointment scheduling. In the event the preferred provider was unable to get the client in care within 14 days, the MSC contacted the next acceptable provider until the individual was placed with a network provider who was able to admit a client to services within 14 days. Through their management information system, the MSC was able to track the date an IVDU or pregnant women was screened, the date when services were authorized and the date the first service was delivered. In the event that a client required treatment services for which there was no capacity, the MSC authorized a lower level of care and ensured that the first appointment was scheduled within 14 days.

The Division assigned a staff member to focus on the development and implementation of specialized services for pregnant women and women with dependent children. This specialist was also designated as Idaho's Women's Services Network Specialist for SAMHSA's Center for Substance Abuse Treatment. The specialist worked with the MSC to develop the services. In addition the Division had four (4) Performance Requirements in its contract with the MSC that pertained to meeting the special needs of pregnant women and women with dependent children and assist in improvements in program development and service delivery.

Capacity was evaluated through Division contract monitoring and MSC required reporting activities. Utilization was evaluated through the use of the state's automated client information system, which generated reports on pregnant women and women with dependent children services. Through this process the State was able to meet the Federal requirements for PWWC clients entering treatment within the specified timeframe.

The Division continued to maintain a protocol for reporting and provision of any interim services at the service contractor level. The MSC was required to notify the Division when their network providers were at 90 percent of capacity. As in past years, data on the rate of growth of the number of IVDUs in Idaho, particularly HIV positive individuals, was so low, that the state had no problems in meeting this federal requirement. No IV drug using individuals had to wait more than 14 days to be admitted into substance use disorder treatment services.

The MSC, through its network of substance abuse treatment providers, has consistently been able to screen IVDU clients and pregnant women for placement within 14 days of requesting services and there has not been a need for interim services for IVDU clients and pregnant women. Subsequently, there are no separate line-item expenditures for Capacity Management and Waitlist System available for Idaho to report. Compliance with this requirement is monitored through quarterly MSC contract monitoring site visits by Division staff.

Capacity Management and Waiting List Systems (formerly Attachment G)

The State failed to provide the total amount of funds expended (or obligated if expenditure data is not available) to comply with the requirements to develop capacity management and waiting list systems for intravenous drug users and pregnant women. This revision has been previously been requested but has not been addressed. Please respond by 3/12/12.

The State failed to provide the total amount of funds expended (or obligated if expenditure data is not available) to comply with the requirements to develop capacity management and waiting list systems for intravenous drug users and pregnant women. Please revise by 2/28/12

Idaho Response - 2009 Data

In 2009, Capacity Management and a Waiting List System were requirements of the Master Services Contractor for Substance Use Disorder Treatment Services. Capacity management tasks were incorporated into the client screening and authorization for care process. The total 2009 cost for capacity management for Pregnant Women was \$45,540. The 2009 expenditures on capacity management services for IVDUs totaled \$197,010. The Waiting List system 2009 cost was \$27,500. Thus, in 2009, Idaho spent a total of \$270,050 on capacity management and wait list services.

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

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

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

FY2009 (Annual Report/Compliance):

In 2009, the Department of Health and Welfare's Division of Behavioral Health continued to use a Management Services Contractor (MSC) to manage the statewide substance use disorder treatment system of care. The MSC was responsible for management of the delivery of services to adults, adolescents, IV Drug Users and Pregnant Women and Women with Dependent Children (PWWC) clients through a network of state approved substance use disorder treatment and recovery support providers. The MSC was also responsible for utilization review (i.e., care management). The Division completed the final stages of the bidding and procurement process in response to an RFP released in June 2008. Business Psychology Associates, the current MSC, was awarded the new MSC contract.

The MSC conducted the initial client screening for all Idaho residents using a 1-800 number. The use of a 1-800 number for screening made the service available to all Idaho residents with no transportation costs for potential clients. The phone system also made it possible for individuals to be screened when they called rather than having to call for an appointment and wait for the next available slot. This greatly improved access for all Idaho residents.

The phone screening included evaluation of financial (up to 175% of federal poverty guidelines) and clinical eligibility, conduct risk and service assessments and authorize assessments at the indicated ASAM PPC-2R level of care. The MSC care qualification call center was available from 8 a.m. to 6 p.m. Mountain Time for client and provider calls, because Idaho contains two time zones (Mountain and Pacific). The MSC maintained specific dates and times to conduct concurrent risk factor reviews with providers to tie with their clinical staffing days to better connect with their work and participate as a part of the treatment team.

The MSC was responsible for the collection of client data for the federal treatment episode dataset (TEDS) and entered it in their client information system and transferred it to the Division's data system. The MSC continued to conduct concurrent risk factor reviews on data submitted by the provider to assess the client's progress and adjust the treatment level of care as indicated. The Interagency Committee on Substance Abuse, the Division and the MSC continued to train clinicians to implement the GAIN (Global Appraisal of Individual Need) screening and assessment tools in order to establish a standardized, comprehensive system for evaluating client needs.

In 2009, the Division continued work with the Idaho Supreme Court to implement processes to serve juvenile and adult clients ordered to undergo an assessment and recommended treatment as a result of statutes 20-520(i) for juveniles and 19-2524 for adults. The Division used the screening process described above for these individuals, recognizing they are automatically eligible, and used the ASAM PPC 2R for placement decisions. In 2009, a total of 1,394, 19-2524 clients were screened with 1,195 of those screening clinically eligible based on ASAM criteria. Additionally in 2009, a total of 204 20-520i clients were screened with 194 of those screening clinically eligible based on ASAM.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

### Prevention

In 2009, The Division of Behavioral Health provided continuing education for employees of prevention facilities. Priority populations for continuing education were:

1. Staff of Community-based Prevention Programs providing youth education;
2. Staff of Community-base Prevention Programs providing parenting education;
3. Substance Abuse Prevention state-funded and Drug Free Communities-funded Coalition Members;
4. Community Members; and,
5. Educators.

Division-funded continuing education opportunities were open to all staff whose positions were partly or wholly funded with SAPT block grant prevention funds. Those living outside of regular commuting area for the training location were offered travel, per diem and when needed, housing or registration fee assistance. The regular commuting area is defined as the distance people in that area regularly travel to work in that community.

Continuing education offered in 2009, focused on the use of online courses. Staff of prevention programs funded wholly or in part with SAPT Block Grant Funds could access two courses online - Prevention Theory and Addiction and the Family. Two additional online courses were developed, but were not yet up online at the end of 2009. These courses are Prevention Business Ethics and Prevention Group Facilitation Theories. Staff taking these courses will also participate in a face to face session to cover material not addressed online. The Annual Idaho Prevention Conference was offered as was the Substance Abuse Prevention Institute. The Prevention Conference was held in May in Sun Valley. The Prevention Institute was held in Boise, Idaho in the summer of 2009. Courses offered were Human Development for the Prevention Professional, Addiction and the Family, Prevention Group Facilitation, and Coalition Development.

Prevention continuing education was operationalized using a variety of methods. Master or Doctorate level instructors who had experience teaching the topic at the college level taught all training. The Department produced the Prevention Institute in Boise and delivered the courses using Department staff, Prevention Technical Assistance and Support Contractor (PTASC) staff or contracted with presenters. The Department participated in the planning of the Idaho Prevention Conference and placed funds in the contract with the PTASC to cover the registration, lodging and travel costs for prevention providers in their network to attend the conference. The development and maintenance of the online courses were included in the PTASC contract.

## Treatment

Continuing education opportunities for staff of the MSC network providers were provided via workshops, trainings and conferences. In 2009, treatment continuing education focused on improving clinical care for clients. Case management training was offered to all qualified substance use disorders professionals. The conference on the ASAM criteria was targeted for individuals who met the requirements for a qualified substance use disorders professionals, but were new in delivering services in the MSC network system. A workshop on clinical supervisors was also offered in 2009. This workshop focused on providing clinical supervisors with the tools that they needed to provide support to professional staff and improve client care. A course on clinical documentation was offered. The target population for this undertaking was qualified substance use disorders professionals whose documentation had been found insufficient during MSC and Division site visits. Finally training on the GAIN assessment was offered around the state to assist clinicians in meeting state requirements.

The annual Idaho Conference on Alcohol Drug Dependence was continued in 2009. The conference included skill-building courses as well as information of evidence-based treatment models. The conference brought together professionals from the fields of treatment, criminal justice, judicial, public and behavioral health and Idaho colleges and universities.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

In 2009 the Department of Health and Welfare's Division of Behavioral Health participated in the Interagency Committee on Substance Abuse. This committee, established in Idaho statutes, was responsible for state level oversight and coordination of Idaho's substance use disorders prevention and treatment system. This group was composed of representatives from the Idaho Supreme Court, agency directors, legislators, and representatives of the Substance Abuse Regional Advisory committees. They were charged with the responsibility of coordination of all substance use disorders prevention and treatment funding and programming within the State budget that was designated to the prevention and treatment of substance use disorders.

This group worked to coordinate services for the individuals that they served to create a single system all state agencies used. Under their direction, a standard substance use disorder assessment tool was established, the WITs data system was implemented and the Division of Behavioral Health's Master Services Contractor (MSC) was responsible for oversight of treatment care for all state agencies and branches of government. The Division also worked with the State Mental Health Authority to develop a plan for co-existing disorders services.

The Division continued to have at a representative on the statewide advisory board for the Safe and Drug Free Schools Program of the Department of Education, the advisory board for the Enforcement of Underage Drinking Laws program of the Department of Juvenile Corrections which facilitated the coordination of substance abuse prevention efforts. Division representatives participated on the planning committees for the annual Idaho Prevention Conference and the annual Idaho Conference on Alcohol and Drug Dependency. The Division issued contracts in FY 2009 in which prevention activities and treatment services continued collaborative services for individuals who are dually diagnosed, provided support to communities wishing to develop anti-alcohol/drug coalitions and continued to maintain an online substance use disorder needs assessment data collection system to aid agencies and communities in planning, grant-seeking and development of comprehensive, collaborative community plans.

The Division continued to participate in quarterly meetings with the Northwest Portland Area Indian Health Board which includes all the tribes with reservations in Idaho to update them on substance use disorder prevention activities and treatment services.

The Division continued the collaborative effort with Department of Health and Welfare's Child Welfare Services Program for on-site substance use disorder screening and case management services in all seven regions. The program joined resources of the usual and customary substance use disorder treatment services with TANF funding from the Child Protection Program to fund services not usually purchased and to assist in engaging clients and retaining them in treatment services. The Division continued to work with Department of Health and Welfare's Self Reliance Program on the implementation of the Temporary Assistance for Families in Idaho (TAFI) applicant substance abuse screening and treatment program. The

Division continued to participate on the Idaho Care and Prevention Council (ICPC) dealing with HIV/AIDS and give updates on prevention activities and treatment services.

The Division also was represented on the Juvenile Justice Children's Mental Health workgroup and maintained a seat on the State Drug Court and Mental Health Court Coordinating Committee to coordinate substance use disorder treatment of drug court and mental health court participants with the other aspects of the Drug Court and Mental Health Court Program. This also assisted in coordinating the drug court and mental health court system with the overall substance use disorder treatment system.

3. Goal #12 was discussed using data from 2010 by mistake. For this BG report purposes, the compliance year to be reported is FY 2009. Please correct and revise accordingly considering FY 2009 as the compliance reporting period.

Idaho Response:

As in past years, The Bureau of Substance Use Disorders supported Regional Advisory Committees for Substance Abuse in 2009. This enabled the Department to meet the intent of Idaho Code to provide for the coordination and exchange of information on all programs relating to the prevention and treatment of alcoholism and drug addiction. Per Idaho Title 39 Health and Safety, Chapter 3 Alcoholism and Intoxication Treatment Act, the membership of these committees included representatives from a broad range of community disciplines. Examples of members were school district staff, treatment and prevention professionals, college and university representatives, health care professionals, adult and juvenile probation staff, community action agency staff, cultural representatives, faith-based group representatives, community coalition members, youth development professionals, general public, fraternal organization representatives, mental health professionals, county and city representatives, legislators and law enforcement.

Per the Alcoholism and Intoxication Treatment Act, the Regional Advisory Committees for Substance Abuse chairs acted as liaison among the local organizations and agencies engaged in activities serving the general public, individuals with risk factors and individuals at risk and individuals abusing alcohol and drugs. In addition, these individuals provided local input to the state level Interagency Committee on Substance Abuse Prevention and Treatment. The Department initiated a collaborative effort with the Child Welfare Services Program for substance use disorder screening and case management services to be made available to clients at the Child Welfare program location. This initiative was implemented in all seven sub-state planning areas. The partnership brought together substance abuse treatment resources and TANF funding from the Child Protection Program to fund services not usually purchased and to assist in engaging clients and retaining them in treatment services.

In 2009, the Substance Use Disorders Program continued to have representatives on the statewide advisory board for the Safe and Drug Free Schools Program of the Department of Education, the advisory board for the Enforcement of Underage Drinking Laws program of the Department of Juvenile Corrections and the Juvenile Justice and Children's Mental Health workgroup. Substance Use Disorders prevention and treatment staff also represented the Department on the planning committees for the 2009 Idaho Prevention Conference and Idaho Conference on Alcohol and Drug Dependency. The Substance Use Disorders Program also worked with the Self Reliance Program on the implementation of the Temporary Assistance for Families in Idaho (TAFI) applicant substance abuse screening and treatment program. Program staff participated on the Idaho Care and Prevention Council dealing with HIV/AIDS and gave updates on prevention activities and treatment services. The Department also maintained a seat on the State Drug Court and Mental Health Court Coordinating Committee to coordinate substance use disorder treatment of drug court and mental health court participants with the other aspects of the Drug Court and Mental Health Court Program. This assisted in coordinating

the drug court and mental health court system with the overall substance use disorder treatment system.

Continuing with established processes, the Department participated in quarterly meetings with the Northwest Portland Area Indian Health Board including the tribes with reservations in Idaho to update them on the full range of services delivered or funded by the Department. In addition, prevention and treatment staff worked informally with tribal members to ensure services were available.

The prevention contractor provided support to communities who sought to develop anti-alcohol/drug coalitions. In 2009, the SEOW workgroup created a plan to develop an online Prevention and Treatment Research website to provide risk-factor data for community groups to use in creating coalitions and developing community plans. Members of the workgroup partnered with community groups, agencies and organizations to expand efforts to support the delivery of prevention services to youth and adults

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

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

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

FY2009 (Annual Report/Compliance):

4. Goal #13 was discussed using data from 2010 by mistake. For this BG report purposes, the compliance year to be reported is FY 2009. Please correct and revise accordingly considering FY 2009 as the compliance reporting period.

Idaho Response:

#### Prevention

In FY 2009, the Prevention Technical Assistance and Support Contractor developed a statewide needs assessment as well as 7 regional needs assessments which included county level data. The needs assessments were based on risk and protective factors identified by Hawkins and Catalano. All community-based prevention services were funded based on the findings of the regional needs assessment. The 2009 needs assessments for each sub-state planning area are still available on the internet at [www.preventionidaho.net](http://www.preventionidaho.net). Sources for data in the needs assessments were the CDC Youth Risk Behavior Survey, Idaho School Climate Survey, Vital Statistics, Crime in Idaho and Child Protection. Additional data come from the Idaho Departments of Transportation, Education, and Labor, and the Idaho State Police, Liquor Control Unit. The National Survey on Drug Use and Health (NSDUH) provided a reference point for the number of persons dependent on either alcohol or drugs and in need of treatment.

For 2009 as in previous years, all funded prevention providers and coalitions delivered services or activities that met priorities identified within the needs assessment. Community-based providers were funded to deliver evidence-based education and alternative activities programming and coalitions received funding to undertake community-based processed and environmental strategies.

State Epidemiological Outcomes Workgroup grant, the Idaho Prevention and Treatment Research workgroup initiated the development of an online surveillance system in 2009. As with the prevention needs assessment, the data elements will be based on the risk factors identified by Hawkins and Catalano. The goal for this system is to collect data at the county level to provide community coalitions with the resources that they need to create needs-based community plans. The plan is for this system will provide Idaho residents with information about current rates as the ability to review past years' data to evaluate trends. The goal is to have the website up within 18 months.

#### Treatment

The Department's needs assessment process involved gathering and reporting data from several sources. The Department used Idaho-specific data from the National Survey on Drug Use and Health and annual updates to the survey to evaluate incidence and prevalence of substance use and abuse in Idaho. The survey was also used to document estimates of need and populations needing substance use disorders services. Substance use disorder treatment data were collected by the Department's treatment Master Services Contractor and uploaded to the Department. Through the efforts of the Master Services Contractor, and the Department, the substance use disorder treatment data was used to create a number of

standard reports that were utilized for State planning and assessment. These standard reports included: State Utilization Management and Grant Data; Level of Care Capacity and Census Management; Budget Tracker; Treatment Completion Data; Length of Stay Report; County/Regional Utilization Report; Pregnant Women and Women with Dependent Children Chart Audit Results and Client, Provider & Stakeholder Satisfaction. Additionally, each of the seven regions in Idaho had a Regional Advisory Committee that provided an annual report and updated information to help determine regional and local needs, emerging trends, gaps in service and the need for programs and services in regions throughout the State.

In FY 2009, per Idaho Statute, assessment of treatment needs was the responsibility of the Interagency Committee on Substance Abuse. The Interagency Counsel members included the directors of all state agencies providing any type of service that related to the prevention or treatment of use or abuse of alcohol and other drugs. ICSA met at least quarterly to review and evaluate data collected and information gathered on regional treatment needs and makes decisions regarding current need and future treatment based on trends and/or unmet needs that were identified. ICSA members received training on using data to prioritize populations prior to establishing treatment priorities for the year. The individuals trained were state agency directors, community representatives, judges, legislators and state agency, SSA and Office of Drug Policy staff. Only those staff involved in establishing state priorities received training.

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

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

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

FY2009 (Annual Report/Compliance):

## Idaho / SAPT FY2012 / Goal \_14: Hypodermic Needle Program

## 2009 Data

It is important to explain the climate, values and acceptable behaviors of Idaho in order fully respond to this request. Idaho is a very large, very conservative state. Over 95% of Idaho's communities have populations of fewer than 25,000 residents. Its northern border is shared with Canada. It is not a forgiving climate for the homeless. As established in previous applications, there are no "drug" districts, even in Boise, Idaho's largest community. Users are distributed throughout the population and not easily identified. The most recent Behavior Risk Surveillance survey, Idaho participants were asked if they had used intravenous drugs, been treated for a sexually transmitted or venereal disease, received money or drugs in exchange for sex, or had anal sex without a condom within the past year. Of those surveyed 2.9% of the participants responded yes to this survey question. Only 2.9% of the Idaho residents surveyed indicated they had used IV drugs or been treated for an STD or were paid for sex or had unprotected anal sex in the past year. The actual percentage of Idaho's population who are IDUs is only a portion of that percentage. This is the only data Idaho has related to this behavior. State rates for IV drug use were not found in the NSDUH data.

In 2009, all treatment-related SAPT block grant requirements were imbedded into the treatment Master Services Contract. The Division of Behavioral Health, Substance Use Disorders staff conducted contract monitoring at the Master Services Contractor's (MSC) site to evaluate compliance with all required elements monthly. These visits included a review all the requirements of the contract including those related to the SAPT block grant. As a part of the contract, the MSC was required to conduct site audits on all community-based substance abuse treatment programs in their network which were funded under the agreement. The purpose of these audits was to evaluate compliance with all applicable provisions of the contract. During this period, provider audits were conducted on all providers at least 1 time per year. Providers who failed to meet audit requirements received additional visits until they met the requirements or were terminated from the network. No providers were found to be conducting needle exchange programs.'

In 2009, The Department passed down the federal prohibition of the use of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to provide hypodermic needles or syringes to individuals for injecting illegal drugs to the MSC. The MSC, in turn, was responsible for ensuring that their contractors did not use SAPT Block Grant funds to provide hypodermic needles or syringes to individuals.

In addition, Department substance abuse treatment subcontractors were paid on a fee for service basis. Allowable services to be charged against the MSC contract were clearly specified. Costs associated with needle purchase or distributions were not reimbursable activities under the treatment contracts.

Finally, in 2009 there was no billing code established within the Division's MSC contract for needle exchange services. All invoices paid by the MSC were reviewed processing for payment to ensure the cost is an allowable expense under the terms of the contract. Likewise, all MSC invoices were reviewed by Division staff prior to payment to ensure they are allowable expenditures under the terms of the contract.

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There was no means within Idaho's established system for a provider to qualify to deliver state funded services or to receive Block Grant funds to support needle exchange programs.

The Department monitored this goal through on-site visits to network providers during the facility approval process at least once every two years. In addition, MSC Field representatives monitored this goal as they visit and conduct on-site audits of providers. The Department and the MSC were ready to take appropriate actions in instances of noncompliance were identified; however, noncompliance with Goal 14 did not occur in 2009.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

In 2009, the Department of Health and Welfare's Division of Behavioral Health continued the practice of conducting independent peer reviews on 5% of all Division approved substance use disorder treatment entities that received SAPT Block Grant funds. In 2009, there were 64 providers statewide. Five percent of resulted in a provider population to be reviewed of three programs to comply with the requirement. In order to maximize the utility of the Peer Reviews, it has been the Division's policy to review groups of providers delivering the same level of care to the same population. For example in 2008, adolescent outpatient providers were reviewed.

The target group of programs to be reviewed in 2009, was adult residential providers. The Division had six adult residential providers in the MSC's network. Due to a change in Division staff to include a retirement and two layoffs owing to budget constraints, only 3 of the reviews were completed in 2009. This enabled Idaho to meet the 5% requirement. All Peer Reviews were supportive in nature, seeking to enhance the quality of client care through identifying strengths and providing opportunities for growth. This goal was discussed with program administrators and peer reviewers prior to the initiation of the reviews.

Division staff coordinated the selection of programs and reviewers and facilitated the review events. At least two qualified substance use disorders professionals served as peer reviewers at each site. They were professional staff from substance use disorder treatment providers who had also delivered services funded by the Block Grant. A Division staff member provided the standardized forms used to ensure the information gathered at the review was consistent with the federal guidelines. Division staff also facilitated the entry and exit interviews but did not participate in any of the file review sessions or focus groups.

The Peer Review visit began with an entrance interview and introductions. The Department staff member set the tone for this to be an enjoyable, informative exchange. This was also the time to state the intent for the peer review process and reiterate that this was not a compliance visit or audit. During the interview the goals for the day and any scheduling issues were discussed. The entrance conference was followed by a tour of the facility. At the conclusion of the tour, the Peer Reviewers began with a file review to comply with the requirements within the Block Grant. They were provided with standardized forms for client record reviews and questions for interviews. The client focus group was conducted without Department or staff of the reviewed program present, as was the staff focus group.

Upon completion, the team convened to plan their report for the exit conference. The managers of programs being reviewed were encouraged to have as many staff as possible be present throughout the day of the visit and participate in the entry and exit interviews. This was an opportune time to foster collaboration and participate in a professional exchange between the parties.

## Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

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

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

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

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

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

## 2009 Data

The Idaho Peer Review is supportive in nature, seeking to develop the programs and to enhance the quality of client care through acknowledging strengths and providing opportunities for growth. The Department annually conducts independent peer reviews on five percent (5%) of all approved SAPT block grant funded entities. The process and all forms used were created through a partnership with providers when the peer review was initiated. The day begins with an Entry Interview facilitated by Department staff. This includes review of the agenda, a clear statement that this is not a contract monitoring or site audit, introductions of all present and concludes with a facility tour. Then the peer reviewers conduct a file review which covers the requirements established in the Block Grant. After the file review, the peer reviewers hold a focus group with the counselors and one with current clients. No supervisors or administrative staff participate in the counselor group and no agency staff participate in the client focus group. At the end of the day, the peer review team meets briefly to put together their report for the exit interview. The exit interview closes the day. The peer reviewers give their verbal report, agency staff are encouraged to ask questions and the reviewers tell them what they do in their agencies. The Department is responsible for organization of the peer reviews, forms for the file review, counselor and client focus groups, reviewer travel and housing, breaks and lunch at the peer review site and facilitating the entry and exit interviews.

The Department annually facilitates the conduct of independent peer reviews on five percent (5%) of all approved SAPT block grant funded entities. In the early spring, the Department sends out a request for treatment agencies to volunteer to participate in the peer review. Once the treatment agencies have been identified, then treatment professionals other substate areas are selected. This is done to ensure there is no conflict of interest due to competition for clients. The Department works with the agencies to set dates that have the least impact on the delivery of their services. The Department holds a conference call with the agencies to discuss the process, the agency's responsibilities and the scope of the review. The agency is responsible provide access to files for review and make staff available to respond to reviewers questions, have treatment professionals available to participate in the counselor focus group and have clients available to participate in their focus group. The Department works with the peer reviewers to arrange for transportation and housing. A second teleconference is held with the reviewers to review the process so they understand their responsibilities and limitations. The peer reviewers are responsible to review files, facilitate the client and counselor focus groups and present their findings at the end of the day.

Division staff coordinated the selection of programs and reviewers and facilitated the review events. At least two qualified substance use disorders professionals served as peer reviewers at each site. They were professional staff from substance use disorder treatment providers who had also delivered services funded by the Block Grant. A Division staff member provided the standardized forms used to ensure the information gathered at the review was consistent with the federal guidelines. Division staff also facilitated the entry and exit interviews but did not participate in any of the file review sessions or focus groups.

The Peer Review visit began with an entrance interview and introductions. The Department staff member set the tone for this to be an enjoyable, informative exchange. This was also the time to state the intent for the peer review process and reiterate that this was not a compliance visit or audit. During the interview the goals for the day and any scheduling issues were discussed. The entrance conference was followed by a tour of the facility. At the conclusion of the tour, the Peer Reviewers began with a file review to comply with the requirements within the Block Grant. They were provided with standardized forms for client record reviews and questions for interviews. The client focus group was conducted without Department or staff of the reviewed program present, as was the staff focus group.

Upon completion, the team convened to plan their report for the exit conference. The managers of programs being reviewed were encouraged to have as many staff as possible be present throughout the day of the visit and participate in the entry and exit interviews. This was an opportune time to foster collaboration and participate in a professional exchange between the parties.

Both the agencies and the peer reviewers found the process very useful and educating. They stated that the exchange of information was very useful and that both reviewers and the agencies reviewed planned to make changes to their agencies. Several of the reviewers asked if their agency could be reviewed.

Technical assistance was available to both the reviewed agency and to the peer reviewers. This assistance was most often about facilitating the exchange of information among the individuals involved in the review. As a part of the file assessment, peer reviewers would find forms or materials that would be useful to them in delivering their services and offered suggestions and resources to staff of the agency being reviewed. When agencies or peer reviewers requested technical assistance from the Division, resources were provided in a number of ways. In some cases it was setting up post-review conference calls, in others it was providing professional manuals and materials and at other times, onsite assistance was made available in the form of training or conferences. If a technical assistance request was made that had state-wide implications, newsletters, Webinars or trainings were offered to the entire provider network.

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

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

In 2009, the Division of Behavioral Health continued to maintain the activities as in previous years. At the MSC and provider level, compliance with this requirement is checked during contract monitoring visits and facility approval site reviews. At the state level, the Division continued to maintain a firewall around the state's automated Client Information System and keep historical data, which might identify clients, in a locked storage cabinet.

The Division held a Confidentiality and Ethics training in FY 2009 as part of the annual Idaho Conference on Alcohol / Drug Dependency (ICADD) to meet the needs of the MSC and treatment providers. In addition courses in Ethics, Confidentiality and HIPAA continued to be included as standing courses offered through the IDEAS! program at five of our colleges and universities.

Idaho continued to take client confidentiality and security of treatment records very seriously. The Department promulgated rules detailing substance use disorders treatment facility approval requirements were foundation of the Idaho's efforts to ensure that client records were securely maintained and not inappropriately disclosed. These rules have the force of law in Idaho. The rules required facilities to have policies and procedures governing the compilation, storage, dissemination and accessibility of client records prior to receiving a certificate of approval. These policies and procedures had to be written and implemented prior to a facility review. The frequency of facility certification site reviews were based on the facility's initial site review and subsequent compliance efforts. A facility with low compliance to facility approval rules was not approved or if the noncompliance issues were non-life threatening or records security/ confidentiality-based may be approved for only 6 months and had to meet certain conditions before the 6-month period is completed. Facilities rated higher could be approved for up to 2 years. All facilities that have been approved were still subject to regular provider audits if they were part of the MSC provider network. A copy of the client records section of the rules is pasted below.

"16.07.20 - Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs, 375.CLIENT RECORDS REQUIREMENTS.

02. Compilation, Storage, Dissemination, and Accessibility of Client Records. The program must have written policies and procedures governing the compilation, storage, dissemination, and accessibility of client records. The policies and procedures must be designed to ensure: (5-1-10) a. The program fulfills its responsibility to safeguard and protect client records against loss, unauthorized alteration or disclosure of information; (5-1-10) b. In the event of unauthorized release client identifying information such as theft, the Department is notified immediately; (5-1-10) c. In the event of closure of program how and where records will be stored; (5-1-10) d. Each client record contains all required information; (5-1-10) e. Uniformity in the format and forms is used in client records; (5-1-10)

04. Storage Facilities. The program must provide facilities for the storage, processing and handling of client records, including locked and secured rooms and files. (5-1-10)

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05. Electronic Storage of Client Data. When a program stores client data in electronic or other types of automated information systems, they must have security measures to prevent inadvertent or unauthorized access to such data. (5-1-10)

07. Disposal of Client Records. The program must have a written policy governing the disposal of client records. Methods of disposal must be designed to assure the confidentiality of client information. (5-1-10)

08. Confidentiality and Disclosure of Information. The program must have written policies and procedures that protect the confidentiality of client records and govern the disclosure of information in the records under Section 006 of these rules. (5-1-10)”

Of special concern to the Department was the inappropriate disclosure of client treatment records. Legally in Idaho, this data can only be disclosed if there was a current release of information identifying to whom the data may be released, the specific data that may be shared and when the release is terminated. If the agency failed to meet any of these requirements, facility approval was withheld until such time as they met all requirements.

In addition to the facility review and approval process which was done at least once every 2 years, compliance with client confidentiality requirements was also checked during Treatment Master Services Contractor service audits. As with facility approval site visits, the frequency of a provider’s audits was based on the initial audit. If the provider met the established service standards, one site visit was conducted annually. If the provider failed to meet the standards, they were required to complete a corrective action plan and were subject to quarterly site visits. The audit questions are pasted below.

1. Does the client record include a completed Confidentiality Agreement with 42 CFR 2?
2. Does the client record include a completed DHW release of information form, no blank lines and is signed? (If the client is an adolescent, under 16, a parent or guardian has to sign the release).
3. Does the client record include completed Release of Information forms? (Not to include DHW release as listed above in indicator #4).

**Goal #17: Charitable Choice**

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

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

FY2009 (Annual Report/Compliance):

## 2009 Data

In 2009, the Department of Health and Welfare's Division of Behavioral Health provided charitable choice information to potential faith-based providers who expressed an interest in providing substance abuse services during 2009. A formal letter describing the charitable choice provisions and regulations was sent to any faith-based organization that contacted the Division regarding interest in providing services governed by the Division including substance abuse prevention or treatment. All faith-based organization had to be approved treatment or recovery support facilities in order to qualify to be in the MSC's provider network.

The Division mandates through contract language that the MSC orient their providers about Charitable Choice requirements to include a thorough explanation of the Charitable Choice rule, to include why charitable choice partners are important, how charitable choice protects participants and recipients, what charitable choice is and is not, and charitable choice in a nutshell. The Division monitored the MSC through receiving information at least yearly on meetings held by the MSC for the purpose of orienting providers on Charitable Choice provisions.

The Division worked with the MSC to oversee that any network services delivered by an agency related to a faith-based group gave notice to all potential beneficiaries of the relationship. The MSC was required to notify individuals that they were being referred to a faith-based organization for services, offer them an alternative if the requested one and maintain a record of referrals made to religious organizations that offered treatment or recovery services. The Division monitored compliance with the MSC as referrals were made. Compliance with the Charitable Choice requirements was part of the ongoing Division and MSC compliance review process.

During 2009 one treatment service provider, Change Point – Turnaround, located in Region 2 was contracted with the MSC met the criteria for Charitable Choice.

During FY 2009 3 prevention programs contracted with the PTASC defined themselves as faith-based and met at least one of the following criteria:

1. The service is located on the property of a religious organization;
2. The fiscal agent is a religious organization or the business name reflects a recognized religious group or affiliation with such a group; and,
3. The overarching purpose of the organization is based in the adherence to, education of or sharing of a specific faith/religion.

The faith-based programs were required to meet Substance Abuse Prevention Standards and to have Qualified Prevention Professionals deliver the courses. These programs were located in Regions 1, 3 and 4, and served 215 recurring participants in 2009. The programs provided evidence-based education curriculums to children and youth in school districts and to parents. The faith-based agencies were ICARE

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of St. Vincent de Paul, Goodwill Industries, Sandpoint Seventh Day Adventist Church, Lutheran Community Services North West and Catholic Charities of Idaho.

## Charitable Choice (formerly Attachment I)

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

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

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

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

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

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

- State has developed specific referral system for this requirement
- State has incorporated this requirement into existing referral system(s)
- SAMHSA's Treatment Facility Locator is used to help identify providers
- Other networks and information systems are used to help identify providers
- State maintains record of referrals made by religious organizations that are providers
- 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.

In 2009, the Division and the MSC jointly hosted one meeting for the purpose of orienting providers on Charitable Choice provisions.

## Waivers (formerly Attachment J)

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

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

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

## Waivers

### Waivers

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

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

Form 8 (formerly Form 4)

**SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT**

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

Activity	Source of Funds					
	A.SAPT Block Grant FY 2009 Award (Spent)	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 4,869,038	\$ 642,400	\$ 299,000	\$ 13,365,200		\$ 3,256,262
Primary Prevention	\$ 1,671,100		\$	\$ 222,800	\$	\$ 31,100
Tuberculosis Services	\$	\$	\$	\$	\$	\$
HIV Early Intervention Services	\$	\$	\$	\$	\$	\$
Administration: Excluding Program/Provider	\$ 343,500		\$ 316,700	\$ 1,075,000	\$	\$
<b>Column Total</b>	<b>\$6,883,638</b>	<b>\$642,400</b>	<b>\$615,700</b>	<b>\$14,663,000</b>	<b>\$0</b>	<b>\$3,287,362</b>

\*Prevention other than Primary Prevention



**Form 8ab (formerly Form 4ab)**

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

<b>Activity</b>	<b>SAPT Block Grant FY 2009</b>	<b>Other Federal</b>	<b>State Funds</b>	<b>Local Funds</b>	<b>Other</b>
Information Dissemination	\$ 478,162	\$	\$ 145,000	\$	\$
Education	\$ 578,205	\$	\$	\$	\$
Alternatives	\$ 116,744	\$	\$	\$	\$
Problem Identification & Referral	\$ 130,194	\$	\$	\$	\$
Community Based Process	\$ 67,414	\$	\$	\$	\$
Environmental	\$ 23,917	\$	\$	\$	\$
Other	\$ 276,464	\$ 0	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$ 77,800	\$	\$ 31,100
<b>Column Total</b>	<b>\$1,671,100</b>	<b>\$0</b>	<b>\$222,800</b>	<b>\$0</b>	<b>\$31,100</b>

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

<b>Activity</b>	<b>SAPT Block Grant FY 2009</b>	<b>Other Federal</b>	<b>State Funds</b>	<b>Local Funds</b>	<b>Other</b>
Universal Direct	\$	\$	\$	\$	\$
Universal Indirect	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
<b>Column Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Form 8c (formerly Form 4c)**

**Resource Development Expenditure Checklist**

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

Yes  No

<b>Expenditures on Resource Development Activities are:</b>				
<input checked="" type="radio"/> Actual <input type="radio"/> Estimated				
<b>Activity</b>	<b>Column 1 Treatment</b>	<b>Column 2 Prevention</b>	<b>Column 3 Additional Combined</b>	<b>Total</b>
Planning, Coordination and Needs Assessment	\$	\$ 35,786	\$	\$ 35,786
Quality Assurance	\$	\$ 37,638	\$	\$ 37,638
Training (post-employment)	\$ 121,653	\$ 66,592	\$	\$ 188,245
Education (pre-employment)	\$ 157,500	\$ 41,407	\$	\$ 198,907
Program Development	\$	\$ 33,993	\$	\$ 33,993
Research and Evaluation	\$	\$ 34,684	\$	\$ 34,684
Information Systems	\$	\$ 26,364	\$	\$ 26,364
<b>Column Total</b>	<b>\$279,153</b>	<b>\$276,464</b>	<b>\$0</b>	<b>\$555,617</b>

Form 9 (formerly Form 6)

**SUBSTANCE ABUSE ENTITY INVENTORY**

				FISCAL YEAR 2009			
1. Entity Number	2. I-SATS ID <small>[X] if no I-SATS ID</small>	3. Area Served	4. State Funds <small>(Spent during State expenditure period)</small>	5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV <small>(if applicable)</small>
4748	ID100716	Statewide (optional)	\$18,388	\$4,597			
DC0127	ID100779	Statewide (optional)	\$8,500				
IDPV-1-1	X	Region 1		\$18,710			
IDPV-1-10	X	Region 1				\$31,446	
IDPV-1-2	X	Region 1				\$35,300	
IDPV-1-3	X	Region 1				\$4,493	
IDPV-1-4	X	Region 1				\$25,447	
IDPV-1-5	X	Region 1				\$5,098	
IDPV-1-6	X	Region 1				\$41,250	
IDPV-1-7	X	Region 1				\$15,512	
IDPV-1-8	X	Region 1		\$3,305			
IDPV-1-9	X	Region 1				\$19,561	
IDPV-2-1	X	Region 2				\$19,926	
IDPV-2-2		Region 2		\$23,600			

IDPV-2-2	X	Region 2		\$23,000			
IDPV-2-3	X	Region 2				\$26,965	
IDPV-2-4	X	Region 2		\$4,990			
IDPV-2-5	X	Region 2				\$17,014	
IDPV-2-6	X	Region 2				\$8,208	
IDPV-3-1	X	Region 3				\$26,899	
IDPV-3-2	X	Region 3				\$5,000	
IDPV-3-3	X	Region 3				\$33,439	
IDPV-3-4	X	Region 3				\$74,771	
IDPV-3-5	X	Region 3				\$2,781	
IDPV-3-6	X	Region 3				\$74,096	
IDPV-3-7	X	Region 3				\$6,760	
IDPV-4-1	X	Region 4				\$15,044	
IDPV-4-10	X	Region 4				\$45,336	
IDPV-4-11	X	Region 4				\$11,112	
IDPV-4-12	X	Region 4				\$13,856	
IDPV-4-13	X	Region 4				\$31,865	
IDPV-4-14	X	Region 4				\$23,052	
IDPV-4-2	X	Region 4		\$6,498			
IDPV-4-3	X	Region 4		\$4,594			
IDPV-4-4	X	Region 4				\$18,999	
IDPV-4-5	X	Region 4				\$1,576	
IDPV-4-6	X	Region 4				\$21,864	
IDPV-4-7	X	Region 4				\$25,176	

IDPV-4-7	X	Region 4				\$23,170	
IDPV-4-8	X	Region 4				\$9,339	
IDPV-4-9	X	Region 4				\$22,310	
IDPV-5-1	X	Region 5				\$27,507	
IDPV-5-2	X	Region 5				\$7,194	
IDPV-5-3	X	Region 5				\$31,473	
IDPV-5-4	X	Region 5		\$5,908			
IDPV-5-5	X	Region 5				\$27,292	
IDPV-5-6	X	Region 5				\$14,036	
IDPV-5-7	X	Region 5				\$68,765	
IDPV-6-1	X	Region 6				\$17,156	
IDPV-6-2	X	Region 6				\$104,926	
IDPV-6-3	X	Region 6				\$9,929	
IDPV-6-4	X	Region 6		\$16,002			
IDPV-6-5	X	Region 6				\$11,234	
IDPV-6-6	X	Region 6				\$19,536	
IDPV-7-1	X	Region 7				\$5,000	
IDPV-7-2	X	Region 7				\$15,099	
IDPV-7-3	X	Region 7				\$35,314	
IDPV-7-4	X	Region 7				\$62,604	
IDPV-7-5	X	Region 7				\$15,999	
IDPV-7-6	X	Region 7				\$17,915	
IDPV-7-7	X	Region 7				\$5,958	
IDPV-7-8		Region 7				\$12,864	

IDF V-1-8	X	Region /				\$42,004	
IT0006	ID100364	Statewide (optional)	\$357,834	\$89,458			
IT0007	ID100141	Statewide (optional)	\$371,755	\$92,939			
IT0024	ID100081	Statewide (optional)	\$232,055	\$58,014			
IT0026	ID100620	Statewide (optional)	\$245,757	\$61,439			
IT0034	ID100353	Statewide (optional)	\$67,443	\$16,861			
IT0036	ID101446	Statewide (optional)	\$189,821	\$47,455			
IT0036	ID100087	Statewide (optional)	\$5,115	\$1,279			
IT0041	ID100891	Statewide (optional)	\$6,943	\$1,736			
IT0042	ID100448	Statewide (optional)		\$182,054	\$182,054		
IT0043	ID000021	Statewide (optional)	\$52,457	\$13,114			
IT0047	ID101560	Statewide (optional)	\$423,542	\$105,886			
IT0048	ID900508	Statewide (optional)	\$320,004	\$80,001			
IT0051	ID101453	Statewide (optional)	\$90,861	\$22,715			
IT0052	ID100107	Statewide (optional)	\$44,362	\$11,090			
IT0053	WA904620	Statewide (optional)	\$362,347	\$90,587			
IT0055	ID100293	Statewide (optional)	\$669,900	\$16,748			
IT0056	ID100310	Statewide (optional)	\$289,203	\$72,301			
IT0062	ID100084	Statewide (optional)		\$226,526	\$226,526		
IT0065	ID100102	Statewide (optional)	\$44,322	\$11,080			
IT0067	ID101526	Statewide (optional)	\$31,256	\$7,814			
IT0069	ID101943	Statewide (optional)	\$90,604	\$22,651			
IT0071	ID100295	Statewide (optional)	\$192,092	\$48,023			
		Statewide		\$287,700	\$287,700		

IT0470	ID101420	Statewide (optional)		\$201,100	\$201,100		
IT0471	ID000067	Statewide (optional)	\$78,578	\$19,645			
IT0472	ID101164	Statewide (optional)	\$94,689	\$23,672			
IT0474	ID101271	Statewide (optional)	\$31,005	\$7,751			
IT0475	ID100539	Statewide (optional)	\$21,862	\$5,465			
IT0476	ID000067	Statewide (optional)	\$258,862	\$64,715			
IT0578	ID100330	Statewide (optional)	\$9,197	\$2,299			
IT0705	ID100985	Statewide (optional)	\$13,932	\$3,483			
IT0746	ID100794	Statewide (optional)	\$6,516	\$1,629			
IT0747	ID100985	Region 7	\$2,754	\$689			
IT0760	ID100793	Statewide (optional)	\$15,996	\$3,999			
IT0881	ID100603	Statewide (optional)	\$41,732	\$10,433			
IT0961	ID100611	Statewide (optional)	\$37,044	\$9,261			
IT1891	ID100818	Statewide (optional)	\$12,078	\$3,020			
IT1911	ID100370	Statewide (optional)	\$469,520	\$117,380			
IT2105	ID100265	Statewide (optional)	\$7,450	\$1,862			
IT2119	ID100592	Statewide (optional)	\$187	\$47			
IT2120	ID100594	Statewide (optional)	\$67,820	\$16,955			
IT2143	ID100797	Statewide (optional)	\$27,798	\$6,950			
IT2144	ID100898	Statewide (optional)	\$28,148	\$7,037			
IT2151	ID100376	Statewide (optional)	\$29,958	\$7,489			
IT2158	ID100375	Statewide (optional)	\$2,265	\$566			
IT2202	X	Statewide (optional)	\$30,755	\$7,689			
IT2225	ID900367	Statewide (optional)	\$109,824	\$27,456			

IT2281	ID100572	Statewide (optional)	\$30,140	\$7,603		
IT2411	ID100791	Statewide (optional)	\$143,221	\$35,805		
IT2431	ID100699	Statewide (optional)	\$1,438	\$359		
IT2442	ID100798	Statewide (optional)	\$10,526	\$2,632		
IT2465	ID100703	Statewide (optional)	\$195,536	\$48,884		
IT2559	ID100772	Statewide (optional)	\$237,870	\$59,468		
IT2735	ID100568	Statewide (optional)	\$678,423	\$1,696		
IT2752	ID100351	Statewide (optional)	\$123,205	\$30,801		
IT2753	ID100577	Statewide (optional)		\$55,284	\$55,284	
IT2756	ID100463	Statewide (optional)	\$41,454	\$10,364		
IT2813	ID100355	Statewide (optional)	\$40,629	\$10,157		
IT2830	ID100777	Statewide (optional)	\$6,069	\$1,517		
IT2888	ID100914	Statewide (optional)	\$9,837	\$2,459		
IT3132	ID100893	Statewide (optional)	\$106,805	\$26,701		
IT3151	ID100538	Statewide (optional)	\$2,099	\$525		
IT3189	ID100555	Statewide (optional)	\$49,259	\$12,315		
IT3191	ID100553	Statewide (optional)	\$4,069	\$1,017		
IT3194	ID100773	Statewide (optional)	\$32,430	\$8,107		
IT3195	ID100575	Statewide (optional)	\$30,180	\$7,545		
IT3208	ID100251	Statewide (optional)				
IT3224	ID100940	Statewide (optional)	\$1,744	\$436		
IT3574	ID100887	Statewide (optional)	\$43,543	\$10,886		
IT3575	ID100776	Statewide (optional)	\$331,822	\$82,955		

IT3576	ID100584	Statewide (optional)	\$202,201	\$50,550		
IT3577	ID100776	Statewide (optional)	\$4,439	\$1,110		
IT3620	ID100452	Statewide (optional)	\$57,489	\$14,382		
IT3634	ID100888	Statewide (optional)	\$40,195	\$100,419		
IT3634	ID100888	Region 4	\$40,195	\$10,419		
IT3650	ID100542	Statewide (optional)	\$155,795	\$38,949		
IT3701	ID100101	Statewide (optional)	\$14,475	\$3,619		
IT3786	ID100590	Statewide (optional)	\$12,077	\$3,019		
IT3788	ID100608	Statewide (optional)	\$26,314	\$6,578		
IT3834	ID100576	Statewide (optional)	\$41,330	\$10,333		
IT3888	ID100700	Statewide (optional)	\$2,019	\$505		
IT3926	ID100531	Statewide (optional)	\$111,721	\$27,930		
IT3961	ID100772	Statewide (optional)	\$237,870	\$59,468		
IT4010	ID100574	Statewide (optional)	\$67,843	\$16,961		
IT4033	ID100696	Statewide (optional)	\$1,009	\$252		
IT4045	ID100961	Statewide (optional)	\$951	\$238		
IT4064	ID100631	Statewide (optional)	\$123,137	\$30,784		
IT4065	ID100582	Statewide (optional)	\$5,572	\$1,393		
IT4110	ID100544	Statewide (optional)	\$33,304	\$8,326		
IT4186	ID100533	Statewide (optional)	\$5,932	\$1,483		
IT4203	ID100599	Statewide (optional)		\$39,402	\$39,402	
IT4204	ID100911	Statewide (optional)	\$83,289	\$20,822		
IT4210	ID100807	Statewide (optional)	\$2,475	\$619		
IT4224	ID100564	Statewide	\$106,258	\$26,564		

IT4254	ID100501	(optional)				
IT4267	ID100552	Statewide (optional)	\$6,099	\$1,525		
IT4268	ID100777	Statewide (optional)	\$6,069	\$1,517		
IT4280	ID100692	Statewide (optional)	\$47,994	\$11,998		
IT4286	ID100592	Statewide (optional)	\$9,605	\$2,401		
IT4287	ID100593	Statewide (optional)	\$1,367	\$342		
IT4301	ID100898	Statewide (optional)	\$28,148	\$7,037		
IT4391	OR101264	Statewide (optional)	\$73,158	\$18,290		
IT4392	ID100501	Statewide (optional)	\$16,641	\$4,160		
IT4395	ID100771	Statewide (optional)	\$927	\$232		
IT4398	ID100700	Statewide (optional)	\$1,963	\$491		
IT4496	ID100552	Statewide (optional)	\$106,692	\$26,673		
IT4497	ID100897	Statewide (optional)	\$31,931	\$7,983		
IT4504	ID100892	Statewide (optional)	\$66,279	\$16,570		
IT4628	ID100792	Statewide (optional)	\$6,069	\$1,517		
IT4760	ID101164	Statewide (optional)	\$112,136	\$28,034		
IT4824	ID100897	Statewide (optional)	\$5,054	\$1,263		
IT4825	OR101526	Statewide (optional)	\$14,528	\$3,632		
IT4826	ID100451	Statewide (optional)	\$7,064	\$1,766		
IT4999	ID100816	Statewide (optional)	\$66,384	\$16,596		
IT5012	ID100731	Statewide (optional)	\$15,999	\$4,000		
IT5060	ID101560	Statewide (optional)	\$95,437	\$23,859		
IT5075	ID100814	Statewide (optional)	\$2,207	\$552		
IT5122	ID100476	Statewide	\$66,082	\$16,521		

IT5122	ID100470	(optional)					
IT5123	ID100796	Statewide (optional)	\$1,685	\$421			
KC1638	ID100475	Statewide (optional)	\$240,200				
KC1749	ID100477	Statewide (optional)	\$4,204,162	\$1,774,850	\$84,930		
KC1802	ID100478	Statewide (optional)	\$5,900				
KC1814	ID100473	Statewide (optional)	\$222,800			\$417,804	
KC1951	ID100632	Statewide (optional)	\$1,300				
KC2098	ID100633	Statewide (optional)	\$43,500				
KC2099	ID100634	Region 6	\$43,800				
KC2100	ID100477	Statewide (optional)	\$55,700				
KC2101	ID100635	Region 2	\$41,500				
U of I	X	Statewide (optional)	\$5,900				
<b>Totals:</b>			<b>\$14,663,000</b>	<b>\$4,869,038</b>	<b>\$875,896</b>	<b>\$1,671,100</b>	<b>\$0</b>

The state's FY2009 award amount on form 8 is \$4,869,038, but your Block grant expenditures on Form 9 column 5 total only \$3,993,142. This equates to a difference of \$875,896. Please provide a written explanation for this large disparity by 2/28/12.

- Form 8 (formerly Form 4),
- Form 8ab (formerly Form 4ab)
- Form 8c (formerly Form 4c)
- Form 9 (formerly Form 6)

#### Idaho Response - 2009 Data

FY 2009 data, the difference between Forms 8 and 9 SAPT expenditure total is due to the difference in formatting in Form 9. On the forms SAPT-funded Pregnant women and women with dependent children providers are listed in different columns, while on Form 8 they are combined in one column. When you add the \$875,896 expended on services to pregnant women and women with dependent children total reported in column 5a on Form 9 to the SABG for SAPT total in column 5 on Form 9, the combined total is \$4,869,038. Which is consistent with the data reported on Form 8.

## PROVIDER ADDRESS TABLE

<b>Provider ID</b>	<b>Description</b>	<b>Provider Address</b>
2072	Network Interpreting Services	322 East Main St, #300 Burley, ID 83318 208-878-2642
2140	Supportive Housing and Innovative Partnerships	1405 W. Grove Boise, ID 83702 208-331-0900
2144	Hope's Door	720 N. 16th Ave Caldwell, ID 83605 208-459-6279
2216	Family Care Center	3130 South Yellowstone Highway Idaho Falls, ID 83401 208-522-1751
2222	Easter Seals-Goodwill	8260 W. Emerald, #100 Boise, ID 83704 208-672-2900
2230	United Drug Testing Lab	1010 North Orchard Street Boise, ID 83706 208-331-4097
2235	Vineyard Christian Fellowship	4950 N. Bradley Street Boise, ID 83714 208-377-1477
2261	Good Samaritan Rehabilitation	5590 S. Blue Creek Rd. Coeur d'Alene, ID 83814 208-667-4078
2353	Susan Call's Case Management Inc.	313 D. Street, Suite 203 Lewiston, ID 83501 208-305-9333
2819	Advanced Drug Detection, Inc.	208) 522-6012 Nampa, ID 83651 208-461-5151
2868	Chrysalis Women's Transitional	11248 Red Maple Drive Boise, ID 83709 208-424-1323
2894	Lighthouse for Recovery	1135 Yellowstone Avenue, Suite D Pocatello, ID 833201 208-237-3365
3177	Bannock Transportation	518 Filmore Pocatello, ID 83204 208-232-0536

3186	Family Services Alliance of SE Idaho	355 S. Arthur Avenue Pocatello, ID 83204 208-232-0742
3231	Boyd Group LLC.	2115 E. Lakeside Ave. Coeur d'Alene, ID 83814 208-667-5499
3494	Eastern Idaho Community Action Partnership	2480 S. Yellowstone Idaho Falls, ID 83402 208-523-6413
3939	Human Dynamics and Diagnostics	3760 Washington Parkway Idaho Falls, ID 83404 208-522-0140
3952	Personal Development	8100 West Emerald Street Boise, ID 83704 208-375-0752
3974	Nez Perce County Court Services	1113 F Street Lewiston, ID 83501 208-799-3176
4071	Mountain Lake Counseling	804 Airport Way, Suite A & K Sandpoint, ID 83864 208-597-3553
4098	Ada County Sherrif's Office	7200 W Barrister Boise, ID 83704 208-377-6790
4106	Kvitko-Simon, Val	11705 W Tioga Boise, ID 83709 208-362-2743
4124	SOS Transportation	543 3rd Street Idaho Falls, ID 83401 208-542-2333
4127	A to Z Family Services	1501 Bench, Suite B Pocatello, ID 83201 208-785-1326
4139	Treatment and Recovery Clinic	233 Gooding Street North Twin Falls, ID 83301 208-736-5048
4255	Ada County Drug Court	200 W. Front Street Boise, ID 83702 208-287-7670
4335	OATS Family Center	911 S Highway 30 Heyburn, ID 83336 208-679-2273
4374	New Journeys Inc.	496 A Street Idaho Falls, ID 86402 208-542-4511
4385	Valley Drug Testing	1020 Main Street Lewiston, ID 83501

	resumy	208-743-5232
4386	Wood, Robert M.	2202 S Fairway Drive Pocatello, ID 83201 208-220-0728
4429	Proverbs House	2725 N Duane Drive Meridian, ID 83646 208-884-0586
4492	Integrity Wellness Group	418 North River St Hailey, ID 83333 (208) 788-4330
4515	Eleos Recovery Support Services	5483 Kendall Street Boise, ID 83706 208-340-6650
4520	Rathdrum Counseing Center	14954 N Coeur Dalene St Rathdrum, ID 83858 208-687-0538
4521	Second Chances	1214 Logan Caldwell, ID 83605 208-577-8015
4575	Rising Sun Sober Living	5701 Cassia Street Boise, ID 83704 208-338-0861
4633	Pathways Case Management	197 N 4700 E Rigby, ID 8.442 208-538-7754
4695	Provenance Ministry	208-837-4600 Boise, ID 837404 208-287-8900
4722	Thomas-Mowery, Holly	3295 Falcon Drive Meridian, ID 83642 208-392-1285
DC0127	CRI Advantage Inc.	12754 W.Lasalle Boise, ID 83713 208-287-4161
DHW0	Substance Abuse Program	POB 83720/3rd Boise, ID 83720-0036 208-334-0679
IDPV-1-1	AJI Counseling, LLC	PO BOX 103 COEUR D ALENE, ID 83816 208-699-1450
IDPV-1-10	Wallace SD #393	PO BOX 2160 OSBURN, ID 83849 208-556-1556
IDPV-1-11	St. Vincent de Paul	1621 N. 3rd St, Ste 100 Coeur d'Alene, ID 83814 208-676-1515
	Coeur d' Alene	311 N 10TH ST

IDPV-1-2	School District #271	COEUR D ALENE, ID 83814 208-641-2872
IDPV-1-3	Goodwill Industries of the Inland NW	PO Box 359 Ponderay, ID 83852 208-265-1982
IDPV-1-4	Kellogg Middle School K.E.Y. Program	800 BUNKER AVE KELLOGG, ID 83837 208-784-1311
IDPV-1-5	Kellogg School District #391 Even Start Program	800 BUNKER AVE KELLOGG, ID 83837 208-512-3374
IDPV-1-6	Port of Hope	218 N 23RD ST COEUR D ALENE, ID 83814 208-664-3300
IDPV-1-7	Powder Basin Associates Ltd	7905 N MEADOWLARK WAY STE C COEUR D ALENE, ID 83815 208-762-3979
IDPV-1-8	Sandpoint Seventh-Day Adventist Church	PO Box 609 SANDPOINT, ID 83864 208-265-4049
IDPV-1-9	St. Maries School District #41	PO BOX 384 SAINT MARIES, ID 83861 208-245-2579
IDPV-2-1	Clearwater Youth Alliance	PO BOX 2124 OROFINO, ID 83544 208-476-5505
IDPV-2-2	Clearwater Substance Abuse Workgroup	BOX 1114 OROFINO, ID 83544 208-476-3190
IDPV-2-3	Mountain View School District #244	714 JEFFERSON ST GRANGEVILLE, ID 83530 208-983-1569
IDPV-2-4	Nez Perce Tribe - Community Care Team	PO BOX 365 LAPWAI, ID 83540 208-843-7303
IDPV-2-5	Nez Perce Tribe - Students for Success	PO BOX 365 Lapwai, ID 83540 208-843-7303
IDPV-2-6	Whitepine Joint School District #288	PO BOX 9 DEARY, ID 83823 208-877-1151
IDPV-2-7	Mountain View SD - REACH Club	PO Box 294 Elk City, ID 83525 208-842-2218
	Kamiah SD -	1102 Hill Street

IDPV-2-8	Community Coalition	Kamiah, ID 83536 208-935-4044
IDPV-3-1	Family Services Center LLC R3	704 ALBANY ST CALDWELL, ID 83605 208-454-5133
IDPV-3-2	Homedale School District #370	116 E OWYHEE AVE HOMEDALE, ID 83628 208-337-4611
IDPV-3-3	Hopkins Game Time Int'l. Inc. R3	PO BOX 872 NAMPA, ID 83653 208-442-7481
IDPV-3-4	Lutheran Community Services Northwest R3	2920 CASSIA ST BOISE, ID 83705 208-323-0996
IDPV-3-5	Parma School District #137	905 E MCCONNELL AVE PARMA, ID 83660 208-722-5115
IDPV-3-6	Vallivue School District #139	5207 S MONTANA AVE CALDWELL, ID 83605 208-468-4921
IDPV-3-7	Varner Counseling LLC R3	1111 S ORCHARD ST STE 156 BOISE, ID 83705 208-336-2308
IDPV-3-8	Council School District - Washington Adams Counties SA Coalition	PO Box 215 Midvale, ID 83645 208-566-4822
IDPV-3-9	Caldwell SD	1101 E. Cleveland Blvd Caldwell, ID 83605 208-455-3300
IDPV-4-1	Basin School District #72	PO BOX 227 IDAHO CITY, ID 83631 208-392-6710
IDPV-4-10	Lutheran Community Services Northwest R4	2920 CASSIA ST BOISE, ID 83705 208-323-0996
IDPV-4-11	Rocky Mountain Academy	875 E PLAZA DR STE 103 EAGLE, ID 83616 208-939-9937
IDPV-4-12	The Landing Foundation, Inc	4802 West Kootenai BOISE, ID 83705 208-336-2308
IDPV-4-13	Varner Counseling LLC	4802 West Kootenai BOISE, ID 83705

	R4	208-336-2308
IDPV-4-14	Women's and Children's Alliance	720 W WASHINGTON ST BOISE, ID 83702 208-343-3688
IDPV-4-15	Eagle Kids Academy	875 E Plaza Drive, Ste 103 Eagle, ID 83616 208-939-9937
IDPV-4-16	Family Service Center, R4	704 Albany Caldwell, ID 83605 208-454-5133
IDPV-4-17	Boise County - SFP	Valerie Delyea PO Box 486 Idaho City, ID 83631 208-571-2962
IDPV-4-18	Cascade SD	35 Atkin Lane Cascade, ID 83611 208-382-4406
IDPV-4-19	New Hope-Nueva Esperanza	2002 Blossom Place Meridian, ID 83646 208-703-2714
IDPV-4-2	Boise County Community Justice Coalition	PO BOX 486 IDAHO CITY, ID 83631 208-392-4431
IDPV-4-20	Valley County TND	550 Deinhard Lane McCall, ID 83638 208-634-5652
IDPV-4-3	Boise County TND+	PO BOX 486 IDAHO CITY, ID 83631 208-392-5899
IDPV-4-4	Boise Independent School District #1	8169 W VICTORY RD BOISE, ID 83709 208-854-4165
IDPV-4-5	Crossroads Mental Health Services	1010 N. Orchard St. Suite 2 Boise, ID 83706 208-368-0372
IDPV-4-6	DrugFree Idaho	PO Box 500 BOISE, ID 83071 208-570-6404
IDPV-4-7	Garden Valley School District	1053 Banks Lowman Hwy GARDEN VALLEY, ID 83622 208-462-3756
IDPV-4-8	Hopkins Game Time Int'l. Inc. R4	PO BOX 872 NAMPA, ID 83653 208-442-7481
IDPV-4-9	Horseshoe Bend School District #73	398 SCHOOL DR HORSESHOE BEND, ID 83629 208-793-2225

IDPV-5-1	5th Judicial District Drug Court	PO Box 126 Twin Falls, ID 83303 208-736-4122
IDPV-5-2	Blaine County School District #61	520 N 1ST AVE HAILEY, ID 83333 208-788-3091
IDPV-5-3	Boys and Girls Club of Magic Valley	999 FRONTIER RD TWIN FALLS, ID 83301 208-736-7011
IDPV-5-4	Lincoln County Coalition	111 W B ST STE C SHOSHONE, ID 83352 208-420-6883
IDPV-5-5	Minidoka County Strengthening Families Program	PO BOX 368 RUPERT, ID 83350 208-436-7156
IDPV-5-6	Twin Falls School District #411	301 MAIN AVE W TWIN FALLS, ID 83301 208-733-8456
IDPV-5-7	Walker Center	605 11TH AVE E GOODING, ID 83330 208-734-4200
IDPV-6-1	Alices House	291 N SHILLING AVE BLACKFOOT, ID 83221 208-785-9659
IDPV-6-10	Shoshone Bannock Tribes	PO Box 306 Fort Hall, ID 83203 208-478-3805
IDPV-6-2	Bannock Youth Foundation	PO BOX 246 POCATELLO, ID 83204 208-234-1122
IDPV-6-3	Bear Lake School Dist #33	PO BOX 300 PARIS, ID 83261 208-945-2891
IDPV-6-4	City of Montpelier Coalition	461 N 10TH ST MONTPELIER, ID 83254 208-847-8881
IDPV-6-5	Oneida School District #351	126 W 600 N MALAD, ID 83252 208-766-4470
IDPV-6-6	Still Waters Out Reach	755 W CENTER ST POCATELLO, ID 83204 208-232-4800
IDPV-6-7	Caribou Youth Coalition	159 South Main Soda Springs, ID 83276 208-547-1930
IDPV-6-8	Priestley Mental Health	PO Box 54 Franklin, ID 83237

	Health	435-512-8417
IDPV-7-1	5 County Detention and Youth Rehabilitation	PO BOX 55 SAINT ANTHONY, ID 83445 208-624-1345
IDPV-7-2	Family Support Services	630 N FRONT ST ARCO, ID 83213 208-527-8933
IDPV-7-3	Fremont County Joint School District #215	147 N 2ND W SAINT ANTHONY, ID 83445 208-624-3416
IDPV-7-4	Juvenile Help Options LLC	2553 SAINT CHARLES AVE IDAHO FALLS, ID 83404 208-589-6971
IDPV-7-5	Lemhi's After School Promise	PO BOX 24 SALMON, ID 83467 208-940-0409
IDPV-7-6	Salmon School District #291	401 S. Warpath SALMON, ID 83467 208-756-2415
IDPV-7-7	Teton River Health & Wellness Services	115 ELM AVE REXBURG, ID 83440 208-351-0304
IDPV-7-8	Upper Valley Resource and Counseling LLC	1223 S. Railroad Ave Sugar City, ID 83448 208-359-0519
IT0006	Port of Hope 508 E. Florida	8100 West Emerald Street Nampa, ID 83686 208-463-0118
IT0020	Walker Center - SSA 605 11th Avenue East	605 11th Avenue East Gooding, ID 83330 208-934-8461
IT0024	Road to Recovery, Inc. 600 East Oak Street	343 E. Bonneville Pocatello, ID 83201 208-233-2492
IT0034	Crossroads Mental Health Services 1010 North Orchard, S	1010 North Orchard, S Boise, ID 83704 208-368-0372
IT0036	Powder Basin Associates 7905 Meadowlark Way,	7905 Meadowlark Way Coeur D Alene , ID 83815 208-762-3979
IT0038	Powder Basin Associates 7167 First Room 200	7167 First Room 200 Bonners Ferry , ID 83805 208-267-8182

IT0041	Powder Basin Associates 105 Pine Street, Suit	105 Pine Street, Suit Sandpoint , ID 83864 208-255-2950
IT0042	Riverside Recovery 1720 18th Avenue	18th Avenue Lewiston , ID 83501 208-746-4097
IT0043	Riverside Recovery 155 "B" Main	155 "B" Main Orofino , ID 83544 208-476-9393
IT0047	Bannock Youth Foundation dba MK Place 735 North Main	735 North Main Pocatello , ID 83204 208-234-4722
IT0048	Addictions Rehabilitation Association 163 East Elva	163 East Elva Street Idaho Falls, ID 83402 208-522-6012
IT0051	The Club Inc/Recovery Now 2001 South Woodruff, Suite 6	1970 E. 17th St, #111 Idaho Falls, ID 83402 208-528-5900
IT0052	Upper Valley Resource & Counseling 36 North 2nd West	36 North 2nd West Rexburg , ID 83440 208-359-0519
IT0053	Daybreak SSA 628 South Cowley	628 S Cowley St Spokane, WA 99202 509-624-3227
IT0055	Ada County Juvenile Court Services 7180 Barrister	7180 Barrister Boise , ID 83704 208-287-5628
IT0056	Idaho Youth Ranch Harbor House	Harbor House 288 North Ridge Avenue Idaho Falls, ID 83402 208-529-6696
IT0062	Women and Children's Alliance 720 West Washington	720 W. Washington Boise, ID 83702 208-343-7025
IT0065	Weeks & Vietri 818 South Washington	818 South Washington Moscow, ID 83843 208-359-0519
IT0067	Safe Haven 372 S. W. 1st. Avenue	372 S. W. 1st. Avenue Ontario , OR 97914 541-881-1271
	Mountain States	

IT0069	Chemical Dependency 1305 2nd St. South, Suite 201	1305 2nd St. South, Suite 201 Nampa, ID 83651 208-709-6041
IT0071	Renewal Services of Idaho 708 Main St., Suite B	708 Main St Caldwell, ID 83605 208-455-8600
IT0472	Bell Chemical Dependency 2005 Kimball	2005 Kimball Caldwell , ID 83605 208-459-6557
IT0578	Jorge Padron 1050 Memorial Drive	1050 Memorial Dr. Idaho Falls, ID 83402 208-522-6925
IT0705	Road to Recovery, Inc. Region 4 FACS	Region 4 FACS 1720 Westgate Boise , ID 83702 208-334-0701
IT0747	Road to Recovery, Inc. Region 7 FACS	1970 E 17th St., #111 Idaho Falls , ID 83402 208-528-5900
IT0881	Counseling Center of Southeast Idaho 496 A St.	496 A St. Idaho Falls , ID 83402 208-552-7100
IT0961	Road to Recovery, Inc. Outpatient Services	490 N. Maple Blackfoot , ID 83221 208-785-6688
IT1911	Ascent Behavioral Healthcare 366 SW 5th Ave., St. 100	366 S.W. Fifth Avenue, STE 100 Meridian, ID 83642 208-898-9755
IT2119	Preston Counseling 140 S. State	140 S. State Preston , ID 83263 208-241-6970
IT2143	Solutions for Life 239 Idaho St.	239 Idaho Street American Falls, ID 83211 208-463-0202
IT2144	Pacific Rim Consulting, LLC 459 S. Arthur Ave.	459 S. Arthur Avenue Pocatello, ID 83204 208-232-8840
IT2151	Aspen Center Rehabilitation & Counseling	140 North 1st East Driggs , ID 83422 208-354-3601
IT2152	Benewah Medical Center 1115 B	POB 388 1115 B Street

IT2130	Center 1115 B Street	Plummer, ID 83751 208-686-9355
IT2202	Owyhee Community Health Owyhee Community Health	Owyhee Community Heal Shoshone-Paiute Tribes HWY 225 PO Box 130 Owyhee , ID 89832 775-757-2415
IT2225	Four Directions Treatment Center Four Directions Treat	Four Directions Treat Agency Rd. Fort Hall , ID 83203 208-478-3969
IT2281	Competency Development Center 2469 Wright Ave.	2469 Wright Ave. Twin Falls , ID 83301 208-736-5048
IT2411	Pro Active Advantage 2223 Overland	2223 Overland Burley, ID 83313 208-837-4600
IT2431	Empowerment Counseling 159 N. Idaho Street	159 N. Idaho Street Arco , ID 83213 208-527-3344
IT2442	Mental Wellness Centers 551 Highland Drive	551 Highland Drive Arco , ID 83213 208-542-1026
IT2559	Community Services Counseling 974 Corporate Ln., #102	963 S. Orchard Suite b Boise, ID 83705 208-336-6792
IT2735	Crossroads Mental Health Services 110 Rattlesnake Blvd.	110 Rattlesnake Blvd. Mountain Home , ID 83647 208-587-7206
IT2752	Sitman, Inc. 202 2nd Ave. N., Suit	202 2nd Ave. N., Suit Twin Falls , ID 83301 208-732-6112
IT2753	Sitman, Inc. 1100 North Lincoln	1100 North Lincoln Pocatello , ID 83301 208-732-6112
IT2756	Salmon Mental Health Clinic 111 Lillian, Suite 101	111 Lillian, Suite 101 Salmon, ID 83467 208-476-9393
IT2813	Lifestyle Changes Counseling 371 Locust St. South	371 South Locust Twin Falls, ID 83301 208-734-5230
IT2830	Behavioral Reform, Inc. 1150	1135 Yellowstone Ave. Pocatello , ID 83204

	N. Arthur Ave.	208-232-4669
IT3132	Family Recovery Center Foundation Inc 1420 E. 17th, Suite C	1420 East 17th Avenue Idaho Falls, ID 83404 208-535-0175
IT3151	Powder Basin Associates 210 E. Dalton Ave.	210 E. Dalton Ave. Coeur d'Alene , ID 83814 208-762-3979
IT3189	Integrity Therapeutic Services 34 S. Main St.	34 S. Main St. Payette , ID 83661 208-642-3552
IT3191	Integrity Therapeutic Services 36 E. Idaho St., # 1	36 E. Idaho St., # 1 Weiser , ID 83672 208-549-2163
IT3194	Preferred Child & Family Services 284 Martin St.	284 Martin St Twin Falls, ID 83301 208-733-7186
IT3195	Preferred Child & Family Services 1369 E. 16th St.	1369 E. 16th St. Burley , ID 83318 208-678-9114
IT3208	Road to Recovery, Inc. Boise Outpatient S	Outpatient Services 5460 Franklin Rd., Suite L Boise , ID 83705 208-384-4234
IT3224	The Club Inc/Recovery Now 804 S. Holmes	804 S. Holmes Idaho Falls , ID 83401 208-529-4673
IT3574	D7 Treatment Program 159 East Main	159 East Main Rexburg , ID 83440 208-705-6048
IT3575	D7 Treatment Program 445 N Capital Ave, St	445 N Capital Ave, St Idaho Falls , ID 83402 208-317-8346
IT3577	D7 Treatment Program 833 Shoup	833 Shoup Idaho Falls , ID 83402 208-206-0911
IT3620	Valley View Recovery 412 Hill St	412 Hill St Kamiah , ID 83536 208-935-0399
IT3634	Journey Counseling & Consulting 304 North State St.	304 North State St. Grangeville , ID 83530 208-983-1840

IT3650	ChangePoint 618 D. St., Suite C	618 D Street Suite C Lewiston, ID 83501 208-750-1000
IT3701	Powder Basin Associates 204 Oregon, Suite A	204 Oregon, Suite A Kellogg , ID 83837 208-783-0427
IT3786	Behavioral Reform, Inc. 310 N. Shilling Ave.	310 N. Shilling Ave. Blackfoot , ID 83221 208-782-0376
IT3888	Counseling Center of Southeast Idaho 382 Gladstone	382 Gladstone Idaho Falls , ID 83404 208-552-4684
IT3926	Alliance Family Services 1200 Ironwood Dr., Suite 101	1200 Ironwood Drive Suite 101 Coeur d'Alene, ID 83814 208-664-9729
IT4010	Positive Connections 647 Filer Ave.	647 Filer Ave. Twin Falls , ID 83301 208-737-9999
IT4033	New Hope Community Health 9460 W. Fairview Ave.	9460 W. Fairview Ave. Boise , ID 83704 208-672-9200
IT4045	Integrity Therapeutic Services 1818 S. 10th Ave, Sui	1818 S. 10th Ave, Sui Caldwell , ID 83605 208-459-4412
IT4065	D7 Treatment Program 250 F St.	250 F St. Idaho Falls , ID 83405 208-709-6041
IT4203	Road to Recovery, Inc. Discovery House 2	Discovery House 2 309 N. Garfield Pocatello , id 83205 208-269-0438
IT4210	Brannon & Brannon Psy. Services 534 Trejo Street Suite 100	534 Trejo - Suite 100 Rexburg, ID 83340 208-947-7277
IT4267	Family Services Center 317 Happy Day Blvd.	317 Happy Day Blvd. Caldwell , ID 83605 208-454-5133
IT4268	Behavioral Reform, Inc. 1135 Yellowstone Ave.	1135 Yellowstone Ave. Pocatello , ID 83201 208-238-9400

IT4280	Powder Basin Associates 709 Center Avenue	709 Center Avenue Saint Maries , ID 83861 208-245-9076
IT4287	Preston Counseling 164 S. Fifth St.	164 S. Fifth St. Montpelier , ID 83254 208-852-2407
IT4391	Unio Recovery Center 686 NW 9th St.	686 NW 9th St. Ontario , OR 97914 541-889-2490
IT4392	Safe Haven 2007 E. Chicago St.	2007 E. Chicago St. Idaho Falls , ID 83405 208-206-0911
IT4395	Empowerment Counseling 401 Main Street	401 Main Street Challis , ID 83226 208-527-3344
IT4398	Counseling Center of Southeast Idaho 440 N. Capital	440 N. Capital Idaho Falls , ID 83402 208-552-4684
IT4497	West Marriage & Family Counseling SITE-1102 Arthur St.	1102 Arthur St. Caldwell , ID 83605 208-454-8107
IT4504	Powder Basin Associates 1203 Michigan Suite A	1203 Michigan Suite A Sandpoint , ID 83864 208-255-2950
IT4628	Road to Recovery, Inc. Discovery House 2	1135 Yellowstone Ave. Pocatello , ID 83201 208-478-6150
IT4824	Foundations Services Group, Inc. 1648 N. Washington, S	1648 N. Washington, S Emmett , ID 83617 866-300-4023
IT4826	Foundations Services Group, Inc. 2007 Chicago	2007 Chicago Caldwell , ID 83605 208-454-9400
IT4999	Patriot Center, Madsen Alternative Therapeutic 330 W. Main St.	330 West Main Street Emmett, ID 83617 208-365-3642
IT5012	Diamonte Wellness Group 418 N. River St., Suite 21E	418 N. River St., Suite 21E Blaine , ID 83333 208-788-3440

IT5075	Emmett Family Services 2007 E. Quail Run Rd., #1	426 Hwy 16 Emmett, ID 83617 208-365-2525
IT5122	Business Psychology Associates 380 E. Parkcenter Blvd.	380 E. Parkcenter Blvd. Ste. 300 Boise , ID 83706 208-343-4080
IT5123	Restored Paths 109 E. Harrison	109 East Harrison Coeur d'Alene, ID 83815 208-664-9217
KC1638	Boise State University	1910 University Dr Boise, ID 83725 208-426-3471
KC1814	Benchmark	PO BOX 9088 Moscow, ID 83843 208-891-9582
U of I	University of Idaho	Room 206, 832 Ash Street Moscow, ID 83844-3043 208-885-7679

Form 9a (formerly Form 6a)

Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Elementary School Students [12]	Clearinghouse/information resources centers [ 1 ]	1
	materials sent home [ 9 ]	19
	Ongoing classroom and/or small group sessions [ 12 ]	24
	text label changes each time I load the form [ 27 ]	5
	community service projects [ 46 ]	8
Middle/Junior High School Students [13]	Clearinghouse/information resources centers [ 1 ]	1
	materials sent home [ 9 ]	18
	Ongoing classroom and/or small group sessions [ 12 ]	19
	text label changes each time I load the form [ 27 ]	1
	community service projects [ 46 ]	7
High School Students [14]	Clearinghouse/information resources centers [ 1 ]	1
	materials sent home [ 9 ]	13
	Ongoing classroom and/or small group sessions [ 12 ]	17
	text label changes each time I load the form [ 27 ]	6
	Student Assistance Programs [ 32 ]	5
General Population [15]	Clearinghouse/information resources centers [ 1 ]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	3
	Community team-building [ 44 ]	3

	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [ 52 ]	4
Parents/Families [16]	Clearinghouse/information resources centers [ 1 ]	1
	materials sent home [ 9 ]	14
	Parenting and family management [ 11 ]	16
	Student Assistance Programs [ 32 ]	4
	community service projects [ 46 ]	1
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [ 52 ]	1
Preschool Students [17]	Ongoing classroom and/or small group sessions [ 12 ]	3
Coalition leadership training [18]	Health fairs and other health promotion, e.g., conferences, meetings, seminars [ 7 ]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [ 41 ]	3
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [ 51 ]	1

This is 2009 data

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

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

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services	D.Median Cost of Services	E.Standard Deviation of Cost
<b>Detoxification (24-Hour Care)</b>					
Hospital Inpatient	0	0	\$ 0	\$ 0	\$ 0
Free-standing Residential	0	0	\$ 0	\$ 0	\$ 0
<b>Rehabilitation / Residential</b>					
Hospital Inpatient	0	0	\$ 0	\$ 0	\$ 0
Short-term (up to 30 days)	444	432	\$ 3249.15	\$ 4104	\$ 1509.12
Long-term (over 30 days)	306	296	\$ 10120.20	\$ 8280	\$ 4994.01
<b>Ambulatory (Outpatient)</b>					
Outpatient	4563	3807	\$ 786.53	\$ 495.36	\$ 876.99
Intensive Outpatient	3450	2745	\$ 1085.24	\$ 652.92	\$ 1191.01
Detoxification	179	169	\$ 526.93	\$ 480	\$ 259.52
<b>Opioid Replacement Therapy (ORT)</b>					
Opioid Replacement Therapy	0	0	\$ 0	\$ 0	\$ 0

Form 10b (formerly Form 7b)

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

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	1,081	693	294	15	7	0	0	5	0	27	19	0	0	15	6	689	305	253	78
2. 18-24	2,809	1,484	777	28	12	0	0	14	8	47	25	0	0	307	107	1,529	797	311	116
3. 25-44	6,137	3,006	2,000	52	24	0	0	15	13	130	113	0	0	536	248	3,127	2,066	517	271
4. 45-64	1,842	1,017	549	20	4	0	0	3	1	49	29	0	0	131	39	1,074	566	146	43
5. 65 and over	18	14	2	0	0	0	0	0	0	0	0	0	0	2	0	14	2	1	0
6. Total	11,887	6,214	3,622	115	47	0	0	37	22	253	186	0	0	991	400	6,433	3,736	1,228	508
7. Pregnant Women	290		237		2		0		1		9		0	41			243		42

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.

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

## 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)).

No changes were made in 2009.

## SSA (MOE TABLE I)

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

PERIOD	EXPENDITURES	B1(2007) + B2(2008)
(A)	(B)	----- 2 (C)
SFY 2009 (1)	<b>\$19,959,970</b>	<b>\$19,164,635</b>
SFY 2010 (2)	<b>\$18,369,300</b>	
SFY 2011 (3)	\$ 19,067,300	

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

FY 2009  Yes  No

FY 2010  Yes  No

FY 2011  Yes  No

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

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

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

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

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

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

Yes  No

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

**TB (MOE TABLE II)**

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

**(BASE TABLE)**

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)	Average of Columns C1 and C2 C1 + C2 ----- 2 (D)
SFY 1991 (1)	<b>\$ 26,773</b>	<b>3.51 %</b>	<b>\$ 940</b>	<b>\$ 941</b>
SFY 1992 (2)	<b>\$ 23,012</b>	<b>4.09 %</b>	<b>\$ 941</b>	

**(MAINTENANCE TABLE)**

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)
SFY 2011 (3)	<b>\$ 98,525</b>	<b>0 %</b>	<b>\$ 0</b>

Idaho is submitting a request for a waiver for this MOE.

**HIV (MOE TABLE III)**

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

**(BASE TABLE)**

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 ----- 2 (B)
SFY 1998 (1)	\$	\$
SFY 1999 (2)	\$	

**(MAINTENANCE TABLE)**

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

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

Idaho is not a designated state.

## Womens (MOE TABLE IV)

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

#### (MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	<b>\$634,045</b>	
2009		<b>\$875,896</b>
2010		<b>\$877,312</b>
2011		\$ 2,786,886

Enter the amount the State plans to expend in FY 2012 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$ 700,000

**Form T1**Form T1 was pre-populated with the following Data Source: Discharges in CY 2010**EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)**

<b>Short-term Residential(SR)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	<b>13</b>	<b>8</b>
Total number of clients with non-missing values on employment\student status [denominator]	<b>36</b>	<b>36</b>
Percent of clients employed (full-time and part-time) or student	<b>36.1%</b>	<b>22.2%</b>

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>82</b>
Number of CY 2010 discharges submitted:	<b>46</b>
Number of CY 2010 discharges linked to an admission:	<b>41</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	<b>36</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>36</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	<b>0</b>	<b>0</b>
Total number of clients with non-missing values on employment\student status [denominator]	<b>1</b>	<b>1</b>
Percent of clients employed (full-time and part-time) or student	<b>0.0%</b>	<b>0.0%</b>

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>0</b>
Number of CY 2010 discharges submitted:	<b>1</b>
Number of CY 2010 discharges linked to an admission:	<b>1</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	<b>1</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>1</b>

Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file  
 [Records received through 12/7/2011]

<b>Intensive Outpatient (IO)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	<b>168</b>	<b>214</b>
Total number of clients with non-missing values on employment\student status [denominator]	<b>445</b>	<b>445</b>
Percent of clients employed (full-time and part-time) or student	<b>37.8%</b>	<b>48.1%</b>

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>1,027</b>
Number of CY 2010 discharges submitted:	<b>550</b>
Number of CY 2010 discharges linked to an admission:	<b>514</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	<b>446</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>445</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b> <b>[Records received through 12/7/2011]</b>	

<b>Outpatient (OP)</b>		
<b>Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients employed (full-time and part-time) or student [numerator]	<b>210</b>	<b>258</b>
Total number of clients with non-missing values on employment\student status [denominator]	<b>443</b>	<b>443</b>
Percent of clients employed (full-time and part-time) or student	<b>47.4%</b>	<b>58.2%</b>

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>1,059</b>
Number of CY 2010 discharges submitted:	<b>526</b>
Number of CY 2010 discharges linked to an admission:	<b>505</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	<b>444</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>443</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b>	

[Records received through 12/7/2011]

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**Form T2**Form T2 was pre-populated with the following Data Source: Discharges in CY 2010**STABLE HOUSING SITUATION (From Admission to Discharge)**

<b>Short-term Residential(SR)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	31	33
Total number of clients with non-missing values on living arrangements [denominator]	36	36
Percent of clients with stable housing	86.1%	91.7%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	82
Number of CY 2010 discharges submitted:	46
Number of CY 2010 discharges linked to an admission:	41
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	36
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	36
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	1	1
Total number of clients with non-missing values on living arrangements [denominator]	1	1
Percent of clients with stable housing	100.0%	100.0%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	0
Number of CY 2010 discharges submitted:	1
Number of CY 2010 discharges linked to an admission:	1
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	1

Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file  
 [Records received through 5/4/2011]

<b>Intensive Outpatient (IO)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	409	434
Total number of clients with non-missing values on living arrangements [denominator]	443	443
Percent of clients with stable housing	92.3%	98.0%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	1,027
Number of CY 2010 discharges submitted:	550
Number of CY 2010 discharges linked to an admission:	514
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	446
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	443
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b> <b>[Records received through 5/4/2011]</b>	

<b>Outpatient (OP)</b>		
<b>Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with stable housing [numerator]	428	426
Total number of clients with non-missing values on living arrangements [denominator]	440	440
Percent of clients with stable housing	97.3%	96.8%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	1,059
Number of CY 2010 discharges submitted:	526
Number of CY 2010 discharges linked to an admission:	505
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	444
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	440
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b>	

[Records received through 5/4/2011]

**Form T3**

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

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

<b>Short-term Residential(SR)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	21	38
Total number of clients with non-missing values on arrests [denominator]	39	39
Percent of clients with no arrests	53.8%	97.4%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	82
Number of CY 2010 discharges submitted:	46
Number of CY 2010 discharges linked to an admission:	41
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	39
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	39
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	1	1
Total number of clients with non-missing values on arrests [denominator]	1	1
Percent of clients with no arrests	100.0%	100.0%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	0
Number of CY 2010 discharges submitted:	1
Number of CY 2010 discharges linked to an admission:	1
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	1

Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	1
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	414	439
Total number of clients with non-missing values on arrests [denominator]	501	501
Percent of clients with no arrests	82.6%	87.6%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	1,027
Number of CY 2010 discharges submitted:	550
Number of CY 2010 discharges linked to an admission:	514
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	501
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	501
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Outpatient (OP)</b>		
<b>Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients with no arrests [numerator]	447	453
Total number of clients with non-missing values on arrests [denominator]	498	498
Percent of clients with no arrests	89.8%	91.0%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	1,059
Number of CY 2010 discharges submitted:	526
Number of CY 2010 discharges linked to an admission:	505
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	498
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	498

Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file  
[Records received through 12/7/2011]

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

<b>Short-term Residential(SR)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	25	33
All clients with non-missing values on at least one substance/frequency of use [denominator]	39	39
Percent of clients abstinent from alcohol	64.1%	84.6%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		11
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	14	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		78.6%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		22
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	25	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		88.0%

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

Number of CY 2010 admissions submitted:	82
Number of CY 2010 discharges submitted:	46
Number of CY 2010 discharges linked to an admission:	41
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	39
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	39
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b>	
<b>[Records received through 12/7/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
Denominator = All clients		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	0	1
All clients with non-missing values on at least one substance/frequency of use [denominator]	1	1
Percent of clients abstinent from alcohol	0.0%	100.0%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
Denominator = Clients using at admission		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		100.0%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
Denominator = Clients abstinent at admission		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		0
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	

Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>0</b>
Number of CY 2010 discharges submitted:	<b>1</b>
Number of CY 2010 discharges linked to an admission:	<b>1</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>1</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>1</b>
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Alcohol Abstinance – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	321	443
All clients with non-missing values on at least one substance/frequency of use [denominator]	500	500
Percent of clients abstinent from alcohol	64.2%	88.6%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]	[REDACTED]	147
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	179	[REDACTED]
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]	[REDACTED]	82.1%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>

Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		296
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	321	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.2%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	1,027
Number of CY 2010 discharges submitted:	550
Number of CY 2010 discharges linked to an admission:	514
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	501
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	500
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Outpatient (OP)</b>		
<b>A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
Denominator = All clients		
<b>Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge (T<sub>2</sub>)</b>
Number of clients abstinent from alcohol [numerator]	390	460
All clients with non-missing values on at least one substance/frequency of use [denominator]	497	497
Percent of clients abstinent from alcohol	78.5%	92.6%
<b>B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION</b>		
Denominator = Clients using at admission		
<b>Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge (T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		93
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	107	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		86.9%
<b>C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION</b>		

<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		<b>367</b>
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	<b>390</b>	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		<b>94.1%</b>

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>1,059</b>
Number of CY 2010 discharges submitted:	<b>526</b>
Number of CY 2010 discharges linked to an admission:	<b>505</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>498</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>497</b>
<b>Source: SAMHS/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

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

<b>Short-term Residential(SR)</b>		
<b>A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs [numerator]	15	31
All clients with non-missing values on at least one substance/frequency of use [denominator]	39	39
Percent of clients abstinent from drugs	38.5%	79.5%
<b>B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		17
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	24	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		70.8%
<b>C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		14
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	15	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		93.3%

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>82</b>
Number of CY 2010 discharges submitted:	<b>46</b>
Number of CY 2010 discharges linked to an admission:	<b>41</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>39</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>39</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

<b>Long-term Residential(LR)</b>		
<b>A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs [numerator]	0	1
All clients with non-missing values on at least one substance/frequency of use [denominator]	1	1
Percent of clients abstinent from drugs	0.0%	100.0%
<b>B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		100.0%
<b>C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION</b>		
<b>Denominator = Clients abstinent at admission</b>		
<b>Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		0

Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	0	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

<b>Notes (for this level of care):</b>		
Number of CY 2010 admissions submitted:		0
Number of CY 2010 discharges submitted:		1
Number of CY 2010 discharges linked to an admission:		1
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):		1
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):		1
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>		

<b>Intensive Outpatient (IO)</b>		
<b>A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)</b>		
<b>Denominator = All clients</b>		
<b>Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs [numerator]	270	416
All clients with non-missing values on at least one substance/frequency of use [denominator]	500	500
Percent of clients abstinent from drugs	54.0%	83.2%
<b>B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION</b>		
<b>Denominator = Clients using at admission</b>		
<b>Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		168
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	230	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		73.0%
<b>C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION</b>		

**Denominator = Clients abstinent at admission**

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		248
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	270	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T <sub>2</sub> / #T <sub>1</sub> x 100]		91.9%

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

Number of CY 2010 admissions submitted:	1,027
Number of CY 2010 discharges submitted:	550
Number of CY 2010 discharges linked to an admission:	514
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	501
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	500
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]</b>	

**Outpatient (OP)****A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)****Denominator = All clients**

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs [numerator]	359	440
All clients with non-missing values on at least one substance/frequency of use [denominator]	497	497
Percent of clients abstinent from drugs	72.2%	88.5%

**B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION****Denominator = Clients using at admission**

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		102

Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	138	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		73.9%

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

**Denominator = Clients abstinent at admission**

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T <sub>1</sub> )	At Discharge(T <sub>2</sub> )
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		338
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator])	359	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		94.2%

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

Number of CY 2010 admissions submitted:	1,059
Number of CY 2010 discharges submitted:	526
Number of CY 2010 discharges linked to an admission:	505
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	498
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	497
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file</b>	
<b>[Records received through 12/7/2011]</b>	

**Form T6**

Form T6 was pre-populated with the following Data Source: Discharges in CY 2010

### SOCIAL SUPPORT OF RECOVERY - SELF-HELP ATTENDANCE (From Admission to Discharge)

<b>Short-term Residential(SR)</b>		
<b>Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients attending self-help programs [numerator]	0	0
Number of clients attending self-help programs [numerator]	0	0
Percent of clients attending self-help programs		
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]		
<b>Notes (for this level of care):</b>		
Number of CY 2010 admissions submitted:		82
Number of CY 2010 discharges submitted:		46
Number of CY 2010 discharges linked to an admission:		41
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):		39
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):		0
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>		

<b>Long-term Residential(LR)</b>		
<b>Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients attending self-help programs [numerator]	0	0
Number of clients attending self-help programs [numerator]	0	0
Percent of clients attending self-help programs		
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]		
<b>Notes (for this level of care):</b>		
Number of CY 2010 admissions submitted:		0
Number of CY 2010 discharges submitted:		1
Number of CY 2010 discharges linked to an admission:		1
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):		1

Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>0</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>	

<b>Intensive Outpatient (IO)</b>		
<b>Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients attending self-help programs [numerator]	<b>0</b>	<b>0</b>
Number of clients attending self-help programs [numerator]	<b>0</b>	<b>0</b>
Percent of clients attending self-help programs		
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]		

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>1,027</b>
Number of CY 2010 discharges submitted:	<b>550</b>
Number of CY 2010 discharges linked to an admission:	<b>514</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>501</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>0</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>	

<b>Outpatient (OP)</b>		
<b>Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge</b>	<b>At Admission (T<sub>1</sub>)</b>	<b>At Discharge(T<sub>2</sub>)</b>
Number of clients attending self-help programs [numerator]	<b>0</b>	<b>0</b>
Number of clients attending self-help programs [numerator]	<b>0</b>	<b>0</b>
Percent of clients attending self-help programs		
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T <sub>2</sub> -%T <sub>1</sub> ]		

<b>Notes (for this level of care):</b>	
Number of CY 2010 admissions submitted:	<b>1,059</b>
Number of CY 2010 discharges submitted:	<b>526</b>
Number of CY 2010 discharges linked to an admission:	<b>505</b>
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	<b>498</b>
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	<b>0</b>
<b>Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 2/7/2012]</b>	

**Form T7**

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

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

Level of Care	Length of Stay (in Days)			
	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
<b>Detoxification (24-Hour Care)</b>				
1. Hospital Inpatient				
2. Free-standing Residential	172	2	12	355
<b>Rehabilitation / Residential</b>				
3. Hospital Inpatient				
4. Short-term (up to 30 days)	167	15	57	234
5. Long-term (over 30 days)	191	191	191	191
<b>Ambulatory (Outpatient)</b>				
6. Outpatient	200	52	176	308
7. Intensive Outpatient	205	36	135	330
8. Detoxification				
<b>Opioid Replacement Therapy (ORT)</b>				
9. Opioid Replacement therapy	1	1	1	1
10. ORT Outpatient	109	15	110	139

<b>Notes:</b>		
Level of Care	2010 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Total count, all levels of care	1,152	1,088
1. Hospital Inpatient-Detoxification (24-Hour Care)		
2. Free-standing Residential-Detoxification (24-Hour Care)	29	26
3. Hospital Inpatient-Rehabilitation / Residential		
4. Short-term (up to 30 days)-Rehabilitation / Residential	46	41
5. Long-term (over 30 days)-Rehabilitation / Residential	1	1

6. Outpatient-Ambulatory (Outpatient)	526	499
7. Intensive Outpatient-Ambulatory (Outpatient)	550	514
8. Detoxification-Ambulatory (Outpatient)		
9. Opioid Replacement therapy-Opioid Replacement Therapy (ORT)		1
10. ORT Outpatient-Opioid Replacement Therapy (ORT)		6

Source: **SAMHSA/CBHSQ TEDS CY 2010 linked discharge file**  
[Records received through 12/07/2011 ]

**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?*

**Single State Authority capacity and capability to make data driven decisions and potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.**

The Department's treatment Master Services Contractor was responsible for the collection of data on all clients from the initial screening through discharge. The collection of the data enables the Department to respond to all data sets within the Treatment Episode Data Set (TEDS) and the Block Grant annual report including NOMs. The Master Services Contractor also provides all the data that the Department and the Interagency Committee on Substance Abuse Prevention and Treatment for reporting to the Governor and the Legislature. They also used report to make decisions about priority populations, budget allocations and unmet needs. There are currently two data systems used by the Department to create reports. They are the treatment Master Services Contractor's healthcare information system and the Department's Web Infrastructure Treatment System electronic healthcare record. Using secure data transmission protocols to a secure file server within the Department's network the data from both sources are transferred. This enables the Department to meet all HIPAA, 42 CFR, as well as all state and local electronic health care records requirements. After the transmission is completed, the source data is extracted, scrubbed/transformed and loaded into the Department's data warehouse. This enabled the Department to use data from both source to analyze and report on treatment services.

**Types of regular/ad hoc reports generated by the State and who they are distributed and how.**

Both the Department and the treatment Master Services Contractor collect and share data to enable them to draft standard reports. The Reports are provided to Interagency Committee members as well as other state agencies and branches of government as well as to others who request the information. The table on the following page outlines the standard reports, the entity requiring the report and the name of each report

<b>Report Type</b>	<b>Report Name</b>
Block Grant	<ol style="list-style-type: none"> <li>1. Level of Care Capacity and Census Management</li> <li>2. Budget Tracker</li> <li>3. MSC Performance Dashboard</li> <li>4. State Utilization Management &amp; Grant Data</li> <li>5. Treatment Completion Data</li> <li>6. Length of Stay Report</li> <li>7. Provider Performance Report</li> <li>8. County/Regional Utilization Report</li> <li>9. PWWC Chart Audit Results</li> </ol>
Interagency Committee	<ol style="list-style-type: none"> <li>1. Dashboard</li> <li>2. Sentinel Report</li> <li>3. Clinical Supervision</li> </ol>
Drug Court	<ol style="list-style-type: none"> <li>1. Drug Court Length of Stay Report</li> <li>2. Discharge by provider Report</li> <li>3. 19-2524/20-520(i) Report by County</li> </ol>
Department Management	Treatment Outcomes Report
Department Continuous Quality Improvement	<ol style="list-style-type: none"> <li>1. Complaint and Appeal Resolutions</li> <li>2. Regional Coordinator Report</li> <li>3. Client, Provider &amp; Stakeholder Satisfaction</li> </ol>

***State benchmarks, performance targets or quantified objectives, and methods are used by the State in setting these values.***

The Department and the Interagency Committee draft and create and implement benchmarks, targets and objectives for treatment service as needed. The Department's treatment Master Services Contractor is responsible for the management of Idaho's substance use treatment provider network and as a part of that is required to maintain a provider performance evaluation system which requires them and their network of providers to meet specific targets. The treatment Master Services Contractor is responsible for the collection of data on all treatment clients from screening to discharge. All treatment performance data is reviewed with the Department during quarterly contract monitoring visits. This data is also used by the state Interagency Committee on Substance Abuse Prevention and Treatment to evaluate services delivered and set financial and operational performance criteria. The Interagency Committee meets quarterly to review and evaluate the data.

***Actions the State took as a result of analyzing performance management data***

Department staff meet with treatment Master Services Contractor staff regularly to make adjustments to the treatment service system based on the reports listed above. Quarterly contract monitoring site visits evaluate compliance with contract requirements. When the Department staff identify requirements that were not met, sanctions are imposed.

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

The SSA does not have a regular training program.

***Workforce development plans address NOMs implementation/performance-based management practices***

Idaho's workforce development plans do not address NOMs.

***State required providers to supply information about the intensity or number of services received***

Idaho does require providers to supply information about intensity and numbers of services received.

Treatment Performance Measures (Overall Narrative): In reviewing the Treatment Performance Measures, it appears as though the number of clients serviced in all categories significantly declined from FY 2009 to FY 2010. Please discuss how the factors contributing to this decline and how services were adjusted to address this issue. This revision is due by 2/14/12.

The number of individuals receiving treatment in 2010 was less than the number of treatment clients in 2009 for two reasons. The primary reason was that the length of a client's stay in treatment was increased from an average of 184 days in 2009 to an average of 271 days in 2010. This increase in length of stay was due to an initiative by the Department to increase the completion rate of clients in the public substance abuse treatment system. While the total number of clients receiving treatment was reduced, the percentage of clients successfully completing treatment rose from 33% in 2009 to 43% in 2010. The length of treatment, extended by 87 days, reduced access to treatment services, but resulted in better outcomes for those who did receive services. The second reason for the reduction was a concerted effort to remain within the appropriated treatment budget. In previous fiscal years, the treatment budget was overspent which caused a reduction in available funds for the following year. In 2010, a concerted effort was made to ensure treatment services expenditures stayed within the budgeted amount. To that end, near the conclusion of FY 2010, access to services was severely limited due to exhaustion of the budget. It was the combination of these two circumstances that resulted in a reduced number of treatment clients in 2010.

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

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

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

**Form P1**

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

**Measure: 30-Day Use**

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	<b>Source Survey Item:</b> NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] <b>Outcome Reported:</b> Percent who reported having used alcohol during the past 30 days.	Ages 18+ - CY 2009	43.50
		Ages 12–17 - CY 2009	11.60
2. 30-day Cigarette Use	<b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] <b>Outcome Reported:</b> Percent who reported having smoked a cigarette during the past 30 days.	Ages 12–17 - CY 2009	8.50
		Ages 18+ - CY 2009	22.30
3. 30-day Use of Other Tobacco Products	<b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] <b>Outcome Reported:</b> Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 18+ - CY 2009	8.20
		Ages 12–17 - CY 2009	3.90
4. 30-day Use of Marijuana	<b>Source Survey Item:</b> NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] <b>Outcome Reported:</b> Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - CY 2009	6.90
		Ages 18+ - CY 2009	5.40
5. 30-day Use of Illegal Drugs Other Than Marijuana	<b>Source Survey Item:</b> NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" <b>Outcome Reported:</b> Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - CY 2009	5.30
		Ages 18+ - CY 2009	3.50

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

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

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

**Form P2**

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

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

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data	
1. Perception of Risk From Alcohol	<b>Source Survey Item:</b> NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] <b>Outcome Reported:</b> Percent reporting moderate or great risk.	Ages 18+ - CY 2009	84.20	
		Ages 12–17 - CY 2009	79.20	
2. Perception of Risk From Cigarettes	<b>Source Survey Item:</b> NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] <b>Outcome Reported:</b> Percent reporting moderate or great risk.	Ages 12–17 - CY 2009	95.10	
		Ages 18+ - CY 2009	94.90	
3. Perception of Risk From Marijuana	<b>Source Survey Item:</b> NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] <b>Outcome Reported:</b> Percent reporting moderate or great risk.	Ages 18+ - CY 2009	77.70	
		Ages 12–17 - CY 2009	85.90	

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

**Form P3**

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

**Measure: Age of First Use**

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	<b>Source Survey Item:</b> NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of alcohol.	Ages 12–17 - CY 2009 13.10	
		Ages 18+ - CY 2009 16.60	
2. Age at First Use of Cigarettes	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of cigarettes.	Ages 18+ - CY 2009 15.40	
		Ages 12–17 - CY 2009 12.10	
3. Age at First Use of Tobacco Products Other Than Cigarettes	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of tobacco products other than cigarettes.	Ages 18+ - CY 2009 18.70	
		Ages 12–17 - CY 2009 13.50	
4. Age at First Use of Marijuana or Hashish	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of marijuana or hashish.	Ages 12–17 - CY 2009 13.90	
		Ages 18+ - CY 2009 17.50	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	<b>Source Survey Item:</b> NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] <b>Outcome Reported:</b> Average age at first use of other illegal drugs.	Ages 18+ - CY 2009 19.10	
		Ages 12–17 - CY 2009 12.60	

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

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

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

**Form P4**

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

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 93.10	
2. Perception of Peer Disapproval of Cigarettes	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent reporting that their friends would somewhat or strongly disapprove.</p>	Ages 12–17 - CY 2009 92.60	
3. Disapproval of Using Marijuana Experimentally	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age trying marijuana or hashish once or twice?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 85.90	
4. Disapproval of Using Marijuana Regularly	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age using marijuana once a month or more?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 87.20	
5. Disapproval of Alcohol	<p><b>Source Survey Item:</b> NSDUH Questionnaire: “How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]  <b>Outcome Reported:</b> Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2009 89.40	

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

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

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference]</p> <p><b>Outcome Reported:</b> Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>	Ages 18+ - CY 2009 40.90	
		Ages 15-17 - CY 2009 28.30	

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

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

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	<p><b>Source:</b>National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at <a href="http://nces.ed.gov/ccd/stfis.asp">http://nces.ed.gov/ccd/stfis.asp</a></p> <p><b>Measure calculation:</b> Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>	CY 2009	94	

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

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

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	<p><b>Source:</b> National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p><b>Measure calculation:</b> The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>	CY 2009	40.10	

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

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

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	<b>Source:</b> Federal Bureau of Investigation Uniform Crime Reports <b>Measure calculation:</b> The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	CY 2009	111.10	

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

**Form P10**

**NOMs Domain: Social Connectedness**

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

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No]</p> <p><b>Outcome Reported:</b> Percent reporting having talked with a parent.</p>	Ages 12-17 - CY 2009	63.80
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12- 17)	<p><b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times]</p> <p><b>Outcome Reported:</b> Percent of parents reporting that they have talked to their child.</p>	Ages 18+ - CY 2009	93.40

((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><b>Source Survey Item:</b> NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?"</p> <p><b>Outcome Reported:</b> Percent reporting having been exposed to prevention message.</p>	Ages 12–17 - CY 2009 92.60	

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

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

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

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

<b>Forms</b>	<b>A. Reporting Period Start Date</b>	<b>B. Reporting Period End Date</b>
Form P12a Individual-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2009	6/30/2010
Form P12b Population-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2009	6/30/2010
Form P13 (Optional) Number of Persons Served by Type of Intervention	7/1/2009	6/30/2010
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	7/1/2009	6/30/2010
Form P15 FY 2009 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	7/1/2009	6/30/2010

## Form P12a

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

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

Idaho collects the NOMs Access/Capacity data through a proprietary data system, [www.PreventionIdaho.Net](http://www.PreventionIdaho.Net), designed to CSAP/ORC Macro MDS 3.4b. The numbers on Form P12A represent participants in cohort-based, recurring prevention curricula.

**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.

Idaho's prevention data collection system, [www.PreventionIdaho.Net](http://www.PreventionIdaho.Net), was designed to the CSAP/ORC Macro MDS 3.4b specification. Following that specification, each participant indicates their primary racial category using the categories below. In accordance with the MDS 3.4b spec, Idaho's Multi-Racial category and Other category are distinct groups and are not duplicated in the other racial categories. Idaho's Hispanic Ethnicity data were captured independently of Race.

Category	Description	Total Served
A. Age	1. 0-4	177
	2. 5-11	6368
	3. 12-14	6231
	4. 15-17	2719
	5. 18-20	537
	6. 21-24	31
	7. 25-44	504
	8. 45-64	243
	9. 65 And Over	20
	10. Age Not Known	0
B. Gender	Male	8698
	Female	8132
	Gender Unknown	0
C. Race	White	13432
	Black or African American	162
	Native Hawaiian/Other Pacific Islander	46
	Asian	92
	American indian/Alaska Native	330
	More Than One Race (not OMB required)	177
	Race Not Known or Other (not OMB required)	2591
D. Ethnicity	Hispanic or Latino	2711
	Not Hispanic or Latino	14119
	Ethnicity Unknown	0

**Form 12b**

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

Category	Description	Total Served
A. Age	1. 0-4	25094
	2. 5-11	34816
	3. 12-14	14261
	4. 15-17	14250
	5. 18-20	14098
	6. 21-24	17723
	7.25-44	82548
	8. 45-64	80132
	9. 65 And Over	40116
	10. Age Not Known	0
B. Gender	Male	161835
	Female	161203
	Gender Unknown	0
C. Race	White	276934
	Black or African American	1819
	Native Hawaiian/Other Pacific Islander	368
	Asian	3373
	American indian/Alaska Native	3698
	More Than One Race (not OMB required)	7345
	Race Not Known or Other (not OMB required)	29502
D. Ethnicity	Hispanic or Latino	36180
	Not Hispanic or Latino	286858
	Ethnicity Unknown	0

Following the calculation method recommended by Idaho's CSAP contract officer Alan Ward, the total number of people exposed to universal indirect were proportioned using the best possible census data. For Idaho, that is the 2010 US Census estimates.

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

**Form P14**

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

**NOMs Domain: Retention**

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

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

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

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

1. Describe the process the State will use to implement the guidelines included in the above definition. In 2010, the State of Idaho used the NREPP list of proven substance abuse prevention programs as the sole guidance for funding. However, not all SAP programs listed on NREPP were considered for funding, primarily due to delivery costs. A number of the family interventions, for example, can easily cost tens of thousands per family. Idaho announces in its funding application that funding priority will be given to evidence-based programs (EBPs). All applicants respond with NREPP-based programs, hence Idaho has funded nearly 100% EBPs since 2007.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Idaho uses a proprietary MIS, PreventionIdaho.Net, designed to ORC Macro specs 4.2b. Under that system, funded EBPs can be selected and there is an 'Other' category for non-EBPs. For 2010, there were 6 universal, non-EBPs offerings in addition to 669 EBPs.

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

	<b>A. Universal Direct</b>	<b>B. Universal Indirect</b>	<b>C. Universal Total</b>	<b>D. Selected</b>	<b>E. Indicated</b>	<b>F. Total</b>
1. Number of Evidence-Based Programs and Strategies Funded	669	78	747	179	0	926
2. Total number of Programs and Strategies Funded	675	111	786	179	0	965
3. Percent of Evidence-Based Programs and Strategies	99.11%	70.27%	95.04%	100.00%	NaN	95.96%

PreventionIdaho.Net assigns intervention types based on the program developers' specifications as listed on NREPP but does not force the selection of a single intervention type. Many evidence-based programs list more than one intervention type (IOM category). For example, the widely used Positive Action program lists itself as appropriate for use as a Universal, Selective and Indicated program. The problem of assigning a single intervention type to a program is compounded by many delivery scenarios where multiple populations are served. An after school program, for example, is generally available to all students (Universal), some students come or are referred for academic assistance (Selected) and some are present due to multiple risk factors including academic failure, fighting, and other disciplinary reasons (Indicated).

On Form P14, there were no instructions on how to handle a program with multiple intervention types. To avoid over- or under-representing Idaho's evidence-based programs and strategies by type of intervention, the following method was used to reduce programs with multiple intervention types to single categories.

- 1) Programs that listed Universal alone or in combination with other factors were counted as Universal for Form P14.
- 2) Of the remaining programs, programs that listed Selected alone or in combination with Indicated were counted as Selected for Form P14.
- 3) Of the remaining programs, programs that listed Indicated alone were counted as Indicated for Form P14.

The following shows the various combinations of intervention types that were used to report on Form P14.

Of 854 programs direct service programs:

675 werelisted as Universal  
U 515  
U-S 25  
U-S-I 135

Of the remaining 179 programs, program listed as Selected but not Universal  
S 51  
S-I 128

There were no programs in 2010 listed solely as Indicated.

Grand total = 854.

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

IOM Categories	FY 2009 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2009 Total SAPT Block Grant \$Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	669	\$ 971447
2. Universal Indirect	71	\$ 16290
3. Selective	179	\$ 317975
4. Indicated	0	\$ 0
5. Totals	919	\$1,305,712.00

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

Please see footnote for Form P14 for calculation method.

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

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

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

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

**Prevention Attachment D**

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

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

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

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

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

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

### **Description of Supplemental Data**

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

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

## Attachment A, Goal 2: Prevention

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

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

Yes  No  Unknown

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

Yes  No  Unknown

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

SAPT  
Block  
Grant

Yes  
 No  
 Unknown

Other  
State  
Funds

Yes  
 No  
 Unknown

Drug Free  
Schools

Yes  
 No  
 Unknown

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

Yes  No  Unknown

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

Education Bureau?  Yes  No  Unknown

Dissemination of materials?  Yes  No  Unknown

Media campaigns?  Yes  No  Unknown

Product pricing strategies?  Yes  No  Unknown

Policy to limit access?  Yes  No  Unknown

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

Yes  No  Unknown

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

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

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

Yes  No  Unknown

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

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

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

Motor vehicle drivers age 21 and older? 0.08

Motor vehicle drivers under age 21? 1.02

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

Communities: 27

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

Yes  No  Unknown

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

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

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

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